Current Commentary

Making Room at the Table for Obstetrics, Midwifery, and a Culture of Normalcy Within Maternity Care

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The principle of avoiding the worst possible outcomes guided the enormous successes of modern obstetrics in reducing the morbidity and mortality of childbirth. The challenges of improving the quality of childbirth today has prompted health care providers, policymakers, and patients to ask whether this principle is in fact preventing us from supporting the normal processes of childbirth, resulting in undue intervention and potentially causing harm. In this commentary, we suggest that recognizing the strengths of the medical model of childbirth does not preclude looking outside of it to meet the maternity care needs of the majority of healthy, low-risk women. Obstetricians have the good fortune to have a partner in their work among midwives, who hail from a long tradition of incorporating a perspective of "normalcy" in the care of childbearing women. Given the many evidence-based practices demonstrating the strengths of midwifery to actualize patient-centered, low-intervention birth, we advocate for the explicit establishment of professional standards for team-based physician–midwife care. More than merely introducing midwives into a physician-dominated setting, this means elevating the contributions of midwives and meaningfully incorporating a culture of normalcy to standardize practices such as intermittent auscultation, continuous birth support, nonpharmacologic pain management, and positional flexibility in labor. The literature suggests that a woman's health care provider is the most powerful determinant of her birth outcomes; striking the balance between averting poor outcomes and normalcy compels us to make room at the table for both obstetricians and midwives.

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In 1935, 608 of every 100,000 American women died from complications of childbirth, a number surpassed today only by the countries with the worst rates of maternal mortality.[1] Just 50 years later that number fell by 99% to seven deaths per 100,000 women.[2] These advances in maternity care were arguably the greatest public health wins in U.S. history, even trumping gains made with the arrival of antibiotics and public sanitation.[3] We achieved these successes by orienting our system around safeguards to protect women against the worst possible outcomes–an orientation that continues to define the delivery of U.S. maternity care to this day. Nevertheless, recent conversations among care providers, policymakers, and patients have begun to challenge this assumption: have we created a system so focused on the vigilance of mothers and neonates during labor that we interfere with the normal processes of childbearing? Furthermore, what has this vigilance cost us in terms of births unnecessarily subject to intervention, in a diminished sense of agency among expecting mothers, and in health care dollars?

Historically, childbirth was the realm of apprentice-trained women who served as attendants for their communities, providing a supportive presence through this normal life transition. At the turn of the 20th century in the United States, these early midwives had limited and varied scopes of practice determined by the local nature of midwifery regulation in contrast to the national certification found in parts of Europe.[4]

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As the discipline of obstetrics formalized, the medical profession entered the birthing sphere with an explicit recognition of the pathologic outcomes associated with labor and delivery. In an attempt to improve these outcomes and facilitate more standardized education for physicians, maternity care was moved into hospitals and thus out of the hands of midwives, who primarily attended to women in their homes. A dramatic reduction in maternal mortality followed as a result of the rigorous imposition of measures to mitigate what are very real risks of adverse outcomes in childbearing through ready access to lifesaving interventions such as medications to prevent excessive bleeding, sterile conditions, and cesarean delivery. We have since added maternal and fetal monitoring technologies, highly specialized teams, and intensive neonatal care to support the highest risk pregnancies. Women who could never be mothers in a prior era–those born with congenital heart conditions, those who survived cancer, those ages 40 years and older–are increasingly bearing children, and our system is well designed to keep these patients safe.

However, for the average healthy American woman, we have seen the medicalization of childbirth lead to certain trends. The proliferation of continuous fetal monitoring during labor lowers our threshold to hasten delivery using operative means without any demonstrable improvements on population outcomes of stillbirth or cerebral palsy.[5] Labor inductions initiate nearly one in four births and may be associated with higher rates of cesarean delivery.[6] The ready availability of intervention is also reflected in the demands of patients, propagating a language surrounding the "elective" aspects of maternity care. Cesarean delivery, a life-saving surgery when used judiciously, can become the unintended result of a chain reaction starting with an innocent ultrasonography, not-quite-perfect fetal heart tracing, or simply a patient's request. Although we will never know whether a cesarean delivery was truly justified, we do know there is cause for concern with our cesarean delivery rates, which produce risks for hemorrhage, infection, and the need for complex intervention in future pregnancies.

