Medical Board of California
Members, Division of Licensing
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California College of Midwives
3889 Middlefield Road
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Saturday, September 11, 2004

RE: Retirement from duties as Midwifery Liaison to the Medical Board

Dear Medical Board Members,

This is a follow-up letter regarding my retirement as liaison between the Board, the Legislature and California Licensed Midwives. I will continue to represent members of the California College of Midwives and be available to you, especially in regard to the professionalism of licensed midwives, and the appropriate standards of care for community-based midwifery practice.

I want to thank all the members of the Board and the staff for their kindness and help through out the many years. I know it hasn't been easy for any of us and I particularly appreciate the many times they went the extra mile on behalf of California Licensed Midwives.

I attended my first Medical Board meeting May 3rd, 1993. In the following 11 years I have been present at two to four meetings each year. For me, the last decade-plus has been a crash course in administrative law, the medical justice system, the history of midwifery legislation in California and getting to know the physician and lay appointees to the Board, as well as the other hard-working and dedicated people employed by the agency. I made many important friendships that I will always treasure. I particularly enjoyed being a useful source of information about the physiological management of normal birth, the safety of community-based midwifery and the risks of medicalizing maternity care for healthy women with normal pregnancies.

Unfortunately, the history and circumstances that preceded my political activism on behalf of LMs is not such an uplifting story. From 1981 to 1991 I practiced midwifery lawfully, peacefully and without incident as a Mennonite Midwife under the religious exemptions clause. Without any precipitating consumer complaint or bad outcome, two agents of the Medical Board came to my home on August 9th, 1991 and served me with a criminal warrant charging me with five misdemeanors.

I was then arrested and handcuffed in presence of my youngest daughter and transport to the Santa Clara county jail, where I was held in solitary confinement for 13 hours until members of my community could raise $50,000 bail. It's noteworthy that in 1991 the boxer Mike Tyson had just been arrested and charged with felony rape. His bail for rape was $30,000. The misdemeanor charges against me required that my community to pay out $5,000 cash to a bail bondsman. As you know, bail money is non-refundable.

According to an Associated Press news report, sent out on the AP wire, the San Mateo office of the Medical Board stated that I had been arrested as a test case. They were hoping my prosecution would establish a legal precedent that would eliminate the traditional practice of non-medical midwifery under the religious exemptions clause. This incident occurred under the direction of Ken Wagstaff, the executive director of the MBC at the time.

After 20 months of pre-trial hearing (and $30,000 of legal expenses), the DA admitted that

the non-medical (i.e. traditional) practice of midwifery was statutorily neutral in California, i.e., it was *not* a crime. He told my lawyer in my presence that he was aware of the lack of a statutory basis for criminalizing traditional midwifery. He went on to said: **"I called up those guys at the Medical Board and I told them that if they wanted me to keep prosecuting midwives, they were going to have to get some new legislation passed."**

Within a few weeks of this conversation, the criminal prosecution against me was mysteriously dropped (in its 20th month!) and the legality of my practice under the religious exemptions clause was formally acknowledged in the same official documents that dismissed the charges against me. I attended my first Medical Board meeting in Sacramento five days later (May 3, 1993), which was how I discovered that public participation in the public meetings of the agency was virtually non-existent. I interpreted this fact to mean that a crucial element of democratic process – in this case public oversight -- was functionally absent.

Since the mission of the Board is public/consumer safety, I considered this lack of public participation to result in a patronizing and paternalistic process. This seemed to be poor public policy and was the reason I requested that the quarterly board meetings be video broadcast over the Capital's cable system, so that citizens all over our great big state could remain informed and informing.

It also explained a lot about how the agency, under Mr. Wagstaff's command in 1991, could have used its authority in such an irresponsible manner. In targeting me as a member of a class for the purposes of a 'test case', the agency misappropriated the considerable powers of California state government to carry out the long-standing agenda of organized medicine to eliminate all forms of health care by non-physician care providers. I guess I'm just old-fashioned enough to believe that our state government shouldn't be used to carry water for organized medicine.

Shortly after the criminal charges against me were dropped, the California Medical Association approached Senator Killea with a deal. If she would let them gut the pending midwifery legislation written in cooperation with the midwives and permit it to be replaced by a statute that was fatally flawed, the CMA would permit it to pass. During one of the Assembly hearing on SB 350, Senator Killea explained to me that: "**Bad legislation is better than no legislation at all**".

With this collection of precipitating events, the LMPA of 1993 was passed. The same Medical Board that was responsible for the arrest and criminal prosecution of midwives like myself was now identified as the regulatory body for midwives like myself. In a nutshell, that is the story of how I came to be traumatically bonded to the Medical Board. To quote Paul Seidel, the Santa Clara County D.A. who prosecuted me: "Those guys at the Medical Board" may just be stuck with me, as I am a firm believer that the democratic process is a necessary ingredient in any effort to 'protect' the public.

In light of these disturbing experiences and my inauspicious entry in the medical justice system, followed by thirteen years of representing LMs to the Board, I believe that I have earned the right to offer some lengthy observations on the topic of midwifery and the relationship between the Medical Board, professional midwives and the obstetrical profession.

At 60-plus years of age, I am old enough to have seen profound social changes, both in how medicine is practiced and in other topics relative to social justice. I believe in working for social justice. I am fundamentally optimistic that in my life time I will see an end to the prejudice against midwives. I am also confident

that I will live to see our current dysfunctional maternity care system -- one that forces unwanted and unnecessary obstetrical interference healthy women who neither need or want such interventions – be rehabilitated.

