What About Midwifery? [1]

by: Wolfgang Miggiani MD [2]

It is not infrequent that I am asked the question stated in the title of this article. As the father of a daughter who is just starting out in this field, and as a doctor who has always striven to work with, learn from, and teach local midwives wherever we have lived, I can say that I have a very positive outlook on the issue.

Whether it is obvious or not, the question is usually asked with great passion – “what about midwifery?”. People love their midwives, and they want to protect them. (Good!!) Being a Christian physician, I understand the trials and consequences of swimming against the strong currents of the medical “establishment.” But in plain church circles, being both a doctor and a conservative Anabaptist makes me somewhat of an enigma – an oddity. Therefore, this helps me to understand the underlying question behind the first question: “Whose camp are you in – theirs or ours?” My simple answer is YES—both!! If you want the explanation, keep reading…

RISKS AND BENEFITS

It is not one of those things we tend to think about, but with just about everything we do, we subconsciously analyze the risks and benefits. Have you ever contemplated eating a big greasy pizza just before bedtime or going to a crowded shopping center on a busy Saturday? Of course, you have! Well, then you have looked at risks and benefits. Childbirth is a natural, yet important milestone in the lives of our families, so it also deserves some close attention. As it turns out, some of the risks of a medical/hospital approach to childbirth ends up being the benefits of a midwife-managed delivery. But…it also goes the other way around – the risks of a midwifery approach can also be the benefits of a medical/hospital delivery.

The Spiritual Risks and Benefits

Childbirth is not just another medical procedure. People do not clamor to have home dental extractions. Neither do our churches work together to train lay surgeons and construct appendectomy or hernia treatment centers. As Christians, birth has special meaning for us, and the Bible has a lot to say about it. The pain of birth is a consequence of man’s fall: “…in pain you shall bring forth children…” (Genesis 3:16) Yet the result (a child) is a gift – “Lo, children are a heritage of the LORD: and the fruit of the womb is his reward.” (Psalm 127:3)

So, likewise, by the new birth of God’s Spirit, we will be reunited with the Lord of Heaven: “Jesus answered and said unto him, Verily, verily, I say unto thee, except a man be born again, he cannot see the kingdom of God.” (John 3:3) So, it is no wonder that many Christians desire a more personal birthing experience for their baby. But, this often conflicts with the governments’ desire to efficiently manage childbirth, which it sees as just another medical procedure.

Conflict

As we try give the government the benefit of the doubt, we realize that it truly sees home deliveries as a risk (we will talk more about that later). Despite this understanding, many Christians are still put into the uncomfortable position of asking themselves, “Is this God’s turf, or is this Caesar’s turf?” (think Matthew 22:21). How much authority does the government have when it comes into conflict with the ability of Christians to exercise birthing options utilizing a free conscience?

Moreover, the medical community does not improve the appearances of its intentions by the positions that some of its members have taken. I remember in medical school a serious effort was being made to force all medical students to assist in abortions. That was almost 25 years ago! The American Congress of Obstetrics and Gynecologists (ACOG) has pushed for “efforts to destigmatize and integrate [italics added] abortion training” for physicians, physician assistants, nurse practitioners, and midwives.(i) So while ACOG is trying to eliminate barriers to the taking of life, in some ways they are also working to put up barriers against those midwives who strive to assist in the giving and respect of life. In essence, this could potentially be seen as a drive to “weed out” Christians.

Why is there this drive? It is the age-old story of the epic battle of world views. There is very little difference between a child being offered up to Moloch during Old Testament times and an unborn child being offered up to the twin gods of materialism and convenience in our current time period. Where is all this going? Recently, a Swedish, Christian midwife was fired from her job for refusing to participate in abortions. The courts found that she must participate if she wants to practice.(ii) Sweden is not known for its overpopulation nor for its lack of health care access, so it does not seem logical that there is any legitimate worldly reason to not allow her a free conscience in this matter.

