A grass-roots rebellion against establishment obstetrics quietly gathers momentum

BY GENA COREA

CHILDBIRTH 2000

Nativity, A.D. 2000. Susan Rogers wants to give birth the old-fashioned way—vaginally. Since most hospital births are done by cesarean section, Susan decides, after her gynecologist confirms her pregnancy, to deliver at home. The midwife—midwives are illegal but omnipresent in America—screens her for risk factors. She finds none.

Toward the end of the pregnancy, while Susan and her husband are relaxing at their home in the woods of Brattleboro, Vermont, a helicopter swoops down and lands in the backyard. A physician and a policeman emerge from the machine and produce a court order authorizing them to take the unborn baby into protective custody to prevent child abuse. They force the screaming woman into the helicopter.

At the hospital, Susan is taken into a birthing suite decorated with houseplants, flowered drapes, and a bedspread. She sits in a rocking chair, stunned, unaware that during her one and only visit to the gynecologist, he registered Susan's pregnancy with the Regional Perinatal Center and implanted in her vagina a tiny receiver for the electronic fetal monitor along with a device used to track down migratory animals.

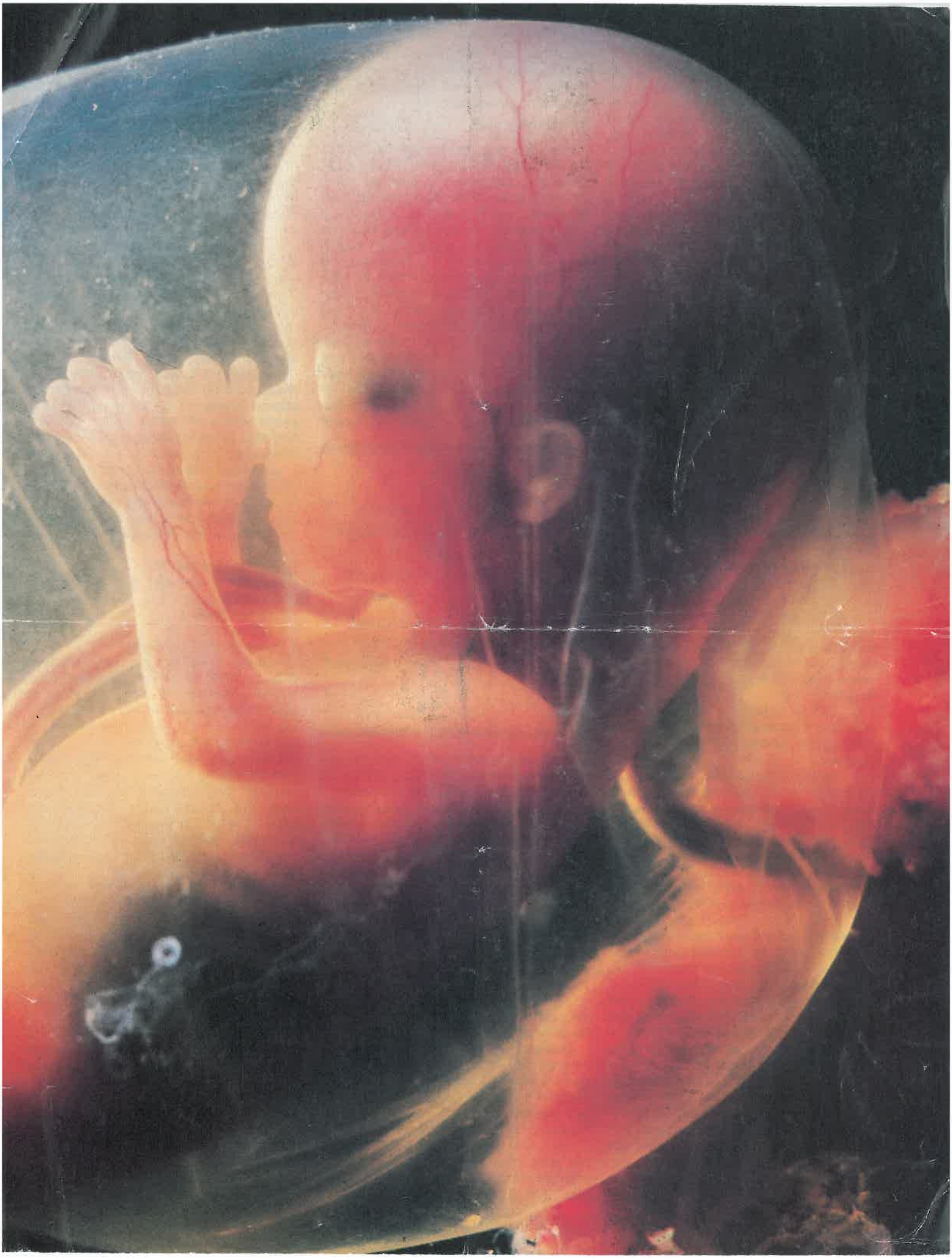
In the computer room, which looks much like a NASA communications center, obstetricians have been following her pregnancy for months. (Doctors at the center often joke that they are conquering inner space.)

