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NURSE MIDWIFERY: CONSUMERS' FREEDOM OF CHOICE

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HEARING

BEFORE THE

SUBCOMMITTEE ON

OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON

INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

DECEMBER 18, 1980

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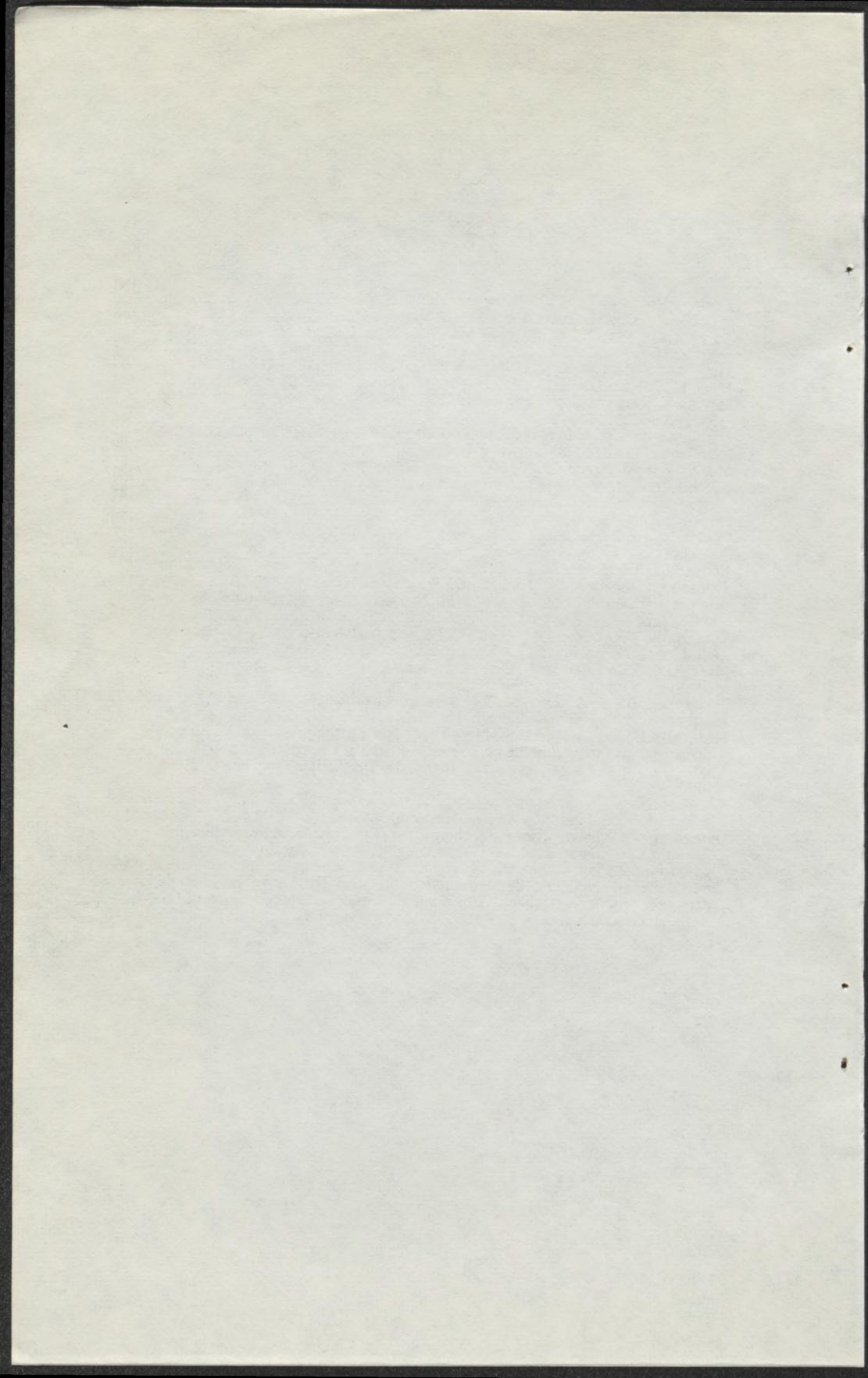
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NURSE MIDWIFERY: CONSUMERS' FREEDOM OF CHOICE

THURSDAY, DECEMBER 18, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Albert Gore, Jr., presiding (Hon. Bob Eckhardt, chairman).

Mr. GORE. The subcommittee will come to order.

Today the Subcommittee on Oversight and Investigations considers the subject of childbirth. It is a subject which touches each of us at least once during our lives. For parents it is an event which can consume more of our personal emotion and concern than any other single event that we might encounter in our lifetime. Last year in the United States there were an estimated 3,473,000 births which took place, just one indication of the magnitude of interest that Americans have in this issue.

Many of our citizens, particularly women, are now examining some of the modern practices surrounding childbirth, particularly with regard to how that birth should take place, what role the mother should play, and who should attend the birth. Recent study suggests that such an examination is not only appropriate, but of some importance, both for the consumer and the medical community. As the risks of routine electronic fetal monitoring are becoming known and its benefits called in serious question, a recent survey showed that 77 percent of the physicians surveyed believed that all labor should have electronic fetal monitoring automatically.

During a period when cesarean section rates in this country increased by 92 percent, the number of live births for each obstetrician fell in nearly half. These increasingly popular technologies and practices are not always independent, but all too often are part of a sequence of escalating heroism involving these and other potentially dangerous interventions.

Alternatives to the established childbirth procedures do exist. Today we will seek to examine those alternatives with an eye not toward encouraging or discouraging one form as opposed to another, but with an eye toward facilitating a better understanding of the risks and the benefits of those different alternatives. We shall examine the benefits brought to childbirth by the nurse-midwife and we shall also inquire as to the risk that might be presented with a nurse midwife attendant. Only with a knowledge of those risks may the prospective parent exercise the freedom to choose the form of care desired.

We will then examine the right of consumers to exercise that freedom of choice without restraint of trade or intimidation.

Most recently, Congress has expressed its concern in the areas both of quality and cost of health care in this country. That debate has considered the role of competition in the health care delivery system, as a means not only to provide relief from the staggering cost of health care but also to improve the quality of that care. Maternal and child health care I believe presents us with an excellent opportunity to explore the nature of the competition and ways which it might be strengthened where it is restrained. We will hear from all sides of this debate; from nurse-midwives as well as the professional organization representing the obstetricians and gynecologists in the United States.

This issue is particularly timely, I believe, in light of the changing attitudes of health consumers and more particularly the women health consumers. I believe a quotation from one of the witnesses who will be appearing before this subcommittee today, Dr. C. Arden Miller, the chairman of the Department of Maternal and Child Health at the University of North Carolina, is appropriate. Speaking in 1978 at the University of Michigan, Dr. Miller said:

A "new" woman patient is emerging—one who accepts responsibility for her health rather than leaving it to the professional.

Women have heightened expectations about their own role in health care; they are learning that they can participate in their medical care. They can also gain competence in self-care and prevention and make informed decisions for themselves. The self-help movement has worked to acknowledge and extend the ability of the consumer to judge the quality of care that she receives. Armed with this knowledge, women can let go of the manufactured dependency that has allowed the medical mystique and paternalism to persist.

I must note that while I believe that the health consumer, equipped with a full understanding of the risks and benefits of the range of alternatives, can make an informed decision, I believe that the physician must have a defined role in each alternative. In the issue we consider today, the well-being of a mother and a child turn on the appropriate level of care meeting the need for that care.

I would like to welcome our first witnesses but before doing so, I am pleased to have my distinguished colleague from Maryland present during this hearing. I would like to now call on her for an opening statement.

Ms. MIKULSKI. Thank you very much.

**TESTIMONY OF HON. BARBARA A. MIKULSKI, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MARYLAND**

Ms. MIKULSKI. Thank you very much.

Congressman Gore, members of the subcommittee, I want to thank you for the opportunity to participate in this hearing by the Subcommittee on Oversight and Investigation on a topic that is very important to me: the importance of allowing real choice in service to health care consumers, and the great value of nurse-midwife practice.

As a member of the Health Subcommittee of the Commerce Committee, I have been working on this issue for the past 2

years—working, in fact, with some of the people who will testify before us this morning. And I am very pleased to be able to announce our first success. My legislation to provide direct medic-aid reimbursement to certified nurse-midwives has finally been enacted by the Congress as part of the budget reconciliation measure which passed last month.

Throughout the process of drafting, explaining and avocating this legislation, I worked closely with the American College of Nurse-midwives and with individual nurse-midwives. They are absolutely a first-rate group of health providers, caring, concerned, deeply involved with the well-being of the families they serve. I am proud to have been their legislative advocate.

As we worked for passage of my nurse-midwife legislation, we always emphasized its profound national policy implications. By opening the reimbursement system for health care we enable consumers to make a true choice among types of service based on their own needs, preferences and values; and at the same time we allow for the real possibility of controlling health care costs, not by denying needed services but by making available a wider range of cost effective services.

I believe that these principles must become an integral part of our national health policy, and I look forward to the opportunity to discuss them further during today's hearing.

But I would also like to take a moment now to talk personally about my own experience. When I joined the Health Subcommittee 2 years ago, I soon discovered that I had become a historic footnote: I am the first woman in the history of the United States to serve on the Health Subcommittee of either body of the Congress. I found this to be a melancholy distinction that throughout the history of the U.S. Congress no woman had had a voice in the health care of women. So through my work on the committee I tried to ask the questions that 53 percent of the population would ask if they were given the opportunity to be a Member of Congress, such as:

Why do we put so much emphasis on high-cost, high-risk technology, and so little on prevention, nutrition, and education? Why do Federal dollars pay for so many radical mastectomies and unnecessary hysterectomies? Why are my natural processes, like pregnancy, menstruation, and menopause, treated like embarrassing diseases, with high-technology equipment and unnecessary hormones and questionable pharmaceuticals?

Mr. Gore, I realize that the timing of this hearing was actually dictated by the congressional calendar, but I would also like to point out that this is a particularly appropriate time of year to think about the true dignity of childbirth, and the beauty of the natural processes that make us all human. Let us remember that the true focus of childbirth is the mother and the baby—not the attendance or the equipment.

All over the world today we see a growing interest by people who want to know more about their own health and want to become more responsible for their own bodies. We see a tremendous surge of interest in nutrition, in exercise, and in keeping ourselves healthy. In the forefront of this movement is the concern by women as health-care consumers, for more participation in deci-

sions about their bodies, for alternative methods of obstetrical and gynecological care.

Not every woman will choose to be delivered by a nurse-midwife nor is every pregnancy suitable for such service. But to the extent that we make choice of service more feasible, I believe that we can significantly improve the quality of care available to American health care consumers. I am proud to have been able to play a role in opening up these choices and I look forward to continuing to do so in the 97th Congress.

Your hearing provides us with an opportunity to explore a new alternative.

Mr. GORE. Thank you for your statement. We are very pleased you were able to join us today for this hearing.

Let me announce for those who are present today that it is the intention of the subcommittee to try to move this hearing along and we are going to go right through the lunch break, so be forewarned about that. We have a relatively long witness list. Our witnesses for the most part have agreed to present summaries and the highlights of their testimony. We are not going to take a formal lunch break. So if you start to get hungry, be forewarned you will have to slip out and get a sandwich.

We will start with our first panel. I would like to call to the witness table Sally Tom, C.N.M., M.S., American College of Nurse-Midwives; and Judy Norsigian, representing the National Women's Health Network.

Let me explain we have a custom in this subcommittee: We have no legislative responsibility. We are purely and simply an investigative subcommittee. Partly for that reason it is our custom to swear in all of our witnesses. So please stand and raise your right hand and repeat after me: Do you swear the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

[Chorus of "I do."]

Mr. GORE. We had a third witness scheduled to be a part of this panel. The attorney with Covington & Burling representing the Nurse-Midwives is Karen Rothenberg. She was to testify; however, 2 nights ago at 8 p.m., she gave birth to a 6-pound, 13-ounce baby, delivered by a certified midwife, I might add; and baby and mother are doing fine.

The subcommittee would like to begin this hearing this morning by officially expressing our best wishes to the entire family. We will do that in person also.

Welcome to both of you. We appreciate your willingness to come and participate in this hearing. Without objection, the text of your prepared statement will be inserted in the record.

[See p. 7.]

I invite you to now proceed with the presentation of any or all of it, as you see fit. Ms. Tom.

TESTIMONY OF SALLY TOM, C.N.M., M.S., AMERICAN COLLEGE
OF NURSE-MIDWIVES, AND JUDY NORSIGIAN, ACTION VICE-
CHAIR, NATIONAL WOMEN'S HEALTH NETWORK

Ms. TOM. Thank you.

Good morning. My name is Sally Tom. I am a certified nurse-midwife and I practice nurse-midwifery in the District of Columbia. I am representing the American College of Nurse-Midwives—ACNM—the professional organization of certified nurse-midwives in the United States. The ACNM is autonomous from all other professional organizations and speaks for its membership on all issues affecting nurse-midwifery practice.

These hearings are focusing on the obstacles to practice which nurse-midwives face. The obstacles should not, however, obscure the coexisting reality that in many communities nurse-midwives, physicians, and hospitals have formed mutually satisfying professional relationships. The ACNM and the American College of Obstetricians & Gynecologists—ACOG—have often worked together on issues of importance to mothers and babies.

The ACNM has benefited from and appreciated ACOG's official support. Nurse-midwifery practice was officially endorsed by the American College of Obstetricians & Gynecologists and the Nurses Association of the American College of Obstetricians & Gynecologists (NAACOG) in a statement issued jointly with the ACNM in 1971 and in a supplemental statement issued in 1975.

A recent Government Accounting Office report mentioned three obstacles to practice which are of concern in these hearings today: physician resistance to nurse-midwifery practice, restrictive State licensing and third-party reimbursement practices.

Two themes emerge from the arguments against nurse-midwifery practice. The first of these is the issue of quality of care and client safety. The record of nurse-midwifery care in the United States in reducing infant mortality and morbidity shows that nurse-midwives are safe. In discussing quality of care, it is important to remember that pregnancy and childbirth are normal physiological events. Normal, healthy pregnancy and delivery are the predominant realities of childbearing. Complications are the exception, not the rule. Nurse-midwives are educated to recognize the symptoms of complications, to begin the appropriate interventions and to call for assistance immediately when complications arise.

The second theme which emerges in the resistance to nurse-midwifery is that of "independent practice." Independent practice appears to mean a nurse-midwife hanging up her shingle in a solo practice patterned after the independent business of the physician in private practice. The implication of this model is that the nurse-midwife would be practicing without a physician, without the system for consultation with physicians, without referral of clients to physicians and without the collaborative management of client care by both a nurse-midwife and a physician which are an integral part of the definition of nurse-midwifery practice. The record needs to be very clear on this matter. Nurse-midwives do not practice midwifery in the "independent practice" model of private solo practice. The "Functions, Standards and Qualifications for Nurse-Midwifery Practice," published by the ACNM, states that nurse-midwifery practice "Occurs within a formal written alliance

with an obstetrician or another physician, or a group of physicians who has/have a formal consultative arrangement with an obstetrician-gynecologist; and exists within a framework of medically approved protocols." Should a nurse-midwife be thought to be violating these standards, she would be subject to investigation by the ACNM and would be vulnerable to censure, suspension, expulsion or decertification.

Nurse-midwives have always practiced and will continue to practice in collaboration with physicians; that relationship will not change. What has begun to change, however, is the monetary relationship between the nurse-midwife and her collaborating physician. Nurse-midwives are now not always employees of physicians. This change means that a nurse-midwife may become economically independent of her physician or hospital. Her professional interdependence with hospitals and physicians remains.

It appears that fear of economic competition underlies much of the resistance to nurse-midwifery practice. The New Jersey Board of Medical Examiners attempted to write regulations for nurse-midwifery practice which restricted the trade of nurse-midwives and which had no relation to safety whatsoever. Nurse-midwives in the District of Columbia have been told by various physicians that they opposed nurse-midwifery expansion on economic grounds.

One physician said, "If your licensure bill passes, nurse-midwives will be delivering all of the babies in the city in 10 years." When one nurse-midwife in private practice with a group of physicians applied for delivery privileges at a local hospital, she was told, "Let's face it, you are competition and we don't want you here. You need to look at what you're dealing with here. This hospital is like a country club. We don't like Jews here, we don't like blacks here * * *" He left the clear impression with the nurse-midwife that the other people not liked at that hospital were nurse-midwives.

Another physician said of his colleagues, "They see you as an economic threat and they don't want to let you in because once they let you in, it'll be like opening the floodgates." Several physicians remarked to her that there were too many physicians in Washington and there was no need for nurse-midwives; with so many physicians, they said, there was not enough business to go around.

This fear of economic competition from nurse-midwives does not appear to be grounded in data. On the contrary, physicians who collaborate with nurse-midwives have found new clients attracted or referred to their practices because of their association with nurse-midwives.

Congress can speed the removal of barriers to nurse-midwifery practice through several means which are listed below and which I would be glad to discuss with the subcommittee.

The American College of Nurse-Midwives welcomes the support which Representative Gore, Representative Mikulski, and the Subcommittee on Oversight and Investigations have shown to nurse-midwifery and to nurse-midwifery consumers. We look forward to working with you on further efforts to remove obstacles to nurse-midwifery practice and to enhance the health of mothers and babies in the United States.

[Testimony resumes on p. 18.]

[Ms. Tom's prepared statement follows:]

TESTIMONY OF AMERICAN COLLEGE OF NURSE-MIDWIVES

Mr. Chairman, Members of the Subcommittee:

My name is Sally Tom. I am a Certified Nurse-Midwife. I practice nurse-midwifery in the District of Columbia. I am speaking as a representative of the American College of Nurse-Midwives (ACNM), which is the professional organization of Certified Nurse-Midwives (CNMs) in the United States, representing 85% of all CNMs. The ACNM is autonomous from all other professional organizations and speaks for its membership on all issues affecting the practice, education, recognition, legislation and economics of nurse-midwifery. The ACNM collaborates with other professional groups which share its primary concern of quality maternal and infant health care for women and babies, and is recognized as an advocate for maternal and child health care issues.

I will describe nurse-midwifery practice and education, touch on the history of Federal involvement in nurse-midwifery practice, discuss at somewhat greater length the obstacles to practice which nurse-midwives have faced recently and offer some recommendations for action.

The first step toward becoming a professional nurse-midwife in the United States is to study nursing, and then practice nursing in the field of maternal and infant health for at least one year. The future nurse-midwife then applies to a nurse-midwifery educational program. Although all of these programs are associated with major universities, some are part of a Master's Degree program, and others grant a certificate rather than a degree. Both kinds of programs offer nurse-midwifery education which prepares the student nurse-midwife for clinical practice. Students in master's programs also receive further education in public health or nursing. Students who successfully complete their educational programs are eligible to take the American College of Nurse-Midwives' certification examination. Those who pass the examination are certified as nurse-midwives - CNMs. All nurse-midwifery programs are accredited by the Division of Accreditation of the ACNM.

According to the official ACNM definition, "A certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. Nurse-midwifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically. This occurs within a health care system which provides for medical consultation, collaborative management, and referral and is in accord with the 'Functions, Standards and Qualifications for Nurse-Midwifery Practice' as defined by the ACNM."

There are approximately 2,200 nurse-midwives in the United States, and approximately 220 more graduate each year. Most nurse-midwives practice in association with institutions such as hospitals, clinics, and birthing centers. A small number offer home birth services.

These hearings today are focusing on the obstacles to practice which nurse-midwives face. These obstacles should not, however, obscure the co-existing reality that in many communities nurse-midwives, physicians and hospitals have

formed mutually satisfying professional relationships. The ACNM and the American College of Obstetricians and Gynecologists (ACOG) have often worked together on issues of importance to mothers and babies. The ACNM has benefited from and appreciated ACOG's official support. Nurse-midwifery practice was officially endorsed by the American College of Obstetricians and Gynecologists (ACOG) and the Nurses Association of the American College of Obstetricians and Gynecologists in a statement issued jointly with the ACNM in 1971 and in a supplemental statement in 1975.

The number of nurse-midwives increased slowly between 1931, when the Maternity Center Association in New York opened the first nurse-midwifery education program, and 1970. By 1970 approximately 600 people had graduated from U.S. schools of nurse-midwifery. In the last 10 years the number of schools has doubled to more than 20 and an additional 1,200 nurse-midwives have graduated.

This rapid growth of nurse-midwifery coincides with the consumer movement and the women's movement, both of which seek to strengthen the client's role in making health care decisions. Consumers seek care which is safe, compassionate and personalized. Consumers are demanding care which offers them decision-making power and reasonable options in childbearing. Meticulous screening throughout pregnancy and birth, combined with freely shared information and continuity of care, are the hallmarks of nurse-midwifery care. In addition, because of the uniquely female nature of childbearing, some women seek nurse-midwifery care in order to receive care from women.

Nurse-midwifery began in this country in 1925 when Mary Breckenridge established the first nurse-midwifery service in eastern Kentucky. The record begun by the Frontier Nursing Service of increasing utilization of prenatal care and reduction in morbidity and mortality for mothers and babies is one which nurse-midwives have continued to this day. Ms. Breckenridge was an American nurse educated in midwifery in the United Kingdom. She had seen how the district midwives brought care to the rural areas of Scotland and decided this model could be used in her native Kentucky. She established the United States' first nurse-midwifery service, staffed by English nurse-midwives and American nurses educated in English midwifery schools, in an isolated, mountainous, desperately poor Appalachian county of eastern Kentucky.

Nurse-midwifery care has since been introduced to other medically underserved areas characterized by poverty, geographical isolation and other social factors associated with poor obstetrical outcomes. Nurse-midwives screen carefully for indications of medical problems and collaborate closely with physicians when complications arise, thus identifying clients who are essentially medically normal from among the population characterized by social risk factors. Nurse-midwifery care has been shown to increase utilization of prenatal care, lower infant mortality and morbidity and to increase maternal well-being among these populations.

At the Frontier Nursing Service "...the maternal mortality rates averaged 9.1 per 10,000 births from 1925-1951; among white women nationwide the maternal mortality rate was 34 per 10,000. Since 1951, the FNS has not lost a single mother to birth related causes. FNS neonatal mortality rates in the years 1952-1954 were 17.3 per 1,000 -- less than the rest of Kentucky and the United States.

Since 1971 the FNS perinatal mortality rates have averaged only 6 per 1,000, which is less than half the average of the rest of the country, even in its best year (14.5 in 1977), and better than the best country in the world, Sweden. The Metropolitan Life Insurance Company of New York estimated in a report in 1932 that if services like the FNS were adopted nationwide, the perinatal mortalities of the time would be reduced by 60,000 per year...¹

Nurse-midwifery services in other rural areas, especially the South and Southwest, have produced similar improvements in pregnancy outcome. The Medical Mission Sisters founded the Catholic Maternity Institute in 1943 to serve the impoverished mothers of Santa Fe County, New Mexico. The Sisters offered prenatal care and births at their Childbearing Center. Many births also took place in adobe homes with no electricity or running water. Prior to the program, in 1939, perinatal death rates of Santa Fe County were 87.6 per 1,000. By 1967 it had been reduced to 15.1, a level of achievement not to be attained by the country at large until over 10 years later. At that time, in 1967, the perinatal mortality rates of the United States were 22.1 per 1,000, while in New Mexico it was even higher at 24.8...²

In the early 1960's a CNM practice was established as a pilot project in Madera County, California. Special legislation made nurse-midwifery legal for the duration of the project. Certified nurse-midwives were introduced as the only new variable in the medically understaffed county's health care system. The mothers served by the project were primarily agricultural workers.

During the first 18 months of the project, the Madera County pre-maturity rate dropped from its previous level of eleven percent to 6.6 percent and the neonatal mortality rate dropped from 23.9 deaths per 1,000 live births to 10.3 deaths per 1,000 live births. There was a significant increase in attendance at prenatal clinics during the pilot project. Mothers who had had no prenatal care and who were cared for during labor and delivery by nurse-midwives experienced a neonatal death rate of 26.8 per 1,000 live births. The neonatal death rate for mothers who had no prenatal care was 50.6 per 1,000 live births after the project ended and nurse-midwifery care during labor was no longer available.

Despite these good results, the California Medical Society opposed legalization of nurse-midwifery, and the nurse-midwives had to leave at the end of the project. After they left, the prematurity rate increased by almost 50 percent and the neonatal death rate tripled.³ In Holmes County, Mississippi, in 1971 the infant mortality rates had dropped from approximately 38 per 1,000 live births to 20 per 1,000 live births, two years after certified nurse-midwives began providing primary care to pregnant women as part of a community-wide focus on the health problems of mothers and babies.⁴

A study by the University of Mississippi Medical Center between October 1, 1972 and April 30, 1973 showed that nurse-midwifery clients kept 94 percent of scheduled appointments, compared with 80 percent of visits kept by clients of the house staff physicians. It should be noted that clients of both physicians and nurse-midwives did not see the same care providers at successive visits.

Among the nurse-midwifery clients 82.6 percent had normal spontaneous vaginal deliveries; 62.1 percent of the house staff clients had normal spontaneous deliveries, with most of the difference found in the rate of low forcep deliveries by the house staff.⁵

At Su Clínica Familiar, a nurse-midwifery childbirth center in southern Texas, all maternity care for normal mothers is provided by certified nurse-midwives. The prematurity rate in 1974, two years after nurse-midwifery care began, was 3.5 percent. In the same year in Texas the prematurity rate was 7.6 percent and for the nation it was 7.4 percent. The nurse-midwifery service has been operating since 1972. The clients are Mexican-American and Mexican women who are primarily migrant workers.⁶

"In 1976 a nurse-midwifery program was begun in Mississippi County in northeast Arkansas. In 1975, 80 percent of births had occurred under general anesthesia in that county. In 1979 general anesthesia rates had fallen to 12 percent, while perinatal mortalities also dropped dramatically.⁷

"In 1941 the Tuskegee School of Nurse-Midwifery opened in Alabama offering services to the area. During the five years of its existence, neonatal mortality rates went from 46 per 1,000 live births to 14 -- more than a three-fold improvement."⁸

Nurse-midwifery services have also resulted in lowered infant mortality and morbidity rates among inner-city mothers.

In 1931 the Maternity Center Association (MCA) opened the Lobenstine Midwifery Clinic to care for immigrant families in upper Manhattan tenements. Between 1931 and 1951, 5,765 mothers registered with the clinic, of which 87 percent gave birth at home attended by (nurse-)midwives. Their maternal mortalities were less than one-third the national rates of the time. Their average neonatal death rates were only 15 per 1,000, while that of New York City as a whole ranged from 28.9 in 1931 to 18.4 in 1951."⁹ Kings County Hospital, New York City, opened a nurse-midwifery service in 1976. In the first 884 births, they had a neonatal mortality rate of 7.9 per 1,000, reflecting the deaths of 7 premature babies.¹⁰

At the North Central Bronx Hospital, whose clients come from one of New York's most distressed areas, where every patient receives nursing care or nurse-midwifery management from nurse-midwives in labor, from January 1 to December 31, 1979, 88 percent of the mothers experienced normal spontaneous vaginal deliveries. Less than 30 percent of all mothers needed analgesia or anesthesia in labor. The neonatal death rate among infants 1,000 grams or over was 4.2 per 1,000.¹¹

Since 1970, nurse-midwifery practice in the United States has expanded to include two additional special populations, adolescents and economically affluent women. Adolescent childbearing carries social and medical risks which can often lead to poor obstetrical outcomes. Nurse-midwifery care, along with physician collaboration has been effective, and has been shown to improve the outcomes of teenage pregnancy.

Between 1976 and 1977 at a clinic for teenagers in Lincoln Hospital in New York City, nurse-midwifery care brought considerable improvement in outcome measures such as maternal weight gain and hematocrit. The rate of low birth-weight babies dropped from 18.1 percent to 6.3 percent.¹² The Office of Adolescent Pregnancy at the Department of Health and Human Services has stressed inclusion of nurse-midwifery services in the projects it funds.

Since the 1970's, professional midwifery services, which have long been available to women of all classes in other countries, are being actively sought by economically affluent women in the United States. Nurse-midwives are responding by participating in a variety of private sector settings.

The Federal government has a long history of support for nurse-midwifery education and practice. Many nurse-midwifery educational programs receive support from the Department of Health and Human Services. Several Federal agencies rely heavily on nurse-midwives to provide care in their programs -- the Indian Health Service, Rural Health Clinics, the Public Health Service's Maternal and Infant Care Projects, the National Health Service Corps, and the Army, Air Force and Navy. Nurse-midwives receive direct reimbursement for services to military families under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and, thanks to diligent work on the part of the members of the House Interstate and Foreign Commerce Committee and to Senator Daniel Inouye, nurse-midwives will soon begin to be reimbursed for services to Medicaid clients.

Several recent Federal government reports support nurse-midwifery practice. The Graduate Medical Education National Advisory Committee's report on physician resources recommended that nurse-midwives be doing 5 percent of all normal deliveries in the United States by 1990 and that Federal support for nurse-midwifery education remain at its current level.¹³ The report on necessary maternal and infant health services prepared for the Select Panel for the Promotion of Child Health focuses on nurse-midwifery services.¹⁴

The Government Accounting Office's report, "Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome" describes nurse-midwives' effectiveness in delivering care to low income families and identifies five barriers to greater utilization of nurse-midwives: "(1) a limited supply, (2) few training programs, (3) physician resistance, (4) non-availability of obstetricians with whom to work, (5) reluctance of some nurse-midwives to practice in rural or other undesirable areas, and (6) restrictive state licensing or third-party reimbursement practices." The report goes on to observe that "although HEW has endorsed use of nurse-midwives, the Health Services Administration has not aggressively promoted use of nurse-midwives in its programs."

The GAO recommended that "...HEW encourage a greater use of nurse-midwife obstetrician teams, help eliminate barriers which preclude nurse-midwives from practicing in hospitals, and provide additional training funds for nurse-midwives, by giving such training higher priority for use of existing funds and/or seeking additional funds from Congress."¹⁵ HEW agreed that better training and practice opportunities are needed for nurse-midwives and promised to convene a working group of HEW operating agencies to develop by March 1980 a plan to promote greater use of nurse-midwives. This plan has not yet been developed, however, the working group has held one meeting and a consultation with nurse-midwives.

It is important, of course, to consider the influence nurse-midwives have on the cost of health care, both to the consumer and to the nation. Data about nurse-midwifery costs is inadequate; however, the available data suggests that nurse-midwifery care is generally less expensive than traditional obstetrical care. In Washington, D.C. the current cost of prenatal, delivery and postpartum care with a nurse-midwifery service is \$800 for clients planning to deliver in the hospital. This includes prenatal care, labor management and delivery, postpartum

care, a two week, six weeks, six months and one year checkups and three postpartum classes. Physician's fees vary from \$800 to \$1,200 and include prenatal care, labor and delivery management, postpartum care, and a six weeks check-up. Hospital costs for nurse-midwifery clients who spend 6 hours or less in the hospital after delivering, are around \$600. Clients who stay the traditional three days will pay close to \$1,000 in hospital costs.

Most nurse-midwives are employees who have no control over prices charged to clients. However, as more nurse-midwives go into practice with physicians and establish private nurse-midwifery practices, we will begin to be able to assess the financial impact of private nurse-midwifery practice. CHAMPUS began reimbursing nurse-midwives within the past year and is conducting a study of the impact of nurse-midwifery reimbursement on their maternity care costs.

While the data is limited, several characteristics of nurse-midwifery practice suggest that nurse-midwives deliver cost-effective care. The average salary of a nurse-midwife in clinical practice in 1976 was \$16,200. Contrast this figure, which has certainly improved somewhat since 1976, with the median income of any obstetrician-gynecologist, which was \$89,310 in 1979. Nurse-midwives' services have to cost employing institutions less than obstetricians.

As we have seen earlier, nurse-midwives have a proven record in reducing infant morbidity and mortality. The reduction in prematurity and low birth weight rates in the many places nurse-midwives have worked certainly must also have meant a reduction in dollars spent by states and private companies on intensive care nurseries.

Nurse-midwives are educated to use technology only when it is indicated by a client's condition. Such limited, rather than routine, use of machines and laboratory tests should result in savings for individual consumers. In addition, nurse-midwives often establish or encourage shorter hospital stays than the usual three day postpartum stay for healthymothers and babies, a practice which results in savings in hospital costs. Clients who have home births with nurse-midwives also would bypass the expenses of a hospital visit.

A Cesarean birth can add as much as \$1,000 to a physician's fee and as much as \$3,000 to hospital fees. Nurse-midwifery services have Cesarean birth rates which are significantly lower than the U.S. rate which is approaching 30 percent in many facilities. The Cesarean birth rate at the nurse-midwifery service at the North Central Bronx was approximately 13 percent in 1979, for example.

Despite the demand for nurse-midwives by consumers, state governments and Federal agencies, despite the record of improved health for mothers and babies, despite cost effectiveness and despite the widespread employment of nurse-midwives throughout the country, resistance to nurse-midwifery practice is strong and seems to be gathering strength.

The GAO report mentioned three forms of obstacles to practice which are of concern in these hearings today: physician resistance to nurse-midwifery practice, restrictive state licensing and third party reimbursement practices. The incidence of resistance is widespread and has been found in recent months in Massachusetts, New York, New Jersey, Pennsylvania, Washington, D.C., Maryland, Delaware, South

Carolina, Tennessee, Texas, Illinois, and South Dakota. Resistance comes from many sources: individual physicians, professional organizations, such as medical societies, hospital departments of obstetrics, public bodies such as state boards of health and state medical practice boards, insurance companies, and occasionally nursing.

The form which the resistance takes varies as well. It includes refusal to provide medical back-up, refusal of permission or privileges for use of hospital facilities, placement of unjustifiable restrictions on nurse-midwifery practice or settings, refusal of third party payors to reimburse nurse-midwives, harassment of physicians who support nurse-midwifery practice, requests for unreasonable payments for liability insurance and misrepresentation of the nature of nurse-midwifery practice to the public.

While scores of rationales for these obstacles exist, and each incident is flavored with its own particular legal, administrative and interpersonal characteristics, two themes emerge from the arguments against nurse-midwifery practice. The first of these is the issue of quality of care and of patient safety. The rare, and often preventable occurrence of a complication of pregnancy or birth is often cited as the reason for preventing nurse-midwives from practicing or for limiting the scope of their practice to less than that for which they have been educated. Two assumptions underlie that rationale. The first is the idea that while nurse-midwives are better than no prenatal or intrapartum care at all, the physician is always more desirable because of his or her education in dealing with complications. The statistics refute that claim. The record of nurse-midwifery care in the United States in reducing infant mortality and morbidity shows that nurse-midwives are safe. Countries with lower infant mortality rates than the United States rely heavily on professional midwives.

The second underlying assumption is that the speed with which severe complications arise is great enough to justify physician presence throughout labor and delivery managed by nurse-midwives. It is important to remember that pregnancy and childbirth are normal physiological practices. Normal, healthy pregnancy and delivery are the predominant realities of childbearing. Complications are the exceptions, not the rule. Nurse-midwives, unlike most physicians, are able to be in constant attendance throughout labor. Thus, nurse-midwives detect problems at the earliest moment and often avert them. Extremely serious complications which develop rapidly are extremely rare. Many common complications of labor and delivery result from the routine interventions of traditional medical care which do not characterize routine nurse-midwifery care. Nurse-midwives are educated to recognize the symptoms of complications, to begin the appropriate interventions and to call for assistance immediately when complications arise.

The second theme which emerges in the resistance of nurse-midwifery practices is that of "independent practice." Licensure, direct third party reimbursement, home birth services and out-of-hospital birth centers all raise the question of whether nurse-midwives are, or should be, "independent practitioners." "Independent practice" appears to mean a nurse-midwife hanging up her shingle in a solo practice patterned after the independent business of the solo physician in private practice. The implication of this model is that the nurse-midwife would be practicing without a back-up physician, without the system for consultation with physicians, referral of clients to physicians and without the collaborative management of client care by both a nurse-midwife and a physician which are an

integral part of the definition of nurse-midwifery practice. The record needs to be very clear on this matter. Nurse-midwives do not practice midwifery in the "independent practice" model of the private solo practice which characterizes much physician practice. The "Functions, Standards and Qualifications for Nurse-Midwifery Practice" states that nurse-midwifery practice "Occurs inter-dependently within a health care delivery system. Occurs within a formal written alliance with an obstetrician; or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist. Exists within a framework of medically approved protocols." The dictates of the "Functions, Standards and Qualifications for Nurse-Midwifery Practice" are clearly explained by Helen Varney, the current president of the American College of Nurse-Midwives in her recently released textbook of nurse-midwifery. "'Independent management' refers to the fact that a patient may never see a physician if her course essentially is normal and she is managed by a nurse-midwife. Thus, the practice of nurse-midwifery within the protocols for practice, which define the practice and provide for medical consultation and referral, is independent... Independent practice means without medical protocols of formalized physician back-up. A certified nurse-midwife always functions within a health care system in a team relationship with a physician and is never independent of physician back-up for consultation, collaborative management, or referral."¹⁶ Should a nurse-midwife be thought to be violating the principles established in "Functions, Standards and Qualifications," she would be subject to investigation by the American College of Nurse-Midwives and would be vulnerable to censure, suspension, expulsion or decertification.

Nurse-midwives have always practiced and will continue to practice in collaboration with physicians; that relationship will not change. What has begun to change, however, is the monetary relationship between the nurse-midwife and her collaborating physician. Nurse-midwives are now not always employees of physicians. In some cases the nurse-midwife has joined the practice of her physician partners. In other cases, nurse-midwives are employing physicians to provide them with consultation and referral services. Nurse-midwives are increasingly eligible for direct third-party reimbursement. Many private insurance companies, including Connecticut General, Travelers, Aetna, and all union insurance programs, will reimburse nurse-midwives in all states. New Mexico, Utah and Maryland have adjusted their insurance codes to include direct reimbursement to nurse-midwives. CHAMPUS reimburses nurse-midwives and Congress recently passed legislation which mandates reimbursement for nurse-midwifery services to Medicaid clients. All of these changes mean that a nurse-midwife may become economically independent of her physician or hospital back-up services. Her professional interdependence with physicians and hospitals remains.

It appears that fear of economic competition underlies much of the resistance to nurse-midwifery practice. The New Jersey Board of Medical Examiners attempted to write regulations for nurse-midwifery practice which restricted the trade of nurse-midwives and had no relation to safety issues whatsoever. Nurse-midwives in the District of Columbia have been told by various physicians that they opposed nurse-midwifery expansion in the District on economic grounds. One physician said, "If your licensure bill passes, nurse-midwives will be delivering all of the babies in the city in 10 years." When one nurse-midwife in private practice with a group of physicians applied for delivery privileges

at a local hospital, she was told, "Let's face it, you are competition and we don't want you here. You need to look at what you're dealing with here. This hospital is like a country club. We don't like Jews here, we don't like Blacks..." He left the clear impression with the nurse-midwife that the other people not liked at that hospital were nurse-midwives. Another physician said of his colleagues, "They see you as an economic threat and they don't want to let you in because once they let you in, it'll be like opening the floodgates." Several physicians remarked to her that there were too many physicians in Washington and there was no need for nurse-midwives; with so many physicians, they said, there was not enough business to go around.

Examples of physician and hospital resistance to nurse-midwifery practice will be presented here today. I would like to cite the status of nurse-midwifery in Washington, D.C. as an example of the problems caused by the lack of a license to practice nurse-midwifery. Nurse-midwives have been practicing in the District of Columbia since 1973. The Healing Arts Practice Act of 1929 gives the legal jurisdiction for midwifery practice to the Commission on Licensure to Practice the Healing Arts. This commission, which has the legal prerogative of establishing a board to regulate midwifery and of granting licensing to midwives has never done either. The Nurse Practice Act, which was passed in 1903, does not define nursing nor does it speak to midwifery licensing or practice. Nurse-midwives currently practice midwifery on their nursing licenses. A local hospital has used the lack of a license to deny access to hospital facilities to a nurse-midwife in private practice with physicians. The lack of a clear legal status has been implicated in the Department of Human Resources' refusal of an offer of free nurse-midwifery services in city-run clinics.

The local chapter of the American College of Nurse-Midwives supports a licensure bill introduced last year in City-Council by Councilwomen Polly Shackleton and Betty Kane. The District of Columbia Medical Society has circulated a letter criticizing the bill, although they have not opposed the concept of licensure. Privately, physicians have expressed the fear that licensure will enable nurse-midwives to compete more effectively for maternity care clients.

In numerous health departments across the country, nurse-midwives are offered positions doing prenatal care, yet are refused hospital privileges by the same physicians who consult with them in the clinic. Fear of economic competition from nurse-midwives has been mentioned on the front pages of OB-GYN News and of Family Practice News.

This fear of economic loss from competition with nurse-midwives does not appear to be grounded in data. On the contrary, physicians who collaborate with nurse-midwives have found new clients attracted or referred to their practice because of their association with nurse-midwives.

Congress can speed the removal of barriers to nurse-midwifery practice through several means:

1. Pass legislation mandating nurse-midwifery reimbursement under Federal Employee Health Benefits Plans;

2. Encourage the Department of Health and Human Services to draft quickly the regulations necessary to implement the recently enacted nurse-midwifery reimbursement under Medicaid;
3. Allot more money specifically to nurse-midwifery education programs;
4. Permit nurse-midwifery students in certificate programs as well as in master's degree programs to receive Public Health Service scholarships;
5. Require assessment of the availability of nurse-midwifery services by State Health Planning and Development Agencies;
6. Investigate the high infant mortality rate in the District of Columbia through hearings before the appropriate committees of Congress; and
7. Ask the Department of Health and Human Services to research the cost impact of nurse-midwifery care, to research further into the obstacles to practice identified in the GAO report and to study the practice patterns on a state-by-state basis.

The American College of Nurse-Midwives welcomes the support Representative Gore and the Subcommittee on Oversight and Investigations have shown to nurse-midwifery and to consumers of nurse-midwifery services. We look forward to working with you on further efforts to remove obstacles to nurse-midwifery practice and to enhance the health of mothers and babies in the United States. Thank you.

