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Piercing the veil:
The marginalization of midwives
in the United States - 2007
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Abstract

This paper investigates the marginalization of certified nurse-midwives (CNMs) in the US. This marginalization occurs despite ample evidence demonstrating that a midwifery model delivers high-quality cost-effective care. Currently midwives attend only 7% of births, compared to 50–75% of births in other developed countries. Given the escalating costs of health care and relatively poor maternal and child health indicators in comparison with other developed countries, these findings are disturbing.

This paper investigates this paradox through **a qualitative case study of two prestigious but declining midwifery services in a large US city**. Fifty-two multi-site in-depth interviews were conducted along with an analysis of relevant archival sources. It was found that **institutions successfully altered maternity care and diminished midwifery services without accountability for their actions**.

These findings illuminate the larger political-economic forces that shape the marginalization of midwifery in the US.

Keywords: US; Midwifery; Certified nurse-midwives;
Political economy of maternity care;
Marginalization of midwives

Introduction

Health care in the US is integrated into a larger market-based economy where competition over resources, status, and power is encouraged between professionals in a hierarchical system. **The lack of coherent public policy regarding health care is problematic for the US, where costs for health care are exorbitant and benchmark indicators for health are abysmal, particularly in the area of maternal and child health.** Lack of state control over health care policy produces **irrationality in equitable access to effective services**. **Cost-effective care is often eschewed in favor of costly ineffective care.** The minor role played by midwifery in maternal health care in the US is a striking example of such irrationality (Gabay & Wolfe, 1995; Strong, 2000).

Skyrocketing costs, limited access, quality, and satisfaction are the four main problems affecting health care in the US. In 2004, the US spent 1.9 trillion dollars on health care, which is 16% of its gross domestic product (OECD, 2005a). This compares to **an average of 9% among 22 developed nations**, all of which have better health indicators (OECD, 2005a). The US currently has 48 million uninsured people (Stoll et al., 2005). The infant mortality rate for the US ranked below 27 other nations in 2003 (OECD, 2005b). Recent reports indicate that **in 2004, the US had the highest rate of preterm births reported since 1981 when comparable data was first collected; rising rates of low birth weight babies; and the highest-ever rate of cesarean births (Martin et al., 2006).** Each of these findings reflects a potential increase in morbidities and mortalities for mothers and babies and contributes significantly to the skyrocketing costs of health care

(Deneux-Tharaux, Carmona, Bouvier-Colle, & Breart, 2006; Kolas, Saugstad, Daltveit, Nilsen, & Oian, 2006; MacDorman, Declercq, Menacker, & Malloy, 2006; Tracy & Tracy, 2003).

These statistics are staggering when one realizes that the US spends nearly twice per capita compared to countries that have an infant mortality rate nearly half that of the US.

Childbirth in the US is treated as an acute event, where 99% of births occur in hospitals and 91% are attended by physicians, despite the fact that according to World Health Organization definitions, 70–80% of births are normal and uncomplicated (Martin et al., 2006; World Health Organization, 1996). Extensive evidence **demonstrates excellent maternal and infant outcomes, cost-effective care, and satisfying experiences for women receiving midwifery care (Blanchette, 1995; Greulich et al., 1994; Jackson et al., 2003; MacDorman & Singh, 1998; Rooks et al., 1986).**

In one meta-analysis of the literature which controlled for potential confounding variables, **findings showed that midwives used fewer interventions and their clients experienced significantly lower cesarean birth, low birth weight, infant, and neonatal mortality rates (Raisler, 2000).**

Despite the findings of this and similar studies, the numbers of midwife-attended births in the US are very low. According to the National Center for Health Statistics, in 1976 midwives attended 1% of births in the US. Figures from 2004 show they attended 7.45% of births (Martin et al., 2006). Though there has been a six-fold increase in the number of midwife-attended births in the US over the past three decades, the number of midwife-attended births remains small, especially in comparison with other developed countries, where 50–75% of births are attended by midwives. These countries report lower infant mortality rates and overall lower costs for maternity care in government-sponsored health care systems (National Vital Statistics System, 2006; World Health Organization, 1996).