Susan's labor is induced with Pitocin, a stimulant. Two hours later, in the computer center behind the suite, the screen displaying her monitoring signal reveals "fetal distress."

The alarm sounds. Susan is rushed into the operating room, strapped to the table, anesthetized. A doctor takes a knife, cuts her abdomen open, and pulls the baby from her womb. Attendants transport the baby to the intensive-care unit for treatment of respiratory distress.

The patient, still dazed, is wheeled back to the homey birthing suite.

This is Norma Swenson's grim vision of



childbirth in the year 2000. Swenson, who holds a master's degree from Harvard School of Public Health, is coauthor of *Our Bodies, Ourselves*. Having been active in childbirth groups for twenty years, she is former president of the International Childbirth Education Association (ICEA).

Why do visions of helicopters dance in her head at night? Because this is happening during the day:

- The executive director of the American College of Obstetricians and Gynecologists (ACOG) declared in 1977 that home birth, a growing trend, constituted "child abuse" and "maternal trauma."
- Three home-birth couples—in Louisiana, Idaho, and North Carolina—were accused of child abuse in early 1978. In the North Carolina case, police, acting on an obstetrician's complaint, forcibly took the woman from her home while she was in labor and transported her to a hospital.
- A low-income woman who wanted natural childbirth refused various interventions, including Pitocin injections to speed up her labor, at Boston City Hospital in June 1978. The hospital tried to get a court order forcing her to accept the drug. Then, as her lawyer explained, "There was some concern that this lady must be crazy because she refuses to do what the hospital staff tells her to do." They called in a psychiatrist to judge her mental health while she was in labor. After many hours, they "persuaded" her to accept Pitocin and anesthesia. Several days later, the hospital announced it was instituting proceedings to take her baby on the ground that she might endanger her child. The baby, placed in a foster home for months, has finally been returned to her.
- Dr. Jack M. Schneider, codirector of the Wisconsin Perinatal Center in Madison, has proposed a national registration of pregnancies.
- A "regionalized system of obstetrical treatment," which involves shutting down maternity services in small community hospitals and transporting mothers and infants to large, technologically oriented hospitals, is being established throughout the United States.

Suzanne Arms, author of *Immaculate Deception*, believes that when America has been fully converted to a regionalized obstetrical system, physicians and health authorities will be closely coordinated enough to make Norma Swenson's helicopter nightmare a real possibility.

Increasingly, women like Susan Rogers want midwives to help them bear their children at home. With the reemergence of midwives in America today, it is important to ask why they ever disappeared.

As Dorothy and Richard Wertz point out in *Lying-In: A History of Childbirth in America*, physicians in the nineteenth century struggled to drive these women, their competitors, from the lying-in chamber. They saw midwives as threats to the very founding of their practice at a time when no established medical profession existed in North America. Women, they feared, might seek midwives for help with all their "female troubles," and doctors would lose at least half their potential patients.

BIRTHING IS LIKE A CAR CRASH

Historians emphasize this point: *Doctors did not replace midwives in America because their attendance at birth assured a safer outcome*. "They just claim that was the case, but it was not," says G. J. Barker-Benfield, assistant professor of history at the State University of New York at Albany and author of *The Horrors of the Half-Known Life*, a book that, in part, explores the origins of obstetrics and gynecology in America. "In fact, I'm trying now to explain the proliferation of gynecological disorders very often following birth at the hands of men. Contrary to being safer, obstetricians may well have been more damaging than midwives." The aggressive obstetrics of men, with the frequent use of forceps to speed up a labor process doctors often found tedious, lacerated cervices and tore holes in the birth canal, Professor Barker-Benfield noted.