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Mr. GORE. Thank you very much. We will hold questions until we have heard testimony from Ms. Norsigian.

TESTIMONY OF JUDY NORSIGIAN

Ms. NORSIGIAN. Good morning. Thank you for this opportunity to present testimony on behalf of childbearing women and their families. I am Judy Norsigian, action vice chair of the National Women's Health Network and the network's representative to the Ad Hoc Committee on Consumer Affairs established by the American College of Nurse-Midwives—ACNM. Other members of this committee include the president of La Leche League, the president-elect of the International Childbirth Education Association, the executive director of NAPSAC—National Association of Parents and Professionals for Safe Alternatives in Childbirth—and a certified nurse-midwife who serves as liaison to the ACNM.

I am also a coauthor of the best-selling book about women's health care, "Our Bodies, Ourselves," as well as administrative coordinator for the Boston Women's Health Book Collective. Until this past March I served for 4 years as a board member on the Health Planning Council for Greater Boston—HSA IV, Massachusetts—and was instrumental in incorporating nurse-midwifery practice into both our health systems plan and our annual implementation plan. I am still an active member of the Birth Center Task Force of HSA IV, convened in June 1978 by this same Health Systems Agency.

In these various capacities I have spoken with 3,000 to 4,000 women over the past 8 years about their childbirth experiences. I also read profusely and watch carefully both the lay and medical literature. In Boston we subscribe to the clipping service which covers all New England newspapers and submits at least 15 to 20 articles weekly on the subject of childbirth and midwifery. Finally, I would like to mention that I am in regular correspondence with dozens of nurse-midwives and physicians supportive of nurse-midwifery from all parts of the country.

As I am sure many of us here are aware, there has been a remarkable resurgence of interest in midwifery in this country. Today I would like to explore the reasons why thousands of women now seek, and in some cases insist upon, nurse-midwives as their primary care-giver during pregnancy and birth.

I would also like to outline some of the disturbing obstacles women have encountered in their efforts to obtain nurse-midwifery care. In a country whose medical and health care system has been built largely upon the principle of free choice, it is especially alarming to note the restrictions being placed upon that freedom.

The reasons why more and more women seek nurse-midwifery care are numerous. One obvious reason has to do with the heightened visibility of nurse-midwives. As McCall's magazine reported in 1973:

* * * the good news is getting around, mostly by word of mouth. Women are telling other women about nurse-midwives and the immensely satisfying new dimensions of skill, sympathy, and personal care they can bring to normal pregnancies. What began not long ago as an expedient plan to relieve overburdened obstetricians of routine uncomplicated maternity cases had quickly come into its own as a first-class "quality" medical style—often preferred outright by mothers-to-be.

At the same time nurse-midwives are achieving greater visibility, more and more women are dissatisfied with conventional obstetrical care. Thus, there is considerable incentive to seek alternatives—alternatives to both the conventional hospital setting and the obstetrician as primary practitioner. This dissatisfaction takes many forms. Major criticisms of obstetricians voiced by women all over the country include:

A medicalized approach to birth which fosters unnecessary interventions and reduces or even eliminates a woman's capacity to be in control of her childbearing experience. This medicalized approach is characterized by: routine use of episiotomy; premature rupturing of membranes; insistence on a supine—horizontal—position for the actual birth—despite considerable evidence that this may be damaging to both mother and baby—routine use of anesthesia; routine induction of labor—this still occurs frequently despite many claims by obstetricians to the contrary; routine use of internal fetal heart monitoring; routine use of IV; an unwillingness to practice in free-standing birth centers or other settings outside the hospital; the high cesarean section rate of most obstetricians.

Inability or unwillingness to provide psychological and emotional forms of support throughout the experience of pregnancy and birth; poor communication skills in general.

A disturbing lack of knowledge in the area of good nutrition during pregnancy.

Inability or unwillingness to be present throughout labor and delivery—this is often the fault of the medical system and not the individual physician.

The increasing incidence of homebirth is another measure of women's dissatisfaction with conventional obstetrical care. In some counties in California, the percentage of babies born at home has increased to 10 percent. Statistics from the Oregon State Health Division—1977—indicated that the number of out-of-hospital births had risen to 2.7 percent of all registered births in 1976. Though nationwide statistics are unavailable, judging from the anecdotal evidence of the National Women's Health Network, childbirth education groups, the Boston Women's Health Book Collective, and similar organizations, probably 1½ to 2½ percent of all U.S. births in 1980 occurred outside the hospital setting.

Although the skills of an obstetrician, especially his or her surgical skills, are essential in handling serious birth complications, the skills of a nurse-midwife are just as essential in preventing—to whatever extent possible—the occurrences of those complications. Nurse-midwives are particularly successful in helping women give themselves the best possible prenatal care, so much so that many women initially at high risk become low risk before the time of birth. In addition, many women have praised the unique support and guidance provided to them by nurse-midwives during labor and delivery. This is especially important during those difficult moments when birthing women feel out of control and, without such assistance, might resort to medication or other interventions that could interfere with the natural birth process.

Mothers who have had one or more previous births attended by an obstetrician are frequently the most enthusiastic about their experiences with nurse-midwives: "It was like the difference be-

tween night and day." "I'd thought all along that I was the problem, that my body just wouldn't work right. My midwife helped me to regain a much more positive image of myself."

Despite the great demand for nurse-midwives, their services are not available to most women. In part this is explained by the small number of nurse-midwives in practice—about 1,500. But far more critical is the substantial and mounting opposition on the part of physicians, especially obstetricians.

Massachusetts, the State I am the most familiar with, only recently legalized the practice of nurse-midwifery—in 1977. Only a few hospitals in the State offer a real nurse-midwifery service, including 7-day-a-week coverage by nurse-midwives. It took childbirth and women's groups 2 years of hard work, including the development of a strong presence on several HSA boards, before we saw established the first freestanding birth center in Massachusetts. The center, which opened in November in Beverly, Mass., is staffed by 2 nurse-midwives and already has signed up over 50 women.

In Boston, almost all obstetricians connected with the teaching hospitals and the medical schools have been opposed to the practice of nurse-midwifery in freestanding birth centers located near hospitals. One hospital currently requires a physician to be present in the room at all nurse-midwife deliveries.

Fortunately, things are changing. This week, after meetings with staff physicians and nurse-midwives from the excellent midwifery service at Boston City Hospital, Dr. Kenneth Edelin, chief of obstetrics and gynecology at Boston City Hospital and a professor at the Boston University School of Medicine, announced his enthusiastic support of a freestanding birth center staffed by nurse-midwives. He is eager to begin the planning process for such a center and already has called for a meeting of all interested parties, including physicians, nurse-midwives and consumers. His conduct and genuine interest in working with community groups stands as a model for all other physicians.

The Mississippi County nurse-midwife program in northeast Arkansas is an excellent example of a successful program encountering problems which may result in its termination. Serving primarily rural, low-income women, the program provided the total prenatal, intrapartum, and postpartum care for about 250 women between July 1979 and July 1980. During that period the nurse-midwives also met at least once with an additional 20 women who moved away or needed to be referred to an obstetrician because of special complications.

The birth outcomes for the 250 women cared for by the nurse-midwives are outstanding and include a 3-percent primary cesarean section rate. Despite the program's popularity and enthusiastic endorsement by the Arkansas State Health Department, State funding was just withdrawn by the new Governor. Given that the Governor's own transition team as well as the State health department recommended refunding, this decision seems quite peculiar.

At the same time, the physician providing backup services for the nurse-midwives—in fact the only obstetrician in the county—has recently lost a partner and finds his remaining partner unwilling to be involved with sharing the backup responsibilities. Though

supportive of the nurse-midwifery program, this obstetrician may be unable to continue his backup unless an additional National Health Service Corps physician can be found.

Last year this program received \$53,000 in Federal funds. It is partially self-supporting, generating revenues from medicaid and all third-party payors except Blue Cross and Blue Shield. However, the elimination of State funds as well as the possibility of losing physician backup could bring about the demise of this program. Timely Federal intervention is necessary to preserve this excellent model of nurse-midwifery care.

Recently, the nurse-midwifery service at John Dempsey Hospital in Connecticut was closed. The two nurse-midwives who practiced there have been attempting—so far without success—to gain privileges at Hartford Hospital. Representatives from the local group, Advocates for Childbearing Rights, can provide details about their frustration with local obstetricians who are interfering with the incorporation of nurse-midwifery care into health plans for the area.

From Michigan we have received dozens of letters from women unable to convince their local hospitals to establish a nurse-midwifery service. They describe intense opposition on the part of obstetricians. Only five, possibly six, nurse-midwives are now in practice in the whole State. Recently, one nurse-midwife was able to obtain privileges in a Detroit hospital, but this is only a small step forward.

Criticism of physician opposition to nurse-midwifery comes from physicians as well:

Introduction of the trained nurse-midwife into the mainstream of obstetrics in the United States has been slow and there is still resistance by many obstetricians and physicians, some of whom continue to live in a dream world and have the egotistical belief that only they are capable of providing good care. Reasons for this vary from a genuine concern that there would be a deterioration of care, to an inability on their part to accept the nurse-midwife as a trained professional colleague capable of using her skills independently.

Usually such physicians do not fully understand the background of the modern trained nurse-midwife and her role in obstetric practice. The major change that is needed in this respect is the involvement of the nurse-midwife in teaching obstetrics to medical students. Other obstetricians fear that the nurse-midwife will threaten them financially. Allan G.W. McLeon, M.D. (Miami, Florida), (*Am. J. Obstet. Gynecol.* Sept. 1, 1975).

Health systems agencies and other planning bodies are in a position to accelerate the incorporation of nurse-midwifery practice into more institutional settings. The Ad Hoc Committee on Consumer Affairs of the ACNM recently mailed to all HSA's and SHPDA's in the country a special resource packet. This included information about nurse-midwifery practice and excerpts from several of the HSP's which have already incorporated nurse-midwifery services as an essential part of good maternity and newborn care. A copy of this packet is attached for your perusal.

The Department of Health and Human Services could also assist in the health planning process by appointing an experienced nurse-midwife to a coordinating position in the office of the Surgeon General. This nurse-midwife could work with all Federal programs involving nurse-midwifery.

Institutional settings where nurse-midwives practice could similarly benefit from establishing a coordinating or administrative

position for a nurse-midwife. This would bring nurse-midwifery out of the gray area between nursing and medicine, neither of which is suited for such an administrative role.

In conclusion, it is very clear that consumers have heartily endorsed the concept of nurse-midwifery and that nurse-midwives are here to stay. Moreover, consumers and nurse-midwives have been at the forefront of establishing safe options in childbirth. The legal regulation of nurse-midwifery practice should rest in the hands of nurse-midwifery consumers and nurse-midwives. It is totally inappropriate for physicians to have any direct control over nurse-midwifery practice, especially in view of the fact that many physicians do not even understand or recognize the special skills of nurse-midwifery—skills, I might add, that most obstetricians do not have.

In all the examples we will be hearing today there is the potential for both protracted struggle and protracted litigation. The situation in New Jersey, where consumers and nurse-midwives found themselves at odds with the New Jersey Board of Medical Examiners, should not be repeated. Many of us urge the American College of Obstetricians & Gynecologists to do its utmost to influence the attitudes and behavior of obstetricians now opposed to the expansion of nurse-midwifery practice.

Nurse-midwives, consumers and physicians can spend the next few years locked in struggle, or we can spend them productively improving the quality and acceptability of options for childbearing women and their families. I hope that we all choose wisely.

Mr. GORE. Thank you very much.

Let me start with a couple of basic questions, Ms. Tom. I want to lay some of the groundwork with this panel. In the next panel we are going to focus on specific examples of alleged restraint of trade. But in your testimony, Ms. Tom, you mention there have been examples of restraint of trade in Massachusetts, New York, New Jersey, Pennsylvania, Washington, D.C., Delaware, South Carolina, Tennessee, Texas, Illinois, and South Dakota. We are going to look at more jurisdictions later on.

What is the general reason for the extreme resistance by the medical profession?

Ms. TOM. The reasons which are expressed to us generally concern fears about safety and practices that may or may not endanger mothers and babies. As I said in my testimony, it appears that economic concerns underly some of those opinions that are expressed about nurse-midwifery practice, but I can only tell you what they say, not what I think they think.

Mr. GORE. There appear to be three general reasons. One is a genuine concern on the part of many that there is an additional risk factor associated with a certified nurse-midwife. Second, an underlying economic challenge which may in some instances not be a valid concern but in other instances may be a valid concern. Three, an inability to accept the certified nurse-midwife as a co-equal member of a childbirthing team.

Are those the three most common reasons that your members have identified?

Ms. TOM. Yes.

Mr. GORE. Let's start at the beginning. There is a difference between a certified nurse-midwife and what a lot of people in the United States think of when they hear the word midwife. Since I have been involved in this issue, I have heard of a whole lot of people who had a grandmother or a great-aunt who was a midwife. There is a difference in most cases. Would you tell us what that is.

Ms. TOM. A certified midwife is a person who has been educated in two disciplines, in nursing and midwifery. They have often practiced nursing 1 or more years in the maternal and child health area and then they go back to school and obtain professional education in midwifery. A lay midwife traditionally has gained her experience through some other means than formal education.

Mr. GORE. And they are not certified?

Ms. TOM. That is correct.

Mr. GORE. The focus of this hearing is on certified nurse-midwives, all of whom have completed a recognized training and skill recognized by the medical professions by the label certified nurse midwife.

The average citizen looking at this issue automatically has the concern: Is there an increased risk or not?

In your prepared statement, many of the parts you did not read through, you have a long list of health studies in areas where nurse-midwives have been practicing, all of which seem to indicate there is no increased risk associated with the use of certified nurse-midwives. To the contrary, the balance appears to be slightly tipped in the other direction, that for a variety of reasons, most of them having to do with inappropriate intervention caused by the medical training of obstetricians, there is actually a small increased risk for a normal uncomplicated pregnancy that is in the hands of the obstetrics profession. Is that too harsh a judgment, or is it merely an accurate summary of those studies you have cited?

Ms. TOM. I think your summary of the studies is accurate. It is important to remember that no research to date has ever been able to pinpoint what it is about prenatal care and careful monitoring during labor that actually is the factor that makes the difference between a good outcome and a bad outcome. Most of those studies cited in my testimony are cases of nurse-midwives going into areas where there was no medical care available or very inadequate care. In those places they were able to reduce the infant mortality and morbidity rates to below the amount that they were before they came, and usually to below the national average.

It is important to remember that the national average of infant mortality is a combination of people who have all different kinds of care and also no care. So I am afraid that the statistics do not go as far as we would like them to in interpreting what is actually happening.

Mr. GORE. Could you describe the Madera County, Calif., study? Could you tell me what occurred there?

Ms. TOM. Yes. The study was a pilot project established in a very rural county of northern California in 1960. This county was severely medically underserved and had high infant mortality and morbidity.

Mr. GORE. On what page of your testimony is that?

Ms. TOM. Page 3. Certified midwives were not legal in California at that time, but through a special dispensation they were allowed to practice in this county for the length of time of the pilot project, which ended up being about 18 months.

During that time the prematurity rate dropped from its previous level of 11 percent to 6.6 percent and the neonatal mortality rate dropped from 23.9 deaths per 1,000 live births to 10.3 deaths per 1,000 live births. There was a significant increase in attendance at prenatal clinics during the pilot project. Mothers who had had no prenatal care and who were cared for during labor and delivery by nurse-midwives experienced a neonatal death rate of 26.8 per 1,000 live births. The neonatal death rate for mothers who had no prenatal care was 50.6 per 1,000 live births after the project ended and nurse-midwifery care during labor was no longer available.

Despite these good results, the California Medical Society opposed legalization of nurse-midwifery, and the nurse-midwives had to leave at the end of the project. After they left, the prematurity rate increased by almost 50 percent. After the project ended, all the statistical indexes showed that mothers and babies were not as well off in that county as during the time of the project.

Ms. MIKULSKI. If the gentleman would yield.

Mr. GORE. Yes.

Ms. MIKULSKI. What is Madera County; could you describe its demographic character?

Ms. TOM. Madera County is a rural county and the clientele was made up primarily of very poor agricultural workers.

Ms. MIKULSKI. People who would not have had access to medical care?

Ms. TOM. That is right. There were very few physicians in this county, and the ones that were there were very overworked.

Mr. GORE. So the neonatal death rate was at 24.9. After the introduction of nurse-midwives it dropped to more than half, down to 10.3. When the California Medical Association was successful in preventing the continuation of the program, the certified nurse-midwives left and the rate tripled, went all the way back up to 32.1?

Ms. TOM. Yes, that is correct.

Mr. GORE. We asked the American College of Obstetricians & Gynecologists if they cared to comment on that study, if there was any refutation of it, if there were any additional explanations they cared to add to that, and there were none, apparently. All such studies are, of course, difficult to interpret, but there are a number of studies, almost all of them pointing in the same direction.

It was published in the Journal of Obstetrics & Gynecology in the journal published by this association, incidentally.

What do we mean by direction and control? That is the next question that I want to pose to you. It seems to me that this disputation plays on two levels. It takes place, first of all, on the gut economic level out in the United States where the experts on both sides are not present but just have practicing obstetricians on the one hand and a group of pregnant women who want an alternative and maybe a few certified nurse-midwives who want to give them an alternative, and a smaller group still that want to have

their baby delivered in the hospital with a certified nurse-midwife attending, and all of a sudden you have this conflict.

Out in the country where the experts and statistics and figures are not present, the debate takes place at this gut economic level, and it is often just raw power. The hospital privileges are denied and the debate ends.

But at a second level where the experts with your group confront the experts with the American College of Obstetricians & Gynecologists, then the debate becomes more sophisticated and is of a different character. But that debate has a big effect on the gut-level debate out in the country because the arguments are used.

The debate between the experts gets down to the question of direction and control; is that correct?

Ms. TOM. Yes.

Mr. GORE. What do we mean by that? Doctors say that certified nurse-midwives have an appropriate role to play so long as they are under the direction and control of doctors. You do not disagree that when a medical incident is imminent or is occurring that requires the skills of an obstetrician or another physician, they should be present and that they should be at the top of the chain of command, so to speak, responsible for the decisions that affect the health of the patient?

Ms. TOM. Yes, that is correct.

Mr. GORE. The dispute, it seems to me, comes down to whether or not physicians are willing to allow a normal pregnancy where there are no complications present whatsoever to be monitored and handled by a certified nurse-midwife and give the responsibility to the certified nurse-midwife of recognizing those circumstances which require the attendance of a physician and the responsibility for making the decision to call the physician into an active part of the team rather than a standby part of the team; is that correct?

Ms. TOM. Yes, that is correct. I would also like to point out that all nurse-midwives do work with formal written protocols that she and her supporting physicians have drawn up. Before clients ever come into the picture, the nurse-midwife and the physician have sat down and reviewed all the possible complications one might expect to encounter, and laid out very carefully what actions are to be taken in each case.

Mr. GORE. So the official position of certified nurse-midwives is that they will not practice without a formal written agreement with a doctor that clearly specifies the circumstances under which the doctor must be present attending the patient personally, the circumstances that will lead the certified midwife to call the doctor in?

Ms. TOM. That is correct.

Mr. GORE. I want to call now on my colleague.

Ms. MIKULSKI. Thank you very much.

I would like to thank you for your testimony. I would like to also thank you for "Our Bodies, Ourselves." I use it on a regular basis and I won't tell you which chapters I read the most.

When we talk about nurse-midwives receiving training, at what kinds of institutions do they receive their appropriate training?

Ms. TOM. Of course, they have all become registered nurses and then they attend programs of education—

Ms. MIKULSKI. Could you give us the names of some of the institutions? Dealing with mythology, it is not like something you send into Montgomery Ward's for.

Ms. TOM. There are 25 universities across the country. To name a few, Yale, Columbia, Georgetown, Johns Hopkins, New York State.

Ms. MIKULSKI. Prestigious institutions.

Ms. TOM. Yes.

Ms. MIKULSKI. Are these associated with medical schools or schools of public health and hygiene?

Ms. TOM. Most are associated with schools of nursing. At the Johns Hopkins University it is the School of Public Health and Hygiene.

Ms. MIKULSKI. It is associated with usually an institution of high academic standing?

Ms. TOM. Yes.

Ms. MIKULSKI. Second, I would like to talk about, if I could, this issue of control and supervision. The difference between a nurse-midwife and an obstetrician-gynecologist. Would there be a difference in type of patient not based on social class but based on medical factors, age, and so forth, being 44 years old and perhaps having a first pregnancy? Would that be a patient you would undertake? Again, would there be a certain triage in sifting out the high-risk people? How would that work? Do you take anybody?

Ms. TOM. We do not take anybody. People do have to be screened. Risk factors are part of the protocols that are identified between nurse-midwife and her supporting physician. We look at each person individually as well as look at what particular medical history they bring with them.

Many times people have factors that do make them at risk for childbearing successfully and need to be referred to a physician or need to be managed in conjunction with a nurse-midwife. In that case, her role becomes one of patient education and support and teaching about the parts of the pregnancy that are normal and healthy, and the physician's role is the management of the complications.

Ms. MIKULSKI. In terms of the actual care, I would like to go through two steps; one, the prenatal care and then the actual delivery care. If a pregnant woman were going to a nurse-midwife, what type of prenatal care would she get? And if an obstetrician-gynecologist were attending.

Ms. TOM. The American College of Obstetricians & Gynecologists has established standards of what proper prenatal care should include, and they are followed by certified nurse-midwives. They would include a health history, laboratory screening on the first visit, full and complete physical examination, assessment of a woman's pelvis—

Ms. MIKULSKI. Who does that?

Ms. TOM. The nurse-midwife, to see if it is large enough for a baby to come through. Patient education and assessment of how far along the pregnancy is, and whether it appeared that the baby was the proper size, and how long the person had been pregnant, and nutrition education are included in prenatal care.

Ms. MIKULSKI. Do you want to elaborate?

Ms. TOM. Nurse-midwives are actively involved in nutrition education. We feel it is very fundamental to prenatal care. We review diet, we make suggestions about foods to add or delete to the diet. We discuss vitamins and mineral supplements and whether or not she needs them in her diet. We look for symptoms of problems that can be indicated by particular dietary patterns.

Ms. MIKULSKI. What would happen, attending the practice of OB-GYN, would that normally happen?

Ms. TOM. Ms. Mikulski, I am going to ask you to ask the doctors that because I am not a physician and I cannot speak for medical practice.

Ms. MIKULSKI. Tell me about the delivery stage; where do you deliver, how do you deliver?

Ms. TOM. Nurse midwives offer births in various places to their clients. Most certified midwives work in hospitals and could be doing hospital births. Some are able to work in birth centers which may be free standing with arrangements for transportation between the birth center and the hospital if there are complications, and some nurse midwives work at home, where they have similar arrangements for complications.

Ms. MIKULSKI. This will be my last question.

Again, there is always the question of safety, and I think perhaps one of the things that has been heightened by concerns about nurse-midwives is in that area. Have there been any recorded incidents? Here is what I think happens. What do you want to go to a nurse-midwife for and have your kid at home, what is going to happen to you if you hemorrhage or go into cardiac arrest? Is that what you want to happen to you?

Now, have there been any incidents of death in the home that could be attributed to the fact that someone is under the care of a nurse-midwife and not under the care of an OB-GYN?

Ms. TOM. Not any that I know of.

Ms. NORSIGIAN. I would like to comment.

Probably there are, whether we know about them or not, but it is important to recognize that no birth is risk free. I think women now are choosing which risks they will take. Many don't want to take the risks of the many interventions which produce a whole host of iatrogenic consequences.

Ms. MIKULSKI. What is iatrogenics?

Ms. NORSIGIAN. Iatrogenesis refers to doctor-induced illness. Many women have had repeated experience with iatrogenesis and would rather have a birth in a nonhospital setting or with a nurse-midwife, with an attendant who is not a surgical specialist and who is not prone to intervene, often without adequate cause.

I think there is no way we can argue either alternative is perfectly safe. Whether we have an obstetrician or midwife, we are taking some risks. The question is, which risks do we take.

Ms. MIKULSKI. Thank you.

Mr. GORE. I think there is an important distinction to be made between the issues surrounding the right of consumers to select a certified nurse-midwife to attend a normal birth and the issues surrounding home delivery.

I know there are advocates of home delivery. It is my impression, after immersing myself in the literature, that in most cases those

who choose home delivery do so because they are unable to choose a hospital setting that allows them to have a certified nurse-midwife present. There are those who choose it for other reasons, but it seems to me that, when you compare the risks, that one outcome of this hearing and the developments which I hope will follow this hearing will be that consumers will have the right to choose the health-care professional they wish to attend the birth of their child, either in the hospital setting or outside of the hospital setting.

Now in evaluating the comparative risk, I think it is important to know that there are a certain percentage of births which are accompanied by complications.

Now you are telling us that percentage is extremely small, and is made smaller by the ability of the trained professional to predict and anticipate complications through cross-observation of the pregnant woman. Is that correct?

Ms. TOM. Yes, sir.

Mr. GORE. What percentage of births are normal and uncomplicated by major events?

Ms. NORSIGIAN. There is a great deal of controversy on that.

Mr. GORE. What is the range within which the dispute takes place?

Ms. NORSIGIAN. I have heard everything from 60 to 98 percent, depending on whom I talked to. I think it is probably 90 to 95.

Mr. GORE. Now what is it after you screen a patient and observe them during pregnancy?

Ms. NORSIGIAN. That can't be answered because screening procedures vary so greatly.

Mr. GORE. If the certified midwife is doing the screening?

Ms. NORSIGIAN. I think it would depend on the place of practice. In a city hospital, where there are a lot of low-income women—often high-risk women—probably the screening will result in a larger percentage of women being referred to an obstetrician. In another setting, where middle-class women might have a history of good nutrition, you probably will have fewer women being risked out.

Mr. GORE. The percentage that I am trying to get is this: In a certified nurse-midwife practice, what percentage of births will be associated with unpredicted, unanticipated complications that require the presence of a physician?

Ms. NORSIGIAN. I don't think anyone has the right answer to that question now.

Ms. TOM. I don't believe there is data to answer that question. I can say that screening also pivots on the question of where the client wants to give birth. Someone who is not suitable because of her risk factors for home birth may be suitable for management by a nurse-midwife in a hospital.

Mr. GORE. Again, the central issue we are addressing here is the right of prospective parents to choose, if they wish to choose, a certified nurse-midwife to attend the birth of their child. They ought to have that right without restraints of trade, and unreasonable hindrance.

I would like to thank both of you for appearing here this morning. As I said, the text of your entire statements will appear in the record.

Mr. GORE. I would like to call now our second panel to the witness table, Dr. Darrell Martin and Susan Sizemore of the Nurse Midwifery Associates in Nashville, Tenn.; Lonnie Holtzman Morris, CNM, Childbirth Center in Englewood, N.J.; Marion McCartney, RN, CNM, Maternity Center of Bethesda, Md., and Ruth Lubic, Maternity Care Association, New York, N.Y.

Stand and raise your right hand.

Do you swear the testimony you are about to give will be the truth, the whole truth and nothing but the truth, so help you God.

[Chorus of "I do."]

Mr. GORE. Thank you very much and, for the reporter, let me just identify that Susan Sizemore is to your immediate right; Dr. Darrell Martin, then Marion McCartney, and Lonnie Holtzman Morris, and Ruth Lubic, in that order.

We will begin with Dr. Martin.

TESTIMONY OF WILLIAM DARRELL MARTIN, M.D., NASHVILLE, TENN.; SUSAN JOHNSON SIZEMORE, R.N., C.N.M., NURSE MIDWIFERY ASSOCIATES, NASHVILLE, TENN.; LONNIE HOLTZMAN MORRIS, C.N.M., M.S., CHILDBIRTH CENTER, ENGLEWOOD, N.J.; MARION McCARTNEY, R.N., C.N.M., MATERNITY ASSOCIATES OF BETHESDA, MD.; AND RUTH WATSON LUBIC, C.N.M., DIRECTOR, MATERNITY CENTER ASSOCIATION, NEW YORK, N.Y.

Dr. MARTIN. Thank you.

I appreciate the opportunity to appear before the Subcommittee on Oversight and Investigations concerning freedom of choice in the health care delivery system.

I am a board-certified obstetrician and gynecologist by the American College of Obstetricians & Gynecologists and a fellow of the college.

I had no formal training of this type in residency. However, after getting into private practice and having more time for patient contact, and a chance to get to know them as members of the community, I became concerned for their needs.

Many people have asked why I am interested in alternatives. When patients asked me to consider certain options and I was unable to find a reason why it was unsafe, I went along with the patient. I very much desired the couple to have a positive birth experience.

My association with nurse-midwives began when, as an attending physician at Nashville General Hospital, affiliated with the Vanderbilt University residency program, I began work with nurse-midwives, particularly Susie Sizemore and Vickie Henderson.

I saw greatly improved care that couples were receiving and the improved perinatal statistics with a 10-percent improvement in prematurity rates alone. With the knowledge that many couples were being denied their services because of economic requirements at Nashville General, I encouraged them to open a private practice. First we negotiated with Vanderbilt Hospital for the midwives to work as employees of the obstetrical department. This did not work out because of outpatient space limitations and economic considerations. We then focused on the option of a private practice.

During this time my frustration with the hospital system was diminished because Hendersonville Community Hospital, owned by Hospital Affiliates International, Inc., opened in the area. Without long-standing politics to stifle change, I was able to obtain the State's first waiver for sibling visitation and siblings at birth, as well as a birthing room and flexible policies and procedures.

My partners, Dr. Rice and Dr. Sanes, and I felt there would be little resistance to the midwives for several reasons:

One, it was a young hospital with little long-standing politics.

Two, my partners and I were doing 95 percent of the deliveries and 50 percent of the surgery at this hospital, giving us input with administration.

Three, there were allied health provisions in the bylaws and nurse-anesthetists were used quite extensively in surgery and labor and delivery.

Fourth, many of the same physicians at Hendersonville had worked with Susie in Madison and approved of her practice. Subsequently, Susie and Vickie applied for privileges at Hendersonville Hospital.

In January 1980 we received a letter stating that privileges were granted subject to the review of the medical protocol. This medical protocol was reviewed and passed by the obstetrical and anesthesia departments but pediatrics refused to review the protocol. Initially they reverted back to issues of whether the practice should be permitted in Hendersonville and raised five concerns. I believe Susie will review these specific concerns.

They found our answers to be satisfactory but still refused to review the protocol. Their final statement was until a pediatrician or family practitioner could be found who would take sole responsibility for the babies delivered at Hendersonville by nurse-midwives, the protocol would not be reviewed and the executive committee changed their position. This action was very upsetting to the midwives and myself and we considered various options.

My partners elected not to proceed past this point, wishing to wait until this person was found. They did not wish to raise any further controversy over this issue. I then faced the decision whether or not to support the midwives, therefore having to separate from my established practice and relocate in Nashville.

Mr. GORE. Are you saying that your fellow doctors served notice that they would not treat any child delivered by a certified nurse-midwife?

Dr. MARTIN. That is exactly right.

Mr. GORE. Why? Were they tainted somehow or other—

Dr. MARTIN. Again, similar to Sally Tom's answer, you might have to ask the pediatricians themselves. I can only assume, and they made one statement, that because of the new service that I provided, that my partners and I provided in the middle Tennessee area, many people were coming from outside the Hendersonville area to receive our services with the husbands being able to attend "C" sections and not having to have IV's; they did not like the idea that they would only be seeing these babies, that we delivered one time and they would be referred back to another pediatrician because they were on the staff of the hospital, and by the bylaws of the hospital they were forced to see those individuals if we deliv-

ered them, they felt that if they allowed the midwives to have privileges that would increase the number of individual patients that they would be seeing.

It is interesting to note though that whether they would have given midwives privileges or not, we would have been able to delivery those exact same babies and they would have indeed had the numbers increased anyway.

Mr. GORE. Thank you.

Dr. MARTIN. I elected in early June to separate from my partners to support what I believed was the right of midwives to have privileges, and hopefully obtain them in Nashville. We chose Southern Hills, a hospital in South Nashville owned by the Hospital Corporation of America, as a place to attempt to obtain privileges, because they had copied the similar policies and procedures that we had instituted in Hendersonville.

I quickly was given privileges and the midwives' privileges were placed in an ad hoc committee for study. During this time, our patients and I became quite upset, because rumors were flying that the birthing room that had been in force for a year would be closed and the administrator of the hospital only made matters worse by telling our patients that the birthing room would be closed at different times, which would be quite upsetting to the patients, not knowing where they might receive their care.

The board of the hospital released a statement that the midwives' application as submitted was not approved, but offered to set up a meeting to review what would be necessary for the practice to begin operating. During this time one of the obstetricians on staff stated that midwives would receive privileges at Southern Hills over his dead body and that there were starving obstetricians in Nashville, therefore we didn't need midwives. I felt with statements like these privileges would be very difficult to obtain.

I attended the meeting with not too much hope for success. The recommendations they made will be reviewed by Susie, but it was clear at the meeting that they would go to any length to block the midwives' privileges if they attempted to meet these requirements. In fact, most of the evening was spent discussing those points.

For example, two obstetricians at the meeting stated that by January the birthing room would be closed. They reasoned that it took more time away from their patients and they wanted a recovery room instead. The administrator stated that new policies and procedures would be implemented since they did not want to create a zoo on labor and delivery.

One obstetrician stated that policies would be changed so that all women would have IV's, preps, enemas, be monitored 100 percent of the time and not be allowed to ambulate. All these would be foreign to our practice. I was called immoral and unethical for taking care of these kinds of patients.

One obstetrician could not understand where all the patients came from who questioned physicians. He stated that questioning a physician was like questioning motherhood, apple pie, and Chevrolet. I could see that whatever compromise we attempted would meet with an undesirable place to practice.

Ms. MIKULSKI. Did he give any answers on those three?

Dr. MARTIN. Not even in Alaska is what he said. I could see that whatever compromise we attempted would meet with an undesirable place to practice, since policy and procedures can be changed and are controlled by the medical staff.

Application for privileges was also ongoing at Vanderbilt. I was hopeful that privileges would be granted for several reasons:

One, a birthing room and liberal policies were developed for inclusion in the new hospital which opened in September 1980.

Two, discussions had already occurred with Vanderbilt but were dropped because of outpatient space limitations.

Three, several of the attendings had worked with Susie and Vickie at Nashville General.

In addition, several of the attendings came from Johns Hopkins where there is a midwifery school as well as midwives in private practice. However, privileges were denied because of alleged space limitations in the new hospital. They stated that as a tertiary referral center they could not accommodate any more normal patients.

It is interesting that 75 percent of their deliveries were low-risk during the past year. Also, private physicians in town were given access to the birthing rooms for their normal patients. They continued to state that they supported midwives philosophically, but that there was no room in the inn and no desire to share with private physicians.

I would like to deal now with the malpractice issue. I had heard from one of the Vanderbilt residents in April that a local obstetrician was bragging that he would get my malpractice insurance for backing up midwives and that he would set midwives back 20 years in the State. I didn't think too much about it since approximately the same time the midwives received an application from State Volunteer Mutual Insurance Co. (SVMIC), with whom I have my malpractice. SVMIC is a physician-owned and operated malpractice carrier. Since midwives have cheaper coverage with their own college, they chose not to take SVMIC coverage.

I began to worry in late July when I received a letter from SVMIC asking me to delineate the nature of my practice. I viewed this as a threat because other practitioners in the State with SVMIC were practicing with midwives and were not required to submit any information.

In addition, effective July 1, the local obstetrician who said he was going to get my malpractice insurance was appointed to the Middle Tennessee Board of SVMIC. I complied with their request for information and had no response until October 31 when a letter was sent to me stating that because of increased risks of undue proportions, my malpractice insurance would not be renewed effective January 1, 1981. Since they refused to give me any more specific information, a hearing has been requested and granted for December 16, 1980.

The basis, as best we could gather in the hearing, and they did not give me an answer on whether they would renew my malpractice insurance, was that the independent nature of this midwifery practice was a major cause for their concern in their inability to assess what they would consider then to be increased liability on my part in this type of practice.

This case has affected many individuals other than myself and my family. When privileges were first denied at Hendersonville Hospital, we submitted a letter to the Joint Practice Committee of the Nashville Academy of Medicine. We asked them to review the ethics of the pediatricians' action as well as help in preventing similar problems at Southern Hills. The information director of the Nashville Academy was instructed not to release any information to the media concerning the midwifery issue, and shortly afterward she resigned her position. The Joint Practice Committee refused to deal with the specifics, but made a general statement supporting collaborative practice. To the best of my knowledge, this recommendation has not been taken back to the general membership of the Nashville Academy.

I have also been recently informed that the Joint Practice Committee has been dissolved. A local television newsperson, in conjunction with the Nashville Academy, had been having town meetings to educate the community on various health-care issues. This newsperson has also reported favorably on the nurse midwives. At this time the town meetings have been stopped.

As you might imagine, this issue has had a tremendous impact on me and my family. As a committed Christian, I had a desire to serve God's people, therefore taking up a struggle for their rights. I did this, however, with little regard for the possible adverse consequences.

In the fall of 1980, I realized that I needed to place my family before the practice. The pressure was overwhelming. Without any overt physician support, lack of malpractice insurance, statements by physicians that they would ruin me, lack of referrals, silent treatments at meetings, removal of favorable policies and procedures, and fear of physical as well as further emotional harm, I felt that I was unable to function effectively as a husband and father, let alone physician to my patients. For these reasons I have elected to relocate to South Carolina.

In conclusion, what can each of us do to help consumers have a choice in health care? Personally, I believe that I must consider legal action as a mechanism for securing privileges for midwives and to protect the rights of consumers. I believe that consumers need to join forces to educate other consumers concerning the safe, legal, and more economical services they are being denied and use this information to exert pressure on physicians, hospitals and lawmakers.

I believe that the American College of Obstetrics & Gynecology has an obligation to its members and to the people they serve to enforce printed statements concerning family-centered maternity care as well as hospital access for midwives. If they are unwilling or unable to do this, then I believe it is the obligation of this committee, as well as State legislatures, to force hospitals to grant access to licensed health care providers.

I pray that what has happened to me will not be in vain, but will serve to emphasize what a dangerous precedent will occur if nothing is done about this issue. I wish that the individuals involved with this issue would read and take to heart several appropriate books and statements, these being the Bible, the hippocratic oath, and the Constitution of the United States.

Thank you very much for the opportunity to relate my story and personal feelings.

[Testimony resumes on p. 45.]

[Dr. Martins' prepared statement follows:]

TESTIMONY FOR THE
CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
December 18, 1980

I appreciate the opportunity to appear before the Subcommittee on Oversight and Investigations concerning freedom of choice in the health care delivery system. I believe that my experience is an excellent example of how consumers are being denied freedom of choice in their birth experience.

Before detailing my attempts to secure alternatives in child-birth, I would like to give you a brief background on my training. I graduated from the University of Pittsburgh in 1969, West Virginia University in 1973, and Vanderbilt University residency program in 1977. I am Board Certified by the American College of Obstetricians and Gynecologists and a Fellow of the College. I conducted a group practice in Hendersonville, Tennessee approximately twenty miles north of Nashville for three and one-half years at which time I left the group practice to become the sole backup for Vickie Henderson and Susan Sizemore, two certified nurse-midwives. In addition, for the past four years I have taught Vanderbilt residents and medical students at Nashville General Hospital. I am now making plans to join a multi-specialty group in Darlington, South Carolina.

Many people have asked why I am interested in alternatives. I have had no training in residency with regard to alternatives-- in fact, it was just the opposite. Most of the patients were high risk. There was little time allowed for contact with the low risk patients. With more opportunity for patient contact and a chance to get to know them as members of the community, I became concerned for their needs. When patients asked me to consider certain options and I was unable to find a reason why it was unsafe, I went along with the patient. I very much desired the couple to have a positive birth experience. During the time my practice was growing, I saw the need to hire a nurse educator to present the alternatives to all couples. This gave them the necessary information to make an educated and informed choice on what would be their birth experience. It also decreased patient anxiety, again making the gestation more pleasurable, and I also believe safer. It became more enjoyable taking care of people who were allowed to help determine how their childbirth progressed. I began using less IV's, no routine preps and enemas, no routine episiotomies. Options which were under the control of other physicians and hospitals including birthing rooms, husband attended C-sections, prolonged bonding, and short stays also became important concerns. My first attempt at a birthing room delivery met with hospital resistance, but I was determined to help the couple because otherwise she would have delivered at home. They had been misled at the birth of their first child. They were told they would be allowed

to bond with the new baby, but instead, with a normal apgar score and normal temperature, the baby was taken away to the nursery not to be touched or seen until twelve hours later. The infant at six weeks of age was noted to have a heart murmur, subsequent surgery was performed, and the baby died. Because of the unkind treatment in the hospital at her delivery she was torn between delivering at home and the safety of the hospital. She had a beautiful delivery in a labor room because I refused to move her into the delivery room. By staying in the room myself and taking temperatures, we were able to keep the baby in the labor room. That delivery taught me two lessons. One was how important bonding is since the mother still has not been able to deal with the death of her first baby. I believe bonding at that birth would have made a difference. Two, it showed me how personally rewarding it can be to give couples what they desire and in many cases need.

My association with Mrs. Sizemore and Miss Henderson began in 1973 when, as a resident, I worked with them in labor and delivery at Vanderbilt. I lost touch with Vickie but remained friends with Susie and followed her career through nurse midwifery school, private practice in Madison, Tennessee, and working at the Maternal Infant Care Project at Nashville General Hospital. Vickie also returned to work at Nashville General after her midwifery training. As an attending physician there, I had the opportunity to work with midwives. I saw the greatly improved care that couples were receiving and the improved

perinatal statistics with a ten percent improvement in prematurity rates alone. With the knowledge that many couples were being denied their services because of economic requirements at Nashville General, I encouraged them to open a private practice. First we negotiated with Vanderbilt Hospital for the midwives to work as employees of the obstetrical department. This did not work out because of outpatient space limitations and economic considerations. We then focused on the option of a private practice.

