Man-Midwives ~
The Historical Tension Between
Midwifery and Obstetrics During the 20th century

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This is a cited and cross-referenced account of the development of obstetrics as a new 20th century profession. It describes how doctors distinguished themselves from a four-hundred year history as "Man-Midwives" by turning themselves into obstetricians and turning normal childbirth into a surgical specialty.

It begins with general information about midwifery and obstetrics in the 20th century in the United States and includes documents identifying the fundamental safety of midwifery care (physiologically-based management) as compared to the routine medicalization of childbirth in a healthy population. The reference key is available at www.collegeofmidwives.org.

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For the last hundred years, physiologically-based maternity care as provided by midwives to healthy women, along with breastfeeding, nurturing of the parent-child bond and access to obstetrical care for complications, has consistently been associated with the lowest rates of mortality and morbidity and highest the long-term wellbeing of mothers and babies.

> "...there is evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process." [WHO, Wagner, MD; 1988]

> "The practice of midwifery is as old as the human race. Its history runs parallel with the history of the people and its functions antedate any record we have of medicine as an applied science. Midwives, as a class, were recognized in history from early Egyptian times." [1925-A; Dr. Hardin, MD, p. 347]

> "The practice of midwifery dates back to the beginning of human life in this world. At this supreme moment of motherhood it is probable that some assistance has always been required and given.
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> "To deny its right to exist as a calling is to take issue with the eternal verities of life. The only points upon which we may argue are the training required for its safe and lawful practice and the essential fitness of those who follow this calling requisite for the safeguarding of the mother and child." [1911-G; Dr. Josephine Baker, M.D, p. 232]

> "Midwifery provides a balance between family and [the] medical perspective on birth. To negotiate and balance the different meanings and perspective of birth within the health care system, it is essential for midwives to have a legitimate and powerful role within the system. Midwifery should be powerful enough to influence both the nature and the delivery of services. This, I believe, would greatly enhance maternity care, which ultimately is the crux of the matter..." [Page, SM, Director of Midwifery, Oxfordshire, England, 1988]

> " …. all major studies EVER done (see the literature) support the fact that trained midwives (i.e., pass a licensure exam, etc) have as good or better stats in out-of-hospital settings than OBs do in hospital. The morbidity/mortality rates are lower in comparable pregnancies, the midwives frequently do a better job of risk reduction management, score higher in perceived quality of care (time element and rapport development count a lot here). I've heard physicians say that if one of the midwives they backed up lost a baby, they were convinced that they too would have lost it. Find a good midwife in your area and give her some support". [Dr. Beverly Miller, obstetrician, 1997 email; ob-gyn-l@obgyn.net, emphasis in original]

In 1915 Dr. P.W. van Peyma, Buffalo, NY, who had 40 years of experience working with midwives and was a member of the Board of Examiners in Midwifery for 25 years, noted the functional difference between the care provided by midwives and physicians:

> "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.
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> "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 them [the clients of midwives] into the hands of such medical men ....". [Dr. Peyma, M.D. 1915]

Other obstetricians also reported rates of morbidity and mortality within the profession of obstetrics that were substantially greater than for midwives of the same era:

> "...The stationary or *increasing* mortality in this country associated with childbirth and the newborn is not the result of midwifery practice …. therefore, their elimination will not reduce these mortality rates", [1924-A; Rebuttal by Dr. Levy, to claims made by Dr. Rucker, M.D. p. 822, emphasis added]
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> "Why bother the relatively innocuous midwife, when the ignorant doctor causes many more absolutely unnecessary deaths". [1911-B; Dr. Williams, M.D, p.180]
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> "In NYC, the reported cases of death from puerperal sepsis occur more frequently in the practice of physicians than from the work of the midwives". [Dr. Ira Wile, 1911-G, p.246]
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> "It may be argued that the effect upon the infant of good and poor [maternity care] would appear principally in the deaths under one month of age and that in this group we should find the highest mortality among the births attended by midwives. Strangely enough, it appears that *especially* in this age group the **infant mortality is lowest for infants attended by midwives** and highest among those delivered by hospitals. .... Hospitals delivered 20% of the babies that died under one month of age but attended only 12% of the births of the city."[1917-B; Dr. Levy, MD.; p.44; emphasis added]

In 1923, Dr. Bailey compared the safety record of student midwives at the Bellevue Hospital School of Midwifery to that of physicians:

> "Their handling of normal cases of labor has been conducted with fewer deaths of the mothers from sepsis and with as low a number of stillbirths and eye infections of the babies as the cases handled by the medical profession."