Background Remarks

But before I get to specific remarks about midwifery licensing issues, I'd like to tell you two short but informative stories about my early life in a deeply segregated society. As a teenager, my Canadian Mennonite family moved to Florida in 1957 and for the first time in my life, I was exposed to and shocked by blatant and institutionalized racial prejudice.

I attended segregated public schools, I trained as a nurse in a segregated hospital and I eventually provided maternity care in the same segregated institution. As a result of living up close and personal with institutionalized prejudice and government sanctioned segregation, I had two very instructive experiences that I want to share with you.

The **first story** is about the public restrooms at a local gas station. Instead of the usual arrangement of two restrooms, one for each gender, the Bay station had three bathrooms. Big signs on each of the three doors proclaimed 'White Ladies', 'White Gentleman' or simply 'colored'.

Today we all can see this violation of common decency as emblematic of a morally-bankrupt system that was dehumanizing and wrong. It needed to be changed and eventually it was. I am amazed and pleased to have lived long enough to see institutionalized segregation in the South come to an end. I believe this to be an example that right does win out if one is willing to work for it and wait for the process to come to fruition.

My **second** remarkable and life-changing experience was as a nursing student and later a staff nurse working in the 1960s in the labor and delivery room of that same racially segregated hospital. Due to its system of medical apartheid, I got to closely observe and directly participate in two entirely different systems, side by side, in the same hospital, at the same time, with the same staff and the same type of patients but totally different management style and outcomes, different as day and night.

It was a naturally-occurring, one-of-a-kind scientific study, contrasting two styles of maternity care – a profoundly interventionist model characterized as "knock'em out, drag'em out" obstetrics, versus a lazier-fair system that resulted in, *ipso facto*, classic physiologically-managed maternity care of the type now routinely provided by midwives like myself. It all depended on whether the mother was black or white.

In our segregated hospital, Caucasian mothers were sent to the all-white labor ward on Five-North. On admission they were immediately given 3 grams of barbiturates (a double dose of sleeping pills). As labor progressed they were injected every 2-3 hours with a narcotic mixture known as "twilight sleep" – large and frequently repeated doses of Demerol (a potent narcotic), a tranquilizer drug and scopolamine, an hallucinogenic drug that caused short-term memory loss and permanent amnesia of events occurring under it influence.

Under the influence of these powerful drugs some women became temporarily psychotic and physically fought with the staff and even bit the nurses. Left unattended, they fell out of bed, chipped teeth or broke arms. To keep drugged women from getting hurt, the hospital required a nurse to stay right at the bedside through out the entire labor. However, we often delivered 8 to 12 patients a shift. When

the nurses were busy, our white mothers were put in four-point leather restraints, the same ones used in the locked psychiatric wards of the hospital. This forced women to labor flat on their back, a position that interferes with and reduces blood flow to the uterus and placenta, making labor extremely painful and often causing fetal distress.

When the time came to give birth, these mothers were moved by stretcher to an OR-style delivery room, given general anesthesia, put in lithotomy stirrups, a "generous" episiotomy was performed, and the baby was extracted via 'low' forceps. It should be noted that the third leading cause of maternal deaths in the 1950 and early 1960s was the result of obstetrical anesthesia.

One of my jobs as a nurse in the all-white Five-North delivery room was to resuscitate these deeply narcotized and respiratorily-depressed babies. Out of every 25 babies or so, one or more would fail to establish respirations, thus dying as a result of the drugs, general anesthesia and/ or the use of obstetrical instruments.

This high mortality rate was iatrogenic in origin, but that has never been recognized or acknowledged by the obstetrical profession. And yet, this high perinatal mortality rate is still within living memory of some older physicians. Their memory of these unnatural events adds to the mythology that normal birth is intrinsically dangerous and requires many medical interventions.

After the baby was delivered, the obstetrician inserted a gloved hand up into the mother's uterus to pull out the placenta. Then the episiotomy incision was sutured, with particular attention paid to the so-called "husband stitch", which was to make things tight for the woman's husband. As an 18 y/o student nurse from a religious family, I was appalled.

Then as a student nurse I was rotated off Five North to One South, the black ward in the basement of the hospital. Oddly enough, the maternity care for black mothers was remarkably simple, straightforward, non-interventive, and in my humble 18 y/o opinion, infinitely more humane. It was also psychologically-sound and made right use of gravity. Biologically speaking, it was both safe and effective.

As judged by the number of newborns who did *not* need resuscitation at birth, it was vastly *more* successful than the highly medicalized care visited on their Caucasian counterparts upstairs on Five North. Frankly, this was all a big relief to me, as I no longer felt that I was being asked to be an agent for a process that was immediately and obviously harmful to mothers and babies.

On One South, there was no labor ward or labor room nurse to care for black mothers. These laboring women were just admitted to their postpartum beds in an old-fashioned four-bed ward. Their labors were not accelerated with Pitocin or any other drugs. Neither were they given narcotics for pain because the two staff nurses, who were responsible for 40-plus other patients, had no time to labor-sit with drugged and combative women having hallucinations. Besides, in a segregated society, no one much bothered about the labor pain of black mothers, who were assumed to either be able to take it or out of luck.