During this time my frustration with the hospital system was diminished because Hendersonville Community Hospital owned by Hospital Affiliates International, Inc. opened in the area. Without long standing politics to stifle change, I was able to obtain the state's first waiver for sibling visitation and siblings at birth, as well as a birthing room and flexible policies and procedures. My partners, Dr. Rice and Dr. Sanes, and I felt there would be little resistance to the midwives for several reasons. One, it was a young hospital with little long standing politics. Two, my partners and I were doing ninety-five percent of the deliveries and fifty percent of the surgery at this hospital giving us input with administration. Three, there were allied health provisions in the bylaws and nurse anesthetists were used quite extensively in surgery and labor and delivery. Fourth, many of the same physicians at Hendersonville had worked with Susie in Madison and approved of her practice. Subsequently, Susie and Vickie applied for privileges at Hendersonville Hospital.

In January 1980 we received a letter stating that privileges were granted subject to the review of the medical protocol. This medical protocol was reviewed and passed by the obstetrical and anesthesia departments but pediatrics refused to review the protocol. Initially they reverted back to issues of whether the practice should be permitted in Hendersonville and raised five concerns. (I believe Susie will review these specific concerns.) They found our answers to be satisfactory but still refused to review the protocol. Their final statement was until a pediatrician or family practitioner could be found who would take sole responsibility for the babies delivered at Hendersonville by nurse-midwives the protocol would not be reviewed and the executive committee changed their position. This action was very upsetting to the midwives and myself and we considered various options. My partners elected not to proceed past this point wishing to wait until this person was found. They did not wish to raise any further controversy over this issue. I then faced the decision whether or not to support the midwives, therefore, having to separate from my established practice and relocate in Nashville. Because of my strong belief in delivering alternatives as well as a strong feeling the midwives would be allowed to practice in Nashville, I chose to support the midwives.

In late June I then applied to Southern Hills Hospital owned by Hospital Corporation of America which is located in south Nashville. It was chosen because it had copied the policies of Hendersonville, and

I would be allowed to function with patients as I had in Hendersonville. Again being a new hospital, I felt that politics would be minimal and; in addition, there was a pediatrician on staff who supported nurse-midwives. The midwives applications were placed in an adhoc committee for recommendation in ninety days. During this time our patients and I became quite upset because rumors were flying that the birthing room would be closed and the administrator only made matters worse by telling couples different stories on when it would close. The board of the hospital released a statement that the midwives applicaton as submitted was not approved but offered to set up a meeting to review what would be necessary for the practice to begin operating. During this time one of the obstetricians on staff stated that midwives would receive privileges at Southern Hills over his dead body and that there were starving obstetricians in Nashville, therefore, we didn't need midwives. I felt with statements like these privileges would be very difficult to obtain. I attended the meeting with not too much hope for success. The recommendations they made will be reviewed by Susie, but it was clear at the meeting that they would go to any length to block the midwives privileges if they attempted to meet these requirements. In fact, most of the evening was spent discussing those points. For example, two obstetricians at the meeting stated that by January the birthing room would be closed. They reasoned that it took more time away from their patients and they wanted a recovery room instead. The administrator stated that new policies

and procedures would be implemented since they did not want to create a zoo on labor and delivery. One obstetrician stated that policies would be changed so that all women would have IV's, preps, enemas, be monitored one hundred percent of the time and not be allowed to ambulate. All these would be foreign to our practice. I was called immoral and unethical for taking care of these kinds of patients. One obstetrician could not understand where all the patients came from who questioned physicians. He stated that questioning a physician was like questioning motherhood, apple pie, and Chevrolet. I could see that whatever compromise we attempted would meet with an undesirable place to practice since policies and procedures can be changed and are controlled by the medical staff.

Application for privileges was also ongoing at Vanderbilt. I was hopeful that privileges would be granted for several reasons. One, a birthing room and liberal policies were developed for inclusion in the new hospital which opened in September 1980. Two, discussions had already occurred with Vanderbilt but were dropped because of out-patient space limitations. Three, several of the attendings had worked with Susie and Vickie at Nashville General. In addition, several of the attendings came from Johns Hopkins where there is a midwifery school as well as midwives in private practice. However, privileges were denied because of alleged space limitations in the new hospital. They stated that as a tertiary referral center they could not accommodate any more normal patients. It is interesting

that fifty percent of their deliveries were low risk during the past year. Also, private physicians in town were given access to the birthing rooms for their normal patients. They continued to state that they supported midwives philosophically, but that there was no room in the inn and no desire to share with private physicians.

I would like to deal now with the malpractice issue. I had heard from one of the Vanderbilt residents in April that a local obstetrician was bragging that he would get my malpractice insurance for backing up midwives and that he would set midwives back twenty years in the state. I didn't think too much about it since approximately the same time the midwives received an application from State Volunteer Mutual Insurance Company, with whom I have my malpractice. SVMIC is a physician owned and operated malpractice carrier. Since midwives have cheaper coverage with their own college they chose not to take SVMIC coverage. I began to worry in late July when I received a letter from SVMIC asking me to delineate the nature of my practice. I viewed this as a threat because other practitioners in the state with SVMIC were practicing with midwives and were not required to submit any information. In addition, effective July 1, the local obstetrician who said he was going to get my malpractice insurance was appointed to the Middle Tennessee Board of SVMIC. I complied with their request for information and had no response until October 31 when a letter was sent to me stating that because of increased risks of undo proportions my malpractice insurance would

not be renewed effective January 1, 1981. Since they refused to give me any more specific information, a hearing has been requested and granted for December 16, 1980.

This case has effected many individuals other than myself and my family. When privileges were first denied at Hendersonville Hospital we submitted a letter to the Joint Practice Committee of the Nashville Academy of Medicine. We asked them to review the ethics of the pediatricians action as well as help in preventing similar problems at Southern Hills. The information director of the Nashville Academy was instructed not to release any information to the media concerning the midwifery issue and shortly afterwards she resigned her position. The Joint Practice Committee refused to deal with the specifics, but made a general statement supporting collaborative practice. To the best of my knowledge, this recommendation has not been taken back to the general membership of the Nashville Academy. I have also been recently informed that the Joint Practice Committee has been dissolved. A local television newsperson in conjunction with the Nashville Academy had been having town meetings to educate the community on various health care issues. This newsperson has also reported favorably on the nurse-midwives. At this time the town meetings have been stopped.

As you might imagine this issue has had a tremendous impact on me and my family. As a committed Christian, I had a desire to serve

God's people, therefore, taking up a struggle for their rights. I did this, however, with little regard for the possible adverse consequences. In the fall of 1980, I realized that I needed to place my family before the practice. The pressure was overwhelming. Without any overt physician support, lack of malpractice insurance, statements by physicians that they would ruin me, lack of referrals, silent treatment at meetings, removal of favorable policies and procedures, and fear of physical as well as further emotional harm, I felt that I was unable to function effectively as a husband and father let alone physician to my patients. For these reasons I have elected to relocate to South Carolina.

In conclusion, what can each of us do to help consumers have a choice in health care? Personally, I believe that I must consider legal action as a mechanism for securing privileges for midwives and to protect the rights of consumers. I believe that consumers need to join forces to educate other consumers concerning the safe, legal and more economical services they are being denied and use this information to exert pressure on physicians, hospitals and lawmakers. I believe that the American College of Obstetrics and Gynecology has an obligation to its members and to the people they serve to enforce printed statements concerning family centered maternity care as well as hospital access for midwives. If they are unwilling or unable to do this, then I believe it is the obligation of this

Committee, as well as state legislatures, to force hospitals to grant access to licensed health care providers.

I pray that what has happened to me will not be in vain, but will serve to emphasize what a dangerous precedent will occur if nothing is done about this issue. I wish that the individuals involved with this issue would read and take to heart several appropriate books and statements -- these being the Bible, the Hippocratic Oath, and the Constitution of the United States.

Thank you very much for the opportunity to relate my story and personal feelings.

William Darrell Martin, M.D.

 William Darrell Martin, M.D.

Mr. GORE. Thank you very much, Dr. Martin. We usually go straight through a panel, but I am really moved by your statement and I cannot contain my sense of outrage.

Let me just briefly recap what your story is, as I understand you.

You are an obstetrician, you did not have any special training in the new kinds of childbirthing techniques in medical school, when you were in medical school, but your patients began to ask you is there some alternative to being strapped down on a table and given a lot of heavy medication and going through the accepted pattern of childbirth?

You had an open mind, you investigated the alternatives your patients requested, and decided some of them made a lot of sense; you learned along with them and tried to respond to the questions of your patients; is that correct?

Dr. MARTIN. Yes, sir.

Mr. GORE. Now, you entered into a contractual relationship with two certified nurse-midwives and you attempted at three separate hospitals to get practicing privileges for the certified nurse-midwives with whom you were practicing, rather they attempted to get privileges, and we are going to hear from them in a minute.

At the first hospital, the pediatricians served notice they would not treat any child delivered by a nurse-midwife. At the second hospital, the hospital refused, saying that they only took, or concentrated on high-risk deliveries, when in fact more than three-quarters of the deliveries are normal deliveries and not high risk at all.

At the third hospital, what happened there?

Dr. MARTIN. Miss Sizemore will give specifics of what they wanted us to change in relation to our practice.

In addition, they made it clear if we attempted to meet those requirements, which we probably could have met some if not all, they would remove all of the policies and procedures which made it enjoyable to practice in the particular hospital and enjoyable for the parents.

Mr. GORE. Finally, the icing on the cake was you were notified by your malpractice insurance company, which is owned and controlled 100 percent by physicians, that your malpractice insurance was canceled, effective December 31, because you were practicing with certified nurse-midwives. Is that correct?

Dr. MARTIN. They didn't specifically say that in the letter. At the meeting 2 days ago it was kind of a roundrobin affair, in terms of trying to get them to really specify what the problem was. They do cover several other physicians in the State of Tennessee who work with midwives. However, that arrangement is an employer-employee arrangement where the midwife is hired by the physician, which was not the way this practice was set up.

Mr. GORE. Isn't it true that there has never been a successful malpractice claim against a certified nurse-midwife?

Dr. MARTIN. Not to my knowledge.

Mr. GORE. In other words, there never has been?

Dr. MARTIN. No.

Mr. GORE. Have you had any lawsuits filed against you by patients?

Dr. MARTIN. I have had one claim filed against myself as well as my partners. Two points concerning that. One is that there are 5,000 physicians covered by State Volunteer Mutual, and to this point in 3 years they have had 1,500 claims. The administrator of a group that I was planning on going into called them for me and they stated there was no problem with my claims history but there was a problem with the issue of midwives.

Mr. GORE. So clearly the issue that led to the cancellation of your malpractice insurance was your decision to practice with nurse-midwives? You don't think there is any question about that, do you?

Dr. MARTIN. I don't have any question in my mind and they have requested us to give them further information, and again the basic issue that they resolve or center around is one of concern that a physician and a midwife would have different carriers in the same office. Since they could not insure, as they state, an independent contract for independent midwives, and the nature of this saying that I don't have control over the midwife but she has control over me.

Mr. GORE. Now, a member of the board of directors of that insurance company is another obstetrician who reportedly threatened to have your malpractice insurance canceled because you were practicing with certified nurse-midwives; is that correct?

Dr. MARTIN. That is correct.

Mr. GORE. Do you have any question in your own mind that that doctor was the moving force behind the cancellation of your malpractice insurance?

Dr. MARTIN. I may never be able to prove it, but I don't have a question in my mind that he was.

Mr. GORE. In my view, this is a genuine outrage, a genuine outrage.

Can you explain to me how you have been treated by your fellow physicians in the medical community as a result of this controversy?

Dr. MARTIN. Well, I think that as a general hold there are probably some physicians—first of all, let me say I don't think all physicians are bad.

Mr. GORE. Nor do I, let me hasten to add.

Dr. MARTIN. Some fellows have given me support, let's say under the cover, but they are generally afraid for their own self, not only for what has happened to me but all physicians are intimately involved in terms of referral ties, referral patients; if they would speak out and support me that might cause them to lose certain referrals from other physicians.

I think that I received the silent treatment, statements that were appropriately said to residents that were able to be given back to me, that I was just ruining myself and my practice and I would be ostracised from the medical community, I would not enjoy the opportunity to have a peer-work relation with my own fellow obstetricians, and I sort of feel I was getting out there on a limb and that the first thing I did they would enjoy very much cutting that limb off.

Mr. GORE. So you felt you had to choose between your responsibilities as a husband and father and the responsibilities you incurred to this movement of which you became a part, and you came to the personal decision that you had to move to another state; is that correct?

Dr. MARTIN. That is correct.

I think one other thing I had considered was to continue the fight in a different way, and I was accepted into Dr. Miller's program for maternal child health. I was also interested in the Robert Wood Johnson scholars program there, which is a clinical track for research.

I feel it is important that research be done in clinical investigations of obstetrics. However, I received no support from the obstetrical department at North Carolina for that. Because of that lack of support, lack of support in the obstetrical department, and the economic considerations revolving around the problems we have had, I have had, I chose to go into private practice, but I still feel that someone needs to follow that type of a track and do the necessary clinical research.

Mr. GORE. I don't mean to imply you were abandoning the fight. I am disappointed we are losing you in Tennessee and you will now be practicing in South Carolina instead.

I want to move on with the panel. I want to give my colleague a chance to ask questions here, or we can move on with the other half of the team.

Ms. MIKULSKI. I want to make a comment, because I do want to hear from the nurse-midwives, and particularly Miss Sizemore, who I am sure has also borne a great deal of heartache in this situation.

Dr. Martin, I would like to thank you for stepping forward and sharing this testimony with us and with the American people.

I would also like to thank you for the efforts in our behalf.

I think that your story is indeed a dastardly one and I want to hear the other half of it, but I am sorry about what happened to you as both a physician and in terms of the terrible burdens on your family.

I am sure that you have had the support of your wife in this and that makes you all feel very good; here you are a professional trained physician, obviously from a very outstanding medical school, and if they treated you like that, and you have at least the powerful position of a physician, you can go to South Carolina and then also find ways to get back on the barricades and in different ways. But nurse-midwives have no other alternative, and no matter where they go, they are going to be running into these same problems. So I wanted to thank you and I appreciate that and ask you also not to give up the fight.

Dr. MARTIN. Thank you.

I do feel that the only way, at least for our particular issue, that it will get resolved at this point is by some type of legal action, to see that it is the only mechanism that is left to us to secure the rights of midwives to have privileges.

Mr. GORE. Let me call on Susan Sizemore, and could I ask the two of you to change seats because the microphone is taped down there.

I want to welcome you to the subcommittee. I admit a personal bias because of our friendship and acknowledge the presence in the audience of Christopher Sizemore, age 10, who is on his first trip to Washington, and welcome you and thank you for your willingness to appear before this subcommittee, and please proceed with your statement.

TESTIMONY OF SUSAN JOHNSON SIZEMORE, R.N., C.N.M.

Ms. SIZEMORE. Before I begin with my statement, I would like to thank you personally, Mr. Gore, for responding to our letters of request for assistance and information. All summer long Vicki Henderson and I worked hard and started a letter campaign, writing everyone we could think of, trying to find out what was happening in other places and who could help. So we were glad to have you on the other end of our communications.

My name is Susan Johnson Sizemore. I am a certified nurse-midwife practicing in Nashville, Tenn. I graduated from the Norfolk General Hospital School of Nursing in 1968. During my 12-year nursing career, I have been employed as a staff nurse, nursing supervisor, nursing administrator, and instructor. I am licensed to practice in four States and my specialty is maternal and child health. I graduated from Meharry Medical College's nurse-midwifery program in 1975 and am certified by the American College of Nurse-Midwives. I am a member of the American College of Nurse-Midwives, the American Nurses Association, the International Childbirth Education Association, and the American Society for Psychoprophylaxis in Obstetrics—Lamaze.

After graduation from midwifery school, I was immediately employed by an obstetrician, not Dr. Martin, with whom I worked for 1 year. During this time I enjoyed an active midwifery practice and became the first nurse in Tennessee to obtain hospital staff privi-

leges as Allied Staff—Madison Hospital. During this time I suffered many distasteful experiences, all of which prevented me from exercising the professional prerogatives essential to anyone working in a collaborative practice. I left that practice promising myself that I would never again place myself in a position of professional subjugation.

In September 1976, I joined the core staff of Metropolitan Nashville General Hospital's high-risk maternal and infant care program, serving disadvantaged inner city residents. The program's emphasis is on prevention, utilizing the services of a multidisciplinary team of providers including obstetricians and nurse-midwives. The program has been very successful in reducing the rate of prematurity and infant mortality. Collegial relationships are excellent and the team work of various disciplines is abundantly evident. Client/patients are very happy with the services provided and the program, although not neighborhood-based, has a true sense of community.

The program enjoys the status of having become a model program, being visited frequently by interested persons from both within and outside the State. The maternal and infant care program began receiving many phone calls from women in the Nashville community who were very interested in midwifery services. Many of the families earned too much income to qualify for this program. The program social worker began keeping track of the number of applicants with incomes above the Federal poverty scale. Within 1 year's time she turned away 200 interested people. At that time there were no private midwifery services in Nashville available to the community at large.

In the fall of 1979, Ruth Ann Leach, a local television newswoman, filmed a documentary on the childbirth revolution titled, "Ever Since Eve." This powerful work challenged the community to make more birth alternatives available to the people.

Victoria Henderson, CNM, and I began exploring the possibilities of entering a collaborative practice with Dr. Darrell Martin and his two partners, Gilmore Sanes and Ron Rice. All are board-certified obstetricians-gynecologists, practicing in a suburb of Nashville at a new hospital owned by Hospital Affiliates International, Inc., that had incorporated several innovative childbirth alternatives in design and policy.

Such alternatives included a birthing room, sibling presence at birth, 24-hour rooming in, early hospital discharge, et cetera. After several planning meetings with Drs. Martin, Rice, and Sanes, it was agreed that Ms. Henderson and I would open an office in downtown Nashville and remain financially independent. In Tennessee it is illegal for members of separate professions to incorporate in a business venture together. We could, however, open our own midwifery practice and contract with the physicians for medical direction, consultation, referral and collaboration on the medical aspects of patient care. Careful attention was taken to insure that the practice would meet all legal requirements and the standards of our professions.

The physicians would come to our office three afternoons per week to provide medical direction and direct patient care. They would also back us up at Hendersonville Community Hospital for

inpatient care. In early March Ms. Henderson and I successfully negotiated a business loan with a local bank and proceeded to lease and equip our office. Nurse-Midwifery Associates formally opened for business on May 18, 1980.

Hendersonville Community Hospital bylaws has provisions for hospital privileges for nonphysician providers. Such privileges are essential to the practice of the nurse member of the collaborative practice. Without such privilege the nurse has no rightful access to the jointly managed client/patient who is hospitalized. Ms. Henderson and I submitted applications for staff appointment to this category and on February 22, 1980, received a letter from the hospital administrator which stated that our applications for privileges as nurse-midwives had been approved subject to the approval of a written protocol detailing our function in the care of patients. The written protocol was reviewed and approved with minor revision by the obstetric and anesthesia committee.

On March 26, 1980, the pediatric committee met and recommended to the hospital chief of staff that the nurse-midwifery program not be implemented because of serious concerns. The six pediatricians later agreed that their concerns were adequately addressed. Ms. Henderson and I attended the executive committee meeting on April 23, 1980, and were assured that the pediatric committee would discuss the issue further and attempt to come to some satisfactory resolution.

On May 20, 1980, the chairman of the pediatric committee announced to the executive committee that the six pediatricians on staff refused to review the midwifery protocol, and further refused to care for babies delivered by midwives. They insisted that we locate a physician who would assume full responsibility for all babies delivered by a nurse-midwife and to accept all medicaid patients. They refused to discuss it further, saying the subject had taken up too much of their valuable time.

The chairman of the pediatrics committee reiterated the department's position that if its members were forced to accept these newborns, some of the pediatricians would probably leave the medical staff. Subsequently, we were told we did not have privileges at the hospital to provide patient care, and subsequently Drs. Sanes and Rice withdrew their support for our practice. Their corporation's position was that if any physician wanted to back up nurse-midwives, that physician must leave the corporation. Dr. Darrel Martin decided to leave the corporation and relocate with us in Nashville.

Ms. Henderson and I applied for allied staff privileges at Vanderbilt University Hospital on May 20, 1980. Dr. Martin has had admitting privileges at this institution for several years. Vanderbilt was planning a move later that summer to a new hospital which would increase the delivery capacity from 2,000 to 2,500 births per year. This new facility has two birthing rooms and fairly liberal family-centered maternity care policies. While it features functioning as a high risk referral center, only 20 percent—400 out of 2,000—births last year were high risk referrals.

We had conversations with the chairman of the obstetrics and gynecology department, Lonnie Burnett, M.D. several times during the summer months. Finally, on August 14, 1980, Ms. Henderson

and I met with Dr. Burnett. He told us that the institution's commitment was to high-risk care in obstetrics, that normal maternity patients were admitted to satisfy the practice needs of the faculty and that the birthing rooms were there for their use. He felt that at full volume our projected 200 deliveries per year would overtax the institution and its various programs.

We received a letter from William Kreykes, hospital administrator, written August 29, 1980, citing, in addition to the resource capabilities of the department of obstetrics and gynecology, that all members of allied staff are full-time employees of the institution and have faculty appointments in the school of medicine. He states that Vanderbilt considers this relationship a necessary one for allied staff. Vanderbilt returned our applications unsigned by any committee. That is contrary to their bylaw requirements.

Despite Vanderbilt's stated position, many physicians in private practice utilize the resources of the hospital regularly and are not employees of the institution. Furthermore, I am a faculty member in the school of nursing and have also had teaching responsibilities for Vanderbilt medical students for 4 years.

Our client/patients continued to deliver at Vanderbilt. Dr. Martin provides his professional services but we are not permitted to function as nurse-midwives.

In our continued efforts to seek resolution to our problems within appropriate professional channels, we submitted on June 14, 1980 a request to the local joint practice committee. We requested that the committee hear about the problems we had encountered seeking access to hospitals. The committee has equal nurse/physician membership and an opportunity for dialog across the table.

At first the request was denied by the Nashville Academy of Medicine. After pressure from the local press and the decision by District III Tennessee Nurses Association to meet unilaterally on the subject, a meeting was scheduled. The outcome was a statement later adopted by both the local medical and nurses' associations that joint practices could exist in a variety of appropriate settings and that when the patient was hospitalized the nurse as well as the physician should have access.

On June 2, 1980, Ms. Henderson and I submitted applications to Southern Hills Hospital. It is owned by Hospital Corporation of America, another proprietary institution. This hospital was chosen because of its birthing room and liberal family-centered policies, bylaw language permitting the inclusion of nonphysician providers and Dr. Martin's appointment to medical staff. Southern Hills Hospital formed an ad hoc committee on June 18, 1980 to study the legal, regulatory, reimbursement, and patient care aspects of our request. Several meetings were canceled, rescheduled, et cetera, and several letters were unanswered; communications were poor at best.

We were finally invited to meet with the ad hoc committee on August 7, 1980. We submitted a copy of our written protocol and answered questions regarding our practice. An unfavorable practice climate continued to develop at Southern Hills Hospital, evidenced by attempts to close the birthing room; attempts to keep Ms. Henderson and myself from being physically present during the labor and delivery of our client/patients even in the role as

support coaches, and threats that the obstetric department was going to promulgate departmental regulations requiring that all labor patients have intravenous fluids, electronic fetal monitoring and restriction of ambulation.

The ad hoc committee recommended to the executive committee that our request for privileges be denied. The executive committee made this same recommendation to the hospital board of trustees.

On October 16, 1980, the board of trustees of Southern Hills Hospital voted to deny privileges. They stated that we could not attend a maternity patient throughout labor and delivery without the physical presence of an obstetrician. They claim there are numerous legal, medicaid, medicare, JCAH, as well as safety requirements which dictate their position. They advised us by a letter dated October 27, 1980, that they were willing to reconsider our applications if we met several requirements, including onsite/over the shoulder supervision of all functions. In addition, we must locate a second backup obstetrician, and obtain insurance indemnifying the hospital for any liability associated with our practice.

We were in the process of gathering information refuting the legal basis for some of their requirements when Dr. Martin received a letter from his malpractice carrier State Volunteer Mutual, informing him that his present practice situation assumed risk of such proportion that they would not renew his liability coverage as of January 1, 1981.

On April 15, 1980, State Volunteer Mutual sent a letter to Drs. Martin, Rice, and Sanes suggesting that they purchase liability insurance for their employed nurse-midwives. Since the rates were seven times more than we currently pay for identical coverage, we were not interested.

I was told that Dr. B. K. Hibbett III, said if Dr. Martin or any other obstetrician backed up nurse-midwives in private practice he would have their malpractice insurance canceled. He became a director of State Volunteer Mutual Insurance Co., which is physician owned. Later he allegedly stated his intent was to put mid-wifery back in this State by 20 years, as well as cancel Dr. Martin's malpractice insurance.

Dr. Martin received a letter from the insurance company written July 31, 1980, requesting a copy of our joint practice contract. Dr. Martin honored their request. He heard no more from this company until the October 30, 1980, letter notifying him of the insurance cancellation.

Dr. Martin is leaving Nashville at the end of December to begin practice in another State. Ms. Henderson and I have negotiated with other obstetricians about backing our practice and collaborating with us. These physicians cite several areas of problems they foresee, such as, (1) notoriety and fear of colleague anger; (2) the malpractice insurance threat; (3) their understanding that the American College of Obstetricians & Gynecologists has taken the position that the certified nurse-midwife must always be an employee and unable to receive fee for service directly from the consumer.

For the above-stated reasons, these obstetricians have all become too busy to affiliate with us. We have run out of possibilities as of December 13, 1980. We now are forced to close our doors to maternity care consumers on December 31, 1980.

We still provide midwifery services to the disadvantaged poor at Metropolitan Nashville General Hospital and we will continue to do so. Apparently it is quite acceptable to the medical community of Nashville for poor women to receive our services. In fact, they are the only ones who indeed have a choice. Self-paying or non-medicaid third-party paying clients do not have this choice, they must be delivered by an obstetrician if choosing any one of a number of hospitals for delivery.

Thank you very much.

Mr. GORE. Thank you very much.

What we have here is a case where a lot of consumers have asked for the service that you are attempting to provide?

Ms. SIZEMORE. Yes.

Mr. GORE. They want the service. It is cheaper, arguably safer, at least as safe, and yet the established medical community or some members of that established medical community have forced you to go out of business by denying you the opportunity to practice, and they have made professional life so miserable for the doctor with whom you were associated that he felt it necessary to move to another State?

I believe that is an outrage.

Ms. SIZEMORE. It is real hard to understand it and to gain some perspective on it, other than to come to the conclusion that many people in medicine in Nashville choose not to work collegially with nurse-midwives. That they truly intend nurse-midwives to be employees or work in places other than the hospital if they attempt to deliver services to the middle paying class and that women consumers and families choosing the services of a self-employed midwife must have their children at home.

Mr. GORE. I have a whole lot more questions. I am going to withhold as a courtesy to the other members of our panel, naturally. My interest is keying on the Tennessee case.

We have three other cases that are quite similar from other parts of the country, and I am going to ask now for testimony on a case in New Jersey, from Lonnie Holtzman Morris, a certified midwife with the childbirth center in Englewood.

Welcome and please proceed with portions or all of your statement as you see fit.

Ms. MIKULSKI. Could you wait 1 second? I would like to ask Ms. Sizemore a question before we go on.

For clarification, your business closed, the one you floated the loan for?

Ms. SIZEMORE. That is correct.

Ms. MIKULSKI. You are going to be on the staff of Metropolitan Nashville General Hospital?

Ms. SIZEMORE. Yes, ma'am.

Ms. MIKULSKI. Could you tell me quickly, could you tell me how that works; in other words, how will you be practicing, will you be on the staff of the hospital or in an employee relationship, rather than in solo practice?

Ms. SIZEMORE. We are very fortunate Vicki and I have worked there for 4 years and we continue to do so on a part-time basis. Nashville General Hospital has been very happy with our services

over the years and they have been very gracious to offer us our full-time positions back.

Ms. MIKULSKI. So you will be an employee—

Ms. SIZEMORE. Yes, once again.

Ms. MIKULSKI [continuing]. Of Nashville General Hospital, rather than in an independent practice?

Ms. SIZEMORE. Yes.

Ms. MIKULSKI. And Nashville General Hospital is like my City Hospital in Baltimore, it is the hospital focusing primarily on services of the poor and—

Ms. SIZEMORE. Yes; anyone in Nashville can use the services of General Hospital, but anyone in Nashville cannot use the services of the MIC program there because of the Federal guidelines requiring that services be provided to the disadvantaged poor. So, if you want a midwife at General, you have to be poor.

Ms. MIKULSKI. But then are you restricted to only practicing in the MIC service?

Ms. SIZEMORE. Yes.

Ms. MIKULSKI. You can't—if Sally Smith, whose income is \$35,000 a year, goes in to have a baby at Nashville General and she says, I want to have Susie Sizemore as my nurse-midwife, she can't have you?

Ms. SIZEMORE. That is right; if you wanted to come and see me at General Hospital, I would have to tell you that I couldn't provide you with the services.

Ms. MIKULSKI. Thank you.

Mr. GORE. Let the record be clear on this point. The medical community appears to have no objection whatsoever, based on quality of any other matter, where poor women are concerned. Where there is not a substantial economic stake involved, it is perfectly all right, apparently, for certified nurse-midwives to assume complete direction, control, whatever words of art you want to use. The controversy only arises where middle-income women or upper-income women hear about the alternatives provided by and associated with certified nurse-midwives and request certified nurse-midwives, when they would otherwise be going to and paying fees to obstetricians, is that right?

Ms. SIZEMORE. That seems to be the problem.

I am sure that there are questions to be answered about the safety and protocol, et cetera, but it is interesting that in Nashville people have not raised those questions, they have, rather, said "these are wonderful nurse-midwives," "we work with these midwives", "they are fine practitioners, but they need to go and practice at another hospital. We go to another hospital and it is still the physicians that control the vote on every committee and we get nowhere.

Ms. MIKULSKI. If the gentleman would yield for a second.

In your comments there is no objection in terms of service to the poor. I would like to say there is considerable resistance to my legislation, that will provide direct reimbursement for nurse-midwives to operate in a solo practice the way you did. Nobody came and rang the bells, at least we are going to get some kind of help. There was a resistance, reservation, and we had to fight very hard to get this legislation.

As you know, medicaid is for people who are poor, and so we find that there is resistance to nurse-midwives throughout the community. The only place there isn't resistance is when the nurse-midwife is an employee. If she is an employee, and somebody can decide what she is going to make, then it is OK, but the minute she can function as an independent professional, an independent practitioner, then it's tough there, whether it is medicaid paying for it or Blue Cross, or whatever, and that is where the resistance is, for you to be able to act as an independent professional within, of course, appropriate oversupervision that your protocols demand.

Mr. GORE. I think that is an important clarifying point. I think there are two prerequisites for your practice.

No. 1, assurance of third party payment, and Congresswoman Mikulski has taken the lead successfully in changing the medicaid law. There will now be a fight in the trenches over the regulations implementing that legislative change, and I offer my assistance in that fight.

Ms. MIKULSKI. I was going to ask you for that because I think those regulations are going to be a pip.

Mr. GORE. We will revisit that issue.

The second prerequisite is hospital privileges, and it was within the context of hospital privileges that I was addressing the apparent discrepancies between the level of concern shown at hospitals where middle- and upper-income patients formed the clientele as contrasted with hospitals where only poor women are seen.

Thank you for your patience.

Lonnie Holtzman Morris, please proceed.

Ms. MIKULSKI. I apologize.

Mr. GORE. No, no.

TESTIMONY OF LONNIE HOLTZMAN MORRIS, C.N.M., M.S.

Ms. MORRIS. My name is Lonnie Morris and I am a certified nurse-midwife, but I am also a health care consumer and a mother. My interest in midwifery began in 1971 after the birth of my first child. I had planned to have a natural birth but my doctor, the chief of obstetrics-gynecology at Hackensack Hospital, gave lip service to my plans but did as he pleased. He arrived at the hospital 30 minutes before my delivery, medicated me since I would "never be able to tolerate the pain," and then delivered my baby with forceps. My daughter now suffers from a seizure disorder due to a birth injury and requires learning disability training four times per week.

I completed my midwifery education in 1975 at Columbia University with a master's degree in maternal child care. I set out to find a position that was going to provide women with the type of care I would have liked to have received.

Dr. Robert Livingston, a board-certified obstetrician-gynecologist, welcomed me into his practice and we began our 5-year relationship. We applied to Englewood Hospital for hospital privileges so that I could deliver the few middle-class women who would select a certified nurse-midwife for care. The chief of obstetrics-gynecology at Englewood Hospital at that time stated "We don't want to talk to you—women might as well be going to a witch doctor if they are going to use the services of a certified nurse-midwife, C.N.M." I

asked him to put that in writing and I received a nice letter telling me there was nothing in the bylaws allowing for the practice of certified nurse-midwives.

At the same time three women who had attempted unassisted home births came to our office for repair of lacerations. It was at this point that we decided to open the Childbirth Center which would offer me a way of practicing my profession and provide an alternative for those women who were turning away from the traditional health care delivery system.

Our practice began to flourish. The feedback from the families were excellent. The press wrote favorable articles about the cost effectiveness and the safety of this type of delivery as well as the client satisfaction. Our happiness was short lived.

In 1977, the New Jersey Board of Medical Examiners published their first set of proposed regulations regarding the practice of nurse-midwifery.

They stated at that time:

One. All births must take place in hospitals.

Two. Certified nurse-midwives could not do episiotomies or repairs of same, a common obstetrical practice necessary for the safe delivery of some women.

Three. Certified nurse-midwives could not provide any family planning services or well-women gynecological services.

We again applied to Englewood Hospital for privileges for certified nurse-midwives to practice and we were again refused. One physician summed it up by saying, "You'll never get privileges at Englewood Hospital. There are 18 obstetricians-gynecologists in the area and we have to make a living." The board of medical examiners wanted to limit my practice to the hospital and the hospital wanted no part of me. Surely they wished I would evaporate into thin air.

The negotiations with the board of medical examiners has continued for 3 years. We met with the board on numerous occasions, presented statistics, research articles, et cetera, but they remained strong in their unwillingness to change their minds regarding our practice.

A public hearing was held in March and again in April 1980. Speakers from all over the country presented statistics and supported a full range of midwifery practice. Consumers participated and aired their desires for alternatives in obstetrical-gynecological care. The most recent draft of the regulations have been approved and will become law on January 8, 1981. Although they have changed from the earliest version, they severely cripple the practice of the nurse-midwife in the State of New Jersey. The regulations put severe limitations on the certified nurse-midwife practicing at the hospital, and reduce the number of patients these certified nurse-midwives may care for by one third. The major problem areas are:

One. Certified nurse-midwives may not care for the primagravida who is under 16 or over 35 years of age. The experience of certified nurse-midwives across the country has been very favorable with both these age groups. The teenage population has responded well to the certified nurse-midwife and have lowered their high-risk status substantially.

Additionally, I have dealt with a substantial number of women who have put off having a family until after the age of 35. These women have waited to start families until they have completed their education or because of career plans. We have not experienced any greater complication rate since they are a well nourished, healthy, middle-class population.

Two. Women delivering babies in other than a hospital may not use any drugs for pain relief. Clearly this is aimed at punishing a woman for using an alternative. Bite the bullet or go to the hospital.

Three. Certified nurse-midwives may only practice family planning in a physician's office or a licensed facility, and only if a physician is present in the building. This presents a great problem. Why must we only practice in a physician's office? Why not in a certified nurse-midwife's office? If a backup physician is participating, why must they share an office? Why must a physician be present in the building?

I have a large family planning practice of middle-income young women who cannot afford large fees for family planning. My major mode of family planning is the noninterventional diaphragm fitting. The local obstetrician-gynecologist charges \$60 to \$75 for a diaphragm fitting. In our office the charge is \$30.

The young college student feels more comfortable with another woman and does not have the finances to go to the physician. Additionally, the added time we spend with the patient increases the chances for success with her family planning choice. Why must I hire a physician to sit in the office to read a book and raise my fees? Isn't this an unnecessary duplication of services and a waste of the physician's valuable time and a waste of the consumer's precious money?

The Obstetric-Gynecologic Society and American College of Obstetricians & Gynecologists, chapter 3, circulated letters in March of 1980 that this committee may find of interest. The obstetrician-gynecologist on the board of medical examiners is also an officer in this group, and the organization began sending letters to all the obstetricians-gynecologists in the State urging them to:

Protect the women of today from the risks forgotten by their grandmothers—since the certified nurse-midwives were showing a growing desire to deliver babies out of hospitals, and worse yet they are practicing family planning without a physician being present.

From an independent physician this might be tolerable, but from someone of this stature—a member of the board of medical examiners and from an organization that we have long respected—this is intolerable.

In July of 1980 the Obstetric-Gynecologic Society circulated another letter telling the obstetricians-gynecologists in the State that they must unite to fight the certified nurse-midwives. They stated in this letter that they were going to hire a part-time public relations person to stir up the public against the certified nurse-midwives and increase press for the physicians.

We have certainly never tried to decrease the public respect for the physician; such an action on their part toward the certified nurse-midwives is indicative of a problem.

The insurance problems I have encountered are also indicative of the difficulties the certified nurse-midwives have in remaining a member of the health care delivery system. Blue Cross-Blue Shield holds 90 percent of the insurance market, and up until 1 month ago they refused to deal with me. It was only after I started legal action that I was able to establish some type of reimbursement for my clients through Blue Cross of New Jersey. New York Blue Cross on the other hand has ignored my correspondence and I recently began suit against them since one-third of my patient population reside in neighboring Rockland County and are covered by New York Blue Cross/Blue Shield.

Blue Shield flatly refused to reimburse for deliveries by the certified nurse-midwife although they do reimburse for podiatrists and psychologists. It seems to me that in this time of rising costs a delivery that is half the price of a hospital delivery and has been in existence for 4 years with impeccable safety statistics should be covered by all major medical insurance carriers and the families that use these less costly services should not be penalized.

Another interesting problem has been with New Jersey Disability. The New Jersey Department of Labor refused to cover a woman if she is delivered by a certified nurse-midwife and only a doctor may sign the claim form for her disability insurance that is a standard deduction and mandatory in the State of New Jersey—another penalty to the client for seeing a certified nurse-midwife and for opting for a less expensive form of care.

This is another limitation on the nurse-midwives' practice. Why use a midwife if you will be penalized by your insurance company and you won't be able to collect the disability for the 1 one month prior to birth and 1 month postpartum that you have paid for? Why use this care renderer if this is the case?

Another problem that I faced was finding backup physicians when Dr. Livingston planned on moving to Florida. I was invited by the chief of obstetrics-gynecology at Holy Name Hospital to move my birth center to their hospital. I had backup from the chief and his associates and 3 months before we were to begin practicing and after 4 months of negotiations, the medical board overruled the obstetric-gynecology department and banned the certified nurse-midwife from practicing at the hospital.

Finding other backup on such short notice was difficult, but we did secure backup from two obstetricians-gynecologists in the area and have had a wonderful 6 months of coverage by them. Our new backup physicians received a great deal of pressure from the physicians in our community not to work with us. Vague reference was made to the fact that they could lose their insurance coverage or that they could be sued for our mistakes. The results of our 4 years of operation has been good. We are currently delivering 220 babies per year. To date there have been 700 births.

Approximately 20 percent of our patients are transferred to the care of the physician at some point during the pregnancy. The outcome of these pregnancies are included in our statistics.

Our cesarean section rate is approximately 6 percent as compared to the 15-25 percent rate in major medical universities. Our forcep delivery rate is 7 percent as compared to 40 percent in New

Jersey hospitals. Eighty-seven percent of our patients have normal spontaneous vaginal deliveries.

Only four women, in our 4 years of operation, were transferred to the hospital during the postpartum period. Only 12 infants required hospitalization following delivery at the Childbirth Center, and 50 percent of these transfers were for overnight observation.

Our prematurity rate has been extremely low, with only 1.9 percent of our babies weighing less than 5.5 pounds. Ninety-nine percent of our babies have Apgar scores of 7-10 at 5 minutes. Our morbidity rate for mother and baby has been low and our mortality rate for newborns ranks well below what would be expected with this number of patients.

Yet we function with a black cloud hanging over our head waiting for something to go wrong—knowing the medical community will blow it out of proportion. I transferred a patient for lack of progress last week and a physician, the assistant chief of obstetrics-gynecology, on the elevator stated, "Another birth center casualty coming into the hospital." It frightens me to think about what will come next. All of this results in limitations to my ability to practice my chosen profession.

I thank you for the opportunity to address you, and we sincerely appreciate any help you can give us.

Mr. GORE. Thank you very much. We will withhold questions until we finish the panel's presentation.

I call now on Ms. Marion McCartney, R.N., C.N.M., Maternity Center of Bethesda, Bethesda, Md.

TESTIMONY OF MARION McCARTNEY, R.N., C.N.M.

Ms. McCARTNEY. My name is Marion McCartney. I am a certified nurse-midwife practicing as one of three members of a private nurse-midwifery service in Bethesda, Md. We offer our clients the options of home or hospital births and in doing so we are one of the few nurse-midwifery services in the country with this range of birthing options.

Five years ago Maternity Center Associates incorporated in Maryland to provide nurse-midwifery services to healthy women who wished to deliver their babies at home. Up until the present time, the certified nurse-midwives (CNM's) who own and work at Maternity Center Associates have delivered approximately 700 babies at home. Another 300 have delivered in the hospital with the backup obstetricians who have provided consultation and referral services for the nurse-midwives.

This system of a well organized CNM home birth service in conjunction with excellent medical backup and consultation for women with complications has worked well in the D.C. area. Statistics will soon be published documenting in detail the outcome for the first 1,000 mothers and infants who used this health care system.