> "The training of midwives in Germany, where they are required to spend 6 months in a government obstetric hospital under the instruction and supervision of trained obstetricians, is far superior to that which the great majority of physicians receive in this country before graduation." 1925-A

Other obstetricians admit maternal death rate "appallingly high"

> "Maternal mortality in the country, when compared with certain other countries, notably England, Wales and Sweden is, according to [Dr.] Howard, '**appallingly high and probably unequaled in modern times in any civilized country**.'

> "...in 1921 the **maternal death rate for our country was higher than that of every foreign country** for which we have statistics, except that of Belgium and Chile." [1925-A; Dr. Hardin, M.D, p.347]

> "The *International Year Book of Care and Protection of Children* gives emphasis to the fact that the Untied States has still a higher rate of maternal mortality than any other of the principal countries of the world …. Pregnancy causes more deaths among women ages 15-40 years of age than any other disease except tuberculosis.

> "Twenty five thousand women die in the United States every year from direct and indirect effects of pregnancy and labor. Three to five percent of all children die during delivery and thousands of them are crippled." [1925-A .p. 350]

Testimony on the efficacy of midwifery care was presented in 1931 to the White House Conference on Child Health and Protection by the Committee on Prenatal and Maternal Care. Dr. Reed concluded, in his 1932 report, that:

> "...untrained midwives approach and *trained midwives surpass* the record of physicians in normal deliveries has been ascribed to several factors. Chief among these is the fact that the circumstances of modern practice induce many physicians to employ procedures which are calculated to hasten delivery, but which sometimes result in harm to mother and child.

> "On her part, the midwife is not permitted to and does not employ such procedures. She waits patiently and lets nature take its course." [emphasis in original]

On May 9, 1932, Dr. Louis Dublin, President of the American Public Health Association and the Third Vice-President and Statistician of the Metropolitan Life Insurance Company, after analyzing the work of the midwifery outcomes of the Frontier Nursing Service in rural Kentucky, made the following statement:

> "We have had a small but convincing demonstration by the Frontier Nursing Service of Kentucky of what the well-trained midwife can do in America. .... The midwives travel from case to case on horseback through the isolated mountainous regions of the State. There is a hospital at a central point, with a well-trained obstetrician in charge, and the very complicated cases are transferred to it for delivery" [Dr. Dublin, MD, 1032].

"In their first report they stated that they have delivered over 1000 women with only two deaths -- one from heart disease, the other from kidney disease. During 1931 there were 400 deliveries with no deaths. [as reported by Dr. Guttmacher, 1937-A, p.136]

"The study shows conclusively that the type of service rendered by the Frontier Nurses safeguards the life of the mother and babe. If such service were available to the women of the country generally, there would be a **savings of 10,000 mothers' lives** a year in the U.S., there would be **30,000 less stillbirths and 30,000 more children alive** at the end of the first month of life.

"What are the advantages of such a system? It makes it economically possible for each woman to obtain expert delivery care, because an expert midwife is less expensive than an expert obstetrician. Midwives have small practices and time to wait; they are expected to wait; this is what they are paid for and there they are in no hurry to terminate labor by ill-advised operative haste.

"Though we cannot make an exact comparison between the maternal mortality in the United States and that in European countries, we can at least make a rough comparison. All who have studied the problem agree that the rate for Holland, Norway, Sweden, Denmark is far superior to our own. Why? … it must be due to a difference in the patients themselves and differences in the way that pregnancy and labor are conducted in the two regions."