This paper summarizes results from a qualitative case study analysis of two longstanding midwifery services that experienced practice closure or problems in the summer of 2003. I decided to examine what occurred in these midwifery services because of their longevity, demonstrated success, and associations with prominent health care institutions. However, I could have chosen from a number of similarly influential midwifery services that likewise experienced practice **closures or problems in the US during the same time period, including practices in Austin and San Antonio, Texas; Chicago, Illinois; Cleveland and Cincinnati, Ohio; Washington, DC; New York City; Baltimore, Maryland; and California.** The two cases I selected for in-depth study are

representative of what is happening to midwives across the nation. Close scrutiny helps elucidate some of the factors that contribute to the underutilization of midwives in the US.

The case of CNMs/CMs is explored because they: (1) must demonstrate core competencies; (2) graduate from externally accredited educational programs; (3) complete a national certification exam; and (4) adhere to licensure standards that are recognized and accepted in every state in the US. CNMs/CMs are able to provide care to most healthy pregnant and birthing women in all settings—including hospitals, clinics, freestanding birth centers, and homes. Importantly, state and federal laws presently mandate reimbursement for midwifery services.

Philosophically, midwives adhere to an ethical code that states that every individual has a right to safe, satisfying health care with respect for human dignity and cultural diversity. Midwives support women's rights to self-determination and encourage women to be active participants in decision-making processes. Midwives trust the normal physiologic process of pregnancy and birth. They strive to support and enhance normal processes through providing education and continuity of care to women, minimizing intervention in normal processes, and maintaining collaborative partnerships with physicians and other members of the system in order to optimize outcomes and experiences for women and their families (ACNM, 1989).

Direct-entry midwives (DEMs) also practice in the US. They attend births at home or in some freestanding birth centers. Education, regulation and licensure of DEMs are determined by individual states (Bourgeault & Fynes, 1997; Lay, 2000).

Marginalization

As part of an effort to define and address the health care needs of vulnerable populations, over the last decade the nursing profession has focused on professional marginalization and its impact on health care practices (Hall, 1999; Hall, Stevens, & Meleis, 1994; Vasas, 2005). The premise upon which this study is based is **that entire professions can be marginalized, as in the case of midwifery, and that the marginalization of midwives affects clinical practice, limits access to care, decreases overall quality of care, and increases costs of health care— all critical components of a high-functioning health care system.**

In this literature, **marginalization is defined as the process through which persons are peri-pheralized by a dominant, central majority** (Hall et al., 1994). It has to do with the social, political, and personal construction of boundaries, **deciding who controls and maintains these boundaries, and who is permitted inside.** The marginalization of professions occurs via a process of social closure where dominant groups or stakeholders have power and control over market conditions that protect their interests from competitors (Saks, 2001).

Biomedical hegemony

....**The history of midwifery in the US is a unique case when compared to other countries in that the profession of medicine [in the US] successfully exiled midwifery from mainstream medicine in the early 1900s.** In large part, the **marginalization of midwives is one casualty of the professionalization of medicine.**

.....Writing **in the context of physician control over birth**, Jordan (1997, p. 58) states, **“The power of authoritative knowledge is not that it is correct but that it counts.”** Professionals become more powerful when social and cultural factors induce individuals to surrender to them their private judgment (Starr, 1982). **When authoritative knowledge is linked to a group with a strong economic and political power base, that group may be able to escape accountability. These factors have shaped obstetrical dominion, the culture of birth,** and the marginalization of midwifery.

Political-economic factors

A political-economy framework identifies how markets for health care products and services interact with national health care policies to address the health care needs of a population. **The political process has to do with how nation states organize and make crucial decisions regarding governments’ obligations to promote and protect the welfare of their citizens.** Prevailing rational thinking presumes that nation states will find the most cost-effective way to render high-quality health care to citizens by doing a thorough assessment of evidence-based research, along with holding groups accountable for the respective roles they play in providing care. According to the Organization for Economic Cooperation and Development (OECD), **member nations, with the exception of the US, have chosen to provide universal health care coverage to their citizens** (Docteur, Suppanz, & Woo, 2003).

Rather than guarantee health care access, the US has in large part relied on market forces to deliver health care, **resulting in significant inequities**. Under such circumstances, the state offers support and protection to health care consumers and professionals in the form of statutory and regulatory laws that monitor education, licensure, and payment for providers, along with ensuring the relative safety of health care products and technology to protect citizens from harm. However, an over-reliance on market forces to deliver health care leads to problems. Health care does not conform to traditional economic theories in the same way as non-health- related markets because of issues relating to information, authority, power, wealth, and control. **Health care markets are further complicated by the fact that consumers are dependent, vulnerable, naive, and often uninformed when it comes to their health** (Gilpin, 1996; Starr, 1982).