We are in a pivotal moment when many areas of health care are examining whether "more is better": minimizing computed tomography scans to avoid "incidentalomas," the thoughtful use of cancer screening tools after weighing the risks of false-positives, even the questioning of routine checkups.[7] We fear finding something that will then compel us to act, escalating the invasiveness of care with unclear benefit. Of course, what is missing is a reference point of what is normal; the concept of normalcy is secondary in the medical model of health, in which a suspicion of pathology is often the lens for each interaction or decision.

Midwifery has much to offer in this respect, hailing from a long tradition of "honoring the normalcy of women's lifecycle events."[8] In the 19th and early 20th centuries, midwives evolved from the early birth attendants described previously to rigorously trained professionals who most often work in collaboration with physicians.[9] Throughout this time, midwifery has maintained a strong orientation toward woman-centered care, the therapeutic use of human presence, and nonintervention unless medically indicated. However, in the United States, where physicians attend 92% of births, workforce imbalances alone cannot explain why midwives have struggled to (re)enter the culture of childbirth. Physicians' perceptions of midwives' role vary widely: many physicians are grateful to have another set of hands to share 24/7 coverage on labor and delivery units, but still consider birthing a physician-led enterprise; others see midwives as partners who bring a different set of strengths to caring for women. In truth, some physicians reluctant to embrace this partnership have assumed the care of a patient from one of the minority of midwives who attend births far outside accepted parameters of care. We believe that mutual exposure will allow obstetricians and midwives to gain an understanding of one another that not only allows outlier cases to be properly contextualized, but may curb these cases altogether.

In 2012, the American College of Nurse Midwives launched the "Healthy Birth Initiative," an effort to provide tangible tools for health systems seeking to redirect the care of childbearing women toward an assumption of wellness and normalcy and away from medicalization. Within the United States, studies suggest midwife-led labor is associated with lower cesarean delivery rates, less reliance on oxytocin for labor augmentation, less narcotic use, and fewer diagnoses of abnormal labor and fetal distress.[10,11] With the caveat that international studies mostly occur in settings with a well-integrated midwifery workforce, a Cochrane meta-analysis demonstrated continuity midwifery care to yield results similar to those described with no evidence of adverse outcomes for mothers and neonates.[12]

The forces marginalizing midwifery in this country are complex, reflecting the structural evolution of American health care in addition to the beliefs underlying this evolution. However, if we are to redesign maternity care away from a system founded primarily on avoiding poor outcomes toward one that shares this goal while supporting normal physiologic processes, we

can learn from our European counterparts and elevate the contributions of midwives to more than "physician-extenders." In countries such as the United Kingdom, midwives and obstetricians function in complementary rather than interchangeable roles. The National Institute for Health and Care Excellence stoked a controversial debate when it determined that, for healthy pregnant women, the data to have a safe, empowering birth indeed favor midwives, who attend 75% of births in that country.[13] According to the U.K. Birthplace study, low-risk women in midwife-led units were more likely to achieve a vaginal birth and less apt to receive interventions to hasten delivery, with statistically similar neonatal outcomes to obstetric-led units.[14]

The recent lauding of midwifery is frequently interpreted as an affront to the medical establishment by the media, as depicted by headlines such as "Doctors versus Midwives: The Birth Wars Rage On" and "Are Midwives Safer than Doctors?"[15,16] However, it is far from a simple zero sum game, especially given the large areas of our country without access to obstetricians to handle complications and perform cesarean deliveries.[17] Without an appreciation for the roles both professions play in the endeavor of healthy birth outcomes, the public's suggestion that midwives are as capable (or as is sometimes suggested, more capable) of handling birth unearths a deep discomfort that leaves some physicians feeling under fire.