A brief review of those statistics are included at the end of the testimony. [Appendix B. See p. 72.]

Sixteen months ago the CNM's of Maternity Center Associates joined with a group of three obstetricians to provide nurse-midwifery care for women who chose to deliver in a hospital. The nurse-

midwives were to provide the bulk of prenatal and postpartum care and the obstetricians would see the women twice during the pregnancy. The midwives and obstetricians would both be in the hospital during the delivery. The CNM would attend those births that were normal, the obstetrician would attend the women who developed complications. The obstetricians proposed this plan at the Washington Hospital Center and after two rejections, the proposal was granted a 1 year's trial by the department of obstetrics and gynecology. This decision was then approved by the medical board and the board of trustees at the hospital. After a year the program was to be evaluated and a vote taken on whether to continue it on a permanent basis.

After a year's time approximately 35 mothers and babies have delivered at the hospital through this pilot program. Another 28 women in the home birth service who developed complications also delivered at the hospital using the CNM/OB team and another obstetrician who had always backed up the home births. Needless to say, the planned hospital deliveries went very well. There were, of course, no maternal or infant deaths. Complications that did develop were successfully managed by the CNM/OB team approach. Yet at a year's end the department of OB/GYN voted to discontinue the program.

The stated reason was that the midwives continued to do home births, that home births were unsafe and therefore the midwives would no longer be allowed to attend deliveries in the hospital. I would like to note here, however, that approximately one-third of the member of the department are in favor of the nurse-midwifery program and continue to give us their support and encouragement.

Throughout the negotiations for the setting up the program and the later meetings which led to the negative departmental vote, the CNM's were never invited to attend any meetings where the program was being discussed. We were allowed, after making repeated requests, 5 minutes to present our side of the issue before a vote was taken. However, most meetings were never open to the nurse-midwives.

Neither has the hospital ever officially communicated the department's vote to our group. So we continue to attend births, as we have in the past, at the Washington Hospital Center. Our backup physicians continue to strongly support the program. Our colleagues in nursing and medicine and our clients have written numerous letters to the hospital's medical board and the board of trustees in support of our service.

The Corporation Council of Washington, D.C., contacted the hospital and our attorney and expressed concern and interest in the outcome of our case. Our attorney has spoken and written to various committees, boards and individuals of the hospital summarizing our position and more positive resolutions to our program.

Consequently, a new committee has been formed to review the charts of the nurse-midwives for the past year so that objective data can be compiled and considered before further action is taken. Of course, no nurse-midwives are on this committee nor any representatives from nursing or pediatrics, only obstetrics. So how truly objective this committee is remains to be seen.

There is good support for the nurse-midwifery program from hospital administration, nursing, and pediatrics. Our obstetrician backups have been totally supportive of our care and I marvel at the number of meetings, negotiations and general trouble they are willing to go to in order to see the program continue.

I also do believe that we will be allowed to continue at the hospital if our charts are objectively reviewed. Women should not have to deliver at home in order to receive care by a certified nurse-midwife. Hospitals, birth centers, or homes, nurse-midwives and obstetricians should all be available to families. Safe, personalized and economical health care should be the goal and can be readily attained when nurse-midwives are incorporated into health care systems.

[Testimony resumes on p. 72.]

[Attachments to Ms. McCartney's prepared statement follow:]

MATERNITY CENTER ASSOCIATES, LTD.
 5415 Cedar Lane
 Suite 107-B
 Bethesda, Maryland 20014
 (301) 530-3300

JANET L. EPSTEIN, R. N., C. N. M.
 MARION MCCARTNEY, R. N., C. N. M.
 JAMES C. BREW, JR., M. D.
 L. J. DEVDCHT, M. D.

A HOME BIRTH SERVICE THAT WORKS

by

Janet E. Epstein, C.N.M., M.S.M. and Marion McCartney, C.N.M., B.S.N.

In October 1975, Maternity Center Associates, Ltd., became the nation's first incorporated nurse-midwifery service. Chartered under Maryland law, Maternity Center Associates, in Bethesda, is designed to provide primary health care to childbearing women, particularly to women who desire to give birth in their own home. The two of us, both certified nurse-midwives, practice under the general direction of two board-certified obstetricians, are partners in the corporation, and jointly administer the service. Our Advisory Committee is composed of an obstetrician, a pediatrician, a psychiatrist, and another certified nurse-midwife. This Committee meets regularly to provide general advice and to participate in quality assessment activities.

We are registered nurses in the State of Maryland, and over the past several years we served as obstetrical nurses assisting two local obstetricians with home births. The day inevitably came when we "caught" a baby because the physician was unable to come to the home. It was an exhilarating experience for us. After a few such "catches," we decided to attend Georgetown University for the one-year midwifery course. Subsequently, we became certified by the American College of Nurse-Midwives.

The physicians with whom we worked agreed with us that the best way to satisfy the constantly increasing requests for home birth was for us to attend the home births as nurse-midwives. Nurse-midwives are generally concerned with "normal" women and in order to deliver at home, the mother-to-be would have to be normal. This would free the doctors to practice their specialties, particularly women who were high risks or who had complications of pregnancy. These physicians would also act as consultants to our service in case we had problems we wanted to discuss. So far, our experience shows this approach to obstetrics to be a practical and satisfying use of each professional's skills. Furthermore, it helps to fulfill a largely unmet need among expectant mothers. Since the medical profession has chosen to virtually ignore the public's desire for home births, we feel nurse-midwifery services can and should fill this void. The reception of MCA thus far leads us to think that similar organizations hold promise for other areas of the country.

Maternity Center Associates is a medically directed nurse-midwifery service, complying with the rules and regulations of the three jurisdictions in which we practice--Maryland, Virginia and the District of Columbia. Having our own organization affords us a sense of independence in caring for and assisting healthy women and their families. We believe that support and maintenance of optimum health is the unique function of nurses, and this is precisely our goal within the framework of our service.

The philosophy of the Maternity Center Associates is basically very broad. We believe that childbirth should be a positive experience and that expectant parents are committed to doing what they think best for themselves and for their coming child. As professionals we adapt our assistance to

what our clients want, rather than attempt to convert them to prevailing medical philosophy. We believe that expectant parents have a right to give birth comfortably, capably and safely. Furthermore, we believe that a positive childbearing experience contributes to the development of a healthy family unit. Expectant parents have the right and the responsibility to be involved in their own health care. Finally, we believe that cultural beliefs of the expectant parents should be recognized and respected.

In meeting the needs of our clients, we provide comprehensive primary health care to childbearing women, including delivery at home for those who qualify as normal. Routine gynecological services and family planning are also available. There is a strong emphasis throughout on emotional and physical support and health education.

Clients of our home birth service are given all of their primary care by nurse-midwives. Consultation with and/or referral to the Association's physician-consultants or other medical specialists are obtained as required. Obstetrical clients are routinely seen in the office at a frequency of one visit a month up to 28 weeks' gestation, two visits a month up to 36 weeks', and then four visits a month up to term. Interpartum services are provided at home if the client meets the selection standard, or in the hospital. In the hospital, care is provided by the nurse-midwives and the physician staff.

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in preparation for childbirth classes offered in the metropolitan area. Postpartum clients are invited to attend a series of three group discussions centered on new family relationships. These groups are conducted by a psychiatric nurse practitioner who is employed by our service. Our clients are also advised of community resources for new parents.

The home birth clients are carefully selected according to specific criteria. These have been established not only for initial acceptance, but also for the entire prenatal period and for the labor. If any criterion is not met, the client will not be accepted for home delivery; instead appropriate alternatives and/or interventions are suggested. In this case, one of the consulting obstetricians is available to assume direct care of her. In most instances, the physician and the nurse-midwife jointly manage the client's pregnancy and delivery in the hospital.

Potential home birth clients must be initially self-selected. They must expressly request home birth and must give evidence of sufficient commitment. Alternatives to a home birth are discussed with clients and information regarding the nature of obstetrical services in local hospitals, including "in-and-out" deliveries, is provided.

Clients must also meet several non-medical qualifications in order to be accepted for a home birth. These include living within a certain distance of a hospital, agreeing to the transfer of self and/or the infant to a hospital if determined necessary by the attending nurse-midwife or the consulting physician, locating a pediatrician who will agree to see the newborn within 24 hours, attending preparation for childbirth classes or receiving private instruction, and, finally, agreeing to gather necessary supplies and make required preparations at home.

The history and laboratory results of a client requesting home birth must be within normal limits. Normal limits is defined as no evidence of any of the following: hypertension, epilepsy, active syphilis, active tuberculosis, Rh-negative blood with positive antibody titers, severe anemia, diabetes, severe psychiatric disease, heart disease, multiple gestation such as twins, kidney disease, pre-eclampsia, abnormal vaginal bleeding, unusual or abnormal presentations or lie, and previous C-section. Additionally, clients must be no younger than 15, nor older than 42, and have had a limit of five pregnancies. Clients accepted for home birth must appear emotionally mature and stable. Every client is evaluated clinically (and by X-ray if necessary) to rule out cephalopelvic disproportion. Clients accepted for home birth must have a completely normal, antepartum course. This means no evidence of the following: abnormal bleeding, pre-eclampsia, congenital abnormalities, inappropriate gestational size, multiple gestation, or unusual presentation or lie. Labor must begin within 24 hours of rupture of membranes. The fetal head must be engaged in the primigravida. The fetus must be in a vertex position, and there must be no sign of infection. Any of these abnormalities requires that the client deliver in the hospital rather than in the home.

The nurse-midwife tries to make a home visit approximately two weeks before the delivery date. At this time the arrangements made by the client and the physical environment can be assessed, and the expected course of the home confinement can be discussed in the surroundings where it will occur.

Upon learning that the client is in labor, the nurse-midwife notifies the obstetrician on call and proceeds to the home to attend the labor and delivery. After the baby is born, the nurse-midwife consults with the pediatrician chosen by the client.

During the labor, we encourage the client and her family to feel relaxed and in control. The mother eats or drinks as she desires. We see no need to restrict her diet unless she herself elects to do so. She is encouraged to move about, use the bathroom frequently, and assume any position that is comfortable for her. The father of the baby, whenever possible, is the coach. He usually directs the rest of the family and is the major support to the mother. We do very little coaching, since the father and mother have been to preparation for childbirth classes. If the father is not present, we ask the mother to choose a support person whom she cares for and who cares for her. As nurse-midwives, we feel our role is that of specialists hired to make sure all is well. We intervene only where appropriate.

No shaving of the perineal area is done. Rarely a small enema may be used if the mother requests it or if the lower bowel contains hard stool. We use no drugs of any sort during labor. If analgesia or labor stimulation is required, we feel this is best accomplished in the hospital. We do use pitocin, ergotrate and methergine, only if necessary after the baby and the placenta are delivered.

The father of the baby is encouraged to assist us during the delivery. He can choose to be as involved as he feels comfortable. We have found that the overwhelming majority of fathers are eager to help deliver their babies and express pride in doing so. Family and friends usually surround the laboring couple and offer unique support. We encourage the couple to have whomever they desire to share this exceptional experience with them.

Episiotomies are done only if necessary, approximately 20 percent of the time. We repair them at home without difficulty.

Abnormal progress of labor can be treated with medical intervention and possible transfer to the hospital. The following situations require such action: elevated blood pressure, fetus in an abnormal position, meconium-stained amniotic fluid, fetal heart irregularities, prolonged labor using criteria established by Emanuel Friedman, excessive bleeding, unengaged vertex in the primigravida, ruptured membranes over 24 hours, or, last but not least, the wishes of the client.

The nurse-midwife stays with the mother and infant until vital signs are normal, the uterus is well contracted, and the baby is nursing well and shows no signs of distress. A minimum of one hour is always desirable. If any of the following should occur, medical consultation is necessary with possible transfer of the mother and/or the baby to the hospital: hemorrhage, retained products of conception, lacerations beyond the second degree, or infant weight of less than 2500 grams (approximately 5.5 pounds), respiratory difficulties, cardiac irregularities, congenital abnormalities, Apgar score less than 7 at 5 minutes, prematurity, dysmaturity and postmaturity as determined by physical assessment.

In the event that the home birth proceeds abnormally or if, in the nurse-midwife's judgment, assistance is required, the nurse-midwife has the appropriate resources available. In every home birth instance, the obstetrician on call is notified of the onset of labor and is available for telephone and/or on-site consultation. The pediatrician chosen by the client is also available for consultation if a problem develops with the infant.

If the mother or the baby requires hospitalization, the obstetrician or pediatrician admits the client to the hospital. The physicians who are consultants to the service have privileges at many of the major hospitals in

the area. If the situation that requires hospitalization is of an emergency nature and does not allow time for transfer to a hospital in which the consultant is located, then the client is transferred to the nearest hospital. Since adequate accessibility to a hospital is a prerequisite to a home birth, this situation is unlikely to occur. In an emergency, the client is transported by rescue squad, private ambulance, or car. The nurse-midwife always accompanies the client to the hospital.

After successful delivery at home, the nurse midwife completes and signs the birth certificate and gives postpartum instructions to the client. Later, postpartum visits to the family are made to evaluate the condition of mother and baby. The mother is then seen at our office at two weeks and at six weeks postpartum.

Prior to the establishment of our nurse-midwifery service, here in the Washington area there were women who would assist other women to deliver at home because there was no medical assistance available. We have found that these helping women are now willing to join us as birth assistants for the clients who come to us. Recently this has led us to initiate a program for teaching these birth assistants how to draw up various medications in a syringe, listen to fetal heart tones, suction and resuscitate the newborn, and palpate and massage the fundus of the uterus. These trained women have become very valuable aides to us in a delivery. Consequently, we have made it a policy to ask one of these women to join us for every birth. The client has the choice of requesting the one she wants or going along with the birth assistant on call when her labor occurs. We use a system of rotation so that each birth assistant can assist in a home birth. They are encouraged to charge a small fee for their help.

Our home birth service is very active now. Presently we do an average of 15 births a month. So far we are very happy with our results. Client satisfaction seems to be high as reflected by positive feedback. We encourage these women to review their own charts and express their needs to us. This enables us to stay abreast of what kinds of birth they would like to have. We feel it is vital that clients be responsible for their own health care and contribute as much as they can to their own health maintenance. The service is proving to be a tremendous satisfaction and joy to us as nurse-midwives.

There is a clear demand for home birth services in the Washington, D. C. area. Despite some changes in the obstetrical care in some of the area's hospitals, this demand is unquestionably growing. It is difficult to obtain accurate data on home births because the majority of the medical community has chosen to turn its back on these women. They are not interested in collecting data because they disapprove of home births. According to the combined information of two obstetricians and several nurse-midwives who currently provide home birth services, approximately 150 women had their babies at home in 1974. This number is probably on the low side. The recent emergence of an active group called H.O.M.E. (Home Oriented Maternity Experience), which encourages home births, attests to this growing consumer interest.

A review of the literature reveals a complete lack of carefully designed evaluations of home births conducted under controlled conditions by qualified health professionals. The combination of a vocal and growing consumer interest in this area, combined with a need for facts, prompted us to design a study as an integral part of our home birth service.

Specifically, our research will describe and evaluate home births as assisted by certified nurse-midwives under medical direction and carefully selected and controlled conditions. We hope to characterize the women seeking home births and to determine the effectiveness of the criteria by which we accept home birth clients. Furthermore, we want to document the pregnancy outcome of these clients and describe the extent and nature of any complications. Lastly, we want to determine the clients' satisfaction with their home birth experience, whether it turned out to be what they expected, and what site they would choose for their next birth.

Nowhere are women more aware of and less patient with the "system" as in the field of their own reproductive functioning. Disenchantment with available services is demonstrated by the women's clinics which have grown up in urban, and now suburban, areas, most ostensibly to provide gynecologic and contraceptive assistance. But perhaps a more dramatic response seen in maternity care is the return of the home birth, professionally assisted or not. This return is most prevalent on the West Coast; however, it is increasingly more common on the East Coast and is widely documented in the media.

In the Washington, D. C. area and in many other communities around the country, a significant number of expectant parents each year are seeking alternatives to hospital deliveries. Many of these parents want a child-birth experience that is safe but also family-centered and, more important, personally meaningful. We see a maternity home as another excellent alternative by providing technical facilities of the hospital with a very flexible homelike atmosphere.

Although changes are occurring in hospital obstetrics, they are not taking place fast enough for most of these couples. Because these couples believe they cannot achieve the experience they want in the hospital, many of them look to birth at home as their only alternative. We at Maternity Center Associates feel we are successfully and safely meeting these needs.

MATERNITY CENTER ASSOCIATES, LTD.
 5415 CEDAR LANE
 SUITE 107-B
 BETHESDA, MARYLAND 20014
 (301) 530-3300

JANET L. EPSTEIN, C. N. M.
 MARION MCCARTNEY, C. N. M.
 BARBARA C. VAUGHAN, C. N. M.
 JAMES D. BREW, JR., M. D.
 L. J. DEVOCHT, M. D.

Home Birth Statistics

1,000 babies born - 70% at home, 30% hospital. Over 90% of transfers to hospital delivery are made in labor.

Maternal Mortality - 0/1000 births

Neonatal Mortality - 5 (over 1,000 grams (approximately 28 weeks)/ 1,000 babies)

1. Two prematures born 30 weeks gestation (one complicated by a abruptio placenta - mother was heavy smoker)
2. One anencephalic stillborn who died during labor
3. One fetal death in utero at 36 weeks
4. One breech delivery born precipitously at home before nurse midwife arrived at house

Cesarean rate (primary) 7%

Forcep Deliveries 6%

Home - 96% of babies delivered at home had Apgars greater than 7 at 1 minute
 99.4% greater than 7 at 5 minutes

Hospital - 86.8% Apgars greater than 7 at 1 minute

92.9% Apgars greater than 7 at 5 minutes

Mr. GORE. Thank you very much.

We will now hear from Ruth Lubic with the Maternity Center Association in New York.

TESTIMONY OF RUTH WATSON LUBIC, C.N.M.

Dr. LUBIC. I am Ruth Watson Lubic, a nurse-midwife employed by Maternity Center Association as its general director. In this position, which was first held by Madam Frances Perkins, I am responsible for designing and then implementing programs approved by the MCA board of directors, Mrs. Phyllis R. Farley, president. MCA's programs have had, for the over 60 years of its existence, the goal of improving maternity care and have encompassed many innovative demonstrations—prenatal care and parent education in 1917, the first U.S. educational program in nurse-midwifery in 1931—I hope you can keep in mind the number of years; it was 40 years between initiation and recognition—and prepared childbirth in 1948. Public education and continuing education for professional nurses have been persistent themes throughout.

I have been asked to discuss with you the problems MCA has had in mounting and keeping viable its latest demonstration, the Child-bearing Center (CbC), which has now been operating for over 5 years providing options in care to carefully screened healthy families in an out-of-hospital setting. The rationale, design, and outcomes of our successful project are described in a published report entitled, "Evaluation of an Out-Of-Hospital Maternity Center for Low-Risk Patients," which is appended to this testimony.¹

MCA is attempting to respond to families who wish to avoid in-hospital services which they criticize as being impersonal, pathology oriented, dangerous due to infection and overuse of technology, divisive of family units, and costly. In the years since the CbC opened we have seen some hospitals begin to change and offer options, but for many families only a share in decisionmaking, such as is provided by MCA's professional staff, will allay their suspicions.

I have been asked in addition to discuss the costs of providing care in our unit, the concept of which by now has been replicated almost a hundredfold in some 26 States.

From the time MCA began developing the CbC in 1973, staff were very careful to touch all community, professional and regulatory bases to inform them of the plan for attracting back to the system families engaged in do-it-yourself homebirth. We sought advice and hoped for cooperation, although we anticipated that the obstetrical profession would have concerns.

However, no opposition presented itself until we received the first of two phases of legal permissions from the New York State Health Department in August 1974. Then began a series of redressive activities which have persisted to this day, even though, with personal and financial stress, we have eventually overcome the difficulties in each case.

The formally opposing groups have been:

- District II, American College of Obstetricians and Gynecologists.
- National American College of Obstetricians and Gynecologists.
- State and National American Academy of Pediatrics, particularly the Committees on Fetus and Newborn.

New York State Medical Society.

The chairmen of obstetrics and gynecology in six of New York City's seven medical schools.

The New York City Health Department.

The redressive activities have centered on:

- Preventing reimbursement, both commercial and medicaid.
- Interfering with essential hospital backup.
- Attempting to revoke the CbC's legal establishment at licensure and health planning levels.

Less formal, though at times equally damaging, and more individually acted-out redress have included:

- Resignations from the Medical Advisory Board.
- Harassing families seeking backup from individual obstetricians.
- Discrediting the CbC with nurses.
- Discrediting the CbC with foundations.
- Discrediting the CbC with health insurers.

¹The report referred to is from "Health Policy and Nursing Practice," copyright 1980 by McGraw-Hill, Inc., and may be found in subcommittee files.

Issuing opinion papers against out-of-hospital care.

Using *ad hominem* rumor and gossip—although maybe in this instance it would be better called *ad feminem*.

Falsely alleging maternal, fetal and neonatal mortality.

Making unwarranted demands for data—NYCHD.

Threatening to have the police barricade MCA's doors—NYCHD.

The most protracted of the battles was fought on the field of medicaid reimbursement. For 2½ years we struggled for a provider number, even having to appeal to Federal attorneys for a ruling in our favor. During that time we invited 29 obstetrical departments in New York to submit suggestions for a cooperative venture, offering to move closer to, but not inside the hospital. Although three were interested, no plan came to fruition. In one case a medical center offered us adequate space in a nearby building at an initial cost of \$700,000–\$1,000,000 with an annual maintenance of \$70,000–\$100,000, which of course was not acceptable to us.

In the second, the chairman suddenly withdrew because, he said, we were politicizing the concept. The third medical center was advised by its attorneys against entering the venture with us because of potential lawsuits. The latter reason was also given when our backup canceled its State-required legal agreement with MCA.

Mr. Chairman, I know it is a lonely thing to stand at the edge of the moat which surrounds the medical fortress, to watch the great doors close and hear the rasping sounds of the bolts being shot home. Only a few physicians do not scurry inside to be present for the rollcall in ranks. Therefore, I would be remiss if I failed to express MCA's deep gratitude to the board-certified obstetricians and pediatricians who assist us in providing team care to our families, one at risk of losing her hospital privileges.

The members of our medical advisory board, chaired by Bernard Pisani, M.D.; Andrew Fleck, M.D., associate commissioner for child health in the New York State Health Department; the staff and members of the New York City Health Systems Agency, which has rejected the advice of medical groups to disapprove us; and the New York State Public Health Council, which recognized the obstructive political activity of organized medical groups and provided us with permanent establishment.

In addition, we owe thanks to Blue Cross of Greater New York, particularly Peter Rogatz, M.D., for providing its contract holders with the reimbursement for CbC care in spite of extraordinary pressure not to do so.

Finally, we are grateful to other prestigious physicians such as Philip R. Lee, John R. Hogness, C. Arden Miller, Allan Barnes, Charles U. Lowe and George A. Silver, who believed in peoples' right to options and MCA's right to test the out-of-hospital concept.

About our costs, a fiscal audit for the years 1976-1977 reported in January 1979 by Blue Cross/Blue Shield of Greater New York sets forth the information that charges for Childbearing Center care are 37.6 percent of in-hospital care, barring complications. The audit report also noted that the cost to Blue Cross for families delivered at the center is 66.1 percent of the cost to the plan had the same family gone to a hospital setting, also barring complications. Subject to annual review of our service, Blue Cross has reimbursed to families our full charges—currently \$1,000. Charges

are based upon projected costs at full operation and represent the figure necessary for the CbC to be completely self-supporting.

To insure safety, the CbC was staffed from its opening in late 1975 as though it were in full operation. As a result, the actual costs of full care during 1976, 1977, 1978 and 1979 were \$2,016.46, \$1,795, \$1,213.23 and \$1,046.17 respectively. The first two figures were derived by Blue Cross, the latter two by MCA, based on internal audit for 1978 and 1979. MCA expected that running-in costs would exceed income and has absorbed the deficit.

During 1978, the CbC's 1977 operating deficit was virtually cut in half because of operating refinements and increased utilization by families. Our prediction for self-support, 600 families in the program annually, is expected by Blue Cross and MCA to prove both accurate and achievable in 1980. By the middle of December, we have had 592 families in the program.

It is interesting to compare CbC charges of \$1,000 with medicaid reimbursement for in-hospital normal maternity care, as shown in the attachment. In a representative group of hospitals, medicaid is currently paying from \$1,649.53 to \$2,230.04 for normal maternity care with a total 3-day hospital stay, or approximately \$700 to \$1,200 more than MCA charges. For a total 4-day stay, the surplus over MCA's charges varies from approximately \$1,000 to \$1,750.

As can be seen, the out-of-hospital concept promises the medicaid program marked savings, even at full reimbursement for charges of \$1,000 such as the CbC's—MCA is currently appealing an assigned rate of \$885 for total care.

The care that is provided at the homelike Childbearing Center is oriented toward prevention and toward including families as much as possible as members of the decisionmaking team. To some it appears that because there is not a 3- or 4-day hospital stay, the traditional in-hospital and MCA's out-of-hospital program cannot be considered to be equivalent in quality.

It is MCA's position rather that family presence in a hospital setting does not guarantee contact time with qualified professional staff. At MCA a high quality of care has been achieved through carefully educating families and incorporating them in their care at all phases of the maternity cycle. Care during labor and delivery is constant and individualized. Further, because they are not separated from their infants, CbC parents actually have more contact time with their infants than a traditional hospital stay provides, and all family/infant contact is supervised by nurse-midwifery staff.

A pediatric specialist examines the infant in the presence of the parents before they return home. Traditional hospital-oriented management, whether private or clinic, does not begin to provide such professional contact time.

Further economies have been realized through the utilization of nonhospital space as the setting for the functioning of a professional team consisting of nurse-midwives with obstetrical and pediatric consultation. In short, we coordinate families, personnel, equipment and setting in an appropriate manner for healthy normal childbearing, while having made allowances and arrangements for the safe care of those whose progress becomes complicated.

The extensive indepth educational program which emphasizes nutrition, family relationships and self-help/self-care is included in our charges. The home, to which a family returns in 12 hours following birth, is also utilized as a setting for postpartum care. Two visits are made to families by public health nurses during the first 5 days of the infant's life and two visits are made to the center by families during their postpartum period. Unlimited telephone consultation is available. All of this is included in the comprehensive fee of \$1,000.

For all these reasons, MCA maintains that its care is superior in quality to that provided in the traditional hospital setting for which medicaid is reimbursing. Private care—hospital plus obstetrical fees—for normal childbearing in New York City often approaches \$3,000, and prenatal classes are yet another fee.

We submit that Childbearing Center care is markedly less expensive than traditional hospital care for both families and the health care delivery system, while at the same time providing safe, high quality, personalized maternity care. The roles of nurse-midwives and consumers in designing, implementing and operating the CbC has been one of substance and leadership in face of intense opposition. We trust that our experience will assist the committee in its deliberations.

[Dr. Lubic's chart follows:]

MEDICAID REIMBURSEMENT FOR NORMAL CHILD BIRTH

HOSPITAL	OUT-PATIENT VISIT Prenatal* or Postpartum	PER DIEM IN-HOSPITAL RATE			TOTAL COST TO MEDICAID			TOTAL COST TO MEDICAID		
		Mother	Infant**	Total	10 Out-Patient Visits	3-Day In-Hospital Stay	Total	10 Out-Patient Visits	4-Day In-Hospital Stay	Total
Lenox Hill	\$58.58	\$299.79	\$99.93	\$399.72	\$585.80	\$1199.16	\$1784.96	\$585.80	\$1598.88	\$2184.68
Metropolitan	58.04	346.33	115.44	461.77	580.40	1385.31	1965.71	580.40	1847.08	2427.48
Mt. Sinai	62.14	354.00	118.00	472.00	621.40	1416.00	2037.40	621.40	1888.00	2509.40
St. Luke's	57.74	305.55	101.85	407.40	577.40	1222.20	1799.60	577.40	1629.60	2207.00
Columbia	58.63	328.17	109.39	437.56	586.30	1312.68	1898.98	586.30	1750.24	2336.54
St. Vincent's	55.45	291.98	97.33	389.31	554.50	1167.93	1722.43	554.50	1557.24	2111.74
Roosevelt	57.74	305.55	101.85	407.40	577.40	1222.20	1799.60	577.40	1629.60	2207.00
N.Y. Hospital	57.28	353.21	117.74	470.95	572.80	1412.85	1985.65	572.80	1883.80	2456.60
Beth Israel	56.48	318.56	106.19	424.75	564.80	1274.25	1839.05	564.80	1699.00	2263.80
N.Y. Infirmary	56.48	275.92	91.97	367.89	564.80	1103.67	1668.47	564.80	1471.56	2036.36
N. Central Bronx	68.42	386.46	128.82	515.28	684.20	1545.84	2230.04	684.20	2061.12	2745.32
Bellevue	63.05	276.17	92.06	368.23	630.50	1104.69	1735.19	630.50	1472.92	2103.42
Harlem	58.24	266.78	88.93	355.71	582.40	1067.13	1649.53	582.40	1422.84	2005.24

* - Ten prenatal visits are considered to be optimum. In addition, one postpartum visit is considered.

** - The rate for an infant in the normal nursery is 1/3 the adult per diem rate. The rate for an infant in the neonatal intensive care unit is the same as the adult per diem rate.

SOURCE: State of New York, Office of Health Systems Management, HEALTH FACILITIES MEMORANDUM;

- Series 80-13, Date 2-28-80; Subject: Hospital Inpatient Reimbursement Rates of Payment for the Period January 1, 1980 through December 31, 1980.
- Series 80-38 Hospital Outpatient Reimbursement Rates of Payment April 1, 1980 through March 31, 1981.

Mr. GORE. Thank you very much. We have here four cases of certified nurse-midwives attempting to respond to consumer demand for the services they offer, and in all four cases the established medical community has thrown obstacles in the path of the service and made it extremely difficult for them to practice and to respond to this demand for their services.

In three of the services SERNS have been denied hospital privileges. Let me direct my first question to you, Ms. McCartney. Why do you believe you are denied hospital privileges?

Ms. McCARTNEY. I think that a lot of issues go into why I was denied hospital privileges. The first one is that things take forever to change. I truly believe that is one of the issues. The second, it is truly an economic issue in the Washington area. There are a lot of obstetricians, the birth rate is low and we are seen as economic competitors in the field. It is OK if we want to practice in the home but as soon as we take the middle class woman who wants to deliver in the hospital and get into that economic status, then the dates are closed.

Mr. GORE. There is a low birth rate yet a large number of obstetricians. We see a similar set of figures nationwide. The number of live births per obstetrician has been cut almost in half over the last 15 years. Is that correct? It is almost in half?

Dr. LUBIC. That is correct.

Mr. GORE. That has been caused both by the increase in the number of obstetricians and a decrease in the number of live births.

However, in the area where you practice, in the Washington area, what is the infant mortality rate?

Dr. LUBIC. It is very high in Washington. I am not sure what the figure is. I am hearing between 4 and 16. It is very high.

It is 26.

Mr. GORE. It is extremely high. In the country as a whole, the infant mortality rate ranks 15 among nations. Is that correct? There are a lot of reasons for that and those figures are hard to interpret precisely, the number of children per family, the high rate in innercity areas—there are a number of factors involved. Nevertheless, it is unacceptable for this country to rank 15 in infant mortality. We ought to be able to change that record.

Looking at the microcosm in which you practice, the rate is much higher than the national average. You are anxious to enter into a practice that is associated with improved outcome, particularly among teenage pregnancies if I am not mistaken, and yet you have been denied hospital privileges. It is your personal feeling that you were denied hospital privileges because of the threat that you pose to doctors' pocketbooks. Is that correct?

Ms. McCARTNEY. That is correct.

Mr. GORE. I want to ask a question about the proper role of physicians in a team that includes certified nurse-midwives. This gets to the issue of control and direction. Turning once more to the case in Tennessee, I would like to ask Ms. Sizemore, is it correct that your practice includes an agreement with Dr. Martin which carefully and specifically detailed the circumstances under which you would call for Dr. Martin to become an active member of the team?

Ms. SIZEMORE. That is correct. We had what is called a jointly developed written protocol that outlined parameters of responsibility in patient care.

Mr. GORE. At the time Dr. Martin would be called in as an active part of the team, he was in control of the decisionmaking process relative to the patient at that point. Is that correct?

Ms. SIZEMORE. Yes; that is correct.

Mr. GORE. So Dr. Martin was the director of the team during any periods of time when the particular skills of an obstetrician were required to be present. Is that correct?

Ms. SIZEMORE. Yes; that is absolutely correct.

Mr. GORE. Is it your understanding that that arrangement satisfies the definition of direction by a physician that is spelled out in the American College of Obstetricians & Gynecologists Guidelines?

Ms. SIZEMORE. Yes. It has always been my understanding that these guidelines call for the direction of the medical aspects of patient care but certainly would not be interested in directing the nursing aspects of services I would provide. Would you like an example of that?

Mr. GORE. Yes.

Ms. SIZEMORE. As a nursing professional, it is my area of expertise in patient education. It is my area of expertise in counseling on nutrition, and I think those are things that nurses have historically claimed—also patient support and many other examples of health maintenance.

Mr. GORE. The issue of direction has also become involved in economics and there are obstetricians who interpret direction as requiring that the doctor member of the team always be in control of the economics of the arrangement. Is that correct?

Ms. SIZEMORE. You would have to ask the obstetricians about that. This makes no sense to me at all. I do not see where economics has anything to do with quality patient care.

Mr. GORE. I have other questions but I will withhold them and I will call now on Congresswoman Mikulski.

Ms. MIKULSKI. Thank you very much. Listening to your stories has truly been inspirational in terms of the care you have been providing in the midst of the most blatant form of sexual harassment in its institutional form. It is very clearly indicated that when we talk about the struggle over women's bodies in this country that this really goes to the very heart of it.

As many of you know, I am a pro choice person. I believe a woman should be able to control her own body and decide best how to handle herself and choose whatever medical care she wants. When I say pro choice I mean not only in terms of the right to have an abortion but also to seek whatever health care she wants.

I believe that fundamental in your position here is the opportunity to provide a pro choice option. I believe that the same reactionary forces that move wherever women try to exercise control over ourselves and our life processes are out to work now, only in terms of the individual choice—this is the harassment that goes on in terms of institutional choices. I want you to know just how strongly I feel about the issue. Frankly you are up against the major patriarchal forces in our society. I want you to know that you have a friend.

One of the things that runs through all of this is that as long as you are employees there seems to be very little controversy or lack of acceptance or whatever but as you move to these more independent areas that have been outlined that is it.

Do you think it is based primarily on income? I saw in Sally Tom's testimony, that the median OB/GYN annual salary is \$89,310 and the average certified nurse-midwife makes \$16,200 a year. Has this become an issue—the economics of it.

Dr. MARTIN. I respond to the first statement you made. In dealing in your specific instance with those three hospitals the question of their independent practice was never used is the mechanism by which they did not receive access. There was never a concern over employee-employer relationships. That was only raised by the malpractice company. There was no regard for that with our ability or inability to obtain hospital privileges at the three hospitals in Nashville.

Ms. MIKULSKI. If Ms. Sizemore had been your employee and you had applied, do you think the pediatricians would have objected?

Dr. MARTIN. Yes.

Ms. MIKULSKI. Then they are worse sons of guns than I thought they were.

Can I come back to the economics of that, though? Do you feel this is one of the fundamental areas of conflict? When you were in your solo practice what fees did you charge?

Ms. SIZEMORE. When we opened our business in Nashville we set our fees at \$600 for prenatal care, education, labor, delivery and post partum care.

Ms. MIKULSKI. That is the whole package for the 9 months?

Ms. SIZEMORE. Yes; and we would pay Dr. Martin from that package so our families could benefit from his services and not be billed twice for similar services.

Ms. MIKULSKI. What would be the same charge for that delivery package?

Ms. SIZEMORE. In Nashville it would be very similar except for prenatal education. That is not included.

Ms. MIKULSKI. Do you know what that would be?

Ms. SIZEMORE. \$525 to \$675 and then the consumer would pay additionally for the classes.

Ms. MIKULSKI. What about your experience, Ms. Lubic?

Dr. LUBIC. I have been told obstetrical fees in New York City average \$1,500 and I have anecdotal evidence of \$2,500.

Ms. MIKULSKI. Is that for delivery?

Dr. LUBIC. I was just talking about obstetrical fees. The figure that I quoted in my testimony, the \$3,000, represented an average obstetrical fee of \$1,500—

Ms. MIKULSKI. But what does an obstetrical fee cover?

Dr. LUBIC. That includes prenatal visits to the obstetrician's office and his presence to some extent at birth.

The economic issue is important in the sense that one of the ways the child bearing center was attacked was an allegation that birth in our unit actually cost \$5,000. That was in a mailgram that was read into the record of one of the regulatory bodies in New York, signed by the Academy of Pediatrics and the New York State Medical Society. I do not know where they got that figure but it

seems to be important for them to establish the fact we were much more expensive than if they were attended by a private physician or in a hospital, rather than less expensive as our experience showed.

Ms. MCCARTNEY. When we started doing deliveries in the hospitals we were technically employed by the physicians in the hospitals because it was felt by them that was the best way for us to get into the hospital.

Still the departmental vote came out against renewing our privileges. However, we continue to do births at that particular hospital. No definite action has been taken. They are reconsidering that vote. At GW the midwives employed by Group Health are having their practice setting reorganized. It seems the resident staff that used to practice at another hospital are back at GW and they need more practice so suddenly the midwives are having difficulty doing histories and physicals.

They are employed by the Group Health practice. It is not just independently employed CNM's who are getting the harassment.

Ms. MIKULSKI. What impact do you think acceptance of certified nurse-midwives will have on your practice and those not independently employed?

Ms. MCCARTNEY. I think it will help a lot with other third party reimbursers consider whom they will reimburse. In the State of Maryland insurance companies must pay for CNM's for their services but in our D.C. area Blue Cross will not pay. It will not have an effect on my practice which is a middle class practice where we do not see a lot of people on medicaid.

Ms. SIZEMORE. I think it will be very helpful because it will encourage other private insurers, because you will gather experience with nurse-midwife reimbursement and then everyone will look at that. Also, I think it will encourage more nurse-midwives to enter practice and they will become more valuable to physician and hospital employers because of their ability to be reimbursed for services that they provide. Hopefully, it will extend midwives practice into areas that are underserved, and I don't count under served being just rural, but all areas where women are having trouble finding childbirth services that are compatible with their own beliefs.

Ms. MIKULSKI. Thank you.

Did anyone else wish to comment on that?

Dr. LUBIC. I think you might want to consider the apparent paradox in our having great difficulty getting medicaid reimbursements for the Childbearing Center. That was a major battleground. It was one that was fought before we ever had our first birth. All the reimbursement battles were fought a priori and perhaps our structure has something to do with that in the sense that although our nurse-midwives are employees, they are employees of Maternity Center Association.

I, as a senior administrator, am a nurse-midwife also, so that is maybe something you would want to take into consideration. In New York State, I think it is pretty well acknowledged that medicaid is really much more of a hospital support system than it is a mechanism to provide choices and care to low-income families. In other words, reimbursement for an individual obstetrician in New

York State is low enough that it is really uneconomic for him to see medicaid families.

Why the battle was so intense on the medicaid level with our service, I am not entirely sure, but I would hope that you would take that into consideration in thinking through what the problems have been to establish nurse-midwifery practices no matter—where they are, and that is in terms of—what setting they are in.

It may be that the medical establishment in New York, which is dependent on medicaid reimbursement to support the hospital system, saw us as a threat. I am not sure why the battle.

Ms. MIKULSKI. I think the battle centers around—this is one of the first steps to provide medicaid reimbursement with health professionals other than physicians. The resistance has been that this is a foot in the door for what could then lead to other direct reimbursement for nurse anesthetists, new practitioners, and so on.

As you know, we focused on the legislation, the fact we said pregnancy was a natural process and we made a very clear distinction between the delivery of health care and the delivery of medical care, saying only a physician can deliver medical care and is oriented to disease control and management, pregnancy being a different one. However, the resistance has been that this really breaks very new ground and that is—

Ms. SIZEMORE. I think there is no question that the legislation will be helpful. It will set a very good precedent and help open up a lot of services for the residents of this country. We are very grateful. I am very grateful to you for your work on reimbursement.

Ms. MIKULSKI. I have no other questions. I would like to again thank you for the extraordinary work that you are doing and, Dr. Martin and all of you, I hope that the next Christmas and New Year is certainly a happier one, and that is, there is finally room at the inn.

Ms. SIZEMORE. Thank you.

Mr. GORE. I have some more questions.

Congresswoman Mikulski mentioned her support for your profession and mentioned her pro-choice views and some of the connections between the two issues. Let me assure you that many of us who have voted the other way on many of those questions also see a great reason for supporting your profession because consumers ought to have the right to choose.

I want to also express a personal view that I have with regard to family bonding and bonding between mothers and children and fathers and children and the family itself as a unit around the birth experience. I think that is very important. I am not so rash as to say that the divorce rate in the United States, the rate at which families break up, is related to the manner of childbirth in this country. I have an open mind. I am prepared to have someone present evidence to that effect, but that is not my point.

I do believe, however, looking at it from the other side, that those consumers who wish an alternative form of childbirth have some pretty good reasons for wanting it, and one of them is family bonding. I am wondering how important you all think that is?

Ms. Sizemore.

Ms. SIZEMORE. I think the work that has been done on the meaning of the attachment period after birth is very significant. It is our professional responsibility to encourage family centered care.

One of the things many clients claim is the difference between the care that nurse-midwives provide and that physicians provide is that we encourage participation of all family members. We view it as healthy and advancing good relationships right from the beginning. This is something Dr. Martin has been very much an advocate of in Tennessee and he has been instrumental in seeing to it that these liberal policies were established at Hendersonville Hospital.

Mr. GORE. Dr. Martin, do you want to respond to that?