States and markets are undeniably intertwined and interrelated. States use political processes to promote the health and welfare of their constituents— thus affecting health care markets and services. Reciprocally, in a market-based health care economy, producers, sellers, and consumers have the potential to influence states and political processes. It is easy to conceive of how a dominant group might be able to influence states and political processes to their advantage. Policies are often constructed that support the market structure to protect economic wealth. But governments also need to safeguard the rights and actions of its citizens and thus have the power to influence health care economies, for example, when private markets fail to fairly distribute the health care work force and products to medically underserved, uninsured populations.

In the US, multiple mechanisms exist through which one pays for health care services. Insurance may be organized through the private or the public sector. Individuals with private insurance either belong to a managed care organization or purchase indemnity insurance that supports a fee-for-service model of health care. Managed care markets attempt to exert greater control over the use of health services by their members in order to decrease costs of health care. Public aid goes to the

disabled, the elderly, the poor, military personnel and their families, and Native Americans. The 48 million people without health insurance are expected to pay out-of-pocket for health care expenses. Ultimately, the rising costs of health care are partly related to covering the costs of the uninsured (Stoll et al., 2005).

This paper integrates marginalization, biomedical hegemony and political-economy theories to examine and explain the underutilization of midwives in contemporary US health care. The case of the marginalization of midwives in the US clearly illustrates one of the ways in which economics and the discourse of power obfuscates what is really best for women's health and for the health care system of a nation. Discourse analysis is about revealing underlying power dynamics and hidden motivations that are behind the veil. Borrowing from the metaphor used by one of my informants, the veil to pierce is the one that values the economic and political sovereignty of the institution of medicine over what is best for mothers, infants, and society.

Methods

This study constitutes a critical analysis of the political economy of health care as viewed through the window of maternity care, the fourth largest health care expenditure and most common reason for hospitalization in the US. Whereas much of the midwifery literature focuses on outcomes or ideological differences between the medical and midwifery models of care, this study is about how economics, power, and authority influence and shape the profession of midwifery and maternity care.

I chose to do a qualitative case study analysis using purposeful critical case sampling methods in order to understand more about the process of marginalization of midwives in the US. I selected two cases that had demonstrated longevity and success in terms of outcomes, and were associated with prestigious and influential institutions. (Names have been changed to protect the confidentiality of participants.) The University-based Midwifery Service [Columbia Presbyterian in NYC], associated with a prominent university and hospital, was a large service that provided care to a mainly immigrant population and served as a clinical site for midwifery students.

In 1955, this institution began the first midwifery education program associated with a university and allowed the first midwife-attended birth in a hospital setting in the US. The midwives in this service provided care to multiple generations of women. A community hospital associated with the University was opened in 1989. **Midwives attended 75% of the births in this setting until it changed its operations in October 2003.** I refer to the second case investigated as the Birth Center. The Birth Center originally opened in 1975 as a demonstration project for a well-known non-profit organization devoted to the well-being of mothers and infants.

This organization helped initiate the first nurse-midwifery education program in 1930. After 20 years, the organization made the decision to transfer ownership of the Birth Center to a local hospital where it was located until its closure in 2003. I conducted 52 multi-sited in-depth interviews with midwives, nurses, hospital and service administrators, childbirth educators, policymakers, and physicians. I also collected secondary data from the media, e-mail correspondence between providers, documentation of policy, and letters written from various agencies on behalf of the midwifery services.

According to this notice, beginning October 1 of that year midwives would no longer be permitted to attend births. No evidence supporting these claims was produced by the hospital or the physicians

from the University despite multiple requests from the media, midwifery service, and influential members of the local community. Later, the hospital reconsidered and decided to modify clinical practice guidelines that limited the scope of midwifery care rather than completely exclude midwives from the hospital setting. Ultimately, these changes resulted in a number of midwives leaving the service and an **84% reduction in the number of midwife-attended births due to practice restrictions.**

Eighty per cent of those interviewed in this case felt that the changes were **the direct result of a Medicaid fraud lawsuit brought against the University in 1999.** At that time, the obstetrical department hired a chart auditor for billing purposes. The auditor discovered that physicians were billing for births attended by midwives. She reported these findings to the state and the FBI, which resulted in a multi-million dollar fraud suit against the University and the hospital. The University settled its portion of the case in December 2002 for US \$5.1 million. **A few months later, the midwives were notified that patients were determined to be too high-risk for midwifery care.**