However, there were many unintended advantages to this system of purposeful neglect. Because they were undrugged, our black women in labor were permitted to walk around freely and socialize with the many other experienced women on the ward. This was very comforting to them and provided a useful

source of encouragement and tips on how to cope with labor pains. In particular, our black mothers avoided lying down in bed, preferring to stand and sway or squat during contractions while holding on to the foot of the bed. As a naive student nurse, I remember asking one laboring mom why she didn't lay down in the bed where she'd "be more comfortable". She looked at me like I was forty different kinds of dumb and answered in an obviously irritated voice: "Because it hurts too bad when you lay down". Right on!

Eventually one of our black maternity patients would start to make deep-throated guttural noises – the unmistakable sounds of pushing -- and so we grabbed a stretcher and threw a sheet over the laboring woman. Then we made a mad dash for the elevator, hoping to get up to the delivery room on Five North before the baby was born. However, so many mothers were high parity that we often did not make it. My very first experience of "midwifing" was receiving the spontaneously born babies of black mothers who delivered on the stretcher in the elevator, between One South and Five North.

The ease and simplicity of these nurse-managed, non-medicalized births was in stark contrast to the invasive methods routinely used by obstetricians on our Caucasian patients five floors above. As nurses, we talked these black mothers through the last couple of pushes and their babies just slipped out, with little fuss.

And wonder of wonder, these spontaneously-born babies *breathed on their own*, since their mothers had not been given narcotics or anesthesia and no artificial, forcible or mechanical means were used to force the labor or extract the baby. There was no painful episiotomy, no river of blood issuing forth from a gapping perineal wound, no forceps, no fundal pressure, no bulb syringe jammed repeatedly down the baby's throat, no manual removal of the placenta, no stitches, no post-anesthesia vomiting, no artificial separation of mother and new baby. Clearly Mother Nature, when respectfully supported and un-meddled with, does a darn fine job.

By today's legal standards these black mothers were actually receiving "substandard" care. Racial prejudice and discrimination of the era had institutionalized what would now be considered as legally negligent treatment. Yet, they clearly were getting the better end of the deal, as black mothers were not made to suffer the routine indignities and painful interventions in their labor that were the inevitable lot of while women.

The black mothers on One South got safer, physiologically managed labors and normal spontaneous births. They were not subjected to the labor-retarding effects of social isolation, to being immobilization on their backs with four-point psychiatric restraints, to the maternal effects of being profoundly narcotized or to the slowly healing episiotomy that made it hard to sit and difficult to care for a new baby. Their babies were not exposed to intrauterine narcotics and resulting fetal distress and did not need to be resuscitated, thus contributing to increased IQ points.

When expecting my first baby I took a lesson in childbirth out of that same book. In an attempt to avoid the detrimental effects of these interventions, I asked my obstetrician if I could have the same kind of care that our black mothers received. He smiled and suggested that I just stay out of the hospital until the baby was ready to be born because "that's what hospitals are for -- drugs and anesthesia".

As a good and faithful nurse I did as I was instructed by the doctor. I labored at home as long as possible, hoping against hope to have a nice nurse-managed birth on a stretcher in the same elevator on the way up to the Five North

delivery room. As luck would have it, I misjudged by just a few miles. While my husband drove the car, I gave birth alone in the back seat of our Renault to a lovely baby girl, just five blocks before we got to hospital. That was the second major area of my experience in midwifery.

Modern Times, Modern Problems

Mastery in maternity care for healthy women means bringing about a good outcome *without introducing any unnecessary harm*. Our present system of obstetrics for normal childbirth does not do this very well. In fact, our maternal-infant mortality record has been remarkably dismal throughout the 20th century when compared to other industrialized countries. This is because obstetrical interventions, originally developed for complications, are inappropriately used on healthy women. This frequently introduces unnatural risks and unnecessary complications. These avoidable problems disturb the normal biology of labor and birth by routinely applying of medical and surgical interventions to nearly 100% of the childbearing population.

For most of the last century the obstetrical profession in the United States has gone to great lengths to convince all of us that physiological management is old-fashioned, inadequate and down-right dangerous. They have purposefully dismantled the infrastructure for providing physiological management, claiming that care for normal childbirth, at least for the affluent and the Caucasian, should consist of a constant stream of medical and surgical interventions provided by physician-surgeons in an acute care hospital setting. When it comes to the astronomical expense of the interventionist model (particularly the 'maternal choice' or elective Cesarean), the sky's the limit, because we are repeatedly assured that this extravagance is buying us better babies.

This is the origin of the conflict we are experiencing today at the Medical Board between independent midwifery and organized medicine. The obstetrical profession seeks to shoot the messenger, as midwives are messengers for normal birth and physiological management. Representatives of American College of Obstetricians and Gynecologists (ACOG) have appeared before the Board many times, trying to convince you that licensed midwives are dangerous because we do not medicalized normal birth as they do, with the routine use of drugs and surgical procedures.

However, we all know that if the physiological management of normal labor and birth by professional midwives in a non-medical setting *actually* represented the kind of danger that A_COG repeatedly claims, they would have *gone to court 12 years ago to obtain an injunction* against the implementation of the LMPA and the practice of LMs. A_COG didn't do that because they can't do that because it is not true. While their unsubstantiated and self-serving claims may fool the lay public, they do not standup under the rules of evidence in a court of law.

A consensus of the scientific literature not only supports physiological management in all settings for healthy women, including both home *and* hospitals, but the scientific literature also comes to the conclusion is that in general physiologically-managed maternity care is actually safer and more cost effective for healthy women than obstetrical intervention. It is the type of maternity care used world-wide. It provides superior maternal-infant outcomes with far less expenditure of money and finite medical resources when compared to the standard obstetrical style of the United States.