Two of my own daughters were adopted from China, where forced abortions are common. It is because of the One-Child policy that we had the opportunity to adopt them. (Just another example of the Lord turning man’s frowardness into a blessing!) Could that happen here? It might be difficult to consider this possibility with the recent change in the tone and direction of the country. Yet, it does not take much of an effort to realize there are powerful secular people in this country who would like to see, for example, the population of the planet decreased by 95% (Ted Turner - Founder of CNN), 50% (Henry Kissinger - Statesman, Nobel Peace Prize Recipient), or 10-15% (Bill Gates - Billionaire).(iii) This would mean a “reduction” of anywhere from one to six billion people!

Does any of this sound familiar?

“And the children of Israel were fruitful, and increased abundantly, and multiplied, and waxed exceeding mighty; and the land was filled with them . . . And he [Pharaoh] said, when ye do the office of a midwife to the Hebrew women, and see them upon the stools; if it be a son, then ye shall kill him: but if it be a daughter, then she shall live. But the midwives feared God, and did not as the king of Egypt commanded them, but saved the men children alive.” (Exodus 1:7,16-17)

To me, it seems like there certainly was, is, and will be a need for God-fearing women, who feel called to the profession of midwifery to practice, with a godly conscience, the vocation of helping bring babies into this world.

Summary

So, in summary, the spiritual risk is that there are worldly providers (many physicians, even some midwives) who do not share a Christian world view. Thus, their counsel may not be compatible with a Christian walk, when we consider their potential abortion mentality, screening for the purposes of termination, human birth control vs God’s control (especially the abortifacients), etc.

But the spiritual benefits of Christian providers (some doctors and many midwives) is the confidence that most likely the advice and counsel you are receiving recognizes the authority and sovereignty of the Lord. And that the human hands ushering in your child’s new life on Earth are those of a practitioner who shares a love for the one true God. The one important caveat to bear in mind though, is that not all midwives are Christian and not all doctors are worldly.

The Economic Risks and Benefits

According to one study, the average uncomplicated normal birth costs 68% less in a home than it would in a hospital.(iv) Anecdotally, I think most of us realize that the savings can be quite a bit more than that. It makes sense. Here is a chart illustrating the concept of The Law of Diminishing Returns, which says that more is not always better.

As you can see, with only a small increase of cost, the quality of care (and lives saved) increases. Think about how minimal the cost is for cleanliness, yet it is probably the greatest life-saving factor. For example, in the 1840s, at the Vienna General Hospital, maternal death rates from infection alone fell from highs of over 30% to generally less than 2% after strict hand washing was enforced!(v)

However, at the higher end of this cost chart, the more that is spent might only result in a smaller number of lives saved. Think of the Neonatal Intensive Care Units and what it costs to run them. They are good to have when you need them, but expensive nonetheless.

Finally, look at the last part of the curve, where even more cost and intervention can actually result in a decrease in the number of lives saved. For example, think about amniocentesis and other usually unnecessary invasive tests that can result in miscarriages or other complications.

So, it sounds like there is no economic reason to forego a hospital delivery, right? It is true that there are numerous positive studies, and it seems that they universally show a lower cost. Still, it is important to realize that there are a number of presumptions about home births here: first, that the out-of-hospital deliveries are low-risk pregnancies, and second, that there is ready access to a receiving hospital if necessary, either of which would change the study outcomes.

This is in all reality an important presumption, because these studies assume that there is a negligible difference in complications between hospital and home deliveries. If there is actually a higher complication rate, the cost of dealing with those complications usually is not taken into account, even though these complications could extend well into the future—even for the rest of that individual’s life.

This leads us to the last section—medical risks and benefits. What are the complication rates for mother and child when comparing home versus hospital deliveries?

MEDICAL RISKS AND BENEFITS

The Risks

So, what is the actual possibility of a bad outcome for the mother and for the child, when comparing a hospital delivery with an out-of-hospital delivery? Before I try to answer that, I would like to talk a little more about the concept of "risk." Yes, God is sovereign, omniscient, and loving: "But even the very hairs of your head are all numbered. Fear not therefore: ye are of more value than many sparrows." (Luke 12:7)