However, demographic data collected by the state health department showed no change in risk characteristics for this health center district (Schwartz, Li, Kelley, & Kennedy, 2004). Although a number of the university physicians were sympathetic to the midwives, it was clear that the obstetrics department and the hospital had a shared agenda. Some respondents felt that the institutions were experts in misdirection, as suggested by the following quote:

“I am amazed with the strategy used by the obstetrics department. They had just paid a huge fine to the US government because of inappropriate billing practices.... Yet the overt articulated reason was that the women in these neighborhoods were high-risk. But the midwives were going to stop doing births October 1, which I never understood. If the women were so high-risk, then it seems like they should immediately go to physician care tonight and if they are not high-risk, then do not use it as an excuse to curtail the practice of midwives.”

Others felt that the changes were related to economics, as implied by this participant.

“What happened to the midwives at the [University-based Midwifery Service] was all about money it was really about serving the needs of the physician. If the midwife is going to help meet those needs, they are welcome to practice. If they look like competition, out they go.”

The hospital, on the other hand, was able to cloak the decision in the discourse of patient safety. One hospital spokesperson said: ‘The issue was never one about money. **It’s just the actual delivery, when, quite frankly, you just want the baby out. And having a competent doctor is very reassuring**’ (Carr, 2003). Another report quoted the Senior Vice President of the hospital who said that: ‘The decision stemmed from an analysis showing that 85% of its pregnant patients have some risk factor. **We needed to move to a model that would have our deliveries being performed by obstetricians**’ (Kugel, 2003).

Yet the obstetrics department and the hospital refused to provide evidence in support of their actions. Without corroboration, it **appears that the focus on risk and safety successfully diverted attention away from billing malfeasance resulting in Medicaid fraud, loss of income to physicians, and competition from midwives.** Publicly, the hospital and obstetricians appeared to be concerned primarily with patient safety. If midwives argued or protested, they appeared to be concerned with themselves rather than the well-being of mothers and babies. According to study

participants, the Birth Center created a special community for families during its 7 years. It also experienced many challenges, including the coming and going of six clinical directors, reimbursement struggles, the loss of their medical director, and rising malpractice insurance costs.

Ultimately, the hospital decided to close the Birth Center in the summer of 2003 because of a 400% increase in malpractice insurance rates for the birth center and its midwives. The board of directors was not involved in this decision:

“We on the board... did not have information about how many law suits, what type, with what expectation of outcome. We did not really know why this insurance company was suddenly saying, ‘Now you are going to have to pay a million dollars.’ Because there was so much information hidden, it made one wonder if we didn’t get sold down the river. I am not sure what the real facts were.”

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[**Aside from editor:** I have an audio tape of the lobbyist for all 3 California med-mal insurers (Judge Cologne, June 1994) admitting in an open medical board meeting that his employers (the insurance carriers) didn’t have any actuarial data substantiating their claims that PHB with a professional midwife was any more likely to lead to litigation than any other type of birth attendant or setting. According to Judge Cologne, the boards of directors of these physician-owned companies based their decision on “common sense” (his words). If the safety of mothers and babies was their motivation, this is unexplainable and inexcusable.

While the situation with Columbia’s nurse-midwifery birth center is obviously different issue than PHB in California, physician-owned med-mal carriers are on record as prohibiting forms of care or hiking up premiums to the level that practitioner are put out of business – all without having any actuarial data to support these “business’ decisions. The author is right to question any decisions that the company is not willing to provide documents identifying actuarial data to justify its actions ]

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Another board member commented:

“They called an emergency board meeting saying that the malpractice insurance was up in two weeks. ... They said they did a competitive analysis and I guess they did. **They said it had nothing to do with specific births, it was just in general. So they decided to close the Birth Center. Ultimately, it was not a decision or even a discussion that included board members.**”

Perhaps it is useful to consider the Birth Center’s successes along with its failures and to keep in mind that according to one of the hospital’s administrators, **2000 births per year were necessary to keep the labor and delivery unit open. During its tenure, the number of births at the birth center went from 100 to nearly 500 births per year, which was one-fourth of the volume needed by the hospital unit in order for it to be sustainable.** It was understandable that hospital administrators would focus on the rising cost of malpractice insurance. Like the discourse of patient safety, there is no argument here; everyone knows that medical malpractice rates are rising, although a **400% rise is atypical.** The fact that **information was never shared with the board** of directors bothered some informants. They wondered why it was exclusively a hospital decision.

