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Modern Medicine vs. Midwifery

For millennia, women have given birth at home with the assistance of other women and, until the late nineteenth century, were rarely attended by physicians or males at all. Many mothers and infants were lost while we gained the scientific knowledge to prevent such losses, or to understand their occurrence. Modern medicine began improving mortality rates with antiseptic methods in sterile environments, and interventions in high risk pregnancies (Kaplan). Today, modern medicine has taken precedence over midwifery; leading to unnecessary interventions in childbirth, increased rates of cesarean sections, and expensive hospital stays.

Hospital births began taking a hold in the early twentieth century, when the advances in antiseptic methods and medications promised a safer, pain-free birth appealed to the women who feared for their lives, and the lives of their unborn children, as they had since the dawn of humankind. In fact, by 1900 50 percent of American births were attended by midwives and the other 50 percent by physicians (Ettinger). However, infant and maternal mortality rates were not much higher in clinical settings than in a clean home attended by a midwife. Regardless, medicalization of childbirth occurred; a change in birth attendants from midwives to physicians (female to male) and location from home to hospital (Ettinger).

“IS nurse-midwifery the solution?” Sister M. Theophane Shoemaker, nurse-midwife and director of Santa Fe’s Catholic Maternity Institute, asked in an article written in 1946. For Shoemaker, the answer was obvious: nurse-midwives, working in collaboration with physicians, could provide a permanent solution to the problem of

poorly distributed and inadequate maternity care that had existed for decades in the United States (Ettinger).

Following World War II, a baby boom erupted throughout the United States. The American birthrate soared between 1945-1965, peaking in 1957 with 4.3 million births (Roark). With so many mothers giving birth and trained midwives were few and far between, physicians and hospitals provided an known alternative.

In the early 1940's Sister Theophane worked in a maternity and nursery unit, witnessing firsthand the effect of new-age medicine during the birthing process. High dosages of scopolamine (an amnesiac) in addition to morphine lead to birthing mothers who were drifting in and out of a state of consciousness animalistic in nature (Ettinger). Many women left the hospital thankful they could not recall the pain of childbirth while others grieved the missing memories; both sometimes left without their infants and some left in a hearse due to high infant and maternal mortality rates, respectively. Sister Theophane trained as a nurse-midwife and began a home delivery nurse-midwifery service in 1944 where she observed a notable difference between midwife attended births and physician attended births (Ettinger).

“We treated mothers as human beings—[seeing] mothers as part of families—and [making] maternity care a real physiological activity rather than a pathological activity. . . . It just was amazing . . . the difference . . . when a mother was conscious, knew what was going to happen to her, was able to control her feelings to some extent, was able to cooperate with you and was able to receive the baby with some kind of mental stimulation, some love. And to put the baby to breast right away after delivery, which we always did, . . . was a very physiologically healthy thing to do. And the simplicity of the

whole operation—I don't want to call it an operation—of the whole procedure was just wonderful.” (Ettinger)

Women began to notice the difference too. Those who could make the choice to see a midwife often did so until physicians began to catch on and perpetuated the belief that nurse-midwives were not safe, ill-trained, or practicing without the knowledge of modern hygiene practices to decrease the risk of sepsis. Nurse-midwives did not let that stop them however, including Sister Theophane, who continued her work with her fellow midwives, fighting prejudice and opposition along the way.

Today, American nurse-midwives attend a small but steadily growing percentage of births. In 2003, nurse-midwives attended 7.6 percent of American births, a rise from less than 1.0 percent in 1975 (Ettinger).

While the number of births attended by midwives is steady growing, the home birth is still struggling to regain footing. Technological advancements and emergency interventions that a hospital provides seem all too good to forego when faced with childbirth; I can attest to this myself. Many women, especially first-time mothers or women who do not have an influential mother in their own life, fear first time childbirth. Labor and delivery, as well as motherhood, is as great of an unknown as pregnancy was before experiencing it for oneself. Physicians attempt to answer your clinical and pathological questions, ease your fears, and provide you with proper care but miss a key component of connection. Midwives, however, can only take on so many patients and therefore have more time to speak with you on a level of understanding with compassion and the matriarchal tone that a soon-to-be-mother needs to soothe her nerves. Unfortunately, society still perpetuates ignorance of midwifery and midwives are still not as numerous as obstetricians; and so the fearful mother often follows the proverbial herd to the

clinical delivery room. It is here where women are often swayed from their birth plans toward what is considered safer, routine, and easy for a physician who doesn't have the time available to wait out labor.