"What about the conduct of labor in the two regions? Here is where the major differences lie. In the first place, ... at least 10 percent of labors in this country are terminated by operation. In the New York Report 20 percent of the deliveries were operative, with a death rate of more that 1 in each 100 of the operated, and 1 in 500 of those who delivered spontaneously. … Fifty-one percent of all the maternal death in Scotland occurred in the 24 percent in which the labor was operative. Let us compare the operative rates of these relatively dangerous countries [USA, Scotland] with those of the countries which are safer.

"In Sweden the interference rate is 3.2 percent, in Denmark it is 4.5, while in Holland ..... it is under 1 percent.

"What is responsible for this vast difference in operative rates? ... Analgesics and anesthetics, which unquestionably retard labor and increase the necessity for operative interference, are almost never used by them in normal cases; and more than 90 percent of their deliveries are done by midwives unassisted. And midwives are trained to look upon **birth as a natural function which rarely requires artificial aid from steel or brawn**." [[Guttmacher; 1937-A, p. 133-136; *emphasis added*]

A more modern-day example of the intrinsic safety of physiological (as compared with medicalized) maternity care occurred between July 1960 and June 1963, as a result of a pilot nurse-midwife program established at Madera County Hospital (California). During the three year program, which served mainly poor agricultural workers, the rate of prenatal care increased, and prematurity and neonatal mortality rate *decreased* at the county hospital from 20 per 1,000 live births to 10.3 per thousand, even among those women who had received no prenatal care. In spite of these good outcomes, the pilot program was discontinued at the insistence of the California Medical Association.

After eliminating the care of midwives, this patient population was turned over to obstetrical management. The neonatal mortality rate immediately *increased*, which suggests that the intrapartum care delivered by nurse-midwifes may have been far more skillful than those delivered by physicians. Under obstetricians, the number of women receiving prenatal care decreased, while prematurity rose from 6.6 to 9.8% and neonatal mortality rose from **10.3** under midwifery care to **32.1 per 1,000 live births under obstetrical management**. It was concluded that the discontinuation of the nurse-midwives' services was the major factor in these negative changes. [Levy, et al, 1971]

Since the early 1940s, maternal mortality statistics have improved dramatically. This was primarily due to economic circumstances that resulted in an improved standard of living and sanitation in the U.S. The other important contributions were the development, during the Second World War, of antibiotics, cross-matching for blood transfusions, and safer anesthetics and surgical techniques. This was a vast improvement for high-risk women, as obstetricians had effective treatment options for complications of childbirth.

Also, complications triggered by obstetrical interventions themselves could now, for the first time, be successfully countered by using the newer drugs, transfused blood, and safer surgical techniques to correct the iatrogenic problems. For the last 2 decades (since the 1980s), maternal deaths in the U.S. have been stable or *rising slightly.* The U.S. currently ranks in 14th place for maternal mortality out of the 30 industrialized countries, behind Cuba and several other poor countries. This is in spite of spending more on maternity care in the U.S. than every other country in the world.

However, the perinatal mortality rate in the United States (stillborn or death of a newborn up to 28 days) is still near the bottom of the pile – 22nd out of 30. Our sky-rocketing cesarean section rate is the second highest in the world; again, the U.S. is at the bottom -- 23rd out of 25 countries. On average, one out of every three mothers giving birth in hospitals and cared for by obstetrical services finds herself having major abdominal surgery (2005). The maternal mortality rate for Cesarean section is 2 to 6 times *greater* than it is for women who give birth normally.

For the last 30 years, the consensus of the scientific literature has recognized physiological care for healthy women, including planned home birth, to be as safe as or safer than hospital birth for a low and moderate risk population of childbearing women.

> "As an obstetrician, I have learned that when things are left to themselves, things usually turn out OK. In essence, **we represent expensive "insurance policies"** to those giving birth in a hospital under our care.
>
> "….how could we ever get enough numbers to compare outcomes with midwives, given the infrequent complication rate of childbirth, especially seemingly low risk ones". [practicing obstetrician, 1/17/97; ob-gyn-l@obgyn.net]

The quantities of these studies are legion and come from all over the North American and European Continents. In the modern era, studies done in the U.S. in the last 30 years start with the Mehl study in 1975, include over a hundred titles that I have not listed, and end with the most recent and the *largest prospective study every done* on PHB and the practice of direct-entry midwives in North America. It was published in the British Medical Journal in 2005.[BMJ-Johnson & Daviss]

These studies all say the same thing – physiological childbirth services, even in non-medical settings (such as the family's home), are safe with a trained birth attendant and access to appropriate

obstetrical services when needed. They all have the same lesson for us – it is the low-tech, low-cost, high-touch preventative measures that keep healthy childbearing women healthy through the months of pregnancy and the hours of childbirth. This type of care is best and most economically provided by midwives in domiciliary locations – parents' homes or independent birth centers.