Historically the obstetrical profession does not have a good track record at changing its practice as scientific evidence demonstrates that customary treatments are ineffective or

harmful. In spite of scientific evidence supporting physiological management as the standard for healthy women, organized medicine continues to justify the medicalization of all normal labors to the public, while it perpetuates its bias against science-based maternity care and its prejudices against midwives.

In its own way, this bias against spontaneous biology is an institutionalized system of apartheid in which mothers and midwives who employ physiological management are discriminated against. Access to obstetrical services is blocked and when those services become a medical necessity, both midwives and mothers are often the victims of retaliation by angry and outraged obstetricians, who in fact do outrageous things with social impunity.

Before the passage of midwifery licensing laws, the strategy of organized medicine was a sudden-death playoff that used criminal arrest and prosecution to achieve its goals. Since the passage of the LMPA, the strategy to eliminate the profession of midwifery is death by a thousand razor cuts. Organized medicine fights the practice of licensed community midwives at every turn, with every dirty trick and with just as much enthusiasm as before the licensing laws were passed. If A_COG were to wear a campaign button in their war against midwives and home birth mothers, they would take their slogan from Bull Conner – the infamous, segregationist sheriff of Birmingham, Alabama who wore a button said "**NEVER**".

The Science of Scientific Evidence

The medical profession has always had an extremely contentious relationship with any scientific discover or theory that threatened established doctrines or practices. Historical examples are the original rejection of the stethoscope, the germ theory of contagion and accurate understanding of the circulation of blood. Bitter controversies between doctors went on for many decades and ruined many careers preceding the final but grudging acceptance and eventual widespread use of these life-altering discoveries.

A modern example of unscientific and harmful medical practices includes the routine prescribing of estrogen for pregnant women in the 1950s, which resulted in vaginal and penile cancer in DES adolescents. Even more recent and wide-spread was the routine prescribing of estrogen for post-menopausal women, based on the unproven theory that this drug would to protect against heart disease and cancer when, in fact, it increased the rate and severity of the very diseases it was supposed to prevent.

Recent examples that include the same kind of ridicule and vigorous rejection of new theories was also visited on Dr. Heimlich, the physician who developed the Heimlich maneuver for choking and the Australian doctor who discovered that the Helicobacter pylori bacteria caused stomach ulcers. It is a historical fact that the most entrenched resistance to the progress of modern medicine is *doctors*.

19th Century Obstetrical Resistance

However, it is the obstetrical profession that had and continues to have the most abysmal track record when scientific evidence shows their customary practices to be ineffective or harmful. The historical record shows that time and again the obstetrical profession has resisted and rejected scientific knowledge *if it refuted their favorite theories or required an unwelcomed change of practice*.

The most disturbing and well-documented display of this regrettable trait comes from the 19th century story of Dr. Philip Semmelweis, who was a professor of obstetrics at a prestigious teaching hospital in Vienna during the 1840s. Dr. Semmelweis amassed

incontrovertible proof that purulent organic material carried under the fingernails of doctors and medical students was the source of the fatal puerperal sepsis commonly known as 'childbed fever', which caused the death of so many newly delivered women and their babies. In his own words Dr. Semmelweis concluded that: "puerperal fever is caused by the examining physician himself, by the manual introduction of cadaveric particles into bruised genitalia"

Unfortunately the obstetricians of Dr. Semmelweis' day, like Bull Conner, also said "**never**", only this time it was to the idea that childbed fever (or any other complication) could possibly be caused by poor obstetrical practices. The specific practice in question was doing vaginal exams on healthy laboring women without having washed their ungloved hands between the autopsy room and the labor ward.

As a result of this dangerous practice undelivered mothers became contaminated with the haemolytic streptococcal bacteria and developed a virulent septicemia that caused death within 72 hours. During the 18th and 19th centuries five to fifty percent of maternity patients (both mother *and* baby) died in the teaching hospitals of Europe from haemolytic septicemia. This did not occur to women who had their babies at home. According to historical records, the all-time worst epidemic of institutional contagion occurred at the University of Jena, when not a single mother left the hospital alive for four years in a row.

The 19th century practice of routine post-mortem dissections of women who died from puerperal sepsis did provide a steady stream of educational opportunities that advanced medical knowledge. In association with these routine autopsies, cadavers were also used to demonstrate the mechanics of obstetrics and permit students to perfect their use of obstetrical instruments.

Prior to the use of cadavers, a biologically-safe teaching manikin, developed by French midwife Madame Cordray, was used to teach midwifery skills to student midwives and instrumental and manipulative obstetrics to medical students. These life-size teaching manikins each had an anatomically correct pelvis, pregnant uterus occupied by a realistic fetal doll, amniotic fluid, placenta and umbilical cord and access to uterine contents thru a working genital tract.

As dissection became a more important part of medical school education the obstetrical manikin fell out of favor all across Europe. Gradually the bio-safe manikin was replaced by the bio-hazardous cadavers of women who died in childbirth. The assumption was that such cadavers were a "superior" teaching resource that would result in a superior medical education. Each dead body to be used for teaching purposes was severed in half at the waist, the viscera removed and the uterus dissected out. This was to prepare the hollowed out lower half of the cadaver to receive a recently deceased newborn, which was placed inside the pelvis for teaching purposes.

By passing a series of dead babies down thru the disarticulated body of a female cadaver, a professor of obstetrics could control the learning experience and assist his medical students to could carry out vaginal exams, determine fetal lie and position, apply obstetrical forceps, practice fetal destructive operations and learn life-saving maneuvers for obstructed births such as podalic version (turning the baby and pulling it out by its feet).