Dr. MARTIN. I concur that the studies that have been done seemed to be very favorable to the fact that it is important in terms of possible later child abuse. Some of the studies related to child abuse were the bonding has not occurred, where there is an incidence of children that spend a long time in the neonatal intensive care units after premature births and then go home and have greatly increased rates of child abuse.

So I do think the bonding is important. I think it is important to try to incorporate more newer studies that might suggest that siblings as well as the mother and the father of the new baby be allowed to, if the family so desires, to be there to help with the bonding and decrease sibling rivalry and other areas.

Mr. GORE. Well, my wife—who is here—and I, were fortunate to share in the experience of the birth of our three children, and it made a great difference to us and has made a great difference to us as a family. I do think that is important. I don't want to overemphasize it, as I say, but I would like to give the other participants the opportunity to comment if they wish.

Dr. LUBIC. I think, in opening our units, what we did was take the complaints and the desires of families and build the services from there rather than taking the hospital and cutting out items that people said they didn't like. We started with the home and added to it things we thought families were seeking in home birth because we were trying to bring in a group of people out of an unsafe, do-it-yourself home situation. So we felt that it was very important for us as professionals to respond to this group of families, and we built the services they wanted.

I agree that studies are looking well, but I regret the fact that we had to wait for studies to come along in order to hand a baby to its mother. It doesn't take any great deal of science to see that a mother reaches for her baby when you put her baby in her arms and yet when I was nursing in hospitals, I saw this happen where mothers were not permitted to touch their babies. It just seems to me there must be an interface between some humanity and science that doesn't always have to wait for everything to be produced in strict scientific detail.

I am happy that Drs. Klaus and Kennell decided there was a species-specific behavior, but I think Representative Gore, you probably recognized that all on your own, without having to read a book.

Mr. GORE. Well, there is a great irony in the philosophy of medicine that as we have seen, these miracles produced by the

American medical community, saving the lives of individuals of all ages, formerly doomed to untimely death. Yet the infant mortality rate continues to be 15 among nations and the element of caring and personal attention which should accompany childbirth is all too often missing in the assemblyline specialized approach that somehow misses a key ingredient.

Did the other two witnesses want to respond to that?

Ms. MORRIS. I think it is not only important for the mother to reach out for her baby but for the father to reach out for the baby and for the entire family to reach out for this baby. In our 4 years of operation we have had siblings at births and families are reporting less sibling rivalry and greater bonding by having the whole family present at the birth.

Ms. MCCARTNEY. I have had a very similar experience. I went last night to a delivery in Reston, Va., at a birth. There was a 4½-year-old daughter and a 73-year-old grandmother—who had been asleep for her own deliveries and was just amazed. Her comment was, "I am 73 years old and I am so amazed at this. The whole process had been cut off from her during her childbearing years and seeing the family together, seeing all the generations together this way, it has got to be the right direction, and yet it is very difficult to institute that kind of thing in a hospital.

Mr. GORE. All right, now we can contrast the nature of the experience for the certified nurse-midwives at the present time with the nature of the experience where the established medical practice prevails. We can compare the risk factors where certified nurse-midwives are present with the risk factors where established obstetrical practice prevails, and we find that at least there is no reason to conclude from any of the studies that there is an increased risk with certified nurse-midwives, but that indeed there may actually be a lower risk for normal parents.

Now, there is one question remaining that I think has to be answered and we are going to get into with the gentleman witnesses as well. What about the case where an unexpected, unanticipated, unpredicted event occurs during the birth? Now, there are such events. The skills of an obstetrician are essential.

Dr. Martin, I would like to ask you first, how do you react to that and are you satisfied that the protocol which you had about Susan Sizemore was sufficient to insure that you would be able to bring your skills in a timely fashion to bear on such an event should it occur when Susan Sizemore contacted you?

Dr. MARTIN. Those are a lot of questions to answer. I am satisfied that in a hospital setting, working in collaborative practice with two certified nurse-midwives that it would not increase the risks. If some unexpected event would occur we would be able to handle it in that setting.

Personally, I would prefer, with the ability to consider the economic considerations, to have a childbirth center intimately in contact with the hospital to be able if in the event a C section was necessary for a cord accident or some rare unexpected event, that we wouldn't compromise the safety of that infant, rare as it may be, because I wouldn't personally be able to look at that couple, even if they were willing initially to accept that risk to have to

deal with that situation. I would prefer that that occur in as close proximity as possible to a hospital.

I might add, though, that if it is necessary to do a C section, for example, and using as an example some hospitals in Nashville, I could do that probably within 5 minutes in an unexpected event—At Vanderbilt. It would take me maybe 30 minutes to do at Hendersonville and maybe at least that long, if not longer, at Southern Hills. So it is not always in a primary care level hospital rather than a tertiary care. In an unexpected event, you can quickly do a C section.

Mr. GORE. But the protocol—let me ask you, were you confident that your skills enable you to recognize the onset of such a complication and provide sufficient time to contact Dr. Martin and sufficient time for him to arrive at a delivery room?

Ms. SIZEMORE. I would even like to argue that the presence of the nurse-midwife with the patient throughout labor provides assurance to the laboring couple that complications will be readily identified and at an early stage. We have the advantage of expert experience and education that helps us identify problems at a very early stage. In most hospitals in the United States we have unattended labors; those not attended by either a nurse-midwife or physician.

Mr. GORE. Say that again.

Ms. SIZEMORE. Most of the labors in the United States of America are attended by nursing professionals who do not have the advantage of additional midwifery education and who are not physicians.

Mr. GORE. So we are not comparing, we are not comparing a case where certified nurse-midwives are present throughout the birth, that is case A. We are not comparing that with a mythical example where an obstetrician is present through most of the labor and watching the progress of the patient. Actually, we are comparing it to a case in the latter instance where the woman in labor is not attended by either a certified nurse-midwife or a doctor, but rather by a nurse who has not, in many cases, received special training in midwifery or obstetrics, but is merely a watch person until the doctor arrives, sometimes in the last 30 minutes, sometimes too late, I guess.

I don't want to put words in your mouth. Go ahead.

Ms. SIZEMORE. I don't want to minimize the competency of the traditional nurses in labor and delivery, but it is my firm belief that the presence of a nurse-midwife who is staying with people throughout their labor, will provide families and others with assurance of safety and quality. This is one thing that can be done to improve the newborn statistics in our country.

I also think that in most hospitals it wouldn't matter if the physician was sitting by the bedside with me, if there was a problem that required a cesarean section intervention, it will take at least half an hour to get the OR team and the anesthetist in there. My physical presence at the bedside identifying the problem earlier is to the patient's benefit.

Also, I would like you to know that with my midwifery education and experience, I am very well prepared to not only identify problems in the early stages, and take proper intervention, which includes contacting the physician, but also to deal with the uncom-

mon life threatening emergency that may occur while awaiting the presence of the physician.

I have never known anyone to show that the presence of a nurse-midwife at a delivery that was maybe complicated with hemorrhage caused a patient harm.

Mr. GORE. Those are important points.

Ms. MORRIS. I wanted to point out the complications just don't occur—that oftentimes there are many red flags that come up that mean that the patient should be in a particular situation transferred to the hospital. We transfer early before real problems occur and get the physician available and in the hospital prior to any life threatening situations occurring.

Also, again in our area, in the three local hospitals immediate C section is not possible, they do not have anesthesia on the premises until the anesthesiologist gets to the hospital and they set up the OR. That is at least 30 to 45 minutes, so that—

Mr. GORE. Wait a minute. If there is a C section you have to wait 30 to 40 minutes in any event for the anesthesiologist?

Ms. MORRIS. That is correct.

Mr. GORE. Why shouldn't we have a requirement that the anesthesiologist be present in the delivery room at all times?

Dr. MARTIN. I think if you would require an anesthesiologist to be at every delivery that is going to greatly increase the cost.

Mr. GORE. Both of you were taking my question much more seriously than it was intended. The point it was intended to make is that if the reason for requiring that an obstetrician be physically present in the delivery room at all times is the small percentage of cases where an immediate C section is required, then it would also make sense to require the constant presence of an anesthesiologist if the same rationale exists.

Maybe I am wrong there. We are going to hear from the American College of Obstetricians & Gynecologists and I am sure he has heard a great deal with which he will express disagreement. They are going to have that opportunity.

Dr. LUBIC. About complications, I want to say I think it has been unfortunate that the practice of nurse-midwifery has had overlaid on it practice that occurs in the hospitals. In other words, nurse-midwives are being judged and the scope of their practice and their ability to practice safely has been judged in terms of what the medical profession knows in the recent decades, which is hospital practice. Things happen in hospitals that would not happen with nurse-midwifery attendants, so I think that is a problem.

But I understand the fear of physicians, who have seen problems in hospitals, that you know can turn to each other and say, boy, aren't we lucky that mother was here. If she had been outside the hospital, she never would have made it. These are all hypothetical situations.

One of the things that MCA is doing is collaborative data collection on some 11 nurse-midwifery operated out-of-hospital centers. I think it takes that kind of data collection and comparison of the data with an in-hospital experience, if that is possible, in order to find out what is safe and what isn't safe.

So a lot of the decisions that have been made about the safety of nurse-midwifery practice have been based on anecdotal experiences

or real fears on the part of the obstetricians. I can understand those fears because when you do see an emergency in the hospital, it is a terrifying thing. But the next step hasn't been taken which is that these are the kinds of experiences you would not see in nurse-midwifery practice because of the screening that goes on. And in the report that I submit in my testimony, there is a copy of the criteria that we use for nurse-midwifery management, and they are very strict criteria.

Mr. GORE. Let me ask you about one such anecdote that has been cited. A subsequent witness is mentioned here—I don't do this in a pointed way—but I want to give you a chance to respond.

Dr. Pearse, the executive director of the American College of Obstetricians & Gynecologists, who is going to be here shortly, or testifying shortly, made a statement that appeared in the Medical World News, to the effect—and I quote—Dr. Pearse rejects the nurse-midwives' claim that they attend only normal non-high-risk patients. He says, "New York City's Maternity Center Association—your institution—the prime example of the freestanding nurse-midwife run centers, transfers up to 27 percent of its patients to a backup hospital through heavy Manhattan traffic during labor or immediately after the birth, and that is after having screened out all of the so-called high risk patients."

Dr. LUBIC. That is a misquotation, I think. I am not sure whether it is the magazines or where it came from. But of the families that came to us in 1979, 27 percent didn't have their babies with us. That is because some of them moved away and some of them were not eligible at first visit. Some of them developed conditions during pregnancy that made them ineligible, such as carrying twins. We would not attempt to handle the birth of twins in our unit.

Actually, of the total number of families with us, 6 percent transferred to the hospital in and around the time of labor, and most of them going in a cab or in their own car. The largest reason for transfer is failure to progress in labor. That is about 12 percent of the families coming into labor, but we have not had an emergency transfer of a mother. I admit that we may, but what we have tried to do, is rather than turn our backs on those families that say I am not going to go to a hospital, to provide them with an option that will safeguard them a lot more than do-it-yourself home birth has done.

I could also point to the experience of an out-of-hospital unit in Texas, called Su Clinica Familiar, where the nearest backup hospital was either 40 minutes or 40 miles away, I am not sure which. Their data have been excellent to this point—and I think the former director is in the room here, Sister Angela Murdaugh. I am sure she would be happy to talk to you about that.

They were dealing with families that were all high risk. So I think in that unit the difference nurse-midwife care can make when you are dealing with Mexican women who come across the border because they want to have their babies in this country, who have multihigh parity, who are poorly nourished, their experience becomes even more meaningful.

I hope we will be able to get some of our statistics in a collaborative way, to report soon. The problem that we have in the out-of-

hospital nurse-midwifery units is that we are all small and we want to be that way, because we try to provide personalized care.

It does take a while to collect the information, but hopefully we will be reporting on that somewhere in the first half of next year so we can get something on the record other than anecdotal information. I recognize the fear and I am very sensitive to it, and I recognize the problems of providing care to high-risk families that perhaps don't seek care as much as they should. It is up to us as professionals to respond to that and not to be victim blaming about it.

Mr. GORE. We are going to have to move on because we still have got several witnesses. Let me talk about the future for just a moment. Envision the year 2000. If you could create an ideal environment for childbirth in this country—Dr. Martin, you said that you would like to see a facility in close proximity to a hospital with the equipment necessary for that tiny fraction of cases that will require additional expertise and equipment, is that correct? That is the ideal situation?

Dr. MARTIN. I think it can occur in a bar. I think that seriously it is just the concept, it is the concern of the people, the nurses, the physicians, all working together to accomplish a common goal for the individual. You can put it all together in a hospital just as well as you could in a birthing center next to the hospital and if the hospitals would cooperate, you could keep the cost down as well.

So it is simply a matter of getting all the groups together willing to cooperate and work out the most safe and reasonable service at a reasonable cost to serve the people. It doesn't have to be necessarily what they are doing at the Maternity Center Association, it could be done in a hospital, one floor of a hospital, if the hospital was willing to cooperate and work in that manner.

Mr. GORE. In constructing an ideal situation, one has to recognize the futility of that task, because it is up to the consumers who choose, they ought to have the right to choose among these alternatives?

Yes?

Dr. LUBIC. I think in designing an ideal system you have to consider those areas that are underserved, very rural areas or very poor urban areas in our cities. There was a followup study done on more than 200 women who did not go to the hospital for prenatal care but appeared on the doorstep of one prenatal care center—Columbia Presbyterian in New York City, part of the Robert Wood Johnson grant.

They went out and interviewed these women asking why didn't they go to the hospital? And why didn't you get prenatal care? Many of the women cited the fact they did not have the money to pay. They are in the gray area between medicaid and the insured, but there were also a number of responses relating to the fact they didn't like hospitals, they didn't see what good it did if you went to have your blood pressure taken and nobody talked to you.

So it is the kind of care that is available and I think that we are going to need to make care available in neighborhoods near to people, because they are not willing to travel long distances and they distrust and dislike the hospital setting. Particularly for the urban poor, I think it is a real knotty problem and something we

are going to have to deal with very vigorously. I think nurse-midwifery services can deal with it.

Mr. GORE. OK. Well, let me thank you all for coming. I appreciate your contribution to this hearing, and particularly to Dr. Martin, we appreciate your willingness to come here today.

Mr. GORE. I think I would like to call now Dr. Arden Miller, professor and chairman, department of maternal and child health, University of North Carolina, and Judith Rooks, expert midwife, Master of Public Health, Expert Consultant, Office of Population Affairs, U.S. Department of Health and Human Services. Stand and raise your hand.

[Witnesses sworn.]

Mr. GORE. Dr. Miller, Ms. Rooks, welcome to both of you. I have enjoyed reading both of your papers, one written by you, Dr. Miller—the speech you gave at the University of Michigan, and the paper that was published which you coauthored, Ms. Rooks, very interesting.

I would like to welcome you to the subcommittee and ask you to proceed with your testimony, beginning with you, Dr. Miller, and could you just start by outlining just briefly your credentials in this area?

TESTIMONY OF C. ARDEN MILLER, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF MATERNAL AND CHILD HEALTH, UNIVERSITY OF NORTH CAROLINA; AND JUDITH ROOKS, C.N.M., M.S., M.P.H., FORMER CONSULTANT, OFFICE OF POPULATION AFFAIRS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. MILLER. Thank you. It is a pleasure to be here. I apologize for not having submitted written testimony in advance. That is not related in any way to a reluctance to put things on the record. I was simply not able to do that.

I am Arden Miller, a pediatrician and professor and chairman of maternal and child health at the University of North Carolina. I have in the past served as the dean of a medical school, as vice chancellor for the Health Sciences in our university and president of the American Public Health Association.

I want to say a word concerning my present responsibilities and role in maternal and child health. It is important to emphasize that that is an academic endeavor which makes no pretense for expertise on how to handle a client or a patient or how to manage a clinical situation. Our interest is program and policy as it relates to health services.

We like to think that we can assess community needs, that we can help design programs, that we know how to administer and evaluate those programs, and how to marshal resources in order to implement them.

The faculty of our department is a mixture of disciplines: pediatricians, obstetricians, sociologists, public health nurses, occasionally midwives.

Our students come from all disciplines as well. They are people who have had experience in clinical services and who are now acquiring some of the policy and programmatic skills that I mentioned.

I would like to begin with my own testimony of interest in midwifery by relating that it goes back a long way to a time when I was a medical student in the late 1940's at Yale. At that time, Yale was much committed on its obstetric services with a program of natural childbirth which attempted to minimize unnecessary medication and intervention procedures.

In order to assist with that, there were nurse-midwives from the Maternity Center Association of New York assigned to the obstetric service to help supervise and teach medical students. It was some of the best teaching I ever had in medical school.

My testimony can be brief for there is little that I can say or had intended to say that others haven't already included in their testimony. What I can best do is insert issues of emphasis.

Mr. GORE. Let me interrupt you at this point to say, without objection, I would like to include in the record the full text of your John Sundwall Memorial lecture to the School of Public Health at the University of Michigan on this subject. [See p. 94.]

Dr. MILLER. Delighted, thank you.

I concur with what had been implicit in much of the testimony: If one looks for reasons why this country is deprived in many areas of the services of midwives, one has to look in the political and economical arenas. The answer is not to be found in terms of health outcomes. All of the studies I know confirm that the health benefits rendered by nurse-midwives stand up to scientific scrutiny exceedingly well.

Mr. GORE. Repeat that. You are an expert, one of the few leading experts in this area, and you just said that all of the studies with which you are familiar support the contention that there is no increased risk associated with certified nurse-midwives? That is a restatement of what you said—

Dr. MILLER. A restatement, but I find that acceptable.

Mr. GORE. Fine.

Dr. MILLER. I think that the risks of nurse-midwives are somewhat different from the risks of other kinds of childbearing settings, but I will get to that later. Certainly no greater difference and no greater—

Mr. GORE. Perhaps less?

Dr. MILLER. Indeed, perhaps less.

Now, in approaching this issue, I find it useful to cite an experience with a study from North Carolina, just published in this week's Journal of the American Medical Association. [See p. 122.]

Mr. GORE. This is a brand new study just published in this week's Journal of the American Medical Association?

Dr. MILLER. That is right, and it is a study that grew out of a class exercise in our department some years ago when we had a group of students who were interested in home deliveries. As a consequence of that, we examined all of the out of hospital deliveries that had occurred in North Carolina over a 3-year period.

If one segregated from that group those home deliveries that had been planned for, and were well supervised in the home, some interesting things were apparent. One is that the neonatal death rate for those deliveries was only 4 per 1,000. That compared with the death rate of inhospital deliveries of about 14 per 1,000.

Now, I don't want that to be misconstrued. I am not advocating necessarily home deliveries. I am certainly not advocating that the deliveries be, as was true under this circumstance, not with nurse-midwives at all, but with lay midwives.

What I think the study confirms is that there is not just one circumstance that is safe for childbearing. There are multiple circumstances and there is room for further enlightenment and further study to identify their risks. I think we demonstrated that with careful selection and careful screening and good planning that the risk of home deliveries with midwives may not be as great as commonly attributed.

The matter of risk is exceedingly important. Each circumstance of childbearing carries its own risks. You have heard about some of them related to childbearing in hospitals.

You mentioned in your opening remarks the escalating heroism of intervention. If labors seem not to be fast and steady, there is a compulsion to give hormones and follow that with monitoring and inductions of various sorts often leading ultimately to cesarean section.

Mr. GORE. What you mean by that, I hate to interrupt you at this point, but this concept is important to what you are saying, the concept of what you referred to as "escalating heroism." That a misdiagnosis or an overreaction to a trial of labor, prolonged or difficult labor, or maybe the use of hormones, which in turn leads to—

Dr. MILLER. Fetal monitoring, which in turn leads to increases in cesarean section rates.

It is important, I think, to emphasize that with many of these interventions the scientific scrutiny to which they have been subjected is in many respects less rigorous than the scrutiny to which the midwifery services are being subjected. One finds that medications, monitoring, many procedures, gain widespread acceptance in hospitals without the validation that people are struggling to provide today in relation to the services of midwives.

A second risk that needs to be identified with hospital deliveries are interventions or surgery of convenience. There is a risk to the mother who happens to go into labor near a weekend that she is more likely to be delivered by cesarean section than the mother who goes into labor early in the week. And there can be no interpretation placed on that except that it is more convenient for the people involved to deliver as quickly and expeditiously as possible.

Mr. GORE. What about during vacation periods or periods immediately prior to vacations?

Dr. MILLER. Traditionally doctors day off? Again, the interventions and inductions—

Mr. GORE. Are you saying that it is not unusual to find cases where labor is artificially induced so that it will be more convenient for the schedule of the doctor?

Dr. MILLER. I think it is more than cases. Epidemiologic data show that all of these procedures are increased just prior to the weekend and at times which are traditionally the doctor's day of vacation.

Mr. GORE. And such a procedure, such a practice, carries with it a risk to the mother and fetus, correct?

Dr. MILLER. Indeed it does, but the extent of our understanding of those risks is not as great as we would like. We know that women delivered by cesarean section have a higher mortality rate than those who are delivered otherwise. We know that 50 percent of them have deep anesthesia, and that in itself has risks. We know that 10 percent of them have blood transfusions and that adds risks.

We know as well from studies reported both from New Haven and from Cleveland that as many as 15 percent of the respiratory distress syndrome of new born babies—a condition associated with premature delivery and low birth rate—is associated with cesarean sections which are done too soon, that is untimely cesarean sections of an elective nature.

Cost has been emphasized and I would add emphasis only to point out in our North Carolina study at least one-quarter of the women who delivered at home did so because they felt that they could not endure the economic burden of a hospital delivery.

Finally there is a risk which has not been emphasized but which needs at least to be mentioned. So far as I know there is no circumstance of delivery and no system that is immune from human error.

Within recent weeks in our own State at a well-known teaching hospital, there was much publicity because of a woman who had faithfully attended every prenatal visit, seeing a different doctor each time, she thought she was in labor and reported to the emergency room. She saw yet a different doctor in training, and was told no, you are not yet in labor. Leaving, she returned later and was told again no, you are not yet in labor. She ultimately gave birth to her baby in the back seat of the automobile.

That is a horror story that is regrettable and is cited only to emphasize that there is no circumstance of delivery that I know that is free of risk; each circumstance has its own kinds of risk.

The issue here is of the kinds of risks that are associated with the deliveries by nurse-midwives. Let me say that I support the contention that a well trained nurse-midwife, even seeing only carefully screened patients, may confront some circumstance requiring the attentions of a physician. It is my impression that the danger signals are abundant for most of these circumstances and that a well trained nurse-midwife would ordinarily have ample time to seek assistance.

Let me conclude only by saying that I subscribe to the view that all women in this country require and deserve safe circumstances of childbearing. We have concentrated a great deal of attention on whether or not those circumstances should be presided over by an obstetrician and/or a midwife. The sad truth is that there are so many circumstances related to childbearing where women are deprived of either of these alternatives. In inner-city areas, one-third of the pregnant poor women appear at emergency rooms in labor without having had prenatal care under any of these alternatives.

I think there is a public responsibility to give assurances that every woman has safe circumstances of childbearing and care before and after delivery. One can't escape the feeling that in solving that problem there may indeed be an exceedingly important role for nurse-midwives.

Beyond that, I would say that insofar as possible, women deserve to be well informed about the different risks of different circumstances of childbearing, and I subscribe to the notion that women deserve the opportunity to make the selection or choice themselves as to which risks they wish to live with.

Thank you.

[Testimony resumes on p. 142.]

[The lecture and study referred to follows:]

THE JOHN SUNDWALL MEMORIAL LECTURE
SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF MICHIGAN
ANN ARBOR, MICHIGAN

WHAT TECHNOLOGY BREEDS
A REVIEW OF RECENT U.S.
EXPERIENCE WITH CAESAREAN SECTION

BY

C. ARDEN MILLER, M.D.
PROFESSOR AND CHAIRMAN
DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF NORTH CAROLINA
CHAPEL HILL, NORTH CAROLINA

WITH THE COLLABORATION OF
BEVERLY A. MOSHER, B.A., M.P.H.
LECTURER, DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF NORTH CAROLINA
CHAPEL HILL, NORTH CAROLINA

MARCH 20, 1978

MANY PLEASURES ATTACH TO DELIVERING THE JOHN SUNDWALL MEMORIAL LECTURE. IT PROVIDES OPPORTUNITY TO HONOR A BELOVED AND ACCOMPLISHED COLLEAGUE IN PUBLIC HEALTH. IT PROVIDES OPPORTUNITY AS WELL TO VISIT ANN ARBOR, STIMULATING CENTER OF LEARNING, OF PUBLIC HEALTH LEADERSHIP, AND OF CLOSE FRIENDS. THANK YOU FOR RENEWING FOR ME THESE HAPPY ASSOCIATIONS.

THE OCCASION PROMPTED ME TO LEARN MORE ABOUT JOHN SUNDWALL AND HIS WORK; THAT TOO IS A PLEASURE. IF I HAD BEEN PRIVILEGED TO KNOW DR. SUNDWALL, AS MANY OF YOU DID, WE WOULD HAVE ENJOYED COMPARING NOTES ON PLACES AND FRIENDS WE SHARED. THEY REACHED WELL BEYOND ANN ARBOR. I SAW DR. SUNDWALL'S TRACKS IN OTHER PLACES LONG BEFORE I KNEW THEY WERE HIS. AS A YOUNG MEDICAL SCHOOL FACULTY MEMBER, I COUNSELED FRESHMAN MEDICAL STUDENTS, SITTING IN THE OFFICES AND LABORATORIES OF HAWORTH HALL AT THE UNIVERSITY OF KANSAS WHERE DR. SUNDWALL HAD TAUGHT ANATOMY AND PATHOLOGY. AT DIFFERENT TIMES WE BOTH SERVED AS ADMINISTRATIVE OFFICERS FOR THE MEDICAL SCHOOL AT THE UNIVERSITY OF KANSAS. I OFTEN ADMIRED THAT UNIVERSITY'S SUPERB STUDENT HEALTH SERVICE, NOT KNOWING THEN THAT IT HAD BEEN DR. SUNDWALL'S CREATION. HE SUCCEEDED IN ESTABLISHING EXCELLENCE WHICH ENDURED. DR. SUNDWALL WOULD BE INTERESTED IN THE AFFAIRS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, WHICH HE SERVED IN A VARIETY OF IMPORTANT WAYS. HE SURELY WOULD FIND PRIDE IN THE KNOWLEDGE THAT THE DISTINGUISHED SCHOOL OF PUBLIC HEALTH WHICH HE FATHERED HAS PROVIDED A RESPECTED DYNASTY OF LEADERSHIP WHICH HAS DONE SO MUCH TO SHAPE THE CHARACTER OF SCHOLARSHIP AND PRACTICE IN THE NATION'S PUBLIC HEALTH EFFORTS.

DR. SUNDWALL'S LONG INTEREST IN STUDENT HEALTH SERVICES SUGGESTS THAT HE HAD WISDOM TO SHARE ON MATTERS OF HUMAN SEXUALITY, FAMILY PLANNING, PREGNANCY AND PARTURITION. THOSE ISSUES HAVE NEVER BEEN ALIEN TO A WELL RUN STUDENT HEALTH SERVICE, ALTHOUGH THEY HAVE ACHIEVED OPEN PROFESSIONAL ATTENTION ONLY IN THE PAST DECADE. CONSISTENT WITH CULTURAL CONSTRAINTS OF THE FIRST HALF OF THIS CENTURY NONE OF DR. SUNDWALL'S PUBLISHED TITLES SUGGEST THAT HE WROTE ABOUT ISSUES OF HUMAN REPRODUCTION. HE WOULD WRITE ABOUT THEM TODAY, FOR THOSE ISSUES ARE HIGH ON THE AGENDA OF CONCERN WHEREVER THERE IS RESPONSIBLE ATTENTION TO THE HEALTH OF YOUNG ADULTS.

THE THEME I ADDRESS TODAY GROWS OUT OF THOSE CONCERNS. IT DEALS WITH HOW BABIES ARE BORN--AND SPECIFICALLY WITH THE ADVANTAGES, RISKS, AND PREDISPOSING CIRCUMSTANCES THAT ASSOCIATES WITH THOSE BIRTHINGS THAT ARE WROUGHT BY THE TECHNOLOGY OF MAJOR SURGERY. ACROSS THE COUNTRY IN 1976, TWELVE PERCENT OF ALL INFANTS WERE BORN BY CAESAREAN SECTION; IN MAJOR MEDICAL CENTERS TWENTY TO TWENTY-FIVE PERCENT WERE DELIVERED BY CAESAREAN SECTION; AND PROFESSIONAL GOSSIP CIRCULATES ABOUT SOME CENTERS WITH A PREDOMINATE MEDICAID CLIENTELE WHERE MORE THAN ONE-THIRD OF ALL BABIES ARE BORN BY CAESAREAN SECTION. DATA ARE NOT AVAILABLE, EXCEPT IN SMALL AREA AND ANECDOTAL FORM, TO DOCUMENT THE RELATIONSHIP BETWEEN MEDICAID PAYMENT AND CAESAREAN SECTIONS, BUT DOROTHY RICE OF THE BUREAU OF VITAL STATISTICS REPORTS THAT SUCH DATA ARE NOW BEING COLLECTED AND WILL BE AVAILABLE FROM 1976 ONWARD.

TRADITIONALISTS REFLECT ON THESE CIRCUMSTANCES FROM MANY VANTAGE POINTS. ONE ASKS SKEPTICALLY IF MEDICAL TECHNOLOGY CAN PERFORM BIOLOGICAL

FUNCTIONS BETTER THAN THE NATURAL PROCESSES THAT HAVE SERVED OVER THE MILLENIA OF HUMAN EVOLUTION. INTO WHAT ARE WE EVOLVING IF A HIGH PROPORTION OF OFFSPRING MUST BE BORN BY SURGICAL INTERVENTIONS? THE QUESTION IS MORE APPROPRIATELY PHRASED IN TERMS THAT ASK HOW TECHNOLOGICAL INTERVENTIONS INTERFERE AND OBSTRUCT NATURAL BIOLOGICAL PHENOMENA.

THESE CONCERNS SHOULD NOT BE CONSTRUED AS A REJECTION OF ALL TECHNOLOGY. IN ONE SENSE, MEASLES, TOO, IS A NATURAL BIOLOGICAL PHENOMENON AND I AM GRATEFUL THAT MEDICAL TECHNOLOGY CAN PREVENT IT. THE THRUST OF OUR CONCERN CANNOT BE A RETURN TO THE SIMPLE UNCOMPLICATED LIFE, FREE OF ALL ARTIFICIAL INTERVENTIONS. HUMAN LIFE IS SO INTERTWINED WITH TECHNOLOGICAL INTERVENTIONS--MEDICAL, AGRICULTURAL, ELECTRONIC--THAT WE DO WELL TO UNDERSTAND THAT WE LIVE IN THE MIDST OF TECHNOLOGICAL REVOLUTION, AND WE MUST STRIVE TO UNDERSTAND ITS ADVANTAGES AS WELL AS ITS ABUSES. CIVILIZED ASPIRATIONS ARE NOT WELL SERVED BY DENIGRATING ALL TECHNOLOGICAL INTERVENTIONS. IF LIFE FOR ROUSSEAU'S SAVAGE WAS EVER SIMPLE AND HAPPY, WE LEFT THAT STATE TOO LONG AGO TO ATTEMPT REGAINING IT. BUT ELIMINATION OF THE THREE MARTINI LUNCH MAY NOT BE SUFFICIENT SIMPLIFICATION FOR THIS SEASON.

CAESAREAN SECTION IS A BOON TO HUMAN REPRODUCTION. IT CLEARLY IS LIFE SAVING FOR SOME WOMEN AND THEIR BABIES, AND IT MAY BE ADVANTAGEOUS FAR MORE FREQUENTLY THAN WAS ONCE PRACTICED. BUT AS WITH OTHER SURGICAL PROCEDURES FOR WHICH INDICATIONS ARE IMPRECISE, LEAVING A BROAD RANGE FOR EXERCISE OF PROFESSIONAL DISCRETION. IT MAY BE A PROCEDURE SUBJECT TO ABUSE, AND THAT PROSPECT REQUIRES CAREFUL ATTENTION.

MY TRADITIONALIST QUESTIONS ARISE FROM THAT CONCERN. NOT MANY YEARS AGO THE CAESAREAN SECTION RATE WAS REGARDED AS A CLUE TO THE

QUALITY OF MEDICAL CARE. AS RECENTLY AS 1965, THE NATIONAL CAESAREAN SECTION RATE WAS 4.5 PERCENT. THOSE HOSPITALS WHICH EXCEEDED THAT RATE WERE SUSPECT FOR EXCESSIVE SURGERY; SPECIAL JUSTIFICATIONS WERE EXPECTED IN TERMS OF AN UNUSUALLY LARGE REFERRAL OF COMPLICATED CASES; SECOND SURGICAL OPINIONS WERE SUGGESTED. IN ONE DECADE IN THE UNITED STATES THE PREVAILING RATE HAS TRIPLED AND ALL IMPLICATION IS LOST THAT LOW RATES ARE ADVANTAGEOUS OR ARE USEFUL AS A CRITERION OF HIGH QUALITY CARE. A REVERSAL OF PROFESSIONAL THINKING HAS OCCURRED. THE BEST MEDICAL CENTERS HAVE THE HIGHEST RATES, AND BOLD OBSTETRIC SUGGESTIONS CAN BE HEARD THAT CAESAREAN SECTIONS ARE NOW SO SAFE FOR BABY AND MOTHER--AND SO CONVENIENT FOR EVERYONE CONCERNED--THAT IT MIGHT WELL BECOME ACCEPTED AS THE DELIVERY OF CHOICE FOR EVERYONE. SOMEHOW A CHAPTER HAS BEEN MISSED. A DRAMATIC CHANGE HAS TAKEN PLACE. WAS IT A GOOD IDEA? WHAT HAS BROUGHT IT ABOUT? WAS THERE A SCHOLARSHIP TO JUSTIFY IT? WHAT ARE THE RATIONALIZATIONS?

THESE QUESTIONS ARE NOT SUFFICIENTLY PRESSING TO PROMPT MY SEARCH OF AN UNFAMILIAR LITERATURE EXCEPT WITH RELATION TO TWO OTHER CIRCUMSTANCES. THE FIRST WAS A NEW FRIENDSHIP WITH RUTH LUBIC AT THE MATERNITY CENTER ASSOCIATION IN NEW YORK CITY; AND THE SECOND WAS A QUESTION POSED BY A GROUP OF STUDENTS IN A SEMINAR CONDUCTED IN OUR SCHOOL OF PUBLIC HEALTH IN THE SUMMER OF 1975.

MYRON WEGMAN INTRODUCED ME TO MS. LUBIC AT A CONFERENCE ON CHINESE MEDICINE AT WINGSPREAD. OUR MUTUAL INTERESTS RANGED WELL BEYOND BAREFOOT DOCTORS, AND WE HAVE MAINTAINED A CLOSE ASSOCIATION EVER SINCE. IN RECENT YEARS, RUTH HAS SHARED WITH ME THE SAGA OF HER CHILD-BEARING CENTER IN NEW YORK CITY. IT IS A LONG AND FASCINATING STORY, AND HERS IN TIME TO TELL IN DETAIL.

THE STORY INVOLVES TWO DELIVERY ROOMS IN A RECONSTRUCTED TOWNHOUSE, PROSPECTIVE MOTHERS ATTEND PRENATAL CLASSES THERE, AND IF JUDGED TO PRESENT NO SPECIAL RISK, THEY MAY HAVE THEIR BABIES THERE, ATTENDED BY MIDWIVES, WITH OBSTETRICIANS ON CALL, AND A HOSPITAL ELEVEN MINUTES AWAY IN THE EVENT OF AN UNANTICIPATED COMPLICATION. A VISIT TO THE CENTER REVEALS A CHEERFUL HOME-LIKE ATMOSPHERE AND ALL THE SUPPORTIVE MEDICAL SERVICES THAT MIGHT BE REQUIRED SHORT OF MAJOR SURGERY. IT IS PRESENTED AS A RESPONSIBLE EFFORT TO DEMONSTRATE AN ALTERNATIVE STYLE OF CHILD BEARING FOR SELECTED WOMEN WHO DESIRE IT. ADVANTAGES, AND RISKS, ASSOCIATE WITH THIS STYLE OF HEALTH CARE AS WITH ANY OTHER; AND DIFFERENT PEOPLE WILL ATTACH DIFFERENT VALUES BOTH TO THE ADVANTAGES AND TO THE RISKS.

THE SPLENETIC PASSION WHICH THE MEDICAL ESTABLISHMENT, AND PARTICULARLY THE OBSTETRIC COMMUNITY OF NEW YORK CITY, ATTACHES TO THE RISKS OF THE MATERNITY ASSOCIATION'S CHILD BEARING CENTER IS SPECTACULAR TO BEHOLD. EFFORTS TO FORCE CLOSURE OF THE CENTER, DEPRIVING IT OF CONSULTATION AND BACKUP SUPPORTIVE SERVICE, HAVE BEEN THWARTED ONLY BY THE MOST HEROIC PERSISTENCE BY MS. LUBIC AND HER BOARD OF DIRECTORS. WHY DOES THIS MOLEHILL OF A DEMONSTRATION PROJECT ATTRACT ALL THE LIGHTNING DESERVING OF AN OLYMPUS? THE ANSWER IS NOT TO BE FOUND IN THE STATEMENT OF OPPOSITION THAT WAS ISSUED BY REGION II OF THE ASSOCIATION OF OBSTETRICIANS AND GYNOCOLOGISTS. IT IS A POMPUS, AUTHORITARIAN DOCUMENT THAT ATTEMPTS TO PROTECT PROFESSIONAL TURF AND FAILS TO DOCUMENT A BASIS IN FACT FOR REJECTING THE ALTERNATIVE WHICH MS. LUBIC ADVOCATES. THE STRENGTH

OF PROFESSIONAL OUTCRY AGAINST ALTERNATIVE DELIVERY SYSTEMS INVITES CLOSE SCRUTINY OF THE FOUNDATIONS FOR THAT STRENGTH.

THE QUESTION THE STUDENTS ASKED WAS A RELATED ONE. THEY HAD BECOME AWARE OF GROWING INTEREST IN HOME DELIVERIES AMONG SOME OF THEIR FRIENDS WHO REJECTED THE LOSS OF CONTROL OVER THEIR OWN LIVES THAT WAS REPRESENTED BY CURRENT HOSPITAL BASED MATERNITY CARE. HARD DATA ON THE POSSIBLE HAZARDS OF HOME DELIVERIES WERE NOT READILY AVAILABLE. THE STUDENTS DETERMINED TO GATHER SOME OF THEIR OWN. THEY FOUND THAT IN 1975 THERE WERE 425 HOME DELIVERIES IN NORTH CAROLINA. ONLY ABOUT FIFTEEN PERCENT OF THEM COULD BE CONSTRUED AS DELIBERATE DECISIONS BY INFORMED PEOPLE WHO WERE SEEKING A DEGREE OF SELF FULFILLMENT BY PLANNING THEIR OWN WELL SUPERVISED CHILDBIRTH IN FAMILIAR HOME SURROUNDINGS. ABOUT 85 PERCENT OF HOME DELIVERIES WERE TO UNEDUCATED, POOR BLACK WOMEN WHO WERE ATTENDED AT HOME BY UNTRAINED MIDWIVES AND WHO SHOWED EVERY EVIDENCE OF HAVING BEEN EXCLUDED FROM CONVENTIONAL INTRAPARTUM CARE BECAUSE OF INABILITY TO ASSURE PAYMENT OF HOSPITAL BILLS. CASES ARE ON RECORD IN OUR PART OF THE COUNTRY WHERE HOSPITALS HAVE TURNED AWAY WOMEN IN LABOR. ABOUT 125 OF THE HOME DELIVERIES IN NORTH CAROLINA IN 1975 OCCURRED IN ONE RURAL COUNTY WHERE THE HOSPITAL SUFFERS THE REPUTATION OF REFUSING ADMISSION TO ANYONE WHO CANNOT ASSURE PAYMENT OF BILLS.

THESE CIRCUMSTANCES CAME TO LIGHT AT A TIME WHEN FUNDS WERE BEING ALLOCATED FOR THE STATE'S PROGRAM OF REGIONALIZED PERINATAL CARE. ALLOCATIONS WERE MADE PREDOMINATELY TO THE MAJOR MEDICAL CENTERS OF THE STATE IN ORDER TO EXPAND NEWBORN INTENSIVE CARE UNITS AND TO ADD

SPECIALIZED STAFF MEMBERS AT THESE CENTERS. ELABORATE TECHNOLOGY WHICH ATTRACTS SUPPORT IN THE FACE OF BLATANT NEGLECT OF SIMPLER SERVICES INVITES REVIEW FOR EFFECTIVENESS. THIS REVIEW FOCUSES ON RECENT EXPERIENCE WITH CAESAREAN SECTIONS. THE LITERATURE IS SURPRISINGLY SPARSE. ONE OF THE BEST AND MOST COMPLETE REPORTS, INCIDENTALY, WAS ISSUED FROM ANN ARBOR'S COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES, REPORTING ON CAESAREAN SECTION IN U.S. PROFESSIONAL ACTIVITY STUDY HOSPITALS, 1967-1974.