"The ability to actively manage childbirth with new technology gives physicians great power to control nature. Month by month this power grows, so that by the year 2000 home births may be outlawed."

During and after the antimidwife campaign, physicians redefined birth, changing it from a normal to a pathological process. They asserted that no precaution—including the employment of a physician—was too great to avoid its frightening dangers.

In 1920, an influential paper advocated routine forceps delivery and episiotomy (an incision made to widen the birth canal) for *all* deliveries. Dr. Joseph DeLee, one of the most revered men in American obstetrics, asserted that normal birth was pathologic and compared it to a baby's getting his head caught in a door.

Demonstrating that physicians still view birth as pathologic, Dr. Edward Hon, developer of the electronic fetal monitor (EFM), recently compared normal labor to a certain railroad crossing "where cars get smashed up and people get killed."

Such a dangerous event seemed to justify what obstetricians now call "active management of labor"—the artificial initiation, control, and termination of labor by doctors. This active management has gone far beyond the routine surgical procedure (episiotomy) that DeLee brought to normal birth, a procedure that has never been demonstrated, by any study, to benefit mothers or babies.

Interviews with prominent obstetricians reveal that by 2000, childbearing women (who under the pathological model of birth have become "patients") and their unborn babies can expect new forms of "active management."

Since obstetricians are developing techniques for reaching babies *in utero*, they may be peered at, medicated, and operated on before they are even born, several doctors enthusiastically told me.

In one procedure, the obstetrician will cut into the pregnant woman's abdomen and uterus and, using what is called a "fiberoptic endoscope," push into the amniotic sac and peer at the fetus through the telescopic lens in the instrument. Then the doctor will clip off a piece of the baby's skin and draw blood from it for what doctors call "diagnostic purposes."

Long-term effects of this procedure on mother and child are unknown; but Dr. R. Alan Baker, a fellow of the American College of Obstetricians and Gynecologists, lists some of the immediate risks to the mother:

- Spontaneous abortion.
- Leakage of amniotic fluid during later months of pregnancy.
- Uterine bleeding.
- Infection.
- Puncture of other organs.
- Rupture of the baby's blood vessels, leakage of the blood into the mother's circulation, and the consequent buildup of antibodies in the mother against her child's blood.
- Psychiatric disturbances.

Baker questions whether fetoscopy—with its risks of uterine trauma, ruptured amniotic sac, damage to the eyes of the fetus from the intensity of the fiberoptic light—is a safe method of diagnosis. He points out that other, more accurate methods are available for determining congenital defects.

FETUS UNDER GLASS

In 2000, doctors will be able to medicate the "sick" fetus by injecting drugs into the amniotic fluid or by inserting a needle directly into the fetus. The success of the procedure, of course, will depend upon the doctor's ability to hit the right part of the unseen baby.

Long-term effects of injecting drugs into the still-developing fetus are unknown. However, testimony by Dr. Yvonne Brackbill, graduate research professor at the University of Florida in the departments of psychology and obstetrics-gynecology, before the Senate Oversight Hearings on Obstetrical Practices, in 1978, might give physicians cause for concern. Brackbill, who reviewed twenty-five studies on the effects of obstetrical medication of the fetus,

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noted that the newborn is an organism poorly positioned for dealing with drugs. The drugs, she observed, "lodge in brain structures that are still developing and are therefore at high risk to damage. They are not readily transformed to nontoxic compounds since the necessary liver functions are immature. And they are not readily excreted because of inefficient kidney function."

Obstetricians could, of course, peer at, medicate, and operate on a fetus more efficiently if it developed in a glass container. Even that is envisioned by one medical ethicist, Dr. Joseph Fletcher of the University of Virginia Medical School. During a discussion of the first test-tube baby, an ABC television interviewer asked Professor Fletcher last July, "Do you foresee the day when artificial wombs made of plastic or metal or whatever will be used?"

