Study reveals conflict between doctors, midwives over homebirth

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Two Oregon State University researchers have uncovered a pattern of distrust - and sometimes outright antagonism - among physicians at hospitals and midwives who are transporting their home-birth clients to the hospital because of complications.

Oregon State University assistant professor Melissa Cheyney and doctoral student Courtney Everson said their work revealed an ongoing conflict between physicians and midwives that is reflective of discord across the country.

The pair recently examined birth records in Oregon's Jackson County from 1998 through 2003, a period when that county saw higher-than-expected rates of prematurity and low birth weight in some populations. The researchers wanted to assess whether those rates were linked to midwife-attended homebirths.

The findings revealed that assisted homebirths did not appear to be contributing to the lower-than-average health outcomes and, in fact, that the homebirths documented all had successful outcomes. But even more importantly to Cheyney, discussions with doctors and midwives uncovered a deep gulf between the two groups of birthing providers, with doctors expressing the firm belief that only hospital births are safe, while midwives felt marginalized, mocked and put on the defensive when in contact with physicians.

"We've been getting insight into their world view, and it's been quite

illuminating," Cheyney said.

Cheyney, who is a practicing midwife in addition to being an assistant professor of medical anthropology and reproductive biology, said she was surprised that physicians, when presented with scientifically conducted research that indicates homebirths do not increase infant mortality rates, still refuse to believe that births outside of the hospital are safe.

"Medicine is a social construct, and it's heavily politicized," she said.

Last year the American Medical Association passed Resolution 205, which states: "the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex…" The resolution was passed in direct response to media attention on home births, the AMA stated.

What is interesting, Cheyney points out, is that 99 percent of American births occur in the hospital, but the United States has one of the highest infant mortality rates of any developed country, with 6.3 deaths per 1,000 babies born. Meanwhile, the Netherlands, where a third of deliveries occur in the home with the assistance of midwives, has a lower rate of 4.73 deaths per 1,000.

One of the biggest problems Cheyney sees is that physicians only come into contact with midwives when something has gone wrong with the homebirth, and the patient has been transported to the hospital for care. There are a number of reasons why this interaction often is tension-filled and unpleasant for both sides, she says.

First is the assumption that homebirth must be dangerous, because the patient they're seeing has had to be transported to the hospital. Secondly, the physician is now taking on the risk of caring for a patient who is

unknown to them, and who has a medical chart provided by a midwife which may not include the kind of information the physician is used to receiving.

And because the midwife is often feeling defensive and upset, Cheyney said, the contact between her and the physician can often be tense and unproductive. Meanwhile, the patient, whose intention was not to have a hospital birth, is already feeling upset at the change in birth plan, and is now watching her care provider come into conflict with the stranger who is about to deliver her baby.

"It's an extremely tension-fraught encounter," Cheyney said, "and something needs to be done to address it." As homebirths increase in popularity, she added, these encounters are bound to increase and a plan needs to be in place so that doctors and midwives know what protocol to follow.

She is working with Lane County obstetrician Dr. Paul Qualtere-Burcher to draft guidelines that would help midwives and their clients decide when they need to seek medical help, based in large part on Cheyney's research, and another that would ask physicians to recognize midwives as legitimate caregivers.

Qualtere-Burcher said creating an open channel of communication isn't easy.

"I do get some pushback from physician friends who say that I'm too open and too supportive," he said. "My answer, to quote (President) Obama, is that dialogue is always a good idea."

Qualtere-Burcher said he believes that if midwives felt more comfortable contacting physicians with medical questions or concerns, there would be a greater chance that women would get medical help

when they needed it.

"Treat (midwives) with respect, as colleagues, and they'll not be afraid to call," he said.

Qualtere-Burcher doesn't expect immediate buy-in, but hopes that if a small group on each side agrees to the plan, it will provide more evidence that a stronger relationship between physicians and midwives will lead to better outcomes for mothers and infants.

"We're having a meeting in early May to propose a draft for a model of collaborative care that might be the first of its kind in the United States," Cheyney said.

Cheyney is also pushing to get hospitals and the state records division to better track homebirths. The department of vital records had no way to indicate whether a birth occurred at home until 2008, and without being able to pull data, Cheyney said it's hard to explore the nature of home birth in Oregon.

She's also working on education programs for midwives in rural areas, including a cultural competency piece as demographics in Oregon continue to change.

Source: Oregon State University