Our task ahead is not to compare the merits of obstetrics and midwifery, but rather to address patients' goals and to work together toward continuous improvement of maternity care in this country. Attention from the obstetric community to soaring cesarean delivery rates resulted in the 2012 consensus statement entitled "Preventing the First Cesarean Delivery," which was a summary of a joint *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists workshop. This statement detailed a call to arms for labor management standards that require more patience and flexibility before wielding a scalpel; in other words, inching that needle away from risk avoidance and toward normalcy.[18]

We applaud the introspection demonstrated by this effort, which in view of an abundance of evidence acknowledges our shared goal to provide the appropriate level of care required to maximize outcomes. Taking this one step further means reaching for guidance from our midwifery colleagues, who already embody principles enabling us to "do less." We advocate that explicitly establishing professional standards for collaborative physician–midwife care is critical to a needed culture change in our birthing units from one that sees laboring women as "disasters waiting to happen" to one that monitors for risk in the context of care that fully encourages normal processes. Examples of what this might look like include providing continuous labor support, facilitating out-of-bed and upright positions for labor, using intermittent auscultation instead of continuous fetal monitoring for low-risk women, and making prudent use of interventions such as induction of labor.[19–21]

Many physician-led maternity units believe that by virtue of staffing midwives, they are reaping midwifery's many benefits, an attitude that reflects a lack of understanding of the philosophical differences between these professions. In fact, midwifery's high-touch, low-technology approach to birth is difficult to sustain in an environment implicitly designed to support the opposite. Returning to our example of fetal monitoring, the majority of women giving birth in a hospital in this country continue to spend their labors attached to continuous fetal monitoring devices despite evidence that have led professional organizations across medicine, midwifery, and nursing to produce statements condoning the use of intermittent auscultation in healthy laboring women. When continuous fetal monitoring becomes a "default" in the name of safety, its potential harms are rendered secondary, among them the medicalization of labor from the perspective of the mother and her health care provider, decreased mobility, and increased risks for cesarean delivery. Midwives who advocate for intermittent auscultation may meet resistance stemming from unfamiliarity or dogma as is typical with the introduction of any organizational change. The other challenging element to such change efforts is the power differential between physicians and advanced practice clinicians, which can lead to an undervaluing of the midwifery perspective. This tension extends far beyond maternity care, representing an area of active dialogue in other fields.[22]

The American College of Obstetricians and Gynecologists recently took the lead in forging a path with advanced practice clinicians across a variety of disciplines. A statement published in March 2016 outlines its commitment to team-based care as means to address the "Triple Aim": improving the experience of care, improving the health of populations, and lowering per-capita costs.[23] The report states that all patients are best served by a team-based approach with collaboration between professions representing just one aspect of a team's success. Beginning with the patient's goals at the center, team-based care also relies on a shared vision, accountability and respect for each member's unique contribution, effective communication, and dynamic leadership.

The report lays a progressive groundwork for the integration of obstetricians and midwives in team-based care. We propose the development of new practice models that begin with a deep understanding of patients' goals and employ a team of obstetricians, midwives, and other maternity care providers to achieve them. Obstetricians would no longer be required to serve as the de facto leader, allowing other members to take the lead when appropriate to patients' needs. For the vast majority of healthy, low-risk women, this would potentially result in a greater role for midwives and bedside nurses in labor and delivery, similar to care in the United Kingdom and other parts of Europe. We anticipate that a team-based approach would overtly identify those gaps in obstetrics where midwifery can shine, allowing us to reduce the overall "treatment intensity" in women who do not warrant it.[24] Although team-based models must pay heed to the state-level scope of practice regulations, it seems these models of care will thrive in a payment structure increasingly rewarding quality over quantity. Future research efforts may evaluate the effectiveness of team-based maternity care models in achieving patient satisfaction, improving quality, reducing costs, and engendering a cultural shift toward normalcy.

Despite tremendous variation in the care of childbearing women, the literature suggests that it is who cares for a woman that is the single most powerful determinant of the patient's experience, particularly whether she will deliver by cesarean.[25,26] This results not from differences in technical skill or access to the latest advancements, but how the balance is struck–culturally, operationally, and technically–between averting poor outcomes and encouraging normalcy. Although there have been marked historical shifts in whether obstetricians or midwives "own" the endeavor of childbirth, mothers and neonates in this country will be best served by making room at the table for both perspectives.

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