"Yes, yes, I foresee it with urgent approval," he replied. "I think I should be eager for the day when I could actually see, let's say through a glass container, a conceptus develop from fertilization through to term and see how all kinds of congenital mishaps which destroy or injure these babies might be prevented by medical tactics and medical strategies."

By 2000, electronic fetal monitors, used now to record the mother's contractions and the baby's heartbeat, may operate without wires, through telemetry (remote-control monitoring of a fetus), says Dr. L. Stanley James, of Columbia University, who specializes in the care of newborns. "That's the same as the astronauts have," he noted.

Dr. Edward Hon acknowledges that all the techniques for such monitors (key elements in the helicopter nightmare) are available today.

"There is a dual electrode that can be placed in the vagina right now," Dr. John Evrard, associate director of community reproductive health services at Women's and Infants' Hospital in Providence, adds. "And I foresee the time when we will have it transmitting to a piece of equipment while the woman is up and walking around. If they can do it from the moon to the earth, they certainly can do it from a woman to a console fifteen feet away."

(Space-age analogies come up extraordinarily often in conversations with obstetricians. Indeed, obstetricians are already using some technology developed in the space program.)

In the future, the monitors may be attached to digital computers. Referring to the development of this "computerized labor system," Dr. Charles Flowers of the University of Alabama School of Medicine wrote in an early paper on the concept that the project was designed "to utilize modern computer and electronic knowledge to monitor the fetus *in utero* with the same thoughtfulness as we monitor a man in space."

Dr. Saul Lerner, in a vision not shared by other obstetricians interviewed, hopes computers will calculate how long each stage of labor should be. In October 1977, Dr. Lerner, past president of the Massachusetts section of ACOG and a faculty member at the University of Massachusetts Medical School, told the *Boston Globe*: "We now have a very aggressive approach to pregnancy. There's a whole new concept plotted out by computers, how long each stage of labor should be. We will not allow a woman to labor for more than four hours without making progress. We do cesarean sections freely."

INTRODUCING THE BIRTH FACTORY

Acknowledging that hospital birth lacks "warmth," some doctors foresee a less mechanized birth by 2000. Obstetricians will develop machines and techniques that are unobtrusive, noninvasive, and less visible, they say. Surroundings will be made more pleasant for mothers. Curtains will be flowered.

"Obstetricians have an economic and emotional stake in suppressing midwives. Yet up to 90 percent of well-nourished childbearing women can give birth without obstetrical intervention."

"We'll be able to monitor things without too much invasion of the patient's body," Dr. Flowers of Alabama predicts. "We're going to combine warmth and a humanistic attitude with newer developments in electronics."

However, the fact that a regionalized system of perinatal care providing high-technology assistance for all pregnant women is now being established throughout the United States casts doubt on the prediction that birth will soon be re-humanized. According to a plan published in 1977, small maternity services in local communities will close down and all birthing mothers will be sent to large regional centers boasting the latest obstetrical technology.

Dr. Muriel Sugarman, a psychiatrist and a member of the Ad Hoc Committee on Regionalization of Maternity Services in Massachusetts, disapproves. The plan, she states, was devised by organized medicine, which believes "... that quality of care is measured by level of technological capability and that birth is a high-risk, intensive-care, disease-ridden process on a par with cardiac surgery. . . ."

In the year 2000, Dr. Sugarman maintains, regionalized care will force mothers to go far from their communities and loved ones to bear their babies "in large, cold, impersonal birth 'factories.' "

Dr. Jack M. Schneider, codirector of what Dr. Sugarman might term a "birth factory"—the Wisconsin Perinatal Center in Madison—predicts that by the early 1980s, all pregnancies, registered by physicians with the regional perinatal center, could be monitored throughout the United States. Commenting on this prediction, Elliott M. McCleary writes in his book *New Miracles of Childbirth*:

"Then virtually every fetus nestled or kicking in every womb throughout America would have an electronic guardian angel in the form of a watchful computer."

Indeed.

It is this potential development, coupled with regionalization, that gives Suzanne Arms the same bad dreams Norma Swenson has. What it will take to realize the helicopter scenario, she thinks, is the implementation of regionalization "to the point where everybody knows what everybody else is doing."