One person observed: **“The birth center is not only competing with the doctors, it is competing with the hospital. If the hospital thinks that the birth center is attracting patients that wouldn’t ordinarily go to the hospital, and the overflow, higher risk are coming to their hospital, they will put up with it. As soon as it looks like the hospital is losing patients to the birth center, in any way shape or form, they aren’t going to like it.”**

When the Birth Center closed in August of 2003, the four remaining midwives were invited to move the practice to an in-hospital birth center. **Within three months, all four midwives had resigned,** stating that what the hospital offered was insufficient to the practice of a midwifery model of care. The rooms were reported to look nice, but **clinical practice guidelines had been revised without their input and were more restrictive than they were in the Birth Center.** The midwives resented the guideline changes, and **women were choosing to go elsewhere for care.** The midwives chose to leave rather than have their practice curtailed by hospital policies.

Cross-case analysis

Despite the fact that each case represents a different model of midwifery care, common themes emerged from the analysis. In both cases political and economic factors were driving forces, though these were often obscured by rational discourses around risk and liability. In the case of the University-based Midwifery Service, it is reasonable to have obstetricians providing care if patients are defined as high-risk. It makes sense to close the Birth Center if malpractice rates are exorbitant. **The marginalization of midwives in both cases seems rational in the context of the claims made, even though no evidence was ever produced in support of these claims.** In neither case did **the public story include reference to the published literature that indicates that midwifery-led maternity care is in the best interests of mothers, newborns, and health care systems.** This paradox is “the veil to pierce.”

Multiple economic forces have affected maternity care in the US. For example, managed care markets have attempted to control health service usage by members in order to decrease costs. Thus managed care has drastically changed financial incentives for providers by challenging the open-ended cost-based reimbursement system that existed in a fee-for service environment. Reimbursement levels dropped significantly and the financial risk in health care was shifted from payers to providers. New financial and business strategies were developed, including increased productivity, large group practices to share overhead expenses and on-call service, and doing more procedures (Perkins, 2003).

In addition to falling reimbursement levels, malpractice premiums are rising and **birth rates are falling for fully insured populations and are stable or slightly rising for minimally insured, underinsured, and uninsured populations** (Bernstein & Makuc, 2004). In a contracted market, with lower reimbursement rates and increased costs of overhead, the response of obstetricians and **hospital administrators is to develop strategies for protecting their economic interests.** Results from this study suggest that minimizing competition and maximizing billing are two such strategies, both of which ultimately shape clinical practice.

Informants suggested that one way to minimize competition is to make the needs of physicians and institutions the priority. **One physician commented: “In a good economy, where everybody is succeeding, physicians are not particularly threatened by midwives economically—forget clinically. But that is not what we have..”**

The implication is that in a weak marketplace, physicians feel more vulnerable and have less tolerance for midwives. Similarly, another physician noted: **“The only place where [midwifery practice] works is where the only person getting reimbursed is the midwife and it is not the medical or institutional need that the physicians also get reimbursed.”**

This statement implies that the health care needs of the woman and the financial needs of the midwife are **secondary to the economic needs of the physician or institution**. Several participants felt that limiting consultant services and controlling hospital credentialing of midwives were ways to minimize competition from midwives.

One midwife said: “Many years ago, I had my first meeting with the then chair of the obstetrics department. The first thing he said to me y was, ‘I am not willing to give up the revenues generated by the midwifery practice.’ So he put me on notice immediately.”

Two other midwives said: “I remember a conversation I had with an obstetrician with whom I had a good relationship. He said, ‘I don’t have any problems with you personally, but the fact is that **my practice is not full and until it is, there is not going to be another nurse-midwife that will get privileges at this hospital.**’ We were told that a decision was made that no more midwives will be added to the medical staff because the midwives were getting too busy and that ‘**There are people who don’t want this to turn into a midwifery hospital.**’”

According to these participants, the economic interests of physicians were a priority.