The Official Plan to Eliminate Physiologic Care and the Midwives Who Provided It

In stark contrast to the testimony and studies quoted above, here is how a 1975 article in the *New York Times Magazine* compared the historical care of midwives to that of obstetrical medicine over the course of the 20th century. Note that statements used to characterize midwives and concurrent events do not in fact have a causal relationship with one another. While both statements are true in the strict sense of individual facts, the use of them in juxtaposition with each other is misleading in the extreme.

> "In the United States ... in the early part of this century, the medical establishment forced midwives -- who were then largely old-fashioned untrained 'grannies' -- out of the childbirth business. Maternal and infant mortality was appallingly high in those days...
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> "As the developing specialty of obstetrics attacked the problem, women were persuaded to have their babies in hospitals, and to be delivered by physicians.... Today it is rare for a woman to die in childbirth and infant mortality is (*low*)..." [Steinmann, 1975]

A more contemporary example of this kind of prejudiced thinking can be found in a letter from the Chief of Obstetrics of a major teaching hospital arguing against a 1977 bill to license direct-entry midwives in California:

> "If we want an increase in cerebral palsy, mental retardation, extended hospitalizations for mothers undergoing infections, fistulas, hemorrhages, and other severe and disabling results of neglected childbirth, only then could one endorse bill AB 1896." [Stanford University Medical Center, Dr. Heinrichs, MD, Ph.D, August 1, 1977]

In an undergraduate master's thesis published in 1979, Dr. Neal DeVitt, M.D, describes how the physiological care provided by early 20th century midwives was impacted upon by the obstetrical profession and why obstetricians were so hostile to midwifery and so anxious to eliminate it.

> "The passage of midwifery into the mature stream of medical advances has resulted in the parturient women gaining the benefits of [fetal] auscultation, a more complete knowledge of anatomy and asepsis at it developed. Yet, due to the [low] status of women, these advances were kept largely within the circle of male practitioners and thus did not influence the care of the many uncomplicated confinements [managed by midwives], which the physician did not attend.
>
> "Conversely, at least in the U.S., physicians had little contact with midwives and never learned their useful traditions, among them, <u>patience with nature</u>. During the 19th century, obstetricians in England and the U.S. wished to show the scientific nature of their profession. Moreover, in the United States, the dignity of the profession was thought to be threatened by the practice of midwifery." [Dr. Neal DeVitt, MD, 1975]

While modern-day observers all agree that obstetrics currently enjoys a very favorable professional status, it should be remembered that man-midwifery (as it was called throughout out the 17th, 18th and 19th centuries) was considered the poor step-sister of modern-medicine. Caring for midwifery cases was denigrated as a form of woman's work that was not worthy of the attention of formally-educated medical men. As late as 1915, Dr. Moran wrote that:

> "Obstetrics is the most arduous, least appreciated, least supported, and least compensated of all branches of medicine".

Dr DeVitt continues to explain:

> "The quality of obstetrics was hampered not only by the past failing of medical education but perhaps more so by the nature of the campaign to eliminate the midwife. To discredit the competence of the midwife as a birth attendant, obstetricians had argued that pregnancy, labor and delivery were not normal physiological processes but so fraught with danger that only an obstetrician could safely attend birth." [Dr. Neal DeVitt, MD; 1975]

> "…the philosophy underlying the campaign to eliminate the midwife created a self-justifying bias towards medical interference in birth. Every time the physician applied forceps or performed a Cesarean delivery, he proved to himself that birth was pathologic and therefore he, the obstetrician, was necessary." [DeVitt, MD; 1975]

Here, in the words of early obstetricians, is the historical story of the 20th century development of obstetrics and how obstetricians distinguished themselves from their history as Man-Midwives:

> " .....the ideal obstetrician is not a man-midwife, but a broad scientific man, with a surgical training, who is prepared to cope with most serious clinical responsibilities, and at the same time is interested in extending our field of knowledge.