IN PRESENTING THIS PAPER, I WISH TO ACKNOWLEDGE THAT SOURCE, AND TO EXPRESS APPRECIATION FOR THE COLLABORATION OF BEVERLY MOSHER, LECTURER IN MATERNAL AND CHILD HEALTH AT THE UNIVERSITY OF NORTH CAROLINA. MY INITIAL REVIEW HAD FAILED TO IDENTIFY A SCIENTIFIC SCHOLARSHIP THAT JUSTIFIED DRAMATIC INCREASE IN CAESAREAN SECTION RATES. AN EMPHASIS ON ECONOMIC INCENTIVES EMERGED. I BELIEVE THIS PERSPECTIVE HAS VALIDITY, BUT IT PROBABLY SHOULD NOT STAND ALONE. MS. MOSHER ADDS INTERPRETATIONS THAT FOCUS ON THE POLITICS OF A MALE DOMINATED SERVICE FOR WOMEN AT A TIME OF HEIGHTENED FEMALE ASSERTIVENESS. IT IS A PERSPECTIVE WITH WHICH I AM NOT ENTIRELY COMFORTABLE, NOT ONLY FOR PERSONAL BUT FOR SCIENTIFIC REASONS. BUT MEDICAL TECHNOLOGIES IN OUR COUNTRY CLEARLY DO NOT EXPAND AND CONTRACT ACCORDING TO THE USUAL RULES OF SCIENTIFIC EVIDENCE. RESPONSIBLE AND CREATIVE ANALYSIS ARE REQUIRED TO UNDERSTAND CHANGES IN TECHNOLOGICAL FASHION, AND ON THESE SCORES, MS. MOSHER'S VIEWS DESERVE THOUGHTFUL CONSIDERATION. SOCIO-CULTURAL FORCES AS WELL AS ECONOMIC ONES, MAY BE CHANGING INTRAPARTUM CARE IN WAYS THAT SCIENCE ALONE CANNOT EXPLAIN. IN CREDITING MS. MOSHER

FOR MANY PERSPECTIVES IN THIS PAPER, I WISH NOT TO DISASSOCIATE MYSELF FROM THEM. IT IS A COLLABORATION.

ATTENTION HAS FOCUSED ON THE RELATIONSHIP BETWEEN THE NUMBER OF SURGEONS AND THE AMOUNT OF SURGERY THAT IS PERFORMED. WELL KNOWN COMPARISONS BETWEEN THE UNITED STATES AND ENGLAND "...FOUND THAT THERE WERE TWICE AS MANY SURGEONS PER CAPITA IN THIS COUNTRY AND TWICE AS MUCH SURGERY BEING PERFORMED HERE. SOME PROCEDURES, PARTICULARLY THOSE FOR WHICH INDICATIONS ARE FREQUENTLY IN DOUBT, WERE FOUND TO BE THREE OR FOUR TIMES AS PREVALENT HERE." THE MEANING OF THESE RELATIONSHIPS IS NOT ESTABLISHED. ASSUMPTIONS THAT HIGH ELECTIVE SURGICAL RATES IMPLY LOW STANDARDS OF PRACTICE DO NOT GO UNCHALLENGED. SOME CIRCUMSTANCES THAT ARE ASSOCIATED WITH A REDUCTION IN THE AMOUNT OF SURGERY SUGGEST BUT DO NOT PROVE THAT AN ECONOMIC INCENTIVE WORKS TO FAVOR THE PERFORMANCE OF SURGERY. THE AMOUNT OF SURGERY IS REDUCED UNDER FIXED SUM PREPAYMENT FOR MEDICAL CARE. CONSULTATION THAT PROVIDES A SECOND SURGICAL OPINION ALSO REDUCES THE AMOUNT OF SURGERY. RECENT REPORTS FROM BLUE CROSS/BLUE SHIELD SUGGEST A TWENTY-FIVE PERCENT REDUCTION IN SURGERY WHERE A SECOND SURGEON'S OPINION IS REQUIRED.

CAESAREAN SECTION IS A FORM OF SURGERY THAT INVITES CONSIDERATION IN THIS CONTEXT. DURING THE PERIOD WHEN CAESAREAN SECTION RATES IN THIS COUNTRY INCREASED BY 92 PERCENT, THE NUMBER OF LIVE BIRTHS FOR EACH OBSTETRICIAN FELL BY NEARLY HALF. A STUDY OF MORE THAN TWO MILLION DELIVERIES IN 204 HOSPITALS BETWEEN 1967 AND 1974 REVEALED A 92.2% INCREASE IN THE RATE OF CAESAREAN SECTIONS (TABLE 1). THE INCREASE PERTAINED TO ALL PARTS OF THE COUNTRY AND TO HOSPITALS OF

ALL SIZES. THE RATES WERE GREATER FOR LARGE HOSPITALS THAN FOR SMALL ONES (10.4% AND 6.7%, RESPECTIVELY IN 1974), BUT SMALL HOSPITALS (FEWER THAN 5,000 ANNUAL DISCHARGES) ACHIEVED BY 1974 AN AGGREGATE CAESAREAN SECTION RATE THAT EXCEEDED THE AGGREGATE RATE FOR TEACHING HOSPITALS ONLY EIGHT YEARS EARLIER (5.7% IN 1967). HIGH CAESAREAN SECTION RATES ARE CLEARLY NOT SIMPLY A REFERRAL PHENOMENON OF COMPLICATED CASES.

DRAMATIC AS THESE FIGURES ARE THEY DO NOT FULLY REVEAL THE MAGNITUDE OF RECENT TRENDS. A SURVEY OF 50 OF THE NATION'S LEADING OBSTETRICIANS REVEALED CAESAREAN SECTION RATES IN LATE 1976 AS HIGH AS 23 PERCENT OF ALL DELIVERIES IN SOME TEACHING HOSPITALS, WITH A NUMBER OF PREDICTIONS THAT EVENTUALLY OVERALL RATES WOULD SETTLE AROUND 12 TO 15 PERCENT AS THE MOST DESIRABLE RANGE, AND PERHAPS AT 20 PERCENT FOR TEACHING HOSPITALS.

THE REASONS FOR THE INCREASE IN CAESAREAN SECTION RATES ARE NOT FIRMLY ESTABLISHED. IN THE SURVEY PREVIOUSLY CITED, 20 PERCENT OF THE SECTIONS WERE JUSTIFIED BECAUSE OF PREVIOUS CAESAREAN SECTIONS; 23 PERCENT OF THEM WERE JUSTIFIED BECAUSE OF "FETO-PELVIC DISPORPORTION, TYPE UNSPECIFIED." THE MEANING OF FETO-PELVIC DISPORPORTION IS NOT CLEAR. DOES IT INVARIABLY MEAN A PHYSICAL DISPORPORTION BETWEEN THE SIZE OF THE PELVIC OUTLET AND THE BABY'S HEAD, OR DOES IT INCLUDE DELAYED OR SLOW LABOR FOR SOME UNKNOWN OR PSYCHOGENIC REASONS? ONE PROMINENT OBSTETRICIAN HAS URGED CAESAREAN SECTION UNLESS "LABOR IS FAST AND STEADY." ACTUAL MEASUREMENT OF THE PELVIS, WHICH ONCE ATTRACTED MUCH ATTENTION, IS SELDOM REPORTED; A TRIAL OF LABOR HAS TAKEN PRECEDENCE.

THE THREAT OF CAESAREAN SECTION IN THE EVENT THAT PROGRESS OF LABOR FALTERS, REMINDS ME ALWAYS OF THE BIRTH OF OUR THIRD CHILD. HELEN'S LABOR PROGRESSED AT HOME IN A BUSINESS-LIKE WAY. WE WAITED UNTIL ONE-MINUTE CONTRACTIONS CAME AT FIVE-MINUTE INTERVALS, THEN DROVE THE SHORT DISTANCE

TO THE HOSPITAL WHERE I WENT IN ONE DIRECTION TO GIVE ASSURANCES THAT BILLS WOULD BE PAID, AND HELEN WENT ANOTHER TO BE QUESTIONED, STRIPPED, PROBED, SHAVED, AND CLEANSED INSIDE AND OUT. THE OBSTETRICIAN, DELIVERY ROOM NURSES, ANESTHETIST, APPROPRIATE HOUSE STAFF, AND STUDENTS FOCUSED WITH IMPATIENT EXPECTANCY ON THE PROGRESS OF HELEN'S LABOR--WHICH SOMEWHERE BETWEEN THE INTERROGATION AND THE ENEMA HAD STOPPED ALTOGETHER. DR. CALKINS PUT TO REST ALL THE STAND-BY RESERVES, ANNOUNCED THAT HE WAS GOING TO HIS OFFICE FOR A NAP, AND URGED THAT HELEN GET UP AND TAKE A WALK. SHE DRESSED AND WE DROVE THE FEW BLOCKS TO KANSAS CITY'S COUNTRY CLUB PLAZA FOR WINDOW-SHOPPING. STROLLING PAST HARZFELD'S, WOOLF BROTHERS, HALLS, AND SWANSONS, WE PAUSED SOMETIMES TO COVET THE GOODS ON DISPLAY IN THE SHOP WINDOWS, AND SOMETIMES TO ACCOMMODATE A FIGUITIVE LABOR PAIN. IN DUE COURSE, HELEN INTERMITENTLY SQUEEZED MY HAND WITH A FIRMNESS THAT COULD NOT BE ATTRIBUTED ENTIRELY TO ECSTASY OVER THE TREASURES SHE WAS VIEWING. I REMEMBER FEELING THE SQUEEZE OF HER HAND THROUGH HER WHITE GLOVE. THE SEASON WAS MID-SUMMER, BUT THOSE WERE THE 1950'S AND NICE LADIES DID NOT RISK GIVING OFFENSE TO THE PUBLIC'S SENSITIVITIES BY EXPOSING NAKED HANDS UNNECESSARILY. (NEWBORN BABIES EVEN THEN WERE BORN NADED BUT ORDINARILY NOT IN PUBLIC VIEW.) HAPPY AND RELAXED FROM OUR WALK, WE RETURNED TO THE HOSPITAL ROOM FROM WHICH HELEN WAS RUSHED TO THE DELIVERY ROOM WHERE OUR THIRD CHILD WAS PROMPTLY BORN. ALL OF HER LIFE THAT CHILD HAS BEEN INORDINATELY ATTRACTED TO EXPENSIVE FINERY.

ACCORDING TO CURRENT PRACTICE--DO A CAESAREAN SECTION UNLESS LABOR IS FAST AND STEADY--THAT CHILD WOULD HAVE BEEN BORN BY MEANS OF MAJOR SURGERY. ILLUSTRATIVE OF HOW ONE INTERVENTIONIST PROCEDURE NECESSITATES ANOTHER INTO A SEQUENCE OF ESCALATING HEROISM, OXYTOCIN MIGHT HAVE BEEN GIVEN TO STIMULATE CONTRACTIONS, AND THAT WOULD HAVE CALLED FOR FETAL MONITORING, WHICH REQUIRES ARTIFICIAL RUPTURE OF THE AMNIOTIC MEMBRANE AND IS ASSOCIATED

WITH A HIGHER RATE OF CAESAREAN SECTION. THE HIGH DRAMA AND ANXIETY WOULD NOT HAVE AFFORDED HELEN AND ME THE CLOSELY BONDING REMEMBRANCE THAT WE NOW ENJOY. BUT ON THE OTHER HAND, IT MIGHT HAVE SPARED OUR DAUGHTER A FRIGHTFULLY EXPENSIVE PRENATAL PSYCHIC INFLUENCE.

BREECH PRESENTATIONS APPEAR AS THE SECOND MOST FREQUENT JUSTIFICATION FOR CAESAREAN SECTION (7.7 PERCENT OF THE CASES). MOST REVIEWERS SUGGEST THAT UNLESS OTHER COMPLICATIONS INTERVENE A BREECH PRESENTATION MAY NOT BE SUFFICIENT CAUSE FOR CAESAREAN SECTION. A RECENTLY REPORTED SERIES FROM THE UNIVERSITY OF SOUTHERN CALIFORNIA IN WHICH RANDOMIZED CASES OF BREECH PRESENTATION WERE DELIVERED BY CAESAREAN SECTION AND BY VAGINA REVEALED OUTCOMES WHICH PROMPTED THE AUTHORS TO CONCLUDE THAT CAESAREAN SECTIONS FOR ALL TERM FRANK BREECH PRESENTATIONS IN AN UNATTRACTIVE POLICY. A THOROUGH REVIEW OF THE SUBJECT IN 1975 IN SCANDINAVIAN LITERATURE CONCLUDED THAT CAESAREAN SECTION COULD BE JUSTIFIED IN AT LEAST ONE-THIRD OF BREECH PRESENTATIONS. THAT FORMULATION SUGGESTS THAT LITTLE MORE THAN ONE PERCENT OF ALL DELIVERIES WOULD BE ACCOMPLISHED BY CAESAREAN SECTION BECAUSE OF BREECH PRESENTATIONS INASMUCH AS THEY OCCUR IN THREE TO FOUR PERCENT OF LABORS.

REFINEMENTS OF TECHNOLOGY HAVE CONTRIBUTED TO THE INCREASE IN CAESAREAN SECTION RATES. AMONG THESE REFINEMENTS IS FETAL MONITORING FOR VARIABLE FETAL HEART RATE. ONE STUDY CONCEALED THE RESULTS ON ALTERNATE CASES OF FETAL MONITORING. THE RATES OF CAESAREAN SECTION AMONG THESE WOMEN WAS .3 PERCENT. THE RATE IN THE CONTROL GROUP AMONG WHOM THE RESULTS OF FETAL MONITORING WERE OPEN TO VIEW WAS 16.5 PERCENT. THERE WERE NO DIFFERENCE BETWEEN THE GROUPS ACCORDING TO THE INFANT OUTCOMES THAT WERE MEASURED.

TEMPTATIONS ARE STRONG TO ATTRIBUTE THE FALLING NEONATAL MORTALITY RATE OF THE LAST DECADE TO THE USE OF TECHNOLOGIES THAT INCLUDE FETAL MONITORING, CAESAREAN SECTION, AND NEONATAL INTENSIVE CARE UNITS. ONE MAJOR

TEACHING HOSPITAL, ALBERT EINSTEIN, OBSERVING A SHARP DECLINE IN NEONATAL MORTALITY WHICH COINCIDED WITH USE OF THESE TECHNOLOGIES, CONCLUDED AFTER CAREFUL STUDY THAT AS MUCH AS THREE-FOURTHS OF THE DECLINE COULD BE ATTRIBUTED INSTEAD TO SOCIO-ECONOMIC VARIABLES WHICH RESULTED IN A REDUCTION IN THE PROPORTION OF INFANTS OF VERY LOW BIRTH WEIGHT.

AN ACCURATE EVALUATION OF THE POSSIBLE BENEFITS OF THE CURRENT EPIDEMIC OF CAESAREAN SECTIONS WILL BE DIFFICULT TO ACHIEVE. PROTECTION OF THE INFANT IS COMMONLY CITED AS AN IMPORTANT BENEFIT OF CAESAREAN SECTION. YET IN THE SURVEY OF 1967-1974, FETAL DISTRESS WAS DIAGNOSED IN ONLY 3.8 PERCENT OF THE BABIES WHO WERE DELIVERED BY CAESAREAN SECTION. LONG RANGE BENEFITS ARE SOMETIMES PRESUMED, HOPEFULLY TO BE CONFIRMED IN THE FUTURE BY DECREASED RATES OF MENTAL RETARDATION, CEREBRAL PALSY, AND LEARNING DISABILITIES. THESE CLAIMS MAY BE SUGGESTED BY INDIVIDUAL CASE STUDIES BUT IN AGGREGATE THEY CONTRADICT EXTENSIVE DATA WHICH CONFIRM THAT THESE DISORDERS PREDOMINATELY HAVE THEIR ORIGIN IN EVENTS THAT EITHER PRECEDE OR FOLLOW THE INTRAPARTUM PERIOD.

SOME HAZARDS OF CAESAREAN SECTION ARE IMMEDIATE. IN THE HOSPITAL SURVEY BETWEEN 1967 AND 1974, THE MATERNAL MORTALITY RATE WAS 80 PER 100,000 CAESAREAN SECTIONS AS COMPARED WITH 27 PER 100,000 WITH OR WITHOUT CAESAREAN SECTIONS. THE HAZARDS OF MATERNAL MORTALITY ARE UNDERREPRESENTED IN THIS STUDY BECAUSE NO FOLLOW-UP WAS DONE ON WOMEN WHO WERE TRANSFERRED TO OTHER HOSPITALS OUTSIDE THE STUDY SAMPLE (97 DEATHS AND 133 TRANSFERS, SOME OF WHOM MAY ALSO HAVE DIED). THE CAESAREAN SECTION POPULATION OF COURSE INCLUDES THE WOMEN WHOSE DELIVERY WAS COMPLICATED BY RISK FACTORS. BUT NO RISK FACTORS COULD BE IDENTIFIED FOR 18.6 PERCENT OF THE DEATHS, AND THE ONLY RISK FACTOR FOR

ANOTHER 16.5 PERCENT OF THE MATERNAL DEATHS WAS A PREVIOUS CAESAREAN SECTION,

INFANTS ALSO SUFFER HAZARDS FROM CAESAREAN SECTIONS. IN A SURVEY OF 100 CONSECUTIVE CASES OF RESPIRATORY DISTRESS SYNDROME IN A TEACHING HOSPITAL, YALE-NEW HAVEN, 15 PERCENT AND POSSIBLY ANOTHER 18 PERCENT WERE ATTRIBUTED TO UNTIMELY OR UNWARRANTED PHYSICIAN INTERVENTION IN THE PREGNANCY. SIXTEEN OF THESE INTERVENTIONS CONSISTED OF CAESAREAN SECTIONS WITHOUT STUDIES ON FETAL MATURITY. NINE OF THESE SECTIONS WERE OCCASIONED BY NO RISK OTHER THAN ELECTIVE REPEAT INTERVENTIONS BECAUSE OF PREVIOUS CAESAREAN SECTION. ANOTHER SERIES AT CASE-WESTERN RESERVE REPORTED THAT TWELVE PERCENT OF ALL INFANTS WITH RESPIRATORY DISTRESS WHO WERE ADMITTED TO INTENSIVE CARE WERE BORN AFTER ELECTIVE INTERVENTION; IN 15 OUT OF 19 CASES THE INTERVENTION CONSISTED OF CAESAREAN SECTION. NO PRIOR DOCUMENTATION OF PULMONARY MATURITY HAD BEEN OBTAINED ON ANY OF THESE INFANTS.

CONCERN ABOUT LONG RANGE HAZARDS OF CAESAREAN SECTION INCLUDE THE EFFECTS OF INHALATION ANESTHESIA, BLOOD TRANSFUSION AND ANTIBIOTICS. MORE THAN HALF OF REPORTED CAESAREAN SECTIONS ARE PERFORMED WITH INHALATION ANESTHESIA. THE HAZARDS OF THE FIRST EPISODE OF ANESTHESIA ARE MINIMAL, BUT THE RISK INCREASES SUFFICIENTLY WITH EACH SUCCEEDING EPISODE THAT UNNECESSARY EXPOSURE SHOULD BE AVOIDED. DATA ON SUCH HAZARDS FROM CAESAREAN SECTIONS WILL NOT ACCUMULATE FOR MANY YEARS.

ABOUT TEN PERCENT OF ALL WOMEN WHO WERE DELIVERED BY CAESAREAN SECTION RECEIVED BLOOD TRANSFUSIONS, AND HALF OF THE TRANSFUSIONS WERE JUDGED IN THE PAS SURVEY TO BE UNJUSTIFIED. THE COMPLICATIONS OF BLOOD TRANSFUSION, MANY OF THEM NOT IMMEDIATELY DISCERNIBLE, SHOULD BE

CONSIDERED WHEN EVALUATING THE RISKS OF CAESAREAN SECTION. LESS BUT LEGITIMATE CONCERN ATTACHES TO THE WOMEN, ABOUT ONE QUARTER OF ALL THOSE DELIVERED BY CAESAREAN SECTION, WHO RECEIVED ANTIBIOTICS WITHOUT JUSTIFICATION. AGAIN, THE POSSIBLE ADVERSE CONSEQUENCES WILL PROBABLY NOT BE ATTRIBUTED TO CAESAREAN SECTION, AT LEAST NOT FOR MANY YEARS.

GREAT CONCERN FOCUSES ON POORLY UNDERSTOOD BUT POTENT PSYCHO-EMOTIONAL ATTACHMENTS BETWEEN MOTHERS AND NEWBORNS. THESE ATTACHMENTS INFLUENCE SUBSEQUENT PARENTING BEHAVIOR INCLUDING CHILD ABUSE. DATA ARE NOT AVAILABLE TO ENLIGHTEN UNDERSTANDING OF THE POSSIBLE EFFECTS OF DEEP ANESTHESIA AND MAJOR SURGERY ON DEVELOPMENT OF THESE SUBTLE YET POWERFUL RELATIONSHIPS. KLAUS, WHO DID SO MUCH TO ENLIGHTEN UNDERSTANDING OF MATERNAL-INFANT BONDING, IS SUFFICIENTLY CONCERNED THAT IN HIS HOSPITAL, SPECIAL MEASURES ARE TAKEN TO ASSURE MATERNAL CONTACT WITH BABIES WHO ARE BORN BY SURGERY, AND GENERAL ANESTHESIA IS AVOIDED WHEN POSSIBLE.

COST IS NOT AN INCONSEQUENTIAL CONSIDERATION. CAESAREAN SECTION ENTAILS FEES FOR OBSTETRICIANS, ANESTHESIOLOGISTS, PATHOLOGISTS, LABORATORIES, OPERATING ROOMS, RECOVERY ROOMS, INTENSIVE CARE UNITS, AND AN AVERAGE OF SEVEN DAYS HOSPITALIZATION, SUBSTANTIALLY LONGER THAN FOR CONVENTIONAL DELIVERY. TOTAL COST RUNS INTO THOUSANDS OF DOLLARS. FINANCIAL HARDSHIPS ON INDIVIDUALS AND ON SOCIETY REQUIRE THAT SUCH EXPENSIVE TECHNOLOGIES BE HELD ACCOUNTABLE. CAESAREAN SECTION RATES ARE INCREASING RAPIDLY WITHOUT SUCH ACCOUNTABILITY.

CONSIDERATION MUST BE GIVEN TO THE POSSIBILITY THAT ECONOMIC INCENTIVES CONTRIBUTE TO AN INCREASE IN THE CAESAREAN SECTION RATE. THE CIRCUMSTANCES ARE CONSISTENT WITH SUCH AN INTERPRETATION BUT DO NOT ESTABLISH IT. A DECLINE IN THE NUMBER OF BIRTHS AND AN INCREASE IN THE NUMBER OF OBSTETRICIANS HAVE COMBINED TO CAUSE A DRAMATIC DECLINE

IN THE RATIO OF LIVE BIRTHS TO OBSTETRICIANS: FROM 260.7 IN 1963 TO 144.9 IN 1975. THESE SAME YEARS PROVIDED NEW SOURCES OF FUNDING, ESPECIALLY FOR POOR PEOPLE BY MEANS OF MEDICAID.

RECENT YEARS OF DECLINING BIRTH RATE ARE ASSOCIATED WITH SHORTENED DURATION OF HOSPITAL STAY FOR UNCOMPLICATED INTRAPARTUM CARE. THESE CIRCUMSTANCES COMBINE TO PRODUCE LOW OCCUPANCY OF OBSTETRIC BEDS, AND SUGGEST THAT ROEMER'S LAW (EMPTY BEDS TEND TO BECOME FILLED) MAY BE OPERATIVE IN THE MEDICAL MARKET, WORKING TO REVISE OBSTETRIC PRACTICE IN ORDER TO FILL EMPTY BEDS. NATIONAL DATA ON UTILIZATION OF OBSTETRIC BEDS ARE DIFFICULT TO ASSEMBLE, BUT SMALL AREA DATA YIELD CONSISTENT FINDINGS. EXAMPLES INCLUDE:

1. "IN 1963 ABOUT 184,000 PATIENTS IN MATERNITY UNITS RECEIVED APPROXIMATELY 878,000 DAYS OF CARE. BY 1973 THE NUMBER OF PATIENTS DECREASED TO JUST OVER 130,000 AND THE DAYS OF CARE DECREASED TO 585,000--DECLINES OF APPROXIMATELY 29 PERCENT AND 33 PERCENT RESPECTIVELY." (OBSTETRIC AND PEDIATRIC SERVICES IN NEW YORK CITY, 1974, HEALTH AND HOSPITAL PLANNING COUNCIL OF SOUTHERN NEW YORK, INC.)
2. ALL HOSPITALS, HENNEPIN COUNTY, MINNESOTA, 1974: OBSTETRICS OCCUPANCY, 58.1 PERCENT (MINNEAPOLIS TRIBUNE, NOVEMBER 10, 1975).
3. IN NORTHEASTERN NEW YORK, A REGION CONTAINING 40 ACUTE GENERAL HOSPITALS, OBSTETRIC UNITS IN 1973 WERE UTILIZED AT SLIGHTLY OVER 50% OCCUPANCY. FOR THE SAME PERIOD, THE MEDICAL-SURGICAL BEDS IN THE REGION WERE UTILIZED AT OVER 85% OCCUPANCY. (A PLAN FOR MATERNITY AND PEDIATRIC CARE FOR NORTHEASTERN NEW YORK, 1974, REGIONAL HOSPITAL REVIEW AND

PLANNING COUNCIL OF NORTHEASTERN NEW YORK, INC.)

4. THE DUKE ENDOWMENT COLLECTS DATA ON 95 PERCENT OF THE SHORT TERM HOSPITAL BEDS IN NORTH AND SOUTH CAROLINA. IN 1976 THERE WAS 46 PERCENT OCCUPANCY OF OBSTETRIC BEDS AND 79 PERCENT FOR MEDICAL-SURGICAL BEDS. THE LARGEST HOSPITALS, WHICH EXPERIENCE HIGHER OBSTETRIC OCCUPANCY THAN SMALL HOSPITALS, STILL SHOWED OBSTETRIC UTILIZATION WHICH LAGGED BEYOND MEDICAL-SURGICAL BY 11 PERCENTAGE POINTS. (THE DUKE ENDOWMENT, CHARLOTTE, N.C.)

WHEN CONSIDERING CAESAREAN SECTION RATES RECOGNITION MUST BE ALLOWED THAT MEDICAL DECISIONS WHICH SEEM ENLIGHTENED AND JUSTIFIED INDIVIDUALLY MAY IN AGGREGATE CONTRIBUTE TO TRENDS WHICH ARE HARD TO DEFEND. THE RAPIDLY INCREASING PRACTICE OF DELIVERING INFANTS BY CAESAREAN SECTION IS NOT ADEQUATELY EXPLAINED BY REPORTED FINDINGS. THE BENEFITS AND HAZARDS OF PRESENT HIGH CAESAREAN SECTION RATES REQUIRE CLOSE SCRUTINY BY BOTH SHORT AND LONG TERM MEASURES. STUDIES SHOULD INCLUDE CONSIDERATION THAT A DECLINING NUMBER OF BIRTHS, AN INCREASING NUMBER OF OBSTETRICIANS, AND UNDER-UTILIZATION OF OBSTETRIC BEDS MAY WORK TO FAVOR EXPENSIVE TECHNOLOGIES OF CHILDBIRTH ON AN ECONOMIC RATHER THAN A MEDICAL BASIS. THIS PROSPECT IS NOT PUT TO REST BY REPORTS THAT BY 1973, AMONG PHYSICIANS ENGAGED IN OFFICE-BASED PRACTICE, OBSTETRICIAN-GYNECOLOGISTS REPORTED A MEDIAN INCOME AFTER TAX DEDUCTIBLE EXPENSES THAT EXCEEDED ALL OTHER SPECIALISTS, INCLUDING GENERAL SURGEONS AND PSYCHIATRISTS--A REMARKABLE ACCOMPLISHMENT IN VIEW OF THE DRAMATICALLY FALLING BIRTH RATE. TECHNOLOGY CAN BREED ECONOMIC EXPLOITATION

AND PHYSICAL ABUSE.

HIGH CAESAREAN SECTION RATES MAY JOIN A LONG LIST OF MEDICO-SURGICAL EXCESSES THAT SEEM JUSTIFIED AND EVEN URGENTLY NECESSARY IN THE EXUBERANT LIGHT OF PROFESSIONAL CAPABILITY, BUT WHICH ARE EXPOSED BY EVIDENCE WHICH IS ACCUMULATED ALL TOO SLOWLY AND PAINFULLY AS MISGUIDED ENTHUSIASM: LEECHES AND PURGES, TONSILLECTOMY, HIGH OXYGEN CONCENTRATIONS FOR LOW BIRTH WEIGHT BABIES, MACRO-DOSES OF VITAMIN K FOR NEWBORN INFANTS, HYSTERECTOMIES FOR MIDDLE AGED WOMEN, PROLONGED BED REST FOR RHEUMATIC FEVER, AND MAYBE CORONARY BYPASS SURGERY, AND EXTENDED HOSPITALIZATION FOR MYOCARDIAL INFARCTION. ALL OF THESE PROCEDURES CAME INTO WIDESPREAD PRACTICE WITH STRONG CONVICTION AND WITH LITTLE EVIDENCE THAT THEY WERE HELPFUL.

TECHNOLOGY CAN ALSO BREED BENIGN NEGLECT AND FALSE SECURITY. WOMEN IN LABOR REPORT THAT THE FETAL MONITORING WIRES ISSUING FROM THE VAGINA PROVIDE A COLD COMFORT AS COMPARED WITH THE PHYSICAL PRESENCE OF A REASSURING AND CARING PERSON. THE CARING PERSON IS APT TO BE DOWN THE HALL READING THE MONITORS. MONITORING PROCEDURES THAT HAVE BEEN INVOKED TO PROTECT AGAINST INAPPROPRIATE MANAGEMENT ARE APPROPRIATELY CHALLENGED FOR THEIR INCONVENIENCE, HIGH COST, AND POTENTIAL HAZARD. ROUTINE PRE-OPERATIVE CHEST X-RAYS, AND ROUTINE MEASUREMENT OF BLOOD OXYGEN LEVELS AMONG INFANTS AS A GUIDE TO OXYGEN THERAPY, HAVE RECENTLY BEEN QUESTIONED AS CONTRIBUTING LITTLE USEFUL INFORMATION. SUCH CHALLENGES TO ENTRENCHED PRACTICE ARE ORDINARILY REQUIRED TO ADHERE TO A MORE STRICT MARSHALLING OF EVIDENCE THAN WAS NECESSARY TO ESTABLISH THE PROCEDURES IN THE FIRST PLACE.

VIGILANCE, BOTH PROFESSIONAL AND LAY, IS JUSTIFIED TO PROTECT AGAINST TECHNOLOGICAL EXCESSES. SPECIAL VIGILANCE IS REQUIRED ON

BEHALF OF VULNERABLE PEOPLE: INFANTS, CHILDREN, POOR PEOPLE, WOMEN, AND THE ELDERLY. THE LIST OF TECHNOLOGICAL ABUSES IS ESPECIALLY RICH IN PROCEDURES INVOLVING PEOPLE WHO COULD OR WOULD NOT ASK FOR EXPLANATIONS NOR CHALLENGE PROFESSIONAL AUTHORITY. IT MAY NOT BE ENTIRELY INADVERTANT THAT THE PROSTATE GLAND, COMMON SITE OF MALIGNANCY AND CAUSE OF MUCH FUNCTIONAL DISTRESS AMONG AGING MEN, IS REMOVED WITH MUCH LESS ALACRITY THAT THE UTERUS. ONE MAJOR MEDICAL CENTER REPORTED THAT IN 1975 SURGICAL INTERVENTIONS INVOLVING THE FEMALE REPRODUCTIVE ORGANS ACCOUNTED FOR FOUR OF THEIR TOP TEN SURGICAL PROCEDURES: CAESAREAN SECTION RANKED AS THE SECOND MOST COMMON SURGICAL PROCEDURE. ONLY ONE OF THESE PROCEDURES, DIAGNOSTIC D & C, HAD APPEARED ON THE TOP TEN LIST FIVE YEARS PREVIOUSLY.

IN AUGUST OF 1977, THE SUN VALLEY FORUM ADDRESSED THE DYNAMICS OF MEDICAL TECHNOLOGY USE. IN DISCUSSING ONE OF THE PAPERS, LEWIS BUTLER SAID THESE THINGS:

"...THE DEVIL IS NOT TECHNOLOGY PER SE, BUT OUR CURRENT SYSTEM OF MEDICAL CARE WHICH CONTAINS STRONG REWARDS FOR EXPANDING THE USE OF NEW TECHNOLOGIES. ...THE FEE-FOR-SERVICE REIMBURSEMENT SYSTEM AND THE TREND TOWARD SPECIALIZATION FAVOR TECHNOLOGY-INTENSIVE PRACTICE BY THE PHYSICIAN. ...HOSPITALS INCREASINGLY ACQUIRE NEW MACHINES AND FACILITIES IN ORDER TO ATTRACT AND RETAIN PHYSICIANS, AND HENCE THEIR PATIENTS. ...ACADEMIC MEDICAL CENTERS...INCREASINGLY SET THE FASHIONS FOR AMERICAN MEDICINE AND ARE INHERENTLY DISPOSED TOWARD EXPANDING THE USE OF NEW TECHNOLOGIES WITHOUT MUCH CONCERN WITH HOW COSTS COMPARE TO BENEFITS."

UNTIL THE OBSTETRICS COMMUNITY CAN COME FORTH WITH BETTER ARGUMENTS AND MORE CONVINCING DATA THAN HAVE SO FAR BEEN DEVELOPED FOR THE RAPIDLY INCREASING CAESAREAN SECTION RATES, WE MUST CONCLUDE THAT THE INCREASE HAS BEEN BROUGHT ABOUT BY FORCES ACCURATELY DESCRIBED BY BUTLER. SIMILAR FORCES MAY BE AT WORK WITH REFERENCE TO SUCH INTERVENTIONS AS ELECTIVE INDUCTION OF LABOR, ARTIFICIAL RUPTURE OF MEMBRANES, ULTRASOUND, OXYTOCIN CHALLENGE TESTS, AND ROUTINE FETAL MONITORING. THE USES, ABUSES, AND ADVERSE CONSEQUENCES OF THESE INTERVENTIONS DESERVE CAREFUL EVALUATION. THEY HAVE COME INTO WIDESPREAD USE WITHOUT BENEFIT OF SUCH STUDY. A REVIEW OF EACH OF THESE INTERVENTIONS HAS NOT BEEN UNDERTAKEN WITH THE SAME CARE AS FOR CAESAREAN SECTIONS, BUT EACH OF THEM DESERVES IT.

REFORMS IN OUR SYSTEM OF MEDICAL CARE ARE REQUIRED. THEIR URGENCY IS MADE POIGNANT BY EVIDENCE WHICH ACCUMULATES THE WORLD OVER ON THE ENORMOUS BENEFITS IN WELL BEING THAT DERIVE FROM SYSTEMS OF CARE THAT SUCCEED IN REACHING ALL PEOPLE WITH BASIC SERVICES, OFTEN OF ASTONISHING SIMPLICITY. APPROPRIATE IMPROVEMENTS IN THE SOPHISTICATION OF TECHNOLOGY CAN BE MADE IN SUCH SYSTEMS. WE HAVE YET TO DEMONSTRATE THAT THE BENEFITS OF HIGH TECHNOLOGY, THAT REACHES ONLY A FEW PEOPLE, WILL DIFFUSE TO THE ADVANTAGE OF THE ENTIRE POPULATION.

TRADITIONAL PROFESSIONS AND INSTITUTIONS OF HEALTH SERVICE PROVIDE LITTLE ASSURANCE THAT REFORM WILL COME FROM WITHIN. THE WOMEN'S MOVEMENT MAY REPRESENT OUR BEST HOPE FOR REFORM, NOT ONLY WITH REGARD TO CHILD BEARING PRACTICES BUT WITH REGARD TO HEALTH PRIORITIES AND SOCIAL JUSTICE. IN ONE RECENT STUDY, ONE-THIRD OF POSTPARTUM WOMEN EXPRESSED DISSATISFACTION WITH THEIR OBSTETRIC CARE DURING PREGNANCY AND DELIVERY. COGNIZANT OF

THE ABUSE POTENTIAL INHERENT IN MUCH OF TODAY'S INTERVENTIONIST TECHNOLOGY OF CHILD BEARING, MANY WOMEN ARE SEEKING ALTERNATIVES. THE NATIONAL CENTER FOR HEALTH STATISTICS REPORTS A 51 PERCENT INCREASE IN OUT-OF-HOSPITAL BIRTHS BETWEEN 1974 AND 1975. AS OTHER COUNTRIES, NOTABLY HOLLAND AND ENGLAND, MOVE THE LOCUS OF DELIVERIES INCREASINGLY FROM THE HOME TO THE HOSPITAL, AN INCREASING NUMBER OF AMERICAN FAMILIES SEE ADVANTAGES IN A REVERSE TREND.

THE RECORD OF ACCOMPLISHMENT OF THE BEST OF THE OUT-OF-HOSPITAL ALTERNATIVES IS NOT EASILY DISMISSED. COMMON TO MANY OF THE ALTERNATIVES IS THE UTILIZATION OF NURSE MIDWIVES WHO ARE PERCEIVED AS PROVIDING AN IDEOLOGICAL ALTERNATIVE TO THE AUTHORITARIAN AND INSENSITIVE OBSTETRICIAN. MIDWIVES ARE VIEWED IN THESE SETTINGS AS HAVING BOTH THE OPPORTUNITY AND THE HISTORICAL MANDATE TO RADICALIZE CHILDBIRTH AND TO PROVIDE TRULY PERSONALIZED FAMILY-CENTERED CARE. THEY ARE EDUCATED IN PREVENTION AND AS HEALTH PRESERVATION ADVOCATES, STRONGLY SCHOOLED TO DO NO HARM. ON AN INTERNATIONAL NOTE, EIGHTY PERCENT OF THE WORLD'S CHILDREN (INCLUDING THOSE IN ELEVEN COUNTRIES WITH LOWER INFANT MORTALITY RATES THAN THE UNITED STATES) ARE DELIVERED BY MIDWIVES.

THE FRONTIER NURSING SERVICE IN EASTERN KENTUCKY INITIATED A NURSE MIDWIFERY PROGRAM IN 1925 WITH A STAFF FROM ENGLAND; THE SERVICE HAS PERSISTED TO THE PRESENT TIME. MIDWIVES PROVIDE HEALTH CARE TO AN EXTREMELY POOR, MOUNTAINOUS AREA OF KENTUCKY AND MAY BE CREDITED WITH SIGNIFICANT IMPROVEMENTS IN HEALTH OUTCOME. THERE HAVE BEEN NO MATERNAL DEATHS IN THIS HIGH-RISK POPULATION IN THE 8,000 BIRTHS SINCE 1952; FOR THE 10,000 BIRTHS BETWEEN 1925 AND 1952 THE INFANT MORTALITY RATE WAS ONE-THIRD THAT OF THE REST OF THE COUNTRY. REGRETTABLY, THE WORK

OF THE FRONTIER NURSING SERVICE IS JEOPARDIZED BY THIRD PARTY PAYERS WHO WILL COVER COSTS ONLY FOR HOSPITAL DELIVERIES.

THE PREVIOUSLY CITED MATERNITY CENTER ASSOCIATION, WHICH HAS WORKED FOR OVER SIXTY YEARS TO IMPROVE THE HEALTH OF WOMEN AND CHILDREN IN NEW YORK CITY, INITIATED A CHILDBEARING CENTER FOR REASONS WHICH FOCUS ON DISSATISFACTIONS WITH HEALTH CARE AS PRACTICED BY MANY OBSTETRICIANS. THE CENTER IS TRYING TO BRING BACK INTO A WELL SUPERVISED SETTING THOSE FAMILIES WHO HAVE OPTED FOR HOME DELIVERY SOMETIMES WITHOUT TRAINED ATTENDANTS. THE CENTER ALSO REPRESENTS A SUCCESSFUL EFFORT TO CONTAIN COSTS IN MATERNITY CARE, WHILE AT THE SAME TIME SERVING AS A MODEL FOR CHILD BEARING CARE IN UNDERSERVED AREAS. THE CENTER IS REMOVED FROM A HOSPITAL SETTING IN THE BELIEF THAT BIASES OF A HOSPITAL STAFF TEND TO HINDER INCORPORATION OF INNOVATION WITHIN HOSPITALS, AND BECAUSE, ESPECIALLY IN TEACHING HOSPITALS, THE NEEDS OF FAMILIES MAY BE GIVEN SECOND PRIORITY RELATIVE TO OTHER INSTITUTIONAL COMMITMENTS.

THE CHARACTERISTICS OF FAMILIES UTILIZING THE CHILDBIRTH CENTER DO NOT SUPPORT CRITICISM THAT ALTERNATIVES IN CHILDBIRTH ARE BEING DEMANDED ONLY BY A "LUNATIC FRINGE". NINETY PERCENT WERE MARRIED, THEY REPRESENTED ALL ETHNIC AND RELIGIOUS AFFILIATIONS AND HAD A MEAN EDUCATIONAL LEVEL OF THREE YEARS OF COLLEGE. SEVENTY-SIX PERCENT OF THE WOMEN WERE NON-SMOKERS AND THIRTY-FIVE PERCENT WERE PRIMIPARAS. ALTHOUGH THE COST OF CHILDBIRTH AT THIS CENTER IS HALF THE AVERAGE HOSPITAL COST, ONLY THREE PERCENT OF THE FAMILIES BIRTHING THERE FELT THAT COST WAS A MAJOR FACTOR IN THEIR DECISION. "VALUES REGARDING THE TYPE

OF CHILDBEARING EXPERIENCE HAD PRIORITY FOR 97 PERCENT OF THE COUPLES". THESE VALUES INCLUDED INCREASED FAMILY COHESIVENESS, BIRTH AS A HEALTHY NONPATHOLOGICAL EVENT, AND A WISH TO BE INCLUDED AS DECISION MAKERS THROUGHOUT THE BIRTH PROCESS. DR. SEYMOUR ROMNEY OF THE ALBERT EINSTEIN COLLEGE OF MEDICINE REPORTED IN 1976 THAT:

"AFTER A YEAR'S EXPERIENCE THE PROGRAM (MATERNITY CENTER ASSOCIATION CHILDBEARING CENTER) HAS UNEQUIVOCALLY ESTABLISHED THE FACT THAT SAFE, MORE PERSONAL, COMPASSIONATE MATERNITY CARE CAN BE OFFERED MORE ECONOMICALLY THAN IN THE HOSPITAL".