Another strategy, according to informants, is to **maximize billing opportunities by pushing for high-volume, high-cost obstetrics**. Seeing more patients, **higher rates of intervention, utilizing residents, and doing more frequent procedures are all ways to maximize billing**. Several participants observed that obstetrical departments want to provide care to populations eligible for Medicaid as one way to increase volume. Years ago, this population was designated to midwives (Langton, 1994; Rosenbaum, 1986). However, changes in health care markets motivated physicians to seek Medicaid patients because reimbursement is relatively quick, easy, and sure.

One administrator from my study said: “Historically in [this city] y midwives were employed by large city hospitals to give care to the mostly indigent underserved Medicaid population. ... But in recent years, they are **basically doing away with or decreasing the number of midwives** in those facilities. With changing economics, **obstetrical services in those institutions are taking over those births.**”

When asked why this change had occurred, this administrator commented: “Midwives filled a gap for quite a while. ... Let’s face it; these were the poor women who did not pay very well.... But **Medicaid reimbursement is now better than some of the private reimbursements, which means these women are suddenly more valuable to private practice physicians.**”

Another midwife observed:

“The physicians got smart and said we **can make money off the Medicaid patients**. That is when midwifery went down the drain in this country. ... When there was a market value on these patients, midwives got into trouble.”

Several informants referred to the use of residents. One administrator commented: “**Every single hospital in [this] city has become a teaching hospital with residency programs ... because it is lucrative.**”

Another midwife remarked: “The whole problem with American health care is that it is not an American medical system it is **a medical education system**. Every institution that accepts medical students or residents receives a tremendous amount of money for participating in the resident program in addition to the receivables they get from providing indigent care. The more residents they take the more money they get.

So if you get rid of the midwives doing the deliveries, and get residents doing the deliveries, you get extra money and don’t have to pay the salary and benefits of the midwife. We say midwives make economic sense, but not in our American medical education system where we place a market value on residents providing care.”

Obstetrical departments can get paid twice for indigent care—they can bill for the service rendered to the patient by the resident and attending physician in addition to the funds they receive for the [medical educational] service rendered to the student/resident.

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[**Aside from Editor:** At first glance, its hard to understand just what an economic double whammy this is, as the medical schools are billing each of their residents for their medical education, while are hospitals are billing third party payers or the federal Medicaid program under the name of the supervising obstetrician who is rarely present or involved in providing this care.

By replacing midwives who scrupulously avoided unnecessary medical intervention, with residents who typically utilize the whole spectrum of medical and surgical interventions as often as possible, **the hospital enjoys a much higher level of billable units**. In addition, the hospital’s reimbursement rate is far greater than if those same patients had been cared for by staff midwives, as the policies of the **federal government only reimburse CNM care at 66% of the rate they pay for obstetrician care.**]

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The conventional medical marketplace encourages the consumption of medical services, as several midwives noted:

“I almost feel like there is another hand that is pushing for the high-cost of obstetrics rather than for the low-cost of obstetrics. That is not good for mothers, babies, or midwives. But it is good for physicians and hospitals and drug companies. What midwives do when they are working in a hospital is not billable. They would rather not use IVs, fetal monitors, and medications. What the hospital looks at is ‘What is this going to get us in billables?’ So the hospital is going to lose money they could have had. They can’t bill as much. They don’t like that.”

Midwifery focuses on education, spending time with women, and avoiding unnecessary intervention or interference with normal processes and prefers to avoid high-volume practice. This may seem to contradict claims that midwives make economic sense; however, cost savings are realized with the analysis of outcomes, such as **lower rates of interventions, fewer low birth weight babies, complications, and surgeries—all of which are extremely costly to health care and other social systems.**

This leads to questions regarding the role of the third party payer in all of this as posited by one childbirth educator: “I wish we could somehow influence payers, because they should care about these things. y It seems as though they should be insisting that physicians be held accountable for

unnecessary cesareans. Why aren't the people who need to save money listening and doing something?"

Maximizing billing practices and minimizing competition in many ways are rational responses to the economic challenges experienced by maternity providers in the US health care system, even though these approaches may not always be in the best interests of women and newborns and certainly does not make sense from the perspective of payers—ultimately, consumers.

Strategies adopted by midwives were different from those developed by physicians and institutions. Some midwives “went to the mat” to fight for their professional rights. **Others chose to go along with the changes in order to keep their jobs.** One midwife, who was sympathetic to those who were complacent, said “You can't blame the poor midwife who needs the job.”

Others were more critical of midwives who did not get involved. One midwife said, “I cannot understand protecting yourself at the expense of our profession and the women we serve.”