> "No longer would we hear physicians say that they cannot understand how an intelligent man can take up obstetrics, which they regard as about as serious an occupation as a terrier dog sitting before a rat hole waiting for the rat to escape." 1911-B; Dr. Williams, M.D.]

> "Obstetrics is held in disdain by the profession and the public. The public reason correctly. If an uneducated woman of the lowest class may practice [midwifery], is instructed by doctors and licensed by the State, [birth attendance] certainly must require very little knowledge and skill --surely it cannot belong to the science and art of medicine." [Dr. DeLee, MD; 1915]

> "When public opinion has thus been raised and educated regarding obstetrics, the midwife question will solve itself. With an enlightened knowledge of the importance of obstetrical art, its high ideals, the midwife will disappear, she will have become intolerable and impossible." [1911-B; Dr. DeLee, MD]

> "If such conclusions are correct, I feel that...[we must] insist upon the institution of radical reforms in the teaching of obstetrics in our medical schools and upon improvement of medical practice, rather than attempting to train efficient and trustworthy midwives." 1911-B; Dr. Williams, M.D. p.166

> "The training of midwives in Germany, where they are required to spend 6 months in a government obstetric hospital under the instruction and supervision of trained obstetricians, is far superior to that which the great majority of physicians receive in this country before graduation." 1925-A

> "In general,...the medical schools in this country and the facilities for teaching obstetrics are far less than those afforded in medicine and surgery; while the teachers as a rule are not comparable to those in the German Universities....Yet young graduates who have seen only 5 or 6 normal deliveries, and often less, do not hesitate to practice obstetrics, and when the occasion arises to attempt the most serious operations." 1911-B; Dr. Williams, M.D. p. 178

> "The story of medical education in this country is not the story of complete success. We have made ourselves the jest of scientists through out the world by our lack of a uniform standard. Until we have solved the problem of how NOT to produce incompetent physicians, let us not complicate the problem by attempting to properly train a new class of practitioners. The opportunities for clinical [i.e. 'bedside'] instruction in our large cities are all too few to properly train our nurses and our doctors; how can we for an instant consider the training of the midwife as well?" [1911-C, p. 207]

> "In 1911, the great American obstetrician, J. Whitridge Williams, [original author of *Williams Obstetrics*], completed a survey of obstetrical education in United States medical schools. Williams found that more than one-third of the professors of obstetrics were general practitioners. 'Several accepted the professorship merely because it was offered to them but had no special training or liking for it.' 13 had seen less than 500 cases of labor, 5 had seen less then 100 cases and *one professor had never seen a woman deliver before assuming his professorship.* Several professors of obstetrics were not able to perform a Cesarean section. [Dr. DeVitt, MD, 1975; emphasis added]

Before a medical student was licensed to practice, Dr. Williams reported that:

> "The actual figures show that in 25 schools, each student sees 3 (deliveries) or less, in 9 schools, 4-5 cases and in 8 others, 5 or more cases, while in some of the smaller hospitals this is possible only by having 4-6 [medical students] examine each patient..."

Dr. Williams was highly critical of this situation:

> "The generally accepted motto for the guidance of the physician is '*primum non nocere*' [in the first place, do no harm], and yet more than 3/4 of the professors of obstetrics in all parts of the country, in reply to my questionnaire, stated that incompetent doctors kill more women each year by improperly performed operations than the ... midwife...." [1911-B; Dr. Williams, M.D.; p.180]

> "So much is needed before we can hope to give to the students graduating from our medical schools adequate training in obstetrics and before we can hope to compete with the German medical schools." [1912-B, p.224]

> "We can get along very nicely without the midwife, whereas all are agreed that the physician is indispensable." [1912-B, p.222]

"The question in my mind is not 'what shall we do with the midwife?' We are totally indifferent as to what will become of her..." [1912-B, p.225]