However, the acquisition of all these life-saving skills by medical practitioners came at an awful price, as the use of cadavers for teaching purposes virtually guaranteed that highly-contaminated organic material would be carried into the labor wards by doctors fresh from the dissection lab. In some hospitals, as

many as 700 new mothers (and their babies) died each year, or approximately **two a day**. In Vienna, 2,000 women died in Division One at the University of Vienna hospital between 1841 and 1846. In Division Two, the midwifery program staffed by midwives, the mortality rate was only 1/5th of that in Division One during the same period of time.

It is important to note that many knowledgeable people were critical of these obviously harmful obstetrical practices. This included other physicians and midwives who were unwilling to settle for superstitious explanations that blamed fatal epidemics of childbed fever on everyone and everything else other than the real culprit – poor obstetrical practices.

The director of obstetrics in Dr. Semmelweis' time had a list of 39 implausible 'reasons,' such as miasma (bad air), a draft of cold air, milk fever, errors in the mother's diet, maternal emotions that suppressed the flow of the lochia (normal bleeding after the birth) and of course, the 'unstable' condition of women.

What these improbable and fatalistic explanations had in common was that each was untreatable and /or unpreventable, thus absolving physicians of any culpability *or* any responsibility to search for a cause or a cure. On the contrary, obstetricians got to portray themselves as heroes, saving women from viciously defective reproductive biology, a fate they clearly deserved as a direct result of God's curse on Eve.

Over the course of the previous century a small but substantial number of astute physicians all over the world – Doctors White in England, Gordon in Scotland, Cederskjšld in Sweden and our own Oliver Wendell Holmes in Boston -- had all observed, studied and warned of the iatrogenic nature of childbed fever.

Repeated virulent epidemics of puerperal fever were virtually absent in places that midwives (who did not use instruments) managed normal birth instead of doctors (who did) and where autopsies were not being done by the same practitioners who attended deliveries. An article by Oliver Wendell Holmes appeared in the *New England Journal of Medicine and Surgery* in 1843, entitled 'The Contagiousness of Puerperal Fever'.

In this he agreed with Doctors White and Gordon that the disease was often transmitted, via an unknown agent, by both physicians and nurses. Unfortunately, these 'radical' life-saving ideas were ridiculed and dismissed as absurd by those who thought it inconceivable that the healing hands a physician (or his instruments or agents) could ever, under any circumstances, be a vector for a contagious fatal illness**.**

History records that Dr. Phillip Semmelweis reformed these iatrogenic practices by introducing prophylactic hand washing in chlorine of lime solution. Like a sudden overnight miracle, maternal deaths in his institution fell from **18**% to **0.2**% in the eight months between April and December of 1847. Henceforth he devoted his entire career to preventing unnecessary maternal deaths by teaching and preaching the use of asepsis principles.

No Good Deed Goes Unpunished

None-the-less Dr. Semmelweis' simple but effective solution was ignored and ridiculed by his contemporaries, who could not wrap their minds around something so unglamorous and straightforward, something that would have required them to take responsibility for harmful practices and institute corrective measures. For his trouble he soon lost his prestigious post in Vienna's most famous hospital, lost his reputation and eventually his profession.

In the end Dr Semmelweis was driven mad by guilt and his inability to "make them listen". At the age of 47, a mere 21 years after receiving his medical degree, he died in an insane asylum, leaving behind a wife and several children.

The medical profession did not finally acknowledge the role of contagion in obstetrical deaths from infection until long after Dr. Semmelweis's death. In 1881 the now famous doctor Louis Pasteur, established the central role of microbes -- commonly known as 'germs' or 'pathogens'-- in causing illness and infection.

On a chalk board at a prestigious medical meeting in France Dr. Pasteur drew a graphic representation of what the streptococcus bacteria looked like under a microscope -- rectangular microbes that resembled a string of box cars on a train track -- and said "Gentlemen, this is the cause of Childbed Fever". With this discovery, Dr. Pasteur delivered the fatal blow to the 2000 years fallacious theory of ***'spontaneous generation'*** -- the erroneous and dangerous notion that life (and infection) could arise spontaneously in organic materials.

The idea of microbial sterility has only been a part of modern medicine for a 150 years. It was not until the discovery of anesthesia in the 1840s to control the extraordinary pain of surgery and 40 years later, the germ theory of disease and resulting aseptic and sterile techniques to prevent the infection, that surgery became a reasonably effective form of medical treatment.

The first obstetrical operation -- a Cesarean -- was done in first century Rome to extract a living child from its dead or dying mother. Almost two millennia later, anesthesia made it possible to do Cesareans on *living women* and sterile technique made it possible for *living women to survive the operation*. Invasive obstetrical procedures, such episiotomy and forceps, were also greatly enhanced by the development of microbiology and safe anesthetics.

Obstetrical Politics in the US

After decades of resistance to the changes brought on by the theory of asepsis and sterile technique, American obstetricians suddenly and enthusiastically embraced these 'new' scientific methods as vastly superior to the old days and old ways. Better yet, this idea of 'cutting edge science' was exciting and provided obstetricians with an opportunity to distinguish themselves from midwifery, which was seen as low class, low pay, low status 'woman's work'.

Obstetrical forceps, episiotomy, and podalic version were favorite methods already used by obstetricians to rise above the low status of midwives. Regrettably these invasive procedures were also associated with fatal septicemias. Suddenly the new ideas of asepsis and sterile technique promised an end to birth-related infections. Obstetricians were confident that the scientific advances of "modern" medicine would now permit them to take control of normal childbirth in ways they dared not do before, forced as they often were to wait on the always inconvenient and often maddeningly slow pace of Mother Nature.