One fascinating finding in my study was the suggestion from **many participants that the solution to the challenges facing midwives was to move to a private practice model and away from the false sense of security gained from being employees of institutions, where salaries and hours were guaranteed.** This is an interesting contrast to the strategy of physicians and institutions, where a private practice model is no longer economically sustainable:

“In the past ...large city hospitals employed large numbers of midwives to care for the mostly indigent underserved Medicaid population. ... But recently, they are eliminating or decreasing midwives in those facilities, which has created a shift towards a private practice model, where midwives work with physicians or in their own private practices.”

If large medical centers replace midwives with physicians and residents, then midwives are forced to look towards a private practice model. One midwife pointed out that this is problematic since **midwives are dependent on their competition to be their consultants,** which affects their ability to set up a practice or receive hospital privileges:

“Regulations have to change for midwives so that we are not beholden to our competition for your financial and professional survival....The law should acknowledge that midwives are autonomous practitioners, licensed by the state to provide care for healthy women, and should mandate that physicians provide consultation as needed ... so that we can be an autonomous, independent profession.”

Ultimately, strategies for the economic sustainability of midwifery were different from those for institutions and physicians.

In general, public policy is written to protect the health of a population in a humane and effective manner that also respects the rights of individuals. It is assumed that public policy is written to address issues that are important enough to merit a written policy, with evidence that the policy will be feasible, practical and effective, have tangible benefits, and be socially and culturally acceptable.

My study suggested that some of the strategies used with respect to public policy are similar to those identified in the marketplace to foster physician and institutional control of health care.

For example, one policymaker addressed legislative efforts to obtain 100% Medicare reimbursement for midwives, which is currently at 65% of what physicians receive. According to this respondent, the committee that advises Congress on Medicare reimbursement issues advised accountability:

“In 2002 the Medicare Payment Advisory Committee (MedPAC), which advises Congress on all Medicare payment issues, did a report on advanced practice nursing. **They recommended an increase in the rate of pay for midwives** and also said ‘We believe that Congress should look at the outcomes of practitioners when they try to determine what their rate of pay should be. ‘It goes further and says **‘We have looked at the outcomes and think that midwives have comparable outcomes to obstetricians.’**”

Ultimately, as of this writing, the American College of Obstetricians and Gynecologists (ACOG) **opposed the changes despite MedPAC recommendations for accountability** with respect to outcomes and reimbursement. When legislation is based on fiction as opposed to evidence, as in this case, it is **irrational and contributes to the ways in which dominant groups maintain power** and make it difficult for others to penetrate the market.

Furthermore, it is irrational with respect to what is best for mothers and babies. Developed countries with government-sponsored health care systems have better maternal newborn outcomes and spend less money on health care. In many of these countries, midwives, who are considered experts in normal pregnancy and birth, provide the majority of maternity care. Specialists assume care of women with complicated pregnancies or births who benefit from their expertise. The goal is to **minimize risks and maximize good outcomes for mothers and babies as opposed to maximizing provider income.** Thus midwifery-led maternity care makes sense.

Public policy that is not evidence-based suggests that we **act “as if” there is good reason for the creation of legislation and regulations that protect the market share for physicians.** Efforts to change these laws take years, money, and extensive lobbying efforts to undo. This is similar to the theory of fictions where the goal is to create reality with illusions (Vaihinger, 1935). **Public policies based on fictions are difficult to undo and in essence, are the same strategies seen earlier that were designed to maximize income and minimize competition for physicians and institutions.** **Funding for obstetrical resident programs is another fiction made into commonsense reality, acting “as if” there is evidence to support the allocation of federal funds for a five-to-one ratio of obstetricians to midwives.** The creation of public policy based on fictions and the philosophy of the “as if” play an important role in the marginalization of midwives in the US.

Conclusions

This study illustrates some of the ways in which state and market forces shape the marginalization of midwives in the US. **Maternity care represents one-fifth of all health care expenditures.** If the US wants to successfully address problems related to quality of care, rising costs and limited access to care, then **the marginalization of this work force is deeply troubling.** Over 10 years ago, some experts estimated that nearly 20 billion dollars could be saved in health care costs by demedicalizing childbirth, developing midwifery and encouraging breastfeeding (Gabay & Wolfe, 1995; Oski, 1993). **It is time to hold the health care system accountable and move towards a midwifery-led model of maternity care.**

In the cases studied, **institutions successfully altered maternity care and diminished midwifery services without accountability for their actions.** In fact, the elimination of midwives seemed to be a rational decision when framed in the context of patient safety and the rising costs of medical malpractice. But **the evidence says that mothers and babies have superior outcomes when midwives attend births and therein lies the paradox.** In the end, it appears that midwifery practice was defined and determined by the economic and **territorial needs** of the institutions and physicians involved instead of the best interests of mothers and babies, or of society as a whole.