At the same time, he has allowed us to learn from patterns (experiences) in the past—patterns that we can call risk. More specifically, I would like to introduce the concept of absolute risk and relative risk, to put things into the proper perspective. A good illustration of this is the chance of being killed by lightning in any given year. According to the National Weather Service, there has been an average of 51 lightning deaths per year. So, in a population of 325 million people, your chance of being killed by lightning is about 1 in 6 million. The data also shows that men are about 4 times (400%) more likely to be killed (as roofers and climbers) than women. Likewise, since there are 50 states and about 50 deaths, statistically, one would expect about 1 death per state (not accounting for population size). Florida (flat, with a lot of lightning), however, sees about five deadly strikes per year (a 500% increased likelihood).(vi)

So, the Relative Risk of a man getting hit is high (400% increase), so is the chance if you live in Florida (500%). Does this mean that if men see dark clouds, they should dive for cover? (Preferably not under a tree!) What if you are from Florida? Should you move to North Dakota (which has not seen a deadly strike in ten years)? The answer is probably not, because the Absolute Risk for Floridians is still less than one, in one million, as is the risk for men in general. However, it would be wise (especially if you are a roofer who lives and works in Florida) to take proper precautions, such as not playing ball outside or not working in high places when you realize an electrical storm is approaching.

NOW, BACK TO DELIVERIES

First, Mothers

Historically, even as late as the early 1900s, becoming a mother was associated with a mortality rate of six to nine mother's deaths per 1,000 live births – nearly 1% for each delivery!(vii) Today, becoming a mother is 99% safer. In modern times, due to sanitation, good surgical techniques, and antibiotics, the rates are in the area of 10-15 per 100,000 live births (the risk actually decreased the greatest (89%) from about 1930 to 1950, when antibiotics came into use).(viii) For comparison, consider that the chance of being killed in an auto accident is about the same in any correlating given year - 10.6/100,000 population (2013 data)(ix)

So, where do midwife assisted deliveries stand in regard to the mother's risk? Since home and birthing center deliveries amount to only about 1% of the total in the U.S., the data is very

limited. One midwife-led study of almost 17,000 deliveries revealed 1 death (due to a blood clot), so this is in the same range as that of the national average.(x)

What about baby?

Most women know that pregnancy and delivery can be difficult and complex. From the moment of conception, about 20% of pregnancies end in miscarriage (one in five), which means that most women will go through one or more during their lifetime. Another, much larger study looked at 14 million deliveries (which included 130,000 non-hospital births). In it, comparisons were made between hospital midwife deliveries and non-hospital midwife deliveries. They found that the risk for a home birth or birthing center baby was roughly 4 times that of a hospital-delivered baby. (1.26 in 1,000 live births vs 0.32 in 1,000 hospital births). This seems to make for a high relative risk, but the absolute risk for both is close to 1 in 1000 deliveries. Therefore, this means that for all three: home, birthing center, and hospital deliveries, God, in his mercy, allows about 999 out of 1000 babies to return home to their families.(xi)

Some Thoughts:

- Out-of-hospital breech deliveries (22.5 per 1000) have 45 times the risk of cesarean deliveries (0.5 per 1000).(xii) This is high risk; so are moms with diabetes and blood pressure issues.
- Twin births have an infant mortality rate of 22 per 1000.(xiii) These children are often premature, and have a significantly higher risk of other medical problems, so they should be managed as high risk.
- First births – relative risk is statistically significant (2.19 per 1000 out-of-hospital vs 0.33 per 1000 in hospital), but is the absolute risk significant (998 compared with 999 babies will still make it home)? The same can also be said for VBACs.

The Benefits of Out-of-Hospital Deliveries

- Cesarean rates approach 30% in some hospitals.
- In non-hospital deliveries, 95% of women avoided a cesarean section. Of those, 89% of women completed a non-hospital delivery, but 6% were assisted in the hospital with Pitocin, vacuum, or forceps. Only 5% ended up requiring a cesarean section.
- About 30-35% of hospital deliveries involve an episiotomy.
- The percentage of women who have no tears in a non-hospital delivery was found to be 49% in the midwife study, whereas for hospital deliveries only 24-34% of women avoided a tear or episiotomy.(xiv)

CONCLUSIONS

Quality Counts

Remember in the last issue, I mentioned that a physician can do 5,000 deliveries, but the question is, “Does he or she do them well?” Accordingly, the same applies to midwives. Does she know her limitations—when to refer out? Also, does she strive to continue educating herself?