They theorized that a faster, more controlled process would be better for mothers and babies. By conducting normal childbirth as a surgical procedure, it could be routinely mechanized and sped up by using drugs, anesthetics, episiotomy, forceps and the manual removal of the placenta. This kind of complete control over normal (otherwise unpredictable) biology was more conservative of the doctor's time, more profitable for the hospital -- a delight to the obstetrician and a relief to the worried husband. Left entirely out of this picture were

the time-tested principles of physiology, which had been discarded as old-fashioned.

In the blink of an eye, operative obstetrics became the hot new "wave of the future", embraced with the same irrational enthusiasm that Americans always bestow on new technology, the same way their contemporaries today are eager to trade in their ballpoint pens for a laptop computer with email and Internet access.

Within a decade normal birth was gone from the average obstetrician's practice; soon after it was eliminated from the medical school curriculum. It was assumed (wrongly it turns out), that if labor and delivery were simply conducted in a hospital under conditions of surgical sterility, all would be well, regardless of the number or magnitude of invasive or operative procedures performed. By 1910, operative deliveries in one renowned NYC hospital were already up to 20% of all deliveries or one out of five births.

This was, in essence, an informal medical experiment, carried out without the patient's informed consent, any research or other forms of scientific scrutiny to determine whether or not the routine use of operative intervention was safe for its intended recipients – healthy women with normal pregnancies. Unfortunately, it was not. Anesthetic accidents, infection, hemorrhage and other surgical complications resulted in a maternal death rate five times that of a normal birth.

During the early decades of the 20th century, the United States had the second worst rate of maternal mortality of any western country. These statistics were an embarrassment to American obstetrics, making them the butt of jokes on the European Continent and sullying the international reputation of American medicine. One American obstetrician complained that: "**Maternal mortality** in this country, when compared with … England, Wales and Sweden is **appalling high** and probably unequaled in modern times in any civilized country".

The obstetrical profession insisted this was the result of 'ignorant' midwives, who were characterized as providing dangerously inadequate care, thus damaging the standing of doctors in the international community. Articles by physicians were published in professional journals discussing this situation as "The Midwife Problem". Part of that "problem" was that midwife-attended births reduced the number of obstetrical patients available to medical students to use as teaching cases.

In 1910 the obstetrical profession embarked on a successful media campaign to eliminate the lawful practice of midwifery, which they insisted was responsible for their bad showing. They claimed that all normal childbirth should instead be managed by obstetricians as a surgical procedure, and that doing so would greatly reduce maternal and infant deaths and disability. Believing that 'doctors know best' society offered no resistance to these ideas.

Legal and legislative barriers constructed by organized medicine resulted in the virtual elimination of the midwifery profession in American within a single decade. Between 1910 and 1920, the number of midwife-attend births dropped from 60% to 13%. By 1930, the only ones left were the black 'granny' midwives in segregated parts of the South. The medicalization of normal birth quickly became the universal standard form of care all across America.

However, there were a few astute physicians who rejected the claim that midwifery was in any way substandard or undesirable. They insisted that expanding the use of medical

interventions to all childbearing women was a dangerous idea.

In 1915 Dr. P.W. van Peyma, who had 40 years of experience working with midwives and 25 years as a member of the Board of Examiners in Midwifery in Buffalo, NY, stated:

"The essential difference between a midwife and a physician is that they [physicians] are free to hasten delivery by means of forceps, version, etc. This, in my experience, results in more serious consequences than any shortcomings of midwives. ...Time is an element of first importance in labor, and the midwife is more inclined to give this than is the average physician. ... The present wave of operative interference is disastrous. ... The situation would not be improved by turning (the clients of midwives) into the hands of such medical men ....". His was a voice crying in the wilderness.

Obstetricians had promised that medicalized birth would produce vastly improve outcomes but given the biological detriment of that plan, it is no surprise that the opposite occurred. There was actually a **15% annual increase in maternal deaths** for the first decade and a **44% increase in neonatal birth injuries** between 1910 and 1930. A physician of the era reported that "...in 1921 the maternal death rate for our country was higher than that of every foreign county for which we have statistics…. [Dr. Hardin; 1925-a, p. 347]

This escalating rate of mortality and morbidity was the consequence of eliminating the safer, physiologically-based care as provided to healthy women by midwives. In place of this protective, non-interventive form of care, obstetrical interventions were substituted en masse. This meant that narcotics, general anesthesia, episiotomy, forceps and other invasive procedures were used at every normal birth.

The More things Change, the More They Stay the Same …. .

In the 1840's, the European power brokers of the obstetrical world all turned their backs on any scientific evidence or suggestion that their practices caused or contributed to maternal deaths from puerperal sepsis. At the start of the 20th century in America, newer generations of obstetricians turned their backs on normal physiology and rejected the principles of physiologic management with similar negative results. Sadly, the basis for these 19th and 20th century policies of routine intervention that are still used by contemporary obstetrics remain unexamined here in the 21st century.