The ability to "actively manage" birthing with the new technology gives obstetricians great power to control nature. Month by month, this power grows. As the world realized last summer with the birth in Britain of Louise Brown—conceived in a petri dish and delivered by a knife—doctors can control not only parturition (the birth process) but reproduction itself.

Physicians can artificially inseminate a woman. They can fertilize an egg artificially. They can implant a fertilized egg in a uterus. Now men like Dr. Robert Goodlin of Stanford are hard at work on those glass or steel wombs whose mass production Dr. Fletcher so joyfully envisions. "Quality control" talk is on the increase.

Articles in the popular press now encourage parents to seek genetic counseling before they conceive, in order to prevent the production of "defective" children.

RETURN OF THE MIDWIFE

But perhaps reproduction and childbirth in 2000 will not be managed entirely as obstetricians would like it to be. A grass-roots rebellion against establishment obstetrics is now beginning to gather momentum. It broke out, quietly at first, in 1960. Parents and childbirth educators, along with many nurses and some physicians, formed the International Childbirth Education Association. Respectfully, they challenged the validity of routine obstetrical practices and pressured obstetricians to adopt "family-centered maternity care." Under that program, husbands would be allowed to stay with their wives during delivery and women would be permitted to see their babies more frequently.

As the Protestants did, the movement is

splitting into sects. In 1975, the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) sprang up. The more militant NAPSAC members were not willing to ask physicians to "allow" them more participation in the birth of their children.

"We've done scientific research to determine what basis there is for hospital birth, and we don't find any basis," Dr. David Stewart, NAPSAC director, notes. "The only justification for going to the hospital is if you have some sickness or complication. This only applies to 10 or 20 percent of mothers." (His wife, Lee, delivered their children at home.)

Studies comparing home and hospital birth have found that for healthy mothers, the home is safer, Dr. Stewart, a physicist, continues. He refers specifically to studies by medical statistician Marjorie Tew and Dr. Lewis Mehl, director of research at the Center for Research on Birth and Human Development.

In 1972, other activists formed the Society for the Protection of the Unborn through Nutrition (SPUN). This group campaigns for scientific nutrition management in obstetrics and discourages obstetricians from prescribing the standard low-calorie, low-salt diet during pregnancy. Pointing to studies linking physician-supervised prenatal diets to serious disorders in the child and to toxemia in the mother, SPUN founders charge that the standard regimen—prescribed by obstetricians who have had no training in applied nutrition—damages the fetus.

In September 1977, SPUN won a precedent-setting case when a jury found an Indiana obstetrician guilty of malpractice for prescribing an inadequate diet and diuretics to a pregnant woman who subsequently gave birth to a mentally retarded child.

As SPUN, NAPSAC, and ICEA were growing, some women, rejecting expensive hospital maternity care they found dehumanizing, began to deliver their babies at home, often with the help of only a few inexperienced friends. These women began to be called upon for help by their friends and neighbors when they too wanted a home birth. They gained knowledge and skill. Some emerged as lay midwives.

In January 1977, more than 200 midwives held their First International Conference of Practicing Midwives in El Paso, Texas. "Home birth is a civil-rights issue," says Judith Luce, a lay midwife in Boston. "It's a woman's civil right to give birth where she chooses to give birth. It's a family's right to maintain the privacy of family life." Nationwide, an estimated 1.5 percent of births occur at home.

Such home-birth activists, who see obstetricians as a special-interest group, challenge the assumption that the values of physicians should be given more weight than their own. Their beliefs are generally summarized as follows: • Up to 90 percent of well-nourished childbearing women can give birth without difficulty or the need for obstetrical intervention. • Rather than continuing research on intensive-care units and sophisticated machinery for defective newborns, specialists in maternity care should emphasize the prevention of birth complications by counseling pregnant women on nutrition and by supplementing inadequate diets. • Obstetricians have an economic and emotional interest in suppressing midwives and in defining the needs of birthing women as highly complex. • As SPUN notes, major technological advancements in obstetrics and perinatology such as intensive-care nurseries, amniocentesis, and ultrasound have not led to marked improvement in maternal and infant health during the past two decades. (Amniocentesis entails inserting a needle into the uterus, drawing fluid from the amniotic sac of the fetus, and testing the fluid for metabolic and chromosomal defects. Ultrasound is a mechanical radiant energy used as an alternative to X rays to visualize the fetus. The external EFM also employs ultrasound in monitoring the fetus during labor.) • Many technological interventions in childbirth lead to iatrogenic (doctor-caused) illness. • The long-term effects of invasive diagnostic procedures and manipulations of normal labor (amniocentesis, elective induction of labor with oxytocin drugs, ultrasound, etc.), while as yet unknown, may be considerable and adverse. • They, as parents, and their children will have to live with any adverse effects, and obstetricians will not.