Although medical and technological advances in maternity care have drastically reduced maternal and infant mortality, these interventions have become commonplace if not routine. Used appropriately, they can be life-saving procedures. Routine use, without valid indications, can transform childbirth from a normal physiologic process and family life event into a medical or surgical procedure. Every intervention presents the possibility of untoward effects and additional risks that engender the need for more interventions with their own inherent risks. Unintended consequences to intrapartum interventions make it imperative that nurse educators work with other professionals to promote natural childbirth processes and advocate for policies that focus on ensuring informed consent and alternative choices (Jansen et al).

Most women who enter a hospital for childbirth today are prepared to receive an intravenous port (IV) for fluids, synthetic hormones, medications, and potentially blood transfusions or platelet infusions; this common practice requires the signature of the mother stating she refuses treatment if she chooses to forego. A midwife, on the other hand, would suggest an IV only if a mother is exhibiting dehydration or needs help with a long labor (administration of Pitocin to induce contractions). When the pain becomes unbearable, as it does, most women will ask for pain relief in the hospital if they hadn't already opted for it; the methods vary but can affect both mother, baby, and come at a high risk for hindering labor. Many women become drowsy or are unable to feel when a contraction is coming on, which can slow delivery, harm the fetus, and require further intervention by use of forceps or even a cesarean section if labor has stalled and baby or

mother are in distress. With a midwife, cesareans and other interventions are not commonplace. Midwives teach pain management with natural, time-tested practices and with loving guidance; not popping in and out of the room only long enough to check that a patient's vitals are normal before running off to care for the other six mothers also in some stage of labor in their unit. Midwives assess risk factors before allowing a home birth, they sometimes work out of hospitals as well or alongside physicians. Data has shown that nurse-midwives serving low risk mothers use less interventions and therefore require less secondary interventions; avoiding the domino affect illustrated above.

Nurse-midwife-managed patients had a significantly lower rate of cesarean section (8.5% versus 12.9%) and operative vaginal delivery (5.3% versus 17%) than the physician-managed patients. Epidural anesthesia and oxytocin for induction and augmentation were used significantly more frequently in the physician-managed patients. Both interventions were associated with an increased rate of cesarean section. Fetal outcomes in the two groups were not statistically different. Women cared for by nurse-midwives had a lower cesarean section rate, fewer interventions, and equally good maternal and infant outcomes when compared with those cared for by physicians (Davis et al).

The above statistics came from a study completed between 1987 and 1990, however, cesarean rates have continued to climb, averaging 32 percent in the U.S. in 2017. With the implementing of modern science, one would assume the rates would decrease.

Hospital stays, medications, surgeries and other costs that are typical of a hospital birth are soaring. In fact, a natural (without intervention) vaginal birth at the hospital typically costs \$2,600 versus \$4,500 for a cesarean (Fetters). This amount is not accounting for additional costs

with perinatal, postpartum, or neonatal care; also not accounting for overnight stays that are typically required unless signing an AMA (a document stating that one is going against medical advice). The cost of an uncomplicated vaginal birth with minor interventions, perinatal, postpartum, and neonatal care over the course of a 36 hour stay was \$19,000 in 2013 at a Maine hospital. This does not account for perinatal care over the course of the pregnancy, which accounted for another few thousand dollars, per my personal experience. In contrast, a midwife provided perinatal care during pregnancy and delivery in a birthing suite and postpartum and neonatal care for 24 hours, then multiple home visits postpartum, for one flat fee of \$3,600 in the year 2018.

Overall, it is clear that modern medicine has added multitudes of interventions to the birthing process that lead to increased risk of cesarean section and costly medical bills. Bringing back the midwife as a first choice and offering physicians as a back up for high risk individuals or in case of an emergency would be best. Hopefully the current movement in liberating women from the bonds of hospital birth will succeed in our country as it has abroad.

Works Cited

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