The Contemporary Conundrum

As can be seen, the connection between the history of classical obstetrics and the habits of 'modern' obstetrics are not as remote as most people might imagine. This highly invasive style was still the norm in the 1960s when I was a nursing student and in the 1970s when I was an L&D nurse. And indeed, it is still being used today, with only slight variation. Cesarean section has now replaced the routine use of forceps as the preferred operative intervention. In 1910, operative deliveries in NYC were 20% of all deliveries or one out of five births. In 2004, operative deliveries (episiotomy, instrumental vaginal delivery, C-section) account for a whopping **77% of all births.**

There has been a huge improvement in public sanitation, standard of living, life expectancy and the growth of preventative medicine since 1910. Contemporary American women are all orders of magnitude healthier than they were in 1910. Now more than 70% of all pregnancies are normal, and yet three out of four of these healthy, wealthy mothers are now giving birth surgically and that number is expected to grow.

Hijacking public imagination, manipulating public opinion

During the last century, the picture in the minds of most Americans for normal childbirth is what they see in the movies, which is birth as obstetrical procedure – something done *to* the mother, rather than *by* the mother. In everyone's mind, it is the doctor, not the mother, who 'delivers' the baby. The classic notion of so-called modern childbirth is of someone so disabled they can only lay passively on a stretcher, bed or operating table, cared for by a host of healthy, able bodied professional standing over them, rapidly performing life-saving "procedures".

This universal picture starts with the laboring woman lying on her back in a hospital bed. It moves on to scenes of her loosing control, thrashing about and finally being given drugs or anesthesia. It progresses on to her lying passively, legs up in obstetrical stirrups, covered up to her chin with sterile sheets, while the surgically garbed, gloved and masked physician stands between the woman's legs. After a few more minutes of some kind of mysterious manipulation 'down there' by the doctor, he or she suddenly holds up the new baby -- a move reminiscent of a magician reaching in and pulling a rabbit out of a hat.

It is presume by all that the baby, which until a minute ago was incarceration in its mother's body, was only able to be liberated as a result of the great effort and consummate skill of the physician. The scene ends as the obstetrician momentarily displays the baby like an obstetrical trophy – a triumph of modern medicine. Then he hands the baby off to the nurse for inspection. The mother's role is to smile, thank her doctor for doing a terrific job and promise to be eternally grateful.

Since the 1920s the picture in the public's mind of modern surgical care has included the image of an austere OR with gleaming chrome equipment, trays of sterile instruments, a patient lying limply on a table covered up with sterile drapes, and a gowned and gloved surgical staff standing by. This picture has been imprinted on our minds by various forms of media and from personal experience. It is a picture that conforms to biological reality, reflecting the needs for providing a safe place for administering general anesthesia, and a sterile environment in order to cut into the inert body of the patient.

Unfortunately, an almost identical scene has become associated with normal birth. We assume that childbirth, like surgery, depends on the mother lying down and remaining passive, while the doctors and staff play the active role. In this scenario, the physician-surgeon becomes responsible for removing a healthy baby from the mother's body in a manner not too dissimilar from removing her gall bladder. Without the conscious awareness of the American public, this erroneous picture displaced, and has now obliterated, the biologically accurate picture of normal maternity care.

In an image that is faithful to biology, the *mother is the active person*. She labors while upright and mobile, she walks about, pushes in gravity-friendly positions and finally gives birth. She is assisted by those whose role is to help and encourage her and provide a safety net in case of difficulty. Those 'helpers' would include women friends, close family members, midwives and general practice physicians.

In the last 100 years, society lost the noun 'midwife', but much more importantly, the *verb* "to midwife". This has nothing to do with gender, professional status or location of birth. 'To midwife' is to assist another person to achieve something that is of great value to them and to society, something difficult but worth the extraordinary effort. To 'midwife' is to

encourage that person go past their comfort zone, in spite of their fears, anxiety, lack of sleep and pain, to say '*YES, I can do it*' when their mind is saying '*NO, NO, it can' be done*'.

Whether the laboring woman is 'midwifed' by a physician or a midwife, gives birth in or out of a hospital, women who give birth spontaneously as a result of their own efforts inevitably say "**if I can do *that*, I can do anything**". You see, pregnancy makes a mother as well as a baby. It's important for childbearing women to feel tested and to experience themselves as competent. This is an important developmental mile stone for a new mother, as it generates the confidence that enables her to take on the new role and the demanding, difficult duties of parenting.

Current Events, Contemporary Science

Today, obstetrics is all about the **routine interference in *normal* pregnancy and birth**. This is, scientifically-speaking, illogical, unscientific and at times, harmful. In 1989 obstetrician Iain Chalmers, the Oxford University researcher who published the first comprehensive review of evidence-based obstetrical practice (*The Guide to Effective Care in Pregnancy and Childbirth*), bestowed the "Wooden Spoon Award" on American obstetricians, with the disdainful comment that of all the branches of medicine in the US, our obstetrical practices were the *least* scientific.

In 2002 the highly-respected national advocacy group – the **Maternity Center Association** of NYC – commissioned a surveyed of healthy women with normal term pregnancies who had given birth in the previous 24 months. This was done in an effort to track contemporary obstetrical trends, the quality of care provided to healthy childbearing women and their satisfaction with the type of care received.

The '**Listening to Mothers**' survey revealed that an average of **seven or more** serious medical or surgical procedures were performed on each and every healthy laboring woman who gave birth under obstetrical management. As reflected in this study, there were **virtually no** spontaneous, unmedicated births (i.e., without medical or surgical interference) in institutional settings. While 70% of childbearing women are healthy, only 22% of them have a normal spontaneous birth in today's hospitals. According to MCA's published report, 99% of healthy pregnant women in the US **do not** receive science-based maternity care from their obstetrical providers. [*Listening to Mothers* by the MCA; October 2003].