"Birth activists, who see ob-gyns as a special-interest group, challenge the assumption that the values of physicians be given more weight than their own."

As Dr. Stewart asserts, parents have a right to choose what may seem to the professional a wrong choice.

QUESTIONABLE PRACTICES

Childbirth organizations offer scrupulously documented critiques of many current obstetrical practices, the benefits of which, they maintain, have never been proven to outweigh their risks. They observe, as Dr. Lewis Mehl does, that standard obstetrical practices have often been established on the basis of single-case anecdotal reports that do not reflect systematic investigation and research.

Testimony presented at Senate oversight hearings on obstetrics last April supported Dr. Mehl's contention. Many drugs, surgical procedures, and instruments commonly used in obstetrics, Senator Jacob Javits stated there, had apparently "never been conclusively tested for the relative risk and benefit."

Dr. Donald Kennedy, Food and Drug Administration (FDA) commissioner, presented testimony that, while dispassionately phrased, constituted a devastating indictment of the unscientific way American obstetricians establish routine practices. In case after case, he reported that upon examination certain drugs and procedures widely used by obstetricians had been found: to be ineffective for the purpose to which obstetricians put it (DES and other synthetic hormones to prevent miscarriages; diuretic drugs to prevent toxemia; and, possibly, electronic fetal monitoring); • to expose mother and/or fetus to serious risks often to achieve an unclear benefit (elective induction of labor; X rays; sex hormones to diagnose pregnancy; pain-relieving drugs during labor; DES and other hormones for miscarriage; and electronic fetal monitoring, which, according to two studies, entails an increased risk of cesarean section without any improvement in infant outcome); • to present possible long-term effects, the extent of which obstetricians remain ignorant of (ultrasonic radiation and all of the above).

Senator Edward M. Kennedy observed at the hearings: "The development of obstetrical technology far outstrips our capacity to assess its appropriate value. As a result, common practice is established before appropriate practices can be defined."

The widespread use of ultrasonic equipment during pregnancy and in fetal monitoring during labor was a perfect example, he added. While ACOG believes ultrasound to be safe and recommends its widespread use, FDA scientists are concerned about its possible dangers, Kennedy noted. (In some animal studies, an increased incidence of fetal deformities has been found after low-level exposure to ultrasound.) EFM is another procedure widely used despite the fact that its efficacy has never been conclusively demonstrated. Developed in the 1950s by Dr. Edward Hon, now chief of perinatal research at University of Southern California Medical School, internal monitoring records fetal heart rate and uterine contraction pressure. The physician breaks the protective bag of waters prematurely and inserts two catheters containing electronic leads. One spiral electrode punctures the fetal scalp and relays the fetal cardiogram. The other relays the rate and pressure of uterine contractions.

Originally planned for high-risk pregnancies, EFM is increasingly being used routinely for *all* labors despite a study by Dr. J. F. Roux showing that one half the tracings

of fetal heart rate and uterine contractions cannot be interpreted, that 25 percent of the women describe fear and pain associated with the monitoring catheter, and that complications include bleeding, minor vaginal and cervical lacerations, uterine perforation, increased incidence of infections, and fetal-scalp hematomas.

Moreover, a study by Dr. Albert Haverkamp of Denver General Hospital comparing the effectiveness of EFM to the old-fashioned method of monitoring fetal heart tones (with a fetascope) revealed no differences in infant outcome between the two groups. But there *was* a striking increase in cesarean sections performed for fetal distress in the electronically monitored group (16.5 percent versus 6.8 percent).

From 1971 until 1976 the cesarean-section rate increased 95 percent in the United States. The rate nationally is almost 20 percent of all births, and some doctors are arguing that it should go even higher.