OTHER SMALL-SCALE MIDWIFERY CLINICS IN TEXAS, NEW MEXICO AND CALIFORNIA PROVIDE COMPREHENSIVE MATERNITY CARE TO RURAL POOR AND HIGH RISK WOMEN AND REPEATEDLY HAVE DEMONSTRATED THAT PREMATURITY, MATERNAL MORTALITY AND INFANT DEATH RATES CAN BE LOWERED SIGNIFICANTLY BELOW NATIONAL FIGURES FOR SIMILAR YEARS.

ONE STARTLING ALTERNATIVE TO CONVENTIONAL CHILD BEARING IS REPRESENTED BY "THE FARM", A LARGE COMMUNE IN EASTERN TENNESSEE. MORE THAN 800 BABIES HAVE BEEN DELIVERED THERE BY MIDWIVES WHO HAVE HAD UNCONVENTIONAL TRAINING AND SUPERVISION FROM PHYSICIANS IN THE AREA. THE PHYSICIANS, AS WELL AS THE STATE HEALTH DEPARTMENT, WERE AT FIRST SKEPTICAL ABOUT THIS STRANGE COMMUNITY AND ITS CHILD BEARING PRACTICES. SO FAR, THE RECORD OF SAFETY AND FAVORABLE OUTCOMES FOR PREGNANCIES AT THE FARM IS IMPRESSIVE--NO MATERNAL DEATHS AND AN INFANT MORTALITY RATE SUBSTANTIALLY BETTER THAN FOR THE REST OF TENNESSEE. OFFICERS OF THE STATE HEALTH DEPARTMENT SHOW NEW INTEREST. CRITICS DISMISS THE FAVORABLE PERFORMANCE AS DERIVING FROM A HIGHLY SELECTED POPULATION OF LOW RISK. BUT THAT IS EXACTLY THE POINT. OBSTETRICIANS POINT TO AGING DATA THAT ARE NOT ABOVE

CRITICISM AND DECLARE THAT ANTICIPATION OF INTRAPARTUM RISKS CANNOT SAFELY BE DONE; ACCORDING TO THESE DATA TWENTY PERCENT OF THE CRISES OF DELIVERY OCCUR IN WOMEN WHO WERE NOT THOUGHT TO BE AT RISK. THE REJOINDER ASKS HOW MANY OF THOSE CRISES WERE GENERATED BY THE HOSPITAL'S INTERVENTIONIST PROCEDURES. THE WHOLE MATTER OF IDENTIFYING POTENTIAL RISKS IS STILL IN QUESTION, BUT IT ILLUSTRATES AN IMPORTANT CIRCUMSTANCE. RIGOROUS EVALUATION STRATEGIES ARE BEING APPLIED TO CHILDBIRTH ALTERNATIVES IN A WAY THAT HOSPITAL PRACTICES HAVE NEVER ADDRESSED FOR THEMSELVES. EVEN SO, THE ALTERNATIVES ARE BEING PROVED LESS EXPENSIVE, AND WIDELY VIEWED AS SAFE FOR LOW-RISK WOMEN, AND REGARDED AS PROVIDING INDIVIDUALIZED, PERSONALIZED, AND NON-OPPRESSIVE FAMILY CENTERED CARE.

A NUMBER OF HOSPITALS HAVE ATTEMPTED TO RESPOND TO THESE CIRCUMSTANCES BY ESTABLISHING WITHIN THEIR OBSTETRIC UNITS A SPECIAL "FAMILY ORIENTED DELIVERY ROOM" FOR PEOPLE WHOSE TASTES RUN THAT WAY. PERHAPS IN TIME THESE EFFORTS WILL CAUSE LESS COERCIVE ATTITUDES TO DIFFUSE THROUGHOUT THE OBSTETRIC SERVICE. BUT IN THE MEANTIME, THE SPECIAL ROOMS APPEAR TO BE CONCESSIONS WITHOUT CONVICTION, A PARODY OF WHAT MANY WOMEN ARE REALLY SEEKING.

ADVOCATING WIDESPREAD DEVELOPMENT OF OUT-OF-HOSPITAL DELIVERY SYSTEMS IS PREMATURE. PROBABLY SUCH SYSTEMS WILL NEVER AGAIN BE SOUGHT BY MORE THAN A SMALL PROPORTION OF WOMEN. THEIR IMPORTANCE NOW IS LARGELY REFORMISM. WOMEN WHO DESIRE AN ALTERNATIVE TO INTERVENTIONIST HOSPITAL BASED MATERNITY CARE DESERVE HELP IN FINDING A SAFE ALTERNATIVE. THOSE SYSTEMS DESERVE CAREFUL STUDY AND SUPPORT.

THE REGIONALIZATION OF PERINATAL CARE, SO ENTHUSIASTICALLY ENDORSED BY ORGANIZED OBSTETRICS, IS HARDLY A REASSURING RESPONSE TO CURRENT PROBLEMS. REGIONALIZATION TENDS TO CLOSE SMALL COMMUNITY BASED MATERNITY

SERVICES. THE RECORD IS NOT CLEAR THAT THEY DO A BAD JOB. FLECK STUDIED SUCH UNITS IN UPPER NEW YORK STATE AND COULD FIND NO DIFFERENCE IN THEIR OUTCOMES AS COMPARED WITH LARGER HOSPITALS IN THE SAME AREA. THREE TRENDS THAT ARE ASSOCIATED WITH REGIONALIZATION ARE DISTURBING:

1. HIGH TECHNOLOGY AT TERTIARY CENTERS IS FURTHER AGGRANDIZED.
2. OUTREACH TO ASSURE INVOLVEMENT OF ALL PREGNANT WOMEN IN EARLY PRIMARY CARE IS NOT ASSURED.
3. AND ALL RESOURCES FOR PERINATAL CARE TEND TO BE PLACED UNDER MONOPOLISTIC PROFESSIONAL CONTROL.

THE WOMEN'S HEALTH MOVEMENT REPRESENTS AN IMPORTANT COUNTERVAILING FORCE TO PROFESSIONAL DOMINANCE OVER MATERNITY SERVICES AND TO GALLOPING TECHNOLOGY THAT IS HELD ACCOUNTABLE TO NO-ONE. THE WOMEN'S HEALTH MOVEMENT HAS EMERGED OVER THE PAST DECADE OUT OF A COMPLEX OF SOCIAL FORCES THAT INCLUDE FEMINISM AND CONSUMERISM. MANY FEMINISTS CHOSE A FOCUS ON HEALTH AS AN AVENUE FOR SOCIAL AND POLITICAL CHANGE BECAUSE THE INSTITUTIONALIZED SEXISM EMBODIED IN THE MEDICAL AUTOCRACY IS A REFLECTION OF THE UNEQUAL POWER RELATIONSHIPS BETWEEN MEN AND WOMEN THAT EXIST IN MOST OTHER STRUCTURES OF AMERICAN SOCIETY. WOMEN WORKING FOR CHANGE IN MEDICAL CARE REPRESENT A TEST OF THE WHOLE SYSTEM. HEALTH AND, SPECIFICALLY, REPRODUCTIVE FREEDOM ARE KEY ISSUES BASIC TO THE STRUGGLE OF WOMEN FOR EQUALITY AND SELF-DETERMINATION. MALES, IN THEIR HEGEMONY OVER ABORTION, BIRTH CONTROL, CHILDBIRTH AND OTHER HEALTH SERVICES ARE, IN EFFECT, THE GUARDIANS OF AN ULTIMATE POWER OVER WOMEN AND THEY USE THE FORCE OF TECHNOLOGY AS A VEHICLE FOR SOCIAL CONTROL.

IF, AS MANY FEMINISTS ARGUE, MEDICINE IN AMERICA IS A SYSTEM OF

SOCIAL CONTROL, THEN THE DEMANDS OF THE WOMEN'S HEALTH MOVEMENT TAKE ON A NEW PERSPECTIVE. WOMEN ARE NOT SIMPLY ASKING FOR MORE, OR TECHNICALLY BETTER CARE, THEY ARE ASKING FOR A RESTRUCTURING OF THE MEDICAL SYSTEM-- A REVOLUTION IN THE DEFINITION OF THE NATURE OF MEDICAL CARE AND ITS SYSTEM OF DELIVERY--INCLUDING THE AREA OF CHILDBIRTH. THEY DEMAND A NEW ACCOUNTABILITY FROM DOCTORS AND THEIR TECHNOLOGY.

THE WOMEN'S HEALTH MOVEMENT HAS BEEN OPERATING ON SEVERAL LEVELS TO PRECIPITATE THIS REVOLUTION. A FEMINIST CRITIQUE OF SCIENCE AND TECHNOLOGY HAS BEEN EVOLVING OVER THE PAST DECADE. THIS ANALYSIS IMPACTS IN THREE BROAD AREAS ALL OF WHICH CHALLENGE, TO SOME DEGREE, AMERICAN OBSTETRICS.

FIRST OF ALL, THE IMPACT IS EVIDENT IN THE CHANGING CONSCIOUSNESS OF WOMEN AS CONSUMERS, AND IN SOME PHYSICIANS. A "NEW" WOMAN PATIENT IS EMERGING--ONE WHO ACCEPTS RESPONSIBILITY FOR HER HEALTH RATHER THAN LEAVING IT TO THE PROFESSIONAL. WOMEN HAVE HEIGHTENED EXPECTATIONS ABOUT THEIR OWN ROLE IN HEALTH CARE; THEY ARE LEARNING THAT THEY CAN PARTICIPATE IN THEIR MEDICAL CARE. THEY CAN ALSO GAIN COMPETENCE IN SELF-CARE AND PREVENTION AND MAKE INFORMED DECISIONS FOR THEMSELVES. THE SELF HELP MOVEMENT HAS WORKED TO ACKNOWLEDGE AND EXTEND THE ABILITY OF THE CONSUMER TO JUDGE THE QUALITY OF CARE THAT SHE RECEIVES. ARMED WITH THIS KNOWLEDGE, WOMEN CAN LET GO OF THE MANUFACTURED DEPENDENCY THAT HAS ALLOWED THE MEDICAL MYSTIQUE AND PATERNALISM TO PERSIST.

THE CENTRAL FOCUS OF THE WOMEN'S HEALTH MOVEMENT CAN BE SUMMARIZED AS A REJECTION OF TRADITIONAL ROLES, ESPECIALLY A REJECTION OF THE DOMINANT RELATIONSHIP OF THE CARER OVER THE CARED FOR. A ROLE OF ENFORCED PASSIVITY IS REJECTED. THIS HEIGHTENED CONSCIOUSNESS HAS AN OBVIOUS ANALOGUE IN THE DEMANDS FOR INDIVIDUALIZED MATERNITY CARE.

AND FOR THE REMOVAL OF THE RITUAL OF DEPENDENCE FROM THE CHILDBIRTH SETTING. AN EXPANDING LITERATURE ACCOMPANIES AND REINFORCES THIS NEW AWARENESS. POPULAR MAGAZINES, FOR EXAMPLE WOMAN'S DAY, FEATURE ARTICLES SUCH AS "IT'S YOUR BODY, NOT YOUR DOCTOR'S" AND "THE NEW MIDWIFE". OUR BODIES OUR SELVES HAS SOLD OVER A MILLION COPIES AND OFFERS TO WOMEN CONCISE REPRODUCTIVE HEALTH INFORMATION AS WELL AS SUGGESTIONS FOR GAINING ENTRY INTO THE MEDICAL SYSTEM AND FOR EVALUATING CARE RECEIVED. WOMEN ARE WORKING TO EXPOSE SEXISM IN MEDICAL TEXTBOOKS AND IN THE ADVERTISEMENTS OF SCIENTIFIC JOURNALS AS PART OF THE STRUGGLE TO CHANGE ATTITUDES AND BEHAVIORS AMONG PHYSICIANS THEMSELVES.

A SECOND AVENUE OF CHANGE ENGENERED BY THE WOMEN'S HEALTH MOVEMENT IS THE PROVISION OF ALTERNATIVE HEALTH-RELATED SERVICES BOTH IN A QUALITY SENSE AND TO FILL UNMET NEEDS. WELL-WOMAN CLINICS ADDRESS THE GAP IN PREVENTION THAT EXISTS IN THE ESTABLISHED MEDICAL SYSTEM. ABORTION AND RAPE CRISIS CLINICS, HOME BIRTH CENTERS AND BATTERED WOMEN SHELTERS ARE EXAMPLES OF SERVICES INITIALLY AND, IN SOME INSTANCES, STILL SUPPORTED BY WOMEN HEALTH ACTIVISTS.

THE MOST FAR-REACHING INROADS BEING MADE, AND THE THIRD FOCUS OF THE WOMEN'S HEALTH MOVEMENT, ARE IN THE AREA OF CHANGING ESTABLISHED INSTITUTIONS. PELVIC TEACHING GROUPS ARE HAVING AN IMPACT ON MEDICAL EDUCATION BY PROVIDING MORE SENSITIVE TRAINING IN GYNECOLOGICAL CARE TO MEDICAL STUDENTS. POSITIVE EXPERIENCES WITH WOMEN-RUN CLINICS HAVE MOTIVATED MORE WOMEN TO SEEK TRAINING AND WORK IN VARIOUS ASPECTS OF HEALTH CARE, INCLUDING THE PHYSICIAN LEVEL. WOMEN HAVE GAINED PUBLICITY FOR A NUMBER OF ISSUES AND BY USING LOCAL RESOURCES THEY

HAVE DOCUMENTED CASES OF ABUSIVE TREATMENT FOR CONGRESSIONAL HEARINGS, COMMISSIONS OF INQUIRY, AND HEALTH PLANNING SESSIONS. PRESENTATIONS BY WOMEN AT THE SENATE HEARINGS ON ORAL CONTRACEPTIVES IN 1970 INITIATED THIS PARTICULARLY EFFECTIVE STRATEGY. SUBSEQUENT HEARINGS ON ABORTION, STERILIZATION, AND DIETHYL-STILBESTEROL HAVE SOLICITED INPUT FROM WOMEN'S ORGANIZATIONS. IN ADDITION TO BEING ISSUE ORIENTED, LOCAL WOMEN'S GROUPS HAVE BEEN COLLECTING VALUABLE INFORMATION ON HEALTH BELIEFS AND PRACTICES. THE WOMEN'S ACTION PROGRAM OF DHEW HAS RECOMMENDED THAT THE INFORMAL NETWORKS AND DATA BASES OF LOCAL WOMEN'S ORGANIZATIONS BE TAPPED AS A CONSIDERATION FOR FUTURE FUNDING OF RESEARCH EFFORTS REGARDING WOMEN. OTHER ACTIVITIES AT THE NATIONAL LEVEL INCLUDE CREATION OF THE WOMEN'S HEALTH NETWORK, A NATIONWIDE CLEARINGHOUSE ON HEALTH POLICY AND LEGISLATION AFFECTING WOMEN'S HEALTH. THE PUBLICATION OF TWO PERIODICALS, HEALTHRIGHT, AND THE ACADEMIC WOMEN AND HEALTH JOURNAL HELP KEEP TIMELY ISSUES IN THE FOREFRONT AND ENABLE CONSUMERS TO REMAIN VIGILANT IN THE STRUGGLE FOR COOPERATIVE MEDICINE AND FOR A NEW UNDERSTANDING OF RELATIONSHIPS BETWEEN PEOPLE AND TECHNOLOGY.

WOMEN HAVE TAKEN RESPONSIBILITY FOR EXPOSING THE OFTEN UNNECESSARY AND OFTEN EXPERIMENTAL NATURE OF MANY MEDICAL PRACTICES, ESPECIALLY HOSPITAL MATERNITY PRACTICE. THE CULTURAL REVOLUTION THAT IS TAKING PLACE IN AMERICA TODAY AROUND THE ROLE OF WOMEN WILL HAVE A PRONOUNCED EFFECT ON THE DELIVERY OF OBSTETRIC SERVICE. THE CHANGES WILL OCCUR IN TERMS OF HUMAN RELATIONSHIPS AND VALUES PLACED ON HUMAN EXPERIENCES, MOST NOTABLY, CHILDBIRTH. PREVAILING TECHNOLOGY OF MATERNITY CARE IN MOST HOSPITALS BREEDS THIS REVOLUTION, AND PROVIDES A VULNERABLE AND DESERVING TARGET FOR THE GROWING SOPHISTICATION OF CONSUMERS. IT HAS BEEN FUELED BY THE VARIOUS STRATEGIES OF THE WOMEN'S HEALTH MOVEMENT, AMERICA'S MOST PROMISING CONSUMER MOVEMENT, AND MAY EXTEND THE PROMISE FOR A MORE HUMANISTIC AND LESS ARROGANT PRACTICE OF MEDICINE AND OBSTETRICS IN YEARS TO COME.

HOME DELIVERY AND NEONATAL MORTALITY
IN NORTH CAROLINA

Claude A. Burnett, III, M.D., M.P.H.¹

James A. Jones, M.P.H.²

Judith Rooks, C.N.M., M.S., M.P.H.³

Carl W. Tyler, Jr., M.D.⁴

C. Arden Miller, M.D.⁵

¹Previously Medical Epidemiologist, Family Planning Evaluation Division, Center for Disease Control, Atlanta, Georgia. Currently Director, Northeast Health District, Georgia Department of Human Resources, Athens, Georgia, (404) 542-8766

²Program Manager, Maternal and Child Health Branch, Division of Health Services, State of North Carolina, Raleigh, North Carolina

³Previously Nurse Epidemiologist, Family Planning Evaluation Division, Center for Disease Control, Atlanta Georgia: Currently Expert Consultant with Office of Population Affairs, Department of HEW, Washington, D.C.

⁴Director, Family Planning Evaluation Division, Center for Disease Control, Atlanta, Georgia.

⁵Professor and Chairman, Department of Maternal and Child Health, School of Public Health, University of North Carolina, Chapel Hill, North Carolina

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Center for Disease Control
Bureau of Epidemiology
Atlanta, Georgia 30333

ABSTRACT

This paper examined neonatal mortality by place and circumstances of delivery in North Carolina during 1974-1976 with particular attention given to home delivery. The usual out-of-hospital versus in-hospital classification of childbirth did not adequately account for the spectrum of neonatal mortality rates. Planned home deliveries by lay-midwives were associated with 3 neonatal deaths per 1,000 live births. Planned home deliveries without a trained attendant were associated with 30 neonatal deaths per 1,000 live births; and unplanned home deliveries were associated with 120 neonatal deaths per 1,000 live births. The women delivered at home by lay-midwives were screened in county health departments and found to be medically at low risk of complications, in spite of having demographic characteristics associated with high risk of neonatal mortality. In contrast, the women delivered at home without known prenatal screening and without a trained attendant had low risk demographic characteristics but experienced a high rate of neonatal mortality. Planning status, prenatal screening, and training of the attendant were important factors in differentiating the risk of neonatal mortality in this uncontrolled, observational study. Controlled studies are needed to investigate the importance of the place and circumstances of delivery to infant survival.

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Summary reports of state vital statistics have traditionally classified births as occurring in-hospital and out-of-hospital. Fetal and infant mortality rates have also been reported using this dichotomy for place of birth. Since such information is the best that is generally available, it has been quoted in defense of the argument that in-hospital delivery is safer than out-of-hospital delivery. However, with increasing interest in home delivery, the places as well as the circumstances of delivery should be classified more precisely before attributing risks of mortality to them. This paper provides an analysis of neonatal mortality in North Carolina over the three years 1974-1976, with special attention given to the spectrum of places and circumstances which characterized out-of-hospital deliveries.

In North Carolina, the proportion of babies born at home has declined from 76% in 1940, to less than 1% in 1975 (Figure 1). With this shift from home to hospital delivery, the maternal mortality rate fell from 50 per 10,000 live births in 1940 to 3 per 10,000 live births in 1975, a decline of 94%. Neonatal mortality also declined, but less dramatically, from 33 per 1,000 live births in 1940 to 13 per 1,000 live births in 1975, a decline of 61%. In 1975, the neonatal mortality rate remained more than 40 times the maternal mortality rate, in spite of nearly universal hospitalization for childbirth.

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Much of the medical profession advocates hospital delivery and views home delivery as a regressive step which would reverse the historical improvement in the safety of childbirth. The majority of women choose to deliver in a hospital where physicians are able to intervene effectively in emergencies, many of which cannot be anticipated even with the best prenatal care. However, an increasing number of women prefer delivery at home for such reasons as having familiar people and surroundings, avoiding perceived risks of highly technical medical care, and reducing cost. In the context of alarming increases in the cost of health care, lower cost alternatives to hospital delivery for selected low risk women should be studied to see if an increase in mortality would result if the practice were widespread.

In North Carolina, lay-midwives legally attend home deliveries in some counties. The practice of these lay-midwives is regulated by the county health departments. Prenatal care involving systematic screening for risk factors must be provided by the health department for each patient; and each home delivery by a lay-midwife must be approved in advance as low-risk. Since 1964 no lay-midwife has been initially certified to practice in a county in North Carolina. Those lay-midwives still practicing are gradually being phased out; 25 were issued a required yearly permit in 1974, 18 in 1975, and 15 in 1976.

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MATERIALS AND METHOD

This study used neonatal death rates as a measure of the risk associated with the place and circumstances of birth. Vital records of live births and neonatal deaths registered in North Carolina for 1974-1976 constituted the initial source of information for the study. Birth records were coded as occurring in hospital, in clinic or office, enroute to a hospital, or at home. Infant death records are routinely linked with their corresponding birth records in North Carolina, making it possible to determine death rates by birth characteristics.

In order to estimate the risk of neonatal mortality associated with the circumstances of home delivery, we classified all home deliveries occurring in North Carolina during 1974-1976 by both their planning status and attendant. If a home delivery was intended by choice with a healthy infant anticipated, it was classified as planned.

Greater emphasis was placed on determining the planning status of those few home deliveries which were followed by a neonatal death. Misclassification of a small number of such deaths would have had a large effect on the reported neonatal mortality rates. Therefore, these deaths were individually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery.

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To obtain the number of infants at risk of these neonatal deaths, we classified all 1,296 home deliveries occurring in North Carolina during 1974-1976 by planning status and attendant. To simplify this classification we made two assumptions. We assumed that all home deliveries attended by a lay-midwife were planned. This assumption was justified for two reasons. First, for a lay-midwife to get a permit to attend a home delivery, a pregnant woman had to be approved by a health department as being at low risk of complications. We considered completion of this process evidence of careful planning. Second, a lay-midwife would have been unlikely to attend an unplanned home delivery and report it on the birth certificate because of the risk of revocation of her permit to do home deliveries.

Our second assumption classified home deliveries of infants weighing 2,000 grams or less at birth and not attended by a lay-midwife as precipitate and unplanned. There were 51 such deliveries. These might have been planned but were classified as unplanned. However, no such assumption was made in the classification of any of the neonatal deaths which followed home delivery. Therefore, the effect of classification error introduced by the second assumption would have been to increase the apparent neonatal mortality rate of home deliveries classified as planned and not attended by a lay-midwife, and to decrease the apparent neonatal mortality rate of home deliveries classified as unplanned.

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In June 1978, a copy of the birth certificates of each of the remaining home deliveries not classified by one of the above two assumptions was sent to the health department of the county of residence of the mother. A brief questionnaire accompanied each certificate requesting that health department staff determine the reason for home delivery and the attendant actually present, if any. Four alternative reasons for home delivery were provided: 1) precipitate, 2) intended, 3) failure to plan for health care, and 4) unknown. Field work by county health department staff was necessary when there was no detailed health department record describing the circumstances of the birth.

Results

Births by Reason for Home Delivery

Table 1 shows a classification of all 1,296 home deliveries for the period 1974-1976. Seventy-two percent of home deliveries were classified as planned. Of these, 766 were attended by lay-midwives and were assumed to be planned; 166 were classified by questionnaire as "intended" and were therefore considered planned. Of the 166 home deliveries classified as "intended", 57% were stated to be by preference, 26% for economic reasons, 8% for religious reasons, and 9% for other or unknown reasons.

Nineteen percent of home deliveries were classified as unplanned. The 51 infants born at home, attended by other than a lay-midwife, and weighing 2,000 grams or less were assumed

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to be precipitate, unplanned home deliveries. An additional 199 were classified by questionnaire as either "precipitate" or "failure to plan for health care" and were also considered unplanned.

Neonatal Deaths by Reason for Home Delivery

The planning status of the home deliveries which resulted in neonatal death is shown in Table 2. Of the 36 neonatal deaths associated with home delivery in North Carolina during the three years, six (17%) followed planned home delivery, and 30 (83%) followed unplanned home delivery.

Of the six neonatal deaths following planned home delivery, three were delivered without a trained attendant present. The other three were delivered by lāy-midwives but had congenital anomalies.

Two of the 30 deaths following unplanned home deliveries were classified as "unplanned - no alternative". Allegedly, one mother, who delivered a 2,800 gram infant at eight months, went to a hospital but was turned away because of lack of funds. The other, who delivered a 1,400 gram infant at seven months, was reported to have been told not to go to the hospital without payment in hand. We concluded that these home deliveries were not intended by choice.

Five of the 30 deaths following unplanned home deliveries were classified as "unplanned - suspected homicide or neglect". Three of these involved unwed teenage mothers who were charged

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with homicide. Of the two remaining deaths, one infant was found drowned in a canal and the other was grossly neglected. We concluded that these home deliveries were either precipitate, or intended without preparation for a healthy infant.

Neonatal Mortality Rates by Reason for Home Delivery

Home deliveries examined as a group, without regard to their planning status, were associated with a neonatal mortality rate of 28 per 1,000 live births. However, when subdivided by their planning status (Table 3), a different picture emerged. The neonatal mortality rate of planned home deliveries was 6 per 1,000, while that of unplanned home deliveries was 120 per 1,000. The relative risk of unplanned home deliveries was 19 times that of planned home deliveries.

The planning status of 112 home deliveries remained unknown following the questionnaire survey. If all of these unknowns had been planned, the neonatal mortality rate of planned home deliveries would still have been 6 per 1,000. If all of these unknowns had been unplanned, the neonatal mortality rate of unplanned home deliveries would have been 83 instead of 120 per 1,000.

The effect of possible classification error introduced by the assumption that the home deliveries of 51 infants weighing 2,000 grams or less and not attended by a lay-midwife were precipitate and unplanned can be similarly examined. If all 51 home deliveries had been planned, the neonatal mortality

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rate of planned home deliveries would still have been 6 per 1,000; and the neonatal mortality rate of unplanned home deliveries would have been 151 per 1,000.

Table 4 shows all neonatal deaths in North Carolina for the three year study period by place and circumstances of delivery, in rank order from the lowest to the highest neonatal mortality rate. The 112 home deliveries with unknown planning status and 11 planned home deliveries with unknown attendant are not included in the births column or in the denominators of the neonatal mortality rates. The rates ranged from zero neonatal deaths for planned home deliveries attended by a physician, to 120 neonatal deaths per 1,000 unplanned home deliveries. Planned home deliveries, prenatally screened as low risk and attended by lay-midwives, were associated with a neonatal mortality rate of 4 per 1,000 live births. However, all of the three deaths following delivery by lay-midwives were associated with congenital anomalies and thus may not have been preventable deaths.

Hospital deliveries, including high risk pregnancies and low birth weight infants, were associated with a neonatal mortality rate of 12 per 1,000 live births. After excluding infants weighing 2,000 grams or less at birth, the neonatal mortality rate for hospital deliveries was 7 per 1,000 while that for lay-midwife home deliveries remained 4 per 1,000. This difference is not statistically significant.

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Three categories of home deliveries can be distinguished in Table 4: 1) unplanned, 2) planned without a trained attendant, and 3) planned with a trained attendant, if planned home deliveries attended by physicians and lay-midwives are classified together. Unplanned home deliveries were associated with 4 times (95% confidence limits 1.4-11.4) the neonatal mortality rate of planned home deliveries without a trained attendant. Planned home deliveries without a trained attendant were associated with 8 times (95% confidence limits, 2.2-31.3) the neonatal mortality rate of planned home deliveries with a trained attendant.

Lay-Midwife Deliveries

Table 5 compares the maternal characteristics of the 467 lay-midwife home deliveries with all 159,333 deliveries occurring in North Carolina during 1975 and 1976. The table also shows the neonatal mortality rates for all deliveries by maternal characteristics. The distributions for the demographic variables age, race, marital status, and education reveal a preponderance of mothers in high-risk categories among lay-midwife home deliveries compared with all deliveries. The patients of lay-midwives were more likely to be young, black, unmarried, and less educated than the average woman who delivered in the state. In spite of their high-risk demographic profile, lay-midwife home deliveries had a relatively low-risk medical profile. They had a low percentage with 0-2 prenatal visits and the infants

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delivered were less likely to be of low weight (2,500 grams or less). This low medical risk profile of lay-midwife home deliveries is consistent with their low neonatal mortality.

Planned Home Deliveries Without a Trained Attendant

In contrast to deliveries by lay-midwives, home deliveries without a trained attendant had a low-risk demographic profile: 5% under age 20, 78% white, 90% married, and 40% educated beyond high school. While they were at high risk with respect to prenatal care (38% with 0-2 prenatal visits), they were at low risk with respect to infant birth weight (only 2% being 2,000 grams or less). Even with these favorable characteristics, their neonatal mortality rate was 8 times that of lay-midwife home deliveries.

COMMENT

The principal finding of this study is that the outcome of delivery varied importantly by both the place and circumstances of delivery. The dichotomy of in-hospital versus out-of-hospital delivery does not adequately classify births with respect to the risk of neonatal mortality. Not even more specific designation of the place of birth suffices to describe risk. Deliveries occurring at home covered the spectrum of lowest, middle, and highest risk of neonatal mortality depending on the planning status and the attendant at the delivery. The women with lay-midwives attending their home deliveries

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represented a select population at high demographic but low medical risk. The screening process carried out through prenatal care at local health departments was apparently effective.

In spite of having a low-risk demographic profile, planned home deliveries without a trained attendant experienced a high neonatal mortality rate. Having less prenatal care and not having a trained attendant at delivery appears to have overcome their demographic advantage and predisposed to higher neonatal mortality.

Unplanned home deliveries were at highest risk of neonatal mortality. They were associated with a neonatal mortality rate even higher than deliveries en route to the hospital, although the difference was not statistically significant. After analyzing 100 consecutive cases of unattended home deliveries in England, Fraser concluded that "while precipitate labour is an important factor, inadequate preparation and instruction of the patient are the commonest causes" of unattended home delivery.(1)

Adequate prenatal care and provision of care appropriate to medical risk has been repeatedly associated with lower neonatal mortality. Montgomery, and later Levy et al., showed that a nurse-midwife program, which emphasized prenatal care for a medically underserved population, was associated with a marked decline in neonatal mortality followed by a sharp rise

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after discontinuation of the program.(2,3) Zackler et al. have reported that a maternal and infant care project, which provided prenatal care to girls who conceived under age 15, was associated with a lower neonatal mortality rate compared with a population which did not receive project services.(4) In large scale studies of vital statistics data, Kessner, et al. in New York and Dott and Forte in Louisiana found that adequate prenatal care was associated with less risk of low birth weight and neonatal mortality.(5-6)

Several limitations of this observational study suggests cautious interpretations of its findings. Inferences regarding the safety of home births should await prospective controlled studies. Potential deficiencies of this study include: the fact that home delivery practices in North Carolina were not necessarily representative of practices in other states; the small number of home births and neonatal deaths in the study; error in classifying the true place and circumstances of birth; and possible under reporting of home births as well as neonatal deaths.

Two aspects of North Carolina births restricted the scope of this study. First, home deliveries and hospital deliveries attended by nurse-midwives were not represented, but are an increasing proportion of deliveries in other states.(7) Second, lay-midwives practicing in North Carolina at the time of the study were all initially certified in 1964 or before, and, therefore, had at least 10 years of experience with home deliveries.

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In spite of having included all births in a three year period, the number of home deliveries in this study remained small. There were so few neonatal deaths that the neonatal mortality rates of subgroups of home deliveries could be substantially altered by the addition or reclassification of several neonatal deaths. The study findings need to be tested where home delivery is a more common occurrence.

Retrospective classification of birth with regard to the intention to deliver in the place and under the circumstances in which delivery actually occurred is difficult at best. Intended home deliveries followed by neonatal death may have been misclassified as precipitate and unplanned. Women who intended home delivery but developed a problem during labor may have gone to the hospital to deliver. It should also be noted that hospitals are appropriately the intended place for most high risk deliveries. This fact confounds comparison of the neonatal mortality rates of hospital and home deliveries.

Some home births may not have been reported to state registrars. This might be expected to be more likely if the infant dies. Such under reporting could conceivably have been more frequent among planned home deliveries where a preventable death might lead to a feeling of guilt. However, because lay-midwives must have a permit for each home delivery and because they would have a reputation to maintain, such under reporting would be expected to be less likely than for home deliveries which were unattended or attended by an untrained person.

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In spite of the limitations of the study, logical extension of the findings suggest the following argument. Cost and preference accounted for over three-fourths of the reasons for planned home delivery attended by other than a lay-midwife. The same might be expected for lay-midwife home deliveries. If alternatives to hospital delivery were sought for reasons of cost and preference, and if carefully screened low-risk deliveries at home with trained attendants were associated with low neonatal mortality, then there should be no reason for elimination of home delivery as an alternative supported by the medical community. For prenatally screened low-risk patients, home delivery and delivery in specialized birth centers by trained personnel such as nurse-midwives may have a cost advantage over hospital delivery without unacceptable risk of neonatal mortality. If this cost advantage is to be realized, and adequate prenatal and delivery services extended to the poor, then the quality of the screening process and the training of non-physician attendants needs to be improved and expanded, not phased out. Monitoring of the quality of prenatal care, the adequacy of screening for high-risk pregnancies, and the training of competent birth attendants all require the knowledge, expertise, and support of the medical community.

TABLE 1

Planning Status of All Home Deliveries
North Carolina
1974-1976

	<u>Number</u>	<u>Percent</u>
<u>Planned</u>	934	72%
Lay midwife (assumed planned)	768	
Classified by questionnaire	166	
<u>Unplanned</u>	250	19%
Birth Weight \leq 2,000 grams (assumed unplanned)	51	
Classified by questionnaire	199	
<u>Unknown</u>	112	9%
	<hr/> 1,296	<hr/> 100%

TABLE 2

Planning Status of Home Deliveries
Resulting in Neonatal Death
North Carolina, 1974-1976

	<u>Number</u>	<u>Percent</u>
<u>Planned</u>	6	17
Infant normal	3	8
Congenital anomaly	3	8
<u>Unplanned</u>	30	83
Precipitate	23	64
No alternative	- 2	6
Suspected homicide or neglect	5	14
TOTAL	36	100

TABLE 3

Neonatal Mortality Rate for Home Deliveries
By Planning Status
North Carolina
1974-1976

	<u>Neonatal Deaths</u>	<u>Births</u>	<u>Rate*</u>
Planned Home Delivery	6	934	6
Unplanned Home Delivery	30	250	120
TOTAL	<u>36</u>	<u>1184</u>	<u>30</u>

*Neonatal deaths per 1,000 live births.

TABLE 4

Neonatal Mortality Rates by Place and
Circumstances of Delivery
North Carolina
1974-1976

	<u>Neonatal Deaths</u>	<u>Births</u>	<u>Rate*</u>
1. Home-Planned Attendant physician	0	55**	0
2. Home-Planned Attendant lay-midwife	3	768	4
3. Hospital	2,805	242,245	12
4. Clinic or office	15	949	16
5. Home-Planned Attendant not physician or lay-midwife	3	100**	30
6. Enroute	12	177	68
7. Home-Unplanned	30	250**	120
TOTAL	<u>2,868</u>	<u>244,544</u>	<u>12</u>

*Neonatal deaths per 1,000 live births

**Excludes 112 home deliveries with unknown planning status and
11 planned home deliveries with unknown attendant.

TABLE 5

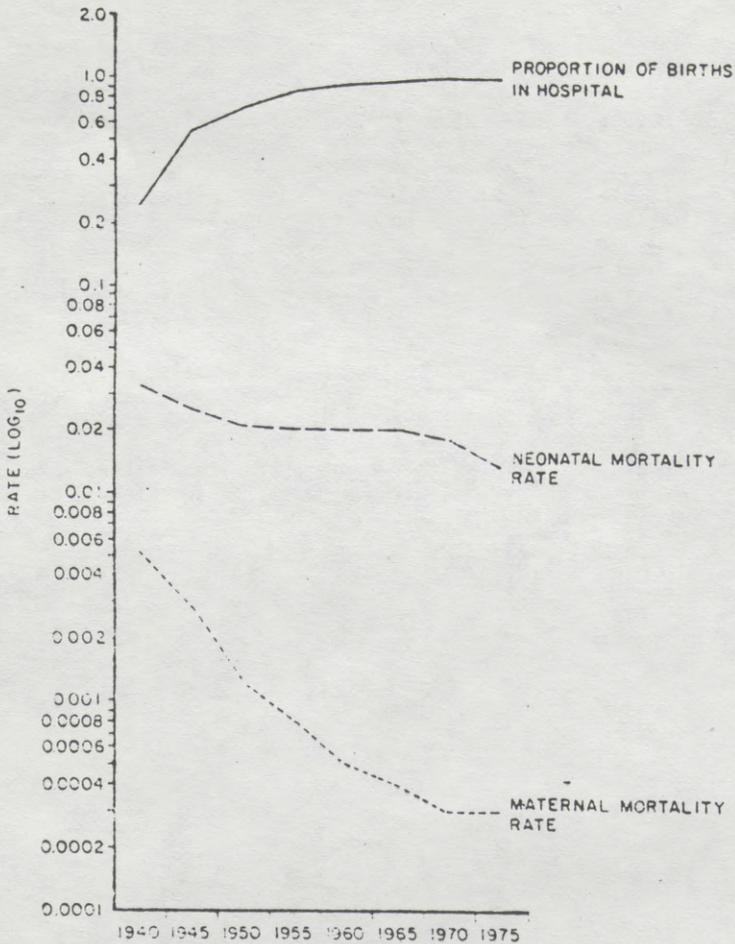
Percent Distribution of Births By Selected Maternal Characteristics For Home Deliveries By Lay Midwives Versus All Deliveries and Neonatal Mortality Rate For All Deliveries North Carolina, 1975-1976

AGE	% HOME Lay-Midwife	% ALL Deliveries	Neonatal Mortality Rate All Deliveries
< 20	40	24	14
20-24	34	35	11
25+	26	41	10
	<u>100</u>	<u>100</u>	
RACE			
White	4	69	10
Non-White	96	31	15
	<u> </u>	<u> </u>	
MARITAL STATUS			
Married	56	84	10
Unmarried	44	16	16
	<u> </u>	<u> </u>	
EDUCATION (years)			
< 12	69	36	14
12	29	42	10
> 12	2	22	9
	<u>100</u>	<u>100</u>	
PRENATAL VISITS			
0-2	5	3	65
3-7	68	19	28
8+	27	78	5
	<u>100</u>	<u>100</u>	
BIRTH WT			
≤ 2000	0	3	238
2001-2500	6	4	24
2501-3000	20	18	5
> 3000	74	74	2
	<u>100</u>	<u>100</u>	
n	457	159,333	

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Fig. 1 PROPORTION OF BIRTHS IN HOSPITAL, NEONATAL MORTALITY RATES, AND MATERNAL MORTALITY RATES, NORTH CAROLINA, 1940-1975



Mr. GORE. Thank you very much. I want to come back to some questions.

I would like to call now on Judith Rooks, expert consultant with the Office of Population Affairs, U.S. Department of Health and Human Services.

Without objection, I would like to include in the record an article, quite a short one, coauthored by Judith Rooks and Marilyn Schmidt of Georgetown University on Hospital Privileges: Experience of the Certified Nurse-Midwife.

[The article referred to follows:]

HOSPITAL PRIVILEGES: EXPERIENCE OF THE CERTIFIED NURSE-MIDWIFE

Judith B. Rooks
 Department of Health, Education and Welfare*
 Marilyn A. Schmidt
 Georgetown University, Washington DC†

INTRODUCTION

Certified Nurse-Midwives (CNM) have practiced in a variety of settings since the first nurse-midwife began practice in the United States fifty years ago. The experience of CNMs in the area of gaining limited hospital privileges is a more recent development. This article addresses the historical basis for hospital privileges for CNMs, issues surrounding this need, and the process utilized in securing these credentials. It is anticipated that this information may be useful to other health professionals in handling similar issues.

NURSE-MIDWIFERY IN THE UNITED STATES

A Certified Nurse-Midwife (CNM) is an individual educated at the professional level in the two disciplines of nursing and midwifery. Currently there are twenty-one (21) basic nurse-midwifery educational programs approved by the American College of Nurse-Midwives (ACNM). These programs prepare individuals who are already registered nurses (RN) to provide and manage the health care needed by essentially healthy women and their infants during pregnancy, labor, delivery and the postpartum period and to provide gynecologic care, including family planning, to essentially well, nonpregnant women. Nurse-midwives must pass a national, written certification examination in addition to successfully completing an approved educational program to be entitled to the distinction, Certified Nurse-Midwife (CNM). CNMs work in association with obstetrician-gynecologists or other physicians to whom they refer patients with high-risk conditions or complications. Full nurse-midwifery practice, including management of labor and delivery, is legal in every state except Kansas and Wisconsin.

Although professional midwives are the standard of obstetric care providers in much of the world, including Great Britain and many countries in Western Europe, in the United States nurse-midwifery grew relatively slowly until recent years. There were approximately 1,000 Certified Nurse-Midwives working in the United States as of late 1976. CNMs delivered at least one in every 100 babies born in the U.S. during that year.