"If the profession would realize that parturition, viewed with modern eyes, is no longer a normal function, but that it has imposing pathologic dignity, the midwife would be impossible of mention." [1915-c; Dr. DeLee, M.D., p.117]

"The midwife has been a drag on the progress of the science and art of obstetrics. Her existence stunts the one and degrades the other. For many centuries she perverted obstetrics from obtaining any standing at all among the science of medicine." [Dr. DeLee, 1915,-c, p. 114]

"The **midwife** is a **relic of barbarism.** In civilized countries the **midwife is wrong**, has **always been wrong.** The greatest bar to human progress has been compromise, and the midwife demands a compromise between right and wrong. **All admit** that the **midwife is wrong.**" [1915-c; Dr. DeLee, M.D. p. 114]

"It is, therefore, worthwhile to **sacrifice everything, including human life** to accomplish the [obstetric] ideal." [Dr. DeLee, 1915]

"Of the 3 professions---namely, the physician, the trained nurse and the midwife, there should be no attempt to perpetuate the last named [midwife], as a separate profession. The midwife should never be regarded as a practitioner, since her only legitimate functions are those of a nurse, plus the attendance on normal deliveries when necessary." [1915-A; Dr. Edgar, M.D. p. 104]

"The doctor must be enabled to get his money from small fees received from a much larger number of patients cared for under time-saving and strength-conserving conditions; he must do his work at the minimum expense to himself, and he must not be asked to do any work for which he is not paid the stipulated fee. This means...the doctors must be relieved of all work that can be done by others ---... nurses, social workers, and midwives.

"The nurses should be trained to do all the antepartum and postpartum work, from both the doctors' and nurses' standpoint, with the doctors always available as consultants when things go wrong; and the midwives should be trained to do the work of the so called 'practical nurses', acting as assistants to the regular nurses and under their immediate direction and supervision, and to act as assistant- attendants upon women in labor---conducting the labor during the waiting period or until the doctor arrives, and assisting him during the delivery.

"In this plan, **the work of the doctors** would be **limited to the delivery of patients**". [1922-A; Dr. Ziegler, M.D., p.412- 413]

This successful campaign to eliminate physiological care and abolish independent midwifery not only impinged on midwives but, in recent times (1970s), obstetricians turned the arguments historically used against midwives against general practitioners and family-practice physicians as well. Obstetricians argued, as always, that even completely healthy women with normal pregnancies, could ONLY be safely cared for by an obstetrically trained surgeon. Obstetricians controlled the committees that set hospital policies for maternity care providers. All over the country the resulting policies have, by and large, prevented not only midwives but often family practice doctors from attending normal births in the hospital. This is perhaps the *most important factor* in the runaway cost

of normal childbirth and in the ever-escalating use of high-tech interventions as a routine part of the obstetrical "package".

All of this leaves us with a profoundly dysfunctional, expensive and unsafe maternity care system with a 99% medicalization rate for healthy women and a 70% rate for the use of surgical procedures during normal childbirth [*Listening to Mothers* Surveys, 2002, 2005]. This includes a persuasive, well-financed and committed group of obstetricians who are rushing us toward the ultimate surgical procedure of childbirth – Cesarean section as the standard of care for the 21st century. This is being done in the name of safer, better and more cost-effective maternity care for healthy women. And yet, we have just read the record – decades after decade of preventable deaths and disabilities, all a result of irrational obstetrical policies. Would you buy a used car from someone with such a track record?

Conclusions

The excesses of 20th century obstetrics as routinely used on healthy women have been as damaging to the health and wellbeing of childbearing women and their unborn/newborn babies (and as expensive) as cigarette smoking promoted by the tobacco companies during this period. We can easily forgive the great hand-washing scandal of the 1840s based on the general ignorance of all humanity about the presence and consequences of microscopic pathogens.