Obstetricians assert that the rates are climbing because they are able to diagnose previously undetected "fetal distress" with EFM and save the baby through quick surgery. Dr. Haverkamp's study, and another conducted by a Harvard School of Public Health physician, challenges this belief. Moreover, Dr. Hon maintains that doctors are performing many unnecessary cesarean sections because they do not understand the meaning of the EFM tracings and they panic unnecessarily. "Most of the sections that are done for fetal distress are really done for obstetrician's distress," Dr. Hon has said.

For the mother, cesarean section is a major operation that always involves the risks of anesthesia and, sometimes, blood transfusion. Half the mothers suffer a post-operative complication. Moreover, women have from five to twenty-six times greater risk of death from cesarean than from vaginal delivery. Despite such statistics, doctors are now routinely reaching for the scalpel at the first sign of irregular fetal-monitor indications.

OBSTETRICAL BACKLASH

Cindy Duffy, an Illinois woman who has had a cesarean, formed Cesarean Support to help others distressed by the operation. She notes that after the births of the 1940s and '50s, when women were often given the hallucinogen scopolamine, put out under general anesthesia, and not allowed to actively participate in the birth, mothers began insisting on "natural" childbirth. Thousands of mothers, she said, have since experienced rewarding births with minimal medical assistance. Now, many women are even delivering at home successfully.

"The obstetrician has seen his profession slowly lose its grip on women and made one last stab at regaining control via surgical interference," says Duffy. "After all, can you do a home cesarean?"

Ms. Duffy is not alone in sensing that obstetricians feel threatened by the growing home-birth trend. Shari Daniels, president of the National Midwives Association, believes the obstetrical establishment, in encouraging prosecution of midwives, is conducting a campaign to stamp out home births.

"In the next twenty years, I think a lot of us are going to have to go to jail," she says.

Citing a murder charge against a lay midwife and threats to dismiss an academician whose study placed a common obstetrical procedure in an unfavorable light, Dr. Stewart says of the obstetricians' campaign, "They mean for blood."

"It's a big-time economic issue," comments George Annas, associate professor of law and medicine at Boston University School of Medicine. "The number of children being born has gone way down and so has the census in obstetrical beds in hospitals. This is just another threat to obstetricians—that people are going to have their babies at home now. It costs them money every time somebody has a baby at home. That, I think, is the primary motivation behind the campaign against home birth."

"Widespread use of ultrasound during pregnancy is cause for concern. In some animal studies, an increased incidence of fetal deformities has been found after low-level exposure to ultrasound."

Physicians, however, state that they oppose home birth because it endangers the lives of women and children. Dr. Edward Hon, who defines home birth as "child abuse," comments: "The dangers are so great with home birth that one wonders whether a woman has the right to make that decision for the unborn baby . . . we do not have a right to expose our minor children to undue hazard." Dr. John Evrard feels home birth is a "terrible mistake" and cites a January 1978 ACOG study showing a two to five times greater infant mortality rate with out-of-hospital birth than with hospital delivery. The study is based on state health department statistics.

Dr. Stewart of NAPSAC contends that the ACOG study has confused out-of-hospital birth with home birth. The two are interchangeable terms since "out-of-hospital" birth statistics include miscarriages and premature births. He notes that the ACOG findings are not consistent with any other studies on home birth. In Holland, where, until recently, half the births occurred at home, the infant mortality rate was half that of the United States, he observes. Moreover, home-birth services in the US, including those run by the Chicago Maternity Center and the Frontier Nursing Service, have had excellent maternal and infant mortality rates.

The doctors' campaign against home birth, which appears to have gone into full swing in 1978, consists of actions against parents who participate in home birth and physicians, lay midwives, nurse-midwives, and childbirth educators who assist such parents.

According to Lee and David Stewart of NAPSAC, obstetricians frequently refuse prenatal care and emergency backup to women who plan home births and, angry with women for having attempted home birth, verbally abuse those who are transported to the hospital. Health-department employees sometimes harass home-birth couples when they register the birth, they note.

In July 1977, ACOG's newsletter announced a registry of "preventable maternal deaths associated with home delivery."

"It is another example of obstetricians' collecting anecdotes and calling it science," Dr. Stewart commented.