That means nearly three million healthy childbearing women are exposed each year to risky, unnecessary, often painful obstetrical interventions. A healthcare system that **over treats** three-quarters of its patients (3 million each year) is both expensive and dangerous. It exposes mothers and babies to unnecessary physical and mental suffering and increased rates of preventable death and disability – the exact opposite of its intended goals.

The most recent expression of this irrational exuberance for surgical intervention is a media campaign by the obstetrical profession to promote the notion that an elective, or medically **unnecessary,** 'maternal choice' cesarean is *safer better and than normal childbirth*.

This public-relations campaign was topped off on October 31, 2003 by a press release by the American College of Obstetricians and Gynecologists' **(ACOG).** ACOG announced a decision by their Ethics Committee, decreeing that it was now considered it "ethical" for obstetricians to perform medically unnecessary cesarean surgeries. This was based, in part, on ACOG's insistence that there was: "a lack of data on the risks and benefits of cesarean vs. vaginal delivery".

This statement is, on its face, false and misleading. It ignores the 30-plus additional risks associated with surgical birth, including a doubling of maternal deaths. A recently-published study found that a woman's risk of experiencing a pregnancy-related death more than triples with cesarean delivery (35.9 deaths per 100,000 deliveries) compared to a woman who delivered vaginally (9.2 deaths per 100,000). The Maternity Center Association's excellent systemic review of the scientific literature entitled "***What Every Pregnant Woman Needs to Know About Cesarean Section***" documents this for the lay public. (PDF file available on line at <www.maternityWise.org>)

In spite of this, the politically dominate forces within the American obstetrical profession cling to the same obstructionist and self-serving relationship with science-based maternity care that was typical Dr. Semmelweis's time. As in 19th century Austria, modern-day obstetrical powerbrokers continue to ignore scientific knowledge that is inconvenient, unprofitable or refutes a favorite theory.

In fact, many in the obstetrical profession are predicting that cesarean delivery will completely replace normal birth within this generation, to become the obstetrical "standard of care", just as instrumental delivery became the standard of care in 1910. New maternity wards are now being built that are replacing labor rooms with operating rooms in anticipation of a 50% C-Section rate by 2010. This should not come as a surprise for a society who has been taught to see childbirth as medical or surgical procedure 'performed' by professionals.

Fixing the Problem at the Policy Level

The challenge for the 21st century is to bring about a **fundamental change in maternity care** in the United States. Normal childbirth services for healthy women must be scientifically-based, compassionate and fiscally sound. This can only be achieved via a rehabilitated national maternity care policy that re-integrates the classic principles of physiological management back into the system.

A rehabilitated maternity policy would integrate the time-tested principles of physiological management with the best advances in obstetrical medicine. This would **create a single, evidence-based standard for all healthy women used by all maternity care providers**. Under a rehabilitated system, management strategies would be determined by the *health status of the childbearing woman and her unborn baby,* in conjunction with the mother's stated preferences, rather than by the *occupational status of the care provider* (obstetrician or midwife). At present, *who* the woman seeks care *from* (obstetrician or midwife) determines *how* she is cared for. This is illogical and needlessly expensive.

Solutions – Win-Win for everybody

I am here to attest to two things – Bull Conner was wrong about segregation and so is the obstetrical profession when it comes its prejudice against physiological management, women who seek a planned home birth (PHB) and midwives. A long over-due and much needed reform of our national maternity care policy will eventually bring an end to *Flat Earth Obstetrics* – the kind of obstetrical hubris that refused to listen to Dr. Semmelweis and that continues in the face of overwhelming scientific evidence to the contrary, to turn normal birth into a risky, expensive medical event and ever-escalating march up the ladder of surgical interventions.

A re-examined national maternity policy would, for the first time in modern history, mean that maternity care for all healthy women would be science-based and mother-friendly, which is to say, to integrate physiological principles with the best advances in obstetrical

medicine to create a single, evidence-based standard for all healthy women.

When that happens, physiological management will be the foremost standard for *all* healthy women with normal pregnancies, taught to and used by *all* practitioners (both physicians and midwives) and for *all* birth settings (home, hospital, birth center). **Then the so-called 'midwife problem' will resolve itself on its own merits.**

My question for the members of this august body is simply this: "When history records the story of this triumph of reason over prejudice, which side will you have been on? Will you know in your own hearts that you did what you could advance both science and social justice? Will your relatives in future generations proudly count you as a humanitarian who worked for rights of healthy childbearing women to receive safe, cost effective and science-based maternity care?

Today is September 11th, 2004. On that extraordinary day 3 years ago, a lot of ordinary people became heroes because they were brave enough to go up the down staircases in the Twin Towers to help people in need, irrespective of the obvious risk to themselves. Hundred of these ordinary heroes died as a result of their courage and commitment.

Mother and midwives are not asking anyone to sacrifice life, limb or livelihood for our cause. **We are however asking for members of the Board to go up the down staircase of medical politics.** We are asking each of you to go the extra mile, to make your decisions based only on the consensus of the scientific evidence and to do the right thing just because it is the right thing to do.

On behalf of healthy childbearing women and their faithful midwives, I thank you for your time and your attention.

Respectfully,

Faith Gibson, LM, CPM,

Executive Director,
American College of
Community Midwives
Coordinator, California College of
Midwives (state chapter of the ACCM)

Cc: All Members of the DOL/ MBC
Anita Scuri, Senior Counsel, MBC
Bruce Hasencamp, former president, MBC; Senator Liz Figuero's Office