What we cannot abide is another hundred years of a slightly different, but no less harmful, blind spot – a twentieth and now twenty-first century version of the hand-washing scandal. In this case, the mechanism for iatrogenesis is the resistance of individual obstetricians, combined with ACOG's institutionalized rejection of the simple and common-sense facts of science-based care for a healthy childbearing population. Physiological management is the efficacious form of maternity care – safest plus most cost-effective -- for healthy women with normal pregnancies. Just like the original hand-washing scandal in 1847, iatrogenic harm has been systemized and institutionalized and as vigorously defended as it was by the contemporaries of Dr Semmelweis, who denied that they could possibly be the cause of any harm.

Currently, the obstetrical profession wants us to think of obstetrics as *the most beneficial form of medical care*, the idea that obstetrical interventions routinely used on all childbearing women is responsible for saving more lives and eliminating more suffering and disability than *any other form of medical or health care*, bar none. Having just read the record, this is hard to swallow.

The obstetrical profession can only come to this fanciful conclusion by denying and covering up the real story of obstetrics in the 20th century. If one does the math generated by all those comparison statistics for midwifery versus obstetrics for a healthy population (be reminded, for example, of Dr. Dublin's remark in 1932 that county-wide availability of physiologically based midwifery care would save 70,000 lives a year; and the discontinuance of the nurse midwifery pilot program in Madera County California in1964, which resulted in the tripling of the perinatal mortality rate), one comes to the chilling but inescapable conclusion that preventable deaths of mothers and babies from inappropriate use of obstetrical interventions on healthy women is equal to or greater than the 6 million that died in the Holocaust during WWII. Institutionalized iatrogenesis is not a beneficent miracle of modern medicine and it is certainly nothing to be proud of!

The antidote for a broken system built on erroneous assumptions and bad habits and kept alive by pseudo-science and lack of investigative journalism can only be found in a return to common sense. Planet-friendly or green maternity care is based on the physiological management of normal birth by

midwives, family practice physicians, and any obstetrician who wants to provide science-based birth services to his or her healthy OB patients. For doctors, this will mean being brave enough to admit that the evidenced-based model of care for healthy women is rightly called by its historical title: midwifery.

The final quote in this document is a superb definition of the historical discipline of "man-midwifery" by a physician speaking in 1911. I personally would like to see his advice returned to its rightful place of honor in our national healthcare policy.

> "The function of the physician in midwifery cases is to secure for the woman the best possible preparation for her labor, to accomplish her delivery safely and to leave her, so far as possible, in good physical condition; to prepare the mother for, and teach her the importance of nursing her baby and to do everything that is possible to bring this about." [TAASPIM - Charles Ziegler, 1911]

This is an excellent definition of appropriate maternity care and the basis for collaborative practice between physicians of all backgrounds and midwives. While there will be some physicians who want to and will have the temperament to employ the skills of midwifery – full-time presence of the primary practitioner during active labor, patience with nature, right use of gravity, etc -- there will be many more, especially those trained as obstetrical surgeons, for whom the *best way* for them to secure these attributes for healthy women will be to recommend the care of midwives.

~"There is no alibi for not knowing what is known"
J. Rovinsky, MD -- a quote from the foreword of Davis Obstetrics:

Midwives are suggesting, in the strongest possible terms, that an exchange of expertise is in order between midwives and physicians. It is as much the responsibility of physicians to be familiar with the time-honored philosophy, principles, and skills of midwifery as it is the duty of midwives to know the principles of anatomy and asepsis and the skills necessary to recognize complications and respond appropriately. Midwives are in agreement that modern obstetrics has much to teach and much to contribute to the wellbeing of the families it serves, and will become far more beneficial when it recognizes physiological management as the gold standard of care. As midwives we have already availed ourselves of both formal and informal study of obstetrical science, in addition to mastering our own discipline of physiologically-based childbirth.

Likewise, the honorable but unassuming traditions midwifery has historically provided -- the art of being "with woman" -- a quietness of spirit, patience with nature, the intimacy skills which serve childbearing families so well -- are also of great value to the bio-medical sciences. We believe that physicians cannot begin to examine their own prejudices without specific information on the nature of these principles and the opportunity to build personal and professional relationships with practicing midwives. This will require a level of honesty that we have not seen for the last 100 years. It must begin by ending the obstetric supervision of professional midwives and providing for genuinely collaborative and complementary relationships between the professions of medicine and midwifery.