Creation of rational, risk-based discourse is an important tool for physicians and institutions to promote their sovereignty, as seen in both cases. The physicians and administrators from the University were wise to **retreat to arguments embedded in the language of safety and risk to rationalize changes made to the midwifery service.** They were similarly wise to **control the terms of the discourse.** For example, hospital administrators and physicians from the obstetrical department refused to participate in my study or to publicize the statistical evidence that provoked their decisions. I relied on secondary sources for their side of the story.

In the meantime, the Medicaid fraud case disappeared; it was irrelevant—“this was not about money.” **The gaze turned to women’s bodies instead, the type of bodies that society wants—“high-risk” in this case.** To Foucault, the medical gaze is a metaphor for the discursive practices in medicine, the development of an institutionalized way of viewing and talking about disease and the body (Foucault, 1975). **If pregnant or birthing women are high risk, then physicians should be providing their care. It is also a way to rationalize the medicalization of birth.**

The dominant discourse that resulted was typical of an **institutionalized way of spreading knowledge about women’s bodies and the way in which they needed to be cared—by obstetricians and medical management of birth.** Martin (2001, p. 57) writes that, “Our focus on technology ... **diverts our attention away from the social relationships of power** and domination that are involved whenever humans use machines to produce goods in our society.”

Attention is successfully **misdirected** from what is really best for mothers and babies in order to benefit the institution. Pregnant women enter into **a system that is perhaps more interested in the economic well-being of the institution than in the safety and well being of the patient.** The economic organization of medicine shapes discourse, which then drives clinical practice as suggested by Perkins (2003). **Evidence of this exists in obstetrics where a process that is reportedly normal 70–80% of the time ends up with multiple interventions, such as 40% of labors induced or augmented and a 29% cesarean section rate** (Martin et al., 2006; WHO, 1996).

Rising medical malpractice premiums provided those in power with the necessary discourse to shut down the Birth Center and **force midwives into a more submissive, less autonomous role. This allowed those in power to increase control over and regulate midwifery practice. The discourse was resoundingly similar in both cases. It was difficult to challenge or question the claims made.** The public knows that cost of malpractice insurance is a problem, and it is easy to see how one might propose that it is a bigger problem for a freestanding Birth Center. The medical gaze once again turned to **the kind of body society wants—bodies that are institutionalized during birth.** After all, institutionalized birth is economically beneficial for institutions and those who lead them.

This study **looks critically at problems within our health care system through the window of maternity care and finds a system that is based on strategies for the economic success of the dominant institutions of medicine.** The suggestion that there is a preference for the high cost of obstetrics to **promote the number of billable procedures is an example of costly ineffective care replacing high-quality cost-effective care.** Although, it may be a wise economic strategy for the institution of medicine, it is not always in the best interests of women, babies and the health care system.

The **institution of medicine must be held accountable for these behaviors** if they do indeed exist. Similarly, the focus on the education of residents must be re-examined. Given what we know about midwifery outcomes, it is unlikely that outcomes are improved when we replace midwives with residents or that care is more cost-effective. In these instances, **the practice of medicine becomes a by-product of economics.** The art of healing and the oath to “do no harm” is diluted.

Given the current health care crisis, we must reexamine our priorities with respect to health care and find ways to promote high-quality cost-effective care. We have the tools we need; we just have to reshape how they are used. **Institutions and providers need to be held accountable for their actions.** It is time for public policy and payers to demand and critically evaluate the evidence in order to make crucial decisions. Providing high-quality cost-effective care is not the priority of a health care system that is based on a paradigm of economic success for institutions and providers. Current health care initiatives in the US are moving towards “Pay for Performance” where the expectation is for the delivery of high-quality cost-effective care in order to get paid (Centers for Medicare and Medicaid Services, 2005).

This movement paves the way for a midwifery-led model of maternity care in the US. When accountability is expected, we will no longer need to pierce the veil that keeps midwifery from the mainstream.

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