As a practicing ER physician (who, as a family physician, has not done routine deliveries in over 15 years), the learning and testing process never stops—Advanced Cardiac Life Support, Advanced Trauma Support, Pediatric Advanced Life Support, emergency medicine board recertification, Continuing Medical Education state requirements, and the list goes on. Likewise, a good midwife also should never stop learning and teaching.

Building Bridges

It is not infrequent that I hear from midwives that they do not get enough support from physicians. This is a valid complaint. No doubt much of this, either directly or indirectly, relates to “turf battles.” However, I believe that for most physicians, IF it is apparent that a midwife is doing all she can to be excellent in what she does, that fact will go a long way toward building a working relationship.

Some Suggestions

Most larger hospitals offer a course called the Neonatal Resuscitation Program (NRP). It is usually taught by Neonatal Intensive Care Unit nurses and pediatricians. Lay midwives could ask about taking this program. If the particular course director will not offer “certification,” it is likely that they would allow an “audit,” which means listening to the lecture, possibly going through the exercises, but not becoming certified.

It works the same way for the Advanced Life Support in Obstetrics, which is a course designed to maintain the quality of deliveries for family doctors. I would be happy to help any midwife get started.

Additionally, midwives could become a volunteer EMT or a paramedic. If an individual is servicing a small hospital in this capacity, a working relationship between physician and midwife will naturally and necessarily develop. This would allow midwives to, in some ways, be a part of the “establishment” without necessarily compromising independence. Potentially lifesaving skills could also be acquired in this way, such as starting and managing an IV, which could then legally be utilized during homebirths.

Unity of Purpose

No doubt I may have stepped on some toes, and pushed many a comfort zone. But when all is said and done, it is good to remember that our purpose on Earth is to glorify God in all that we do: “And whatsoever ye do, do it heartily, as to the Lord, and not unto men; Knowing that of the Lord ye shall receive the reward of the inheritance: for ye serve the Lord Christ.” (Col 3:23-24)

Both physicians and midwives have unique and special roles in what they do, so it is important that we learn from each other, and learn to work with each other, in order to better serve God and our patients. It is entirely reasonable for individual couples to choose either pathway for the care of their families. Pray for wisdom and look for excellence.

Bottom line: it seems short-sighted to get into an “either-or” or a “we-they” mentality, when

an “all of the above” view seems to be the more Scriptural perspective. All Christians would do well to heed the Apostle Paul's admonitions in Romans 12:16 (NLT): “Live in harmony with each other. Don’t be too proud to enjoy the company of ordinary people. And don’t think you know it all!”

Footnotes:

(i) ACOG Committee Opinion Number 612, November 2014
(ii) http://www.lifenews.com/2015/11/12/court-rules-nurse-fired-for-refusing-... [3]
(iii) Watts, David, “Journey to a Brave New World,” www.iuniverse.com [4], p.47
(iv) Anderson RE, Anderson DA. “The cost-effectiveness of home birth,” J Nurse Midwifery. 1999 Jan-Feb ;44(1) :30-5.
(v) Semmelweis, Ignaz (September 15, 1983) [1861]. Etiology, Concept and Prophylaxis of Childbed Fever. Translated by Carter, K. Codell. University of Wisconsin Press.
(vi) http://www.lightningsafety.noaa.gov/fatalities/fatalities14.shtml [5]
(vii) https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm#fig1 [6]
(viii) http://data.worldbank.org/indicator/SH.STA.MMRT [7]
(ix) http://data.worldbank.org/indicator/SH.STA.TRAF.P5 [8]
(x) Cheyney, M., Bovbjerg, M., Everson, C., Gordon, W., Hannibal, D. and Vedam, S. (2014), Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009. Journal of Midwifery & Women's Health, 59: 17–27.
(xi) Grünebaum A, McCullough LB, Sapra KJ, et al. Early and total neonatal mortality in relation to birth setting in the United States, 2006-2009. Am J Obstet Gynecol 2014; 211:390. e1-7.
(xii) Berhan Y, Haileamlak A. The risks of planned vaginal breech delivery versus planned caesarean section for term breech birth: a meta-analysis including observational studies. BJOG 2016; 123:49–57.
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