Besides taking steps against couples who want out-of-hospital births, obstetricians have been pressuring birth attendants to cease their work in homes. Yale-New Haven Hospital in Connecticut has a policy of revoking the obstetric privileges of any staff physician who intentionally participates in a nonemergency home birth, *Ob-Gyn News* reported last January.

Other home-birth attendants, including May Blossom, a registered nurse in Ozark Hills, Missouri, have been charged with practicing medicine without a license.

A precedent for such charges was set in 1974 when police arrested lay midwives in Santa Cruz, California. Arguing that the charge against them—attendance at a normal physiologic function—did not constitute a crime, they refused to plead either guilty or not guilty. However, the State Supreme Court ruled that practicing midwifery without a license is the same as practicing medicine without one.

The battle against midwives escalated when, last July, lay midwife Marianne Doshi was indicted for second-degree murder and practicing medicine without a license following the death of a baby at whose birth she attended. A California Superior Court judge subsequently dismissed the charges against Doshi. Judging from the medical testimony, he said, "I think the child would have died if it had been born in a hospital delivered by a doctor." He admonished the medical profession to have enough "maturity" to accept different birthing practices.

ILL-CONCEIVED LEGALESE

According to Suzanne Arms, author of *Immaculate Deception*, a bill to license midwives, introduced by California As-

semblyman Gary K. Hart, "addresses the basic issues of whether or not people have a right to choose the care givers that they want and whether these care givers have a right to appropriate high-quality training."

The original bill called for the development of midwives as independent health-care providers for women in normal childbirth under the regulation of a Midwifery Examining Committee. After vigorous opposition from organized medicine, the bill was signed into law in September in a watered-down form that no longer mentions midwives specifically but rather "innovative health-care personnel."

Under the authority of the new law, though, the California Department of Consumer Affairs, which supports the licensure of lay midwives, reportedly plans to apply to sponsor a midwifery-training pilot project.

Shari Daniels, president of the National Midwives Association, would like lay midwives licensed throughout the country. In Texas, where she practices, midwives have asked that a Board of Midwives be set up, composed of midwives, consumers, and physicians. In most states now, she observes, the health department or the board of medical examiners would define standards for midwives.

"That means physical control," she points out. "It's like having Avis control Hertz."

Consumers and home-birth advocates are defending themselves somewhat from what they perceive as an obstetricians' campaign against them. In Illinois, members of Home Opportunity for the Pregnancy Experience (HOPE) have been working with state lawmakers to introduce legislation providing for the training and licensing of midwives. And last spring, Rhode Island passed legislation providing for state licensing of midwives.

At the Arizona School of Midwifery in Tucson, British midwives are now training fifty female students and preparing them to meet new state licensing requirements. The school, launched in 1977, is completely legal.

NAPSAC announced a "Clearinghouse for Legal Incidents Against Participants in Out-of-Hospital Birth" in 1978. By cataloging such actions, it would be able, if necessary, to counter "this assault" against conscientious parents and professionals engaged in home birth.

Despite such efforts, Attorney Annas notes: "Right now the obstetricians and pediatricians are organized across the country to oppose home birth. There's really been no concerted consumer movement against that. Parents don't have the interest in it that physicians have. They don't make their living doing that."

By 2000, most pregnant women will probably not participate in childbearing. The physician will "give birth" with his machines and knives. Thousands of renegade mothers, refusing to enter hospitals, will deliver their children at home, attended by midwives.

Obstetricians will wage battle against the midwives. They will hold fast to a tenet in the faith of Medicine: Every new technique represents progress. Doctors will continue to say that the operations they devise and the machines they invent (and sometimes hold patents on) perform socially laudable functions like saving lives.

Doctors will remain the same, but whether they will continue to enjoy the power they now hold depends in part on how the populace regards them. That, in turn, depends on the information people receive about medicine.

Will reporters who provide that information change in the next two decades and begin to demand evidence that these machines actually *do* what physicians say they do? Will they insist on examining reports of controlled studies that demonstrate a technique's efficacy and safety, and if no such studies exist will they report that fact? Or will they continue to write articles uncritically, glorifying technology and the miracles of modern medicine?

If so, the media will help doctors medicalize birth and shape the thinking of the populace.

And when Susan Rogers's neighbors hear that police forcibly took her to a hospital to have her baby delivered by knife, they will think it quite right. ∞