In the United States, nurse-midwifery entered the 1970's serving poor women and their families in inner-city hospitals and isolated rural areas. There was little knowledge of nurse-midwifery among the general public. The picture changed somewhat by the end of the decade. The profession was still relatively small in numbers and most CNMs still worked in systems established to care for poor or other special-need groups. However, the profession was also playing a significant real and symbolic role in major controversies affecting the mainstream of American obstetrics. Feminists, consumer activists, and natural childbirth and breast feeding advocates were publically criticizing and trying to change certain practices and attitudes of modern obstetricians. A small but highly publicized move toward elective home births elicited a strong negative reaction from organized obstetrics. Obstetricians were increasingly faced with well-informed, opinionated middle class women. These women knew the kind of childbirth care they wanted and selected their doctors accordingly. Nurse-midwifery services established to serve poor women in city hospitals began to get calls from "private sector" patients who wanted nurse-midwifery care. Many articles on nurse-midwifery were carried in mass media newspapers and magazines, and nurse-midwifery was heralded as a better approach by many groups who were critical of obstetrical medicine. The need for hospital privileges arises primarily from this new demand for nurse-midwifery services on the part of the private patients.

HOSPITAL PRIVILEGES FOR NURSE-MIDWIVES

The Historical Perspective: Hospital Privileges Were Not Needed
 Until recent years most U.S. Certified Nurse-Midwives who delivered babies in hospitals were direct employees of either the hospitals in which they practiced or other institutions affiliated with those

hospitals. The employing institutions paid the nurse-midwives' salaries, absorbed income generated from their services, and accepted liability for their patients. The patient clientele was actually that of the hospital itself. Intra-organizational contractual agreements and position descriptions were used to delineate the responsibilities of CNMs and administrative and clinical lines of authority. CNM functions and the procedures and types of medications which they could utilize were specified in a "policy manual" mutually agreed upon by all involved parties, usually including the departments of obstetrics and nursing, hospital administration, and the Certified Nurse-Midwives themselves. Nursing in hospital Intensive Care Units provided precedence for the delegation of "medical" functions and the use of standing orders. If there was no legal restriction to the practice of nurse-midwifery in the jurisdiction, the employer-employee relationship between the hospital and the CNM avoided the issue of hospital privileges and enabled CNMs to practice fully with a specified group of clinic patients.

Why Are Hospital Privileges So Important Now?

A study conducted by the ACNM in late 1976 and early 1977 found that sixty-one percent of the U.S. nurse-midwifery work force were in clinical practice; of those in practice, eighty-four percent routinely managed deliveries. Of those who were managing deliveries, sixty-three percent were employed in organizations in which hospital privileges probably were not necessary (51% in hospitals, 10% in the military services, and 3% in health plans). Nevertheless, thirty-seven percent practiced in situations which might require hospital privileges, including thirteen percent who were in private practice with physicians. Only eight percent indicated that they ever managed births in home or other non-hospital settings (such as non-hospital based childbirth centers). Although few CNMs devote the majority of their work time to delivering babies (they averaged 65 deliveries a piece during 1976 - only slightly more than one delivery per nurse-midwife per week), the issue of hospital privileges has become important for several reasons:

- Management of normal labor and birth is an essential element of nurse-midwifery practice.
- The value of continuity of care (the continuous relationship between the patient and her health care provider) throughout pregnancy, labor, delivery and the postpartum period is a basic tenet of nurse-midwifery practice.
- Hospital privileges are one of the two keys (the other being third-party reimbursement) to serving private patients.
- Although support for professional management of childbirth in homes, birthing centers and other non-hospital settings is growing, currently it is not widely accepted in this country.
- Certified Nurse-Midwives who accept positions which do not include management of labor and delivery fear losing their skills and thus their professional identity.
- When prenatal and postpartum care are provided by one person or organization, and intrapartum care is provided by another, many third-party reimbursers pay only the person or entity which conducted the delivery. Thus, CNMs who provide prenatal and postpartum care but do not manage labor and delivery, cannot successfully participate in the fee-for-service (private) sector of health care.

Obstacles and Opposition VS Benefits and Support: Seeking A Positive Balance

Generally the ultimate authority for hospitals resides in their boards of trustees. However, responsibility for recommending the granting, withholding, limiting or withdrawal of hospital privileges is usually delegated to the hospital's organized medical staff. Although the Board of Trustees may not always accept the medical staff's recommendations, a fabric of laws, rules, regulations, guidelines, traditions and assumptions protects the medical profession's control of access to hospitals. Part of this fabric is a ruling of the Joint Commission on Accreditation of Hospitals, which requires that allied health professionals who perform functions customarily performed by physicians must be approved by the hospital medical executive staff. Since hospital privileges have traditionally been granted only to medical and osteopathic physicians and to dentists, Certified Nurse-Midwives who request privileges are often asking the medical staff to make a decision for which they have no precedent. In deliberating such a request the individual members of the medical staff balance their preceptions of

the probable costs and risks versus the probable benefits (for the hospital, its patients, the community, the medical profession and themselves as individuals) in giving or withholding privileges to the CNM. This balance is influenced by:

- a. The circumstances of the hospital (e.g., whether or not it is affiliated with a medical school; whether its obstetric service is losing or earning money, is under-utilized or overcrowded, is or is not threatened by closure because of a low delivery rate each year);
- b. Circumstances surrounding the specific request for privileges (e.g., whether the Certified Nurse-Midwife in question would practice as a partner or employee of a respected physician who is already a member of the hospital's medical staff, as an employee of another agency such as the health department, or as an independent practitioner; the specific nurse-midwife's qualifications, competency, personality, the type of patients the CNM is likely to bring to the hospital);
- c. Circumstances in the community (e.g., the extent and type of local publicity about Certified Nurse-Midwives, whether or not there are other CNMs with hospital privileges in the community or region, and whether there is a local out-of-hospital birthing center of home birth service).

Beyond these cited circumstances there appears to be a number of legal, structural, economic and attitudinal factors which influence the decision on whether or not to grant limited hospital privileges to CNMs. Some of these factors are summarized.

Legal or structural factors

- a. The legal base for nurse-midwifery practice in the state. In states with specific nurse-midwifery licensure, the CNM's legal basis for practice is unequivocal. However, in some states nurse-midwives practice under the Nurse Practice Act or special agreements by or between state and professional authorities or other mechanisms. Some of these mechanisms may not be sufficiently clear to satisfy hospital lawyers.
- b. The hospital's medical staff bylaws: Do they provide for medical staff affiliation for allied health professionals (e.g., nurse-anesthetists, nurse-midwives, optometrists, podiatrists, psychologists)?
- c. Policies of major third-party payors (especially the state Medicaid and Blue Cross and Blue Shield programs) regarding reimbursement for deliveries attended by nurse-midwives.

Economic factors for the hospital:

- a. There may be a possible loss of income to the hospital if major third-party payors refuse to reimburse for deliveries unless a licensed physician was in attendance.
- b. Unlike some types of health care for which the demand may increase with the number of providers, the need for obstetric care is unrelated to the number of persons available to provide the care.
- c. For hospitals which compete for obstetric patients, the addition of CNMs may increase revenues from both the obstetric service and the nursery.
- d. Because of low Medicaid reimbursement rates, some hospitals do not want to increase their service to Medicaid eligible women even when they have unused obstetric beds.
- e. Fear of malpractice claims. (A fear not supported by experience to date)

Economic considerations for individual physicians:

- a. Whether the nurse-midwife's ability to attract certain obstetric patients is seen as an advantage or a disadvantage depends on the balance between supply and demand for obstetric and gynecologic services in the community. The economic relationship between the CNM and the individual physician is an important consideration.
- b. Physicians who employ or are in practice with nurse-midwives may benefit economically
 - if the nurse-midwife attracts new patients to the practice and generates income greater than his/her salary.
 - if the nurse-midwife's management of normal obstetric care frees the physician to increase his/her gynecologic practice (which is usually more lucrative than obstetrics).
- c. Nurse-midwives who are not in practice with physicians, may contract with one or more physicians for medical consultation

and referral. In these instances the nurse-midwife usually pays a set percentage of the practice income for the medical back-up service.

Knowledge and attitudes about nurse-midwifery among members of the hospital medical staff:

- a. Disbelief that nurse-midwifery services are of adequate quality, based on:
 - lack of knowledge or personal experience with nurse-midwifery;
 - confusion between "granny" midwives, lay midwives and Certified Nurse-Midwives;
 - negative bias because of U.S. nurse-midwifery's history of service predominantly to the poor;
 - negative bias associated with the incorrect belief that nurse-midwives specialize in home births;
 - negative bias because of the disparities between the educational preparation of nurse-midwives and that of obstetricians.
- b. General reluctance to change, especially as it relates to the recognition that the CNM may manage childbirth somewhat differently than many obstetricians. CNMs and their patients may create pressure to change some of the hospital's practices and rules.
- c. Perceived potential effect of the introduction of nurse-midwives to the hospital on the status of the individual nurse or physician among colleagues, co-workers, patients and/or the general community.

Steps In Gaining Hospital Privileges

The Professional Affairs Committee of the ACNM has identified steps for gaining hospital privileges. The committee's advice is summarized here:

- a. Determine whether the Medical Staff Bylaws provide for affiliation of allied health personnel. If not, obtain examples of bylaws from comparable hospitals with such privileges. They must meet the criteria established in 1969 by the American Hospital Association and the American Medical Association.
- b. Identify supportive voting members of the medical staff, e.g., obstetricians (colleague, employer, or consultant), hospital administrator, medical director, pediatricians, etc.
- c. Arrange an informational fact finding session to (a) educate the medical staff, relevant department heads, and the hospital attorney; (b) supply examples of standing orders and other relevant papers to describe CNM practices and to discuss them; (c) discuss how CNMs would function in relation to physicians and hospital nursing personnel.
- d. Determine procedure for making application.
- e. If necessary, assist the Bylaws Committee in obtaining relevant information and examples of appropriate bylaws; draft proposed language to be considered.
- f. Make application with all relevant credentials: copy of ACNM certificate, state license, malpractice insurance policy, curriculum vitae, references.
- g. If privileges are refused, discuss the reasons for refusal with the appropriate persons and request a hearing, if possible.

Footnote

1. The opinions and assertions contained herein are the authors' and are not to be construed as official policy of the Department of Health, Education and Welfare or Georgetown University.

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STATEMENT OF JUDITH ROOKS, C.N.M., M.S., M.P.H.

Ms. Rooks. I would like to introduce myself. I am Judith Rooks. I am no longer at the Office of Population Affairs at the Department of Health and Human Services, although I am a consultant in the Office of the Surgeon General. I am not representing the Department of Health and Human Services here.

I am a certified nurse-midwife and I am an epidemiologist. My contribution as an epidemiologist will be the more important today.

I was an epidemiologist for the Center for Disease Control for 8 years. I was an assistant professor on the faculty of the University of Oregon School of Medicine and I am now a consultant in the Department of Health and Human Services.

I have published approximately 30 scientific and professional papers in public health and medical journals.

I directed the most recent national study of the practice of nurse-midwifery in the United States. Recently I coauthored a major report on obstetric care for the Select Committee on Promotion of Child Health.

The issue of how normal childbirth should be managed in the United States is fueled by several unanswered scientific questions regarding the relative safety of the various approaches to childbirth and by differing values concerning childbirth as an experience.

These questions remain unanswered even though there is voluminous scientific literature available. The only perfect scientific study to compare the safety of these various outcomes would be a randomized clinical trial in which women with approximately equal underlying risk are assigned on the basis of the flip of a coin to one or another kind of care, and then look at their outcomes.

Lacking that—and I think that is very unlikely that many women would allow their childbirth experience to be determined in this way—there is always some underlying bias which determines who would select a physician, or who would select a home in preference to a hospital.

These biasing factors are often intimately associated with risk, so that if one group is found to have a better or worse outcome, it may be because they were of higher or lesser risk going into the experience. Thus it is very difficult to say that it was the care that resulted in the outcome differential.

I would now like to speak primarily to the issue of the safety of nurse-midwifery and somewhat to the issue which Congressman Gore raised regarding other aspects of the quality of childbirth care, and of the need for more research in that area.

One of the major unanswered scientific questions regards the nature and degree of risk associated with birth, particularly for women who have no known medical problems or pregnancy complications prior to labor, and who have had careful prenatal care.

The answer to that question has become complicated by concern about the common, or even routine use of numerous procedures and treatments during labor and delivery.

Since these procedures all affect the labor process, and each has its own inherent risks, a serious question has been raised whether, when they are used for normal pregnancies, their risks might

outweigh their benefits, or, in other words, whether they may cause more complications than they prevent or cure.

I would like to give several examples of the methods in question.

Drugs to decrease or obliterate pain are of concern because they may cause a sudden drop in the mother's blood pressure, which in turn decreases the blood supply to the fetus.

Some of them enter the fetal circulation, where they depress the respiratory control center in the fetal brain; when the baby is born it may be too sleepy to breathe or to stimulate its own respiration.

Most pain killers slow down labor, making the contractions shorter, weaker, and further apart.

Regional anesthetics make the woman unable to control her own muscles; as a result she may not be able to push her baby out. Because of these effects of pain medications, it is often necessary to use another drug to increase the strength of labor, or to use forceps to help pull the baby out at the last phrase of the delivery.

The drug which is used to speed up labor is a common cause of fetal distress; this is because the flow of blood to the placenta is cut off during long, hard contractions.

The bag of fluid which surrounds and protects the fetus inside the womb, which is a natural protection, is routinely ruptured early in labor, again to speed the labor up.

This procedure is occasionally associated with prolapse of the umbilical cord, an event which is life-threatening to the fetus, and is commonly followed by an increased incidence of fetal heart rate changes indicative of fetal distress.

Electronic monitoring of labor, used routinely in many hospitals, can result in infection, trauma to the infant or mother, and numerous other problems. It has been associated with both infant and maternal death.

Even keeping a woman in bed during labor can have a bad effect. Studies show that labor is less painful and more efficient when the woman is free to stand, walk, or sit upright, as compared to women who remain in bed.

Yet, intravenous feedings, fetal monitoring equipment, rules, and traditional expectations keep most laboring mothers in bed. And, of course, cesarean sections, which have increased threefold over the past decade. One in six or seven babies is now born in this surgical manner, with rates as high as one in four or one in three in some hospitals.

All of these, and other treatments and procedures used during labor and delivery, can make important contributions to maternal and infant well-being, and may be lifesaving under certain circumstances.

But they are now being used in a very large proportion of pregnancies, most of which are normal and uncomplicated. Understanding the effects of their use is complicated, because they involve both risk and a benefit.

However, as they are used on increasingly low-risk populations, the ratio of risk and benefits may switch over from a net benefit to a net loss.

We know that, even among the lowest risk mothers, unexpected serious complications can arise which require rapid intervention by a physician.

We also know, however, that some women who would otherwise have had a normal labor and delivery and a healthy baby, develop serious complications, dangerous or deadly to their babies, as a result of these medical procedures.

What we don't know is how this balances out.

Are women and their babies in more danger with nurse-midwives, who are less qualified than obstetricians to handle an unexpected emergency?

Or are they safer with nurse-midwives, who are less likely than obstetricians to use pain medication, forceps, drugs to speed up labor, and so forth?

As you know, there are strong proponents for each of these points of view. But there is no adequate data to answer this question once and for all. However, regarding nurse-midwifery services, they have been, as Dr. Miller said, very heavily evaluated. None of these studies are conclusive by themselves but when you take many small studies, none of which are perfectly controlled studies, and put them all together, if there was no trend, you would see in some studies that the nurse-midwife outcomes were worse and in other studies that their outcomes were better, and it would be all over the map. However, this has not been the case. In each of the many evaluative studies done to date, the nurse-midwives results have been as good or better than pregnancy outcomes in the surrounding areas, or in the country as a whole, or for whatever other reference population was selected to be studied as a control group.

There has been no instance of a nurse-midwifery service in the United States that has compiled a bad record. And if there had been, even one bad example would have been very destructively used against nurse-midwifery.

Mr. GORE. I think we might have heard about it if there had been.

Ms. ROOKS. Yes.

However, although we lack a single large-scale, randomized clinical trial which could perhaps provide a definitive answer, there is abundant data evaluating individual nurse-midwifery services.

Although each of these studies is imperfect and inadequate by itself, they accumulate to show a clear trend.

In every case, nurse-midwifery service outcomes have been as good, if not better, than what they replaced.

This may be because nurse-midwives effectively screen out the high-risk patients; because they faithfully utilize their associations with physicians for consultation, referral, and collaboration which benefits their patients; because they give meticulous prenatal care, or because their patients are particularly motivated and willing to comply with advice regarding nutrition and other protective self-care during pregnancy.

I think one of the issues that came up in the New Jersey situation was a restriction on nurse-midwives taking care of pregnant girls, teenagers. The only way to reduce the risk for this population is to help them comply with the necessary self-care, to help them to improve their nutrition, to help them to moderate their behavior in a way that will protect them and their fetuses.

All of the technology in the world can't do that. The only thing is patient care, a long and enduring relationship between the preg-

nant teenager and her care-giver, and nurse-midwives have been effective in this long-term care.

Nurse-midwife's good results may also be related to the fact that they stay with patients throughout labor and closely observe them so when complications arise they are recognized and taken care of quickly.

I think that the feeling that many physicians have that horrendous things happen in labor quite quickly is because they are really not there for the whole time. If they had been there carefully observing the entire time they would have seen that the complication began to manifest itself early, developed slowly and then reached a crescendo.

Nurse-midwife's good results may also be because of the conservative management of labor by nurse-midwives, which minimizes the use of procedures which are risky.

Congressman Gore said, and I was pleased that he raised the point, safety is not the only thing we are concerned about. Everybody wants a safe delivery and a healthy baby but that is not enough. You have a baby to form a family, not just to have a baby.

There is a growing body of data—and we need more—regarding the importance of the social and emotional experience of childbirth. I won't go into it further except to say that it is because this quality of their care—it is not just because nurse-midwives are safe—that people choose them. It is because of the positive value. It is in this realm of the social and emotional experience of childbirth that they are chosen. This is a part of the quality of care issue which also needs to be examined.

Mr. GORE. Thank you very much.

Congresswoman Mikulski.

Ms. MIKULSKI. First of all, Dr. Miller, I would like to compliment you on your comments from page 19 on in which you say that the women's movement may represent our best hope for reform in the area of health care delivery. Of course, I know how you went through your points from page 25 on.

As I seem to review your testimony, you really feel that some of the central things that are going on is in patients really taking care of their own lives and in the area of preventive care.

In your work as the head of the department of maternal and child health, how is that being institutionalized, for example, at the University of North Carolina?

Based on what women are demanding and health consumers generally, do you see changes in medical school education? In any other allied health care education, when people go for their so-called board certification, are they being quizzed in the area of nutrition which you also mention is central to any health care?

Dr. MILLER. I would like to be able to report that kind of optimism and I can indeed report it for some isolated areas where encouraging things are happening. But I am not sure yet that there is generally a high degree of accountability with significant client and consumer involvement and participation in decisionmaking about health services. I suspect you would favor that and I know that I do.

I can identify some areas where I think we have lost ground. Over the past decade a number of Government-supported programs

that at one time required and specified significant degrees of consumer participation and control have had that provision dropped away.

If one takes a longer range view over the past 20 or 25 years, I think things are a lot better and I expect they will get better still. It isn't hard for me to look back to the time when in some parts of the country the act of prescribing a contraceptive was an illegal act. Progress is being made but it is not steady and it is slow.

Ms. MIKULSKI. I know progress is slow but are there efforts being made—I am sure you are in contact with your colleagues. Is there no minimal effort being made in the area of curriculum change to reflect these changing attitudes?

Dr. MILLER. Many of those efforts are going on but I am not ready to speak to the consistency with which they represent a reform. Plus which I am dubious that we can reasonably look toward medical school curriculum revision in the hope it will bring about sweeping social reform in our health care delivery system.

I am just not sure that is going to happen. That may be a way for looking for an easy solution to a difficult problem. I think there needs to be substantial reform in the way we educate and train professional people but I know of an awful lot of well-meaning and hard-working professional people who are just as frustrated by the system as the clients.

Until there is a higher degree of accountability to the general public for those systems, it seems to me a different kind of medical curriculum isn't necessarily going to change things as much as we would like to think it would.

Ms. MIKULSKI. When you mention we have lost ground in the programs that were mandated in the Great Society efforts, the War on Poverty when I was a social worker, it was mandated there be participation by the poor. At that time there was a lot of innovation going on in terms of students and faculty that generated changes in medical school education. We seem to have moved away.

Coming back to the accountability, I am very deeply concerned about the high tech experiences you described. Do you think the PSRO's are used efficiently in dealing with this?

One of the problems is how does one regulate without Government saying what medical practice is? We seem to have a mechanism in place. Do you see the PSRO's being effective in this area or would you offer other alternatives?

Dr. MILLER. My information is largely hearsay. I hear about reports but I have not yet seen them. My personal experience and contact has been rather disappointing in terms of what we can expect from PSRO's. I don't look upon them as a promising way to achieve the accountability that we desire.

I have the impression that PSRO's more than anything have emphasized not quality maintenance but a kind of cost control, and haven't done that very effectively.

Ms. MIKULSKI. I know you are very much interested in this, Mr. Gore, in your position in oversight investigations. I think it might be worthwhile for us to consider the role of PSROs in a further hearing. The PSRO was really meant to monitor excessive utiliza-

tion, over-bedding, excessive diagnostic work, and so on, a peer review process.

It would seem to me you might want to take a look at this because the C section rate is a thing that can be looked at.

I thank you for your comments on that. Your comments, Doctor, speak very well to that.

Ms. Rooks, I would like to thank you for your comments. This definitive article you have done, "Hospital Privileges: Experience of the Certified Nurse-Midwife," I will count as a basic primer in all the other work you will be doing to follow up.

Ms. ROOKS. If it is permissible, I would like to say something regarding the question you asked Dr. Miller.

Ms. MIKULSKI. Yes.

Ms. ROOKS. Regarding the medical school curriculum and inclusion of better information on nutrition, et cetera, I think that I would question whether we should really look to physicians to be the experts on nutrition.

To add this to the expertise which physicians have and which is such a complicated amount of professional material to absorb, to ask them to be society's experts on the entire range of health, including nutrition—I think we make a mistake in asking their advice on such a wide range of health related subjects, because they are not the experts on these things, but yet we go to them for advice.

I think they are the experts in diagnosis and treatment of disease and we should be clear in our differentiation between medicine and health and disease.

Ms. MIKULSKI. That goes right to the heart of my own philosophy which is there are health providers and nutritionists are very important. Just talking about the area of nutrition, my concern is I don't expect the doctor to do all of that but at the same time I would hope that a doctor isn't hostile to that, and also would help make information available in his or her office that really speaks in plain English.

As someone who has been on a diet for many years and told to avoid legumes—what the hell is a legume? After college I found out they are really lima beans. That is the kind of thing we are talking about.

Thank you very much.

Mr. GORE. Thank you, Congresswoman Mikulski.

Let me ask a few brief questions.

As I understand your testimony, you are saying, Ms. Rooks, as an expert in epidemiology, familiar with all of the studies relating to outcomes involving certified nurse-midwives—am I overstating your qualification there or have you indeed not made it a point to become, if not the leading expert, one of the few experts in epidemiology in this area?

Ms. ROOKS. There is an infinite amount of material on epidemiology but for nurse-midwifery there is a finite amount of material. I have read it and I have the additional ability to critique the articles from the point of view of an epidemiologist.

Mr. GORE. You are a certified nurse-midwife and your perspective is less than purely objective and needs to be challenged on that

basis but, nevertheless, your credentials are impeccable, you have examined all of the studies.

How many of them are there relating to certified nurse-midwives?

Ms. ROOKS. In regular literature published, maybe 30 to 50.

Mr. GORE. You are saying that while all of the studies are difficult to interpret because there is no such thing as a perfect study in an area like this, they all point in the same direction. They all indicate that there is a lower risk associated with normal presentation attended by certified nurse-midwives compared to normal presentation attended by obstetricians, that the general direction in which the studies taken together point in that direction. Is that correct?

Ms. ROOKS. They are either equal to or better than. There are no instances in which the outcomes are worse than.

Mr. GORE. So your analysis of the studies taken together is that the risk associated with normal births attended by certified nurse-midwives are equal to or less than the risks where obstetricians are present, and there are no studies which indicate increased risks?

Ms. ROOKS. Yes. And add to that they seek to screen out the high risk cases.

Mr. GORE. Dr. Miller, you focused on both sides of the equation and you say that if we are going to look very closely at the risks associated with nurse-midwifery, then we must also look at the risks associated with the standard medical practice and you point out those risks in some detail in your speech and in your statement.

They include such practices as the routine use of fetal monitoring, induction of labor for the convenience of the doctor's schedule. Right before a weekend or vacation or a day off in the middle of the week the statistics indicate there is an upsurge in the onset of labor for the patients of that doctor who is going to be off that weekend or going on vacation.

You cite a number of other risks, the routine use of heavy medication.

You also cite some of these, Ms. Rooks. I am not saying otherwise.

Let me ask you a specific question. A medication called scopolamine is not used very much any longer, is it?

Dr. MILLER. That is my impression but I don't pretend to be an expert on that.

Mr. GORE. That was used quite regularly, was it not?

Dr. MILLER. Right.

Mr. GORE. How does that medication operate, can you say?

Dr. MILLER. I would prefer not to respond to that. I think that is outside my area of expertise.

Mr. GORE. All right, fine. I will hold the record open to this point for additional material should we decide to include it after review.

In medical school, is a doctor given special training in routine, uncomplicated presentation?

Dr. MILLER. That is so difficult to answer. In your own medical school there are so many people training to deliver babies, so many residents, so many staff members, that we don't have enough deliveries for them.

We send our medical students to England and Scotland to get experience in delivering babies.

Mr. GORE. Are they then classified as foreign medical students from the United States?

Dr. MILLER. Not really.

Mr. GORE. Yours is not the typical case. Let me outline the point I am trying to make and present it as a question so you can challenge it where it goes wrong. There seems to be a feeling there are two contrasting approaches to childbirth, that the approach taken by certified nurse-midwives and consumers who choose certified nurse-midwives to attend the birth is informed by a view of childbirth as a naturally occurring event which is not in the nature of a medical crisis.

On the other hand, the view of childbirth which allegedly is presented in traditional medical schools is informed by the general view of medical crisis, an event which is fraught with opportunities for intervention that are often prematurely seized upon.

Dr. MILLER. I can accept that formulation but perhaps you would be willing to accept that there are many, many exceptions to it. There are many obstetricians who have the same compassionate view of the childbirthing event. Fashions change in obstetrics as they do in other things.

I happened to have had my medical education when the emphasis was very much toward natural childbirth, but the current trend is much as you have described it.

Mr. GORE. So as a general statement that is probably accurate but there are many exceptions. My wife and I, like a lot of other prospective parents who wanted an alternative, looked for an obstetrician who had the view of childbirth that was the former rather than the latter, and we were able to find such obstetricians both in Tennessee and in the District of Columbia.

Let me ask you one more question. This is for our epidemiologist, Judith Rooks. What is the significance of the study published in this issue of the American Medical Association Journal that was cited compared to the survey conducted by the American College of Obstetricians and Gynecologists indicating mortality rate for out-of-hospital births showing 2.5 times that of in-hospital births?

Ms. ROOKS. That is data ACOG cited from State health departments or vital statistics sections in which all births and infant deaths were put together and the rate for the out-of-hospital births was very high.

Dr. Miller and I were both associated with that study in North Carolina.

When we looked more closely at the situation in North Carolina we found many of the out-of hospital births were premature deliveries where the woman would be 6 or 7 months, not realize she was in labor, have a baby at home in bed or wherever, and the baby was very premature, and there was no one at all to assist with the delivery.

A couple of the deaths were apparent infanticides where the child was born at home and left to be exposed to the elements and died.

Some are births that occur in the ambulance or in the family car, racing to the hospital, which is not an optimal situation.

All of these have very high death rates and you add them into the small numbers of births that take place at home and get a high death rate.

We looked even more closely in North Carolina at births that were attended by what are called granny-midwives, who may or may not even have a high school education and who have no nursing training but who are supervised by the Public Health nurses, and who serve poor, high-risk women in rural areas where there are no physicians.

I don't know what it is like in North Carolina now, but then—1974-76—if you went to the hospital and didn't have money in your hand, they sent you home. Several of the out-of-hospital deaths resulted from cases where the woman had gone to the hospital, had no money and had the baby at home unattended completely.

The granny-midwives with no formal training had no preventable infant mortality associated with their births. They had three deaths but they were each due to fetal malformations incompatible with life. This is not an optimal situation but even then there was no preventable mortality.

Mr. GORE. Let me thank you both for appearing here today. It is excellent testimony. We appreciate your contribution.

I would like to call now Dr. Warren Pearse, executive director, American College of Obstetricians & Gynecologists, accompanied by Rosanna L. Lenker, C.N.M., past president, Nurses Association of the American College of Obstetricians & Gynecologists.

I would like to ask you to swear that the testimony you are about to give will be the whole truth, and nothing but the truth, so help you God?

Dr. PEARSE. I do.

Ms. LENKER. I do.

Mr. GORE. I want to extend to you a very special thanks on behalf of the subcommittee for going to an unusual amount of trouble to rearrange your schedule in order to be present with us, Dr. Pearse. We appreciate it and the subcommittee appreciates it.

In addition, insofar as you are a little outnumbered here today, I want to welcome you warmly to the witness table, and you, too, Ms. Lenker. And I would invite you, Dr. Pearse, to proceed with the presentation of your statement. It will be inserted, without objection, in its entirety. You are free to present all of it or highlights.

TESTIMONY OF WARREN H. PEARSE, M.D., EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, ACCOMPANIED BY ROSANNA L. LENKER, C.N.M., PAST PRESIDENT, NURSES ASSOCIATION (ACOG); AND DR. ERVIN NICHOLS, DIRECTOR OF PRACTICE ACTIVITIES (ACOG)

Dr. PEARSE. I expect to be brief in all of my comments. I did wonder if our position on the panel meant we were to conclude with a human sacrifice today but we do appreciate the opportunity to be present.

I am the executive director of the American College of Obstetricians & Gynecologists. I would like to say for the record that I am here not purely as a theorist. I was a practicing obstetrician and gynecologist for 20 years.

Obstetricians don't deliver babies, women do, but I helped to deliver about 3,000 babies.

I designed and carried out a successful maternity program for the urban poor which is still operating. I designed and implemented a program for family planning which covered an entire State which is still in operation 11 years later, so I am not a pure theorist in discussion.

I would like to begin by introducing as well Ms. Rosanna Lenker who is immediate past president of the Nurses Association of The American College and to ask, if I might, for her comments.

Mr. GORE. Ms. Lenker.

Ms. LENKER. Mr. Chairman, I am here as representative of the Nurses Association but I would like to clarify that I have special interest in that, in that I am also a nurse-midwife and I am practicing in the Harrisburg, Pa., area and have been for 6 years, initially starting service on the medical center staff and more recently in the past two months in private practice with a physician in that area.

I have chosen to have my deliveries in a hospital-based setting and try to change the medical system from within by having alternative settings and changing attitudes in nursing and medical staff and setting up a satellite clinic that involves a 60-mile radius to screen high-risk patients.

ACOG has recently published a statement on the expanded rule of the nurse-midwife, and that is introduced into Dr. Pearse's statement, and I am here to answer any questions the committee might have.

Mr. GORE. Thank you.

Dr. PEARSE. I would just like to make a brief introduction and comment on three points. I will not excerpt from or read the statement in the interest of time. [See p. 156.]

I think you would be disappointed if you expected me to be a hostile witness. I am not here to speak against nurse-midwives nor against fully informed consent and this choice, because our policy clearly supports both of them.

I think I have been disappointed by some of the testimony today which has seemed to be entirely negative on the development of nurse-midwifery in the United States. It is our perception that satisfactory practices in association with obstetricians and gynecologists exist in many areas of the country and I think our aim has been to try to make these better.

I think it should be clear there is not universal difficulty in the practice of nurse-midwifery in the United States.

I do believe, Mr. Chairman, as you have already stated, it is important that we separate the issue of nurse-midwifery practice from the place of delivery. Those are two separate issues. We were asked to testify today about the role of the nurse-midwife in childbirth and so forth.

I make just three brief points and these primarily allude to questions that I believe you have raised. In 1971, our college, together with the nurses association with the American College of Nurses, issued a joint statement on maternity care.

This statement was reaffirmed and supplemented in 1975. It remains in effect today. The key recommendations of this statement can, I think, be summed up in two sentences. I quote:

To achieve the aim of providing optimum maternity care for all women, the following recommendations are made: One, the health team organized to provide maternity care will be directed by a qualified obstetrician-gynecologist. Two, in such medically directed teams, qualified nurse-midwives may assume responsibility for the complete care and management of uncomplicated maternity patients.

I think this clearly answers two points that you raised earlier.

Mr. GORE. It does if you don't go on to provide your own definition of complete management which you do in your prepared statement.

Dr. PEARSE. We will come back to that. But I think this statement clearly supports our belief that nurse-midwifery practice is not only safe but, indeed, a valuable collaborative relationship. It provides our concept, and remember, this is a joint statement by three organizations, that nurse-midwives may function fully as members of the health care team.

My second point, if I may, is that concerns are frequently raised about reimbursement. I thought that would be a concern today and indeed it was. We have been concerned about this issue almost entirely I think because of our concern about independent practice of nurse-midwives, and by independent practice I should be clear that we refer to practice without association or direction of physicians.

In 1979, in July we submitted testimony to Congresswoman Mikulski—

Mr. GORE. May I interrupt?

You said by independent practice, you mean without association or direction by physicians. Do you mean to say, or, or do you mean to say, and?

Can you have an independent and certified nurse-midwife in independent practice in your definition of the phrase and still be associated with a doctor?

In your statement you define independent practice as a practice where the nurse-midwife is not under the direction of a physician.

Dr. PEARSE. I think the definition was given by your first panel and I would subscribe to that definition.

[Testimony resumes on p. 165.]

[The prepared statement of the American College of Obstetricians & Gynecologists follows:]

STATEMENT OF
THE AMERICAN COLLEGE
OF
OBSTETRICIANS AND GYNECOLOGISTS

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IS AN ASSOCIATION OF PHYSICIANS WHO ARE CERTIFIED IN THEIR SPECIALTY BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY. OUR MEMBERSHIP HAS GROWN TO MORE THAN 22,000 AND THAT FIGURE REPRESENTS APPROXIMATELY 95% OF THE BOARD CERTIFIED SPECIALISTS IN THE UNITED STATES. THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS REPRESENTS OVER 18,000 NURSES, INCLUDING THOSE WORKING AS OB/GYN NURSE PRACTITIONERS AND CERTIFIED NURSE MIDWIVES. THE STATEMENT WE WILL PRESENT TODAY HAS BEEN PREPARED ON THE BASIS OF DISCUSSIONS UNDERTAKEN AND POLICY DEVELOPED BY AN ACOG/NAACOG TASK FORCE ESTABLISHED MANY MONTHS AGO TO ADDRESS THE EXPANDED ROLE OF THE OB/GYN NURSE PRACTITIONER AND THE CERTIFIED NURSE MIDWIFE.

WE ARE HERE TODAY TO PRESENT OUR VIEWS ON THE APPROPRIATE ROLE AND SCOPE OF RESPONSIBILITY OF NURSE MIDWIVES IN THE PROVISION OF HEALTH CARE TO WOMEN. OUR COMMENTS ARE THE PRODUCT OF PERSONAL AND PROFESSIONAL EXPERIENCE, ANALYSIS OF THE HISTORICAL GROWTH IN NUMBERS AND DEGREES OF INVOLVEMENT BY ALLIED HEALTH PERSONNEL, AND CAREFULLY CONSIDERED, JOINTLY APPROVED STATEMENTS BY THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND THE AMERICAN COLLEGE OF NURSE MIDWIVES WHICH OUTLINE THE SCOPE OF RESPONSIBILITIES FOR NURSE MIDWIVES. IT HAS BECOME APPARENT THAT THOSE STATEMENTS, AS CAREFULLY WORDED AS THEY ARE, DO NOT MAKE CLEAR THE FULL EXTENT OF OUR PROFESSIONAL PERCEPTION AND OPINION OF THE APPROPRIATE ROLE FOR NURSE MIDWIVES. WE INTEND TO CLARIFY THAT PERSPECTIVE TODAY.

THERE IS NO SUBSTITUTE FOR QUALITY IN HEALTH CARE, WHETHER IT IS IN THE DRUG PRODUCTS AVAILABLE OVER THE COUNTER OR IN LABORATORY SERVICES OR IN SURGERY. EVEN AS WE HAVE COME TO CONSIDER CRITICALLY THE ALTERNATIVES IN HEALTH CARE FROM AN ECONOMIC POINT OF VIEW, ATTEMPTING TO CURB RAPIDLY INCREASING HEALTH CARE COSTS, OUR PRIMARY CONCERN CONTINUES TO BE AND WILL ALWAYS BE THE ASSURANCE THAT THE PATIENT IS RECEIVING THE BEST QUALITY CARE AVAILABLE.

THE PATIENT HAS EVERY RIGHT TO CHOOSE THE NATURE AND METHOD OF DELIVERY OF HIS OR HER HEALTH CARE, WHERE THE PATIENT IS EQUIPPED WITH ADEQUATE KNOWLEDGE OF THE CIRCUMSTANCES, RISKS, CONSEQUENCES, COSTS, ETC., TO MAKE A RESPONSIBLE DECISION. WE RECOGNIZE THAT THE PATIENT IS THE CONSUMER OF THE HEALTH CARE WE PROVIDE, AND AS A CONSUMER IS THE INDIVIDUAL RESPONSIBLE FOR MAKING INFORMED CHOICES FOR WHICH THEY PAY, WHICH AFFECT THEIR PERSONAL HEALTH, AND WHICH INTRUDE UPON THEIR EVERYDAY LIFE.

IT IS NOT INCONSISTENT WITH THAT PATIENT/CONSUMER ROLE OF CHOICE TO SAY THAT WE PHYSICIANS HAVE A PROFESSIONAL RESPONSIBILITY TO MAKE RECOMMENDATIONS TO THE PATIENT CONCERNING THOSE CHOICES. IN FACT, THERE ARE INSTANCES WHERE THE PHYSICIAN IS ENTRUSTED BY THE PATIENT WITH THE RESPONSIBILITY OF EITHER MAKING THE CHOICE FOR THE PATIENT OR DIRECTING A COURSE OF CARE WITHOUT ON-GOING SUPERVISION BY THE PATIENT.

FINALLY, IT IS BASIC TO THE PROFESSION OF MEDICINE -- IN FACT, IT IS ELEMENTAL FROM THE VERY ORIGINS OF THE PROFESSION -- THAT A PHYSICIAN HAS A RESPONSIBILITY TO SOCIETY TO INSIST UPON

STANDARDS OF CARE WHICH ARE STRICT AND APPROPRIATE TO REASSURE SOCIETY -- OUR SOCIETY OF PATIENTS AND CONSUMERS -- THAT RESPONSIBLE, CAPABLE, AND QUALITY CARE IS RENDERED. THIS IS NOT A PROFESSION WHICH OFFERS A COMMODITY TO THE CONSUMER; RATHER, IT IS A PROFESSION WHICH PROVIDES A SERVICE, AND THIS SERVICE IS ONE WHICH NOT ONLY AFFECTS THE PATIENT'S PERSONAL SCHEDULE, FINANCIAL STATUS, AND PUBLIC ATTITUDE; IT DIRECTLY AFFECTS THE LIFE AND PHYSICAL WELL-BEING OF THE PERSON. THROUGHOUT OUR COMMENTS, WE WISH TO REMIND THE SUBCOMMITTEE THAT PARAMOUNT AMONG OUR CONCERNS IS THIS RECOGNITION THAT THE HEALTH OF THE PERSON -- WHETHER IT BE WOMAN OR FETUS -- IS AT STAKE AND AS PROFESSIONALS IN THE PROVISION OF HEALTH CARE, WE NOT ONLY RECOMMEND, BUT WE INSIST, THAT APPROPRIATE, QUALITY HEALTH CARE BE PROVIDED TO ALL WHO HAVE A NEED FOR CARE. THIS POSITION FINDS APPLICATION IN OBSTETRICS WITH CONSUMERS WHO CHOOSE BIRTH SETTINGS AND CONDITIONS WHICH UNNECESSARILY INCREASE THE RISK TO MOTHER AND FETUS -- A CHOICE WHICH WE FIND UNACCEPTABLE.

FOR THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, "QUALITY" OF CARE IS AT ALL TIMES THE HIGHEST PRIORITY. AS STATED IN THE ACOG MATERNAL HEALTH POLICY, "EXCELLENCE IN MATERNAL HEALTH CARE IS THE FOUNDATION FOR THE PHYSICAL, INTELLECTUAL, SOCIAL AND ECONOMIC SUCCESS OF ANY SOCIETY." OUR POLICY GOES ON TO STATE, "THE COLLEGE PROPOSES AND SUPPORTS A POLICY FOR MATERNAL HEALTH WHICH WILL PROVIDE THE BEST POSSIBLE CARE AND ENVIRONMENT, BOTH MEDICAL AND SOCIAL, FOR PREGNANT WOMEN AND FOR THEIR NEWBORN INFANTS AT A REALISTIC COST. MATERNAL HEALTH CARE SHOULD ALSO BE

UNDERSTOOD TO INCLUDE THE CARE GIVEN TO THE GROWING AND DEVELOPING FETUS-IN-UTERO."

LET US BE QUICK TO REASSURE THE SUBCOMMITTEE THAT THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IS SUPPORTIVE OF ALLIED HEALTH PERSONNEL AS TRAINED AND QUALIFIED INDIVIDUALS INCORPORATED INTO THE HEALTH PROFESSIONS TO EXTEND AND BROADEN THE REACH OF HEALTH CARE SERVICES. THE MATERNAL HEALTH POLICY ALREADY MENTIONED ADDRESSES THIS ISSUE SPECIFICALLY:

MATERNAL HEALTH CARE REQUIRES THE INVOLVEMENT OF MANY TYPES OF PERSONNEL WHO CONTRIBUTE TO THE WELFARE OF THE PATIENT. THE FOLLOWING MAY BE INCLUDED: OBSTETRICIAN-GYNECOLOGIST, FAMILY PHYSICIAN, PEDIATRICIAN, ANESTