Where Have All the Midwives Gone?

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ABSTRACT

In past centuries, only women attended women in childbirth. Birthing women were in control, choosing who should attend them and where and how to give birth. Men were usually excluded unless they were needed for their strength and their tools if labor was obstructed. Eventually, with the medicalization of childbirth, male physicians became involved, introducing new techniques that interfered with the normal birth process and competed with midwives. By the 19th century, midwives struggled to hold onto their profession and advance through education. Midwives survived in Europe, but in America, they were eventually usurped in the early 20th century when birth began taking place in hospitals and as medical science and technology advanced. Midwives eventually rose again as educated nurse-midwives. Technology and obstetric interventions in normal childbirth continue, in spite of lack of evidence of their efficacy. Midwives are again in jeopardy because of rising malpractice insurance costs, women's trust in technology, and, most recently, renewed efforts by physicians to once again prevent midwives from practicing autonomously and outside the hospital environment in the United States.

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READER'S QUESTION

When I taught childbirth classes, I typically asked women during the first session, “What is your biggest concern or fear about labor and birth?” The magic word for the majority of answers was “pain.” But when we discussed it further, class participants often mentioned fear of the loss of control over pain and the need for unnecessary interventions. Some women were excited when they learned about the midwifery model of care. However, the area's one nurse-midwifery group recently left the small city where I taught, and in the surrounding metro area most of the out-of-hospital birthing centers have closed. This means that expectant couples

no longer have the option of midwifery care. What is happening to the midwives?

– An LCCE Educator in Maryland

COLUMNIST'S REPLY

For centuries, many women have been afraid of giving birth, mainly because of fear of pain and of dying in childbirth. It is rare in this day and age that women living in developed countries die in childbirth. However, many women are still afraid of pain in childbirth.

For centuries past, only women attended women during childbirth, and only women were midwives.

Midwives were empiricists and knew their craft well. Home was the place of birth and, generally, several women were in attendance. This network of women attendants was skilled in assisting the parturient woman by providing comfort measures, nourishment, and nurturing and by patiently waiting for nature to take its course without undue interference with the normal process of labor and birth. Magic played a spiritual role, soothed and comforted the woman, and ensured safe passage of her baby. Such rituals were meant to keep away evil spirits.

Women who lived in the countryside and worked the fields and farms were robust and healthy; their bodies were well equipped to bear children—lots of them. However, when cities developed, such as during the Middle Ages and, later, during the Industrial Revolution, women who lived in squalid, filthy, crowded, disease-prone conditions were not healthy and developed rickets because of poor nutrition and insufficient sunshine. Under these circumstances, women whose pelvises were deformed ran into complications during childbirth. When midwives exhausted their means to help a woman give birth to an obstructed child, their only option was to call upon a barber-surgeon who had tools to separate the fetal parts and extract the infant piecemeal. Gruesome as this seems, the only other alternative was excruciating death for the mother as well as her child.

During the Renaissance in Western Europe, when the trades, arts, and sciences were revived, men who were engaged in similar vocations banded together to form guilds. Barbers and surgeons joined forces because of the similarity of their tools. These were the men whom midwives turned to under great duress. In the following 17th and 18th centuries, barber-surgeons foresaw a profitable profession in the field of childbirth. Before long, men began entering the field of childbirth and perfecting their tools. Peter Chamberlen invented the obstetric forceps in 1588. His brother and other Chamberlen descendants (all barber-surgeons) used the forceps, which were kept a family secret for three generations (Townsend, 1952). This invention laid the groundwork for medical and surgical interventions during childbirth.

Over the next centuries, delivering babies became a medical specialty, the field of obstetrics. Physicians began competing with midwives. Some midwives became fearful of this invasion and spoke out vehemently against these physicians who began

to compete in the practice. Compared to midwives, physicians had a different perspective in their approach to attending women in their confinements. Many physicians did not have the same sensitivity or patience inherent to the traditional practice of midwifery. In their zest to use instruments and other maneuvers to speed up the birth process, which some physicians proclaimed would shorten women's suffering, they often caused much damage to women's reproductive organs. The worst of these was the infliction of vesico- and rectovaginal fistulas, maladies that women had to endure over their lifetimes.

In Europe, in the 18th and 19th centuries, and later in America, more and more individuals entered medical schools and specialized in obstetrics. To gain more clinical practice, they established lying-in hospitals or wards in major hospitals. Asepsis was unknown, so, with unclean hands and tools, physicians examined women and tended to the birth of their babies, leading to epidemics of puerperal fever, which caused thousands of maternal deaths. Fortunately, many individuals contributed to understanding the cause of puerperal fever, including Ignaz Semmelweis, a renowned Hungarian physician; Oliver Wendell Holmes, an American physician; Louis Pasteur, a French scientist; and Joseph Lister, an English surgeon. By the end of the 19th century, germ theory was finally accepted, and the advent of anesthesia made surgery safer and free of pain. Anesthesia administered for pain in childbirth became desirable for many women who chose physicians as their birth attendants.

In the late 19th and early 20th centuries, American obstetricians sought to overtake the entire field of childbirth and declare major war against the traditional midwives in the United States. Midwives wanted an education, but obstetricians fought hard against this idea. Schools for midwifery education were established in European cities, and European health care created a dual system by which midwives continued to attend normal births while physicians handled complications. This did not happen in the United States. American physicians fought hard against midwifery education, in spite of midwives wanting an education, which public-health reformers supported. In the early 20th century, many midwives still practiced in rural, remote areas of the country and with inner-city, poor populations. The next push by American obstetricians was to move the place of birth from homes to hospitals, where midwives were forbidden to practice.

Research findings demonstrate that midwives are safe practitioners, are more sensitive and patient than other care providers, and intervene far less than obstetricians.

In 1920, Dr. Joseph B. DeLee's famous article, "The Prophylactic Forceps Operation," was published in the *American Journal of Obstetrics & Gynecology*. His routine included heavy doses of narcotics and scopolamine, gas anesthesia during birth, forceps to drag the baby out, episiotomy, and pitocin after birth of the placenta (DeLee, 1920). This routine could only be conducted in a hospital, which DeLee and his colleagues strongly advocated.

The rate of hospital births began to increase. By 1951, 90% of births took place in hospitals. By mid-century, lay and granny midwives were almost annihilated, and then nurse-midwives and midwifery schools emerged. But this group was not autonomous as the traditional midwives were.

DeLee's (1920) philosophy was adopted by obstetricians and has prevailed to this day, with the addition of more technology in most births, whether normal or complicated, and without a body of scientific evidence of efficacy. During the Women's Movement of the 1960s and 1970s, birthing women gained more of a choice but, for the most part, routine interventions and technologies continued. To understand and improve current women's childbearing experiences, Childbirth Connection conducted two national surveys—one in 2002 and the other in 2006 in partnership with Lamaze International (see Declercq, Sakala, Corry, & Applebaum, 2006; Declercq, Sakala, Corry, Applebaum, & Risher, 2002). The *Listening to Mothers II* survey (Declercq et al., 2006) collected data from 1,573 women who had given birth in 2005 in the United States. Results showed that multiple interventions and technologies are still routine procedures in the majority of cases. For example, 94% of women reported they had continuous electronic fetal monitoring (Declercq et al., 2006).

Many current, systematic reviews of randomized clinical trials provide a large body of evidence that suggests routine interventions and technologies conducted in normal labor and birth are not indicated, can lead to a domino effect of other interventions and cesarean births, and, in some instances, are harmful to mother and child (Durham, 2003; Fraser, Turcot, Krauss, & Brisson-Carrol, 2004; Freeman, 1990; Howell, 1999; Leighton & Halpern, 2002; Lieberman & O'Donoghue, 2002; Roberts, Algert, Cameron, & Torvaldsen, 2005; Thacker, Stroup, & Chang, 2006). Research findings also demonstrate that midwives are safe practitioners, are more sensitive and patient than other care providers, and intervene far less than obstetricians (Johnson & Daviss, 2005; Kennedy, 2000).

The question remains as to how well informed women are when making decisions for intervention, such as labor induction or augmentation, artificial rupture of membranes, intravenous fluids, epidural analgesia, and cesarean surgery. Some women are choosing home or birthing-center births and midwifery care; however, this number continues to be low. In 2005, only 1% of U.S. women had out-of-hospital births, and less than 10% received care from a midwife (Martin et al., 2007). Midwives face liability issues if they conduct home births, and birthing centers are closing down because of escalating liability insurance premiums (Shaver, 2007). In response to the small but growing demand for midwifery care and home birth and to the success of the documentary film *The Business of Being Born* (Lake & Epstein, 2007), the American Medical Association, in three separate resolutions in 2008, seeks to limit the scope and practice of midwifery, insure physician and regulatory oversight of midwives, and promote legislation to insure that all births take place in hospitals or birthing centers (American Medical Association House of Delegates, 2008a, 2008b, 2008c). Childbearing women need to be made aware of the evidence that now exists on the risks of the routine use of interventions during labor and birth and be thoroughly informed about the pros and cons of all obstetric interventions.

This is what has happened to the midwives in our culture. The re-emergence of midwifery and out-of-hospital birth is in jeopardy. History is threatening to repeat itself. But keep in mind that the future of midwifery is open. This is a case where understanding the past can empower us to create the future that we want.

Lamaze members can view the entire report of the Listening to Mothers II survey by logging in to the Lamaze Web site (www.lamaze.org). Others can purchase the full report from the Childbirth Connection Web site (www.childbirthconnection.org), where the Executive Summary of the report is also available to the public.

Childbearing women need to be made aware of the evidence that now exists on the risks of the routine use of interventions during labor and birth and be thoroughly informed about the pros and cons of all obstetric interventions.

NOTE TO READERS

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For midwifery support and resources, readers are encouraged to visit the following organizations' Web site: Citizens for Midwifery (<http://cfmidwifery.org/>) and American College of Nurse-Midwives (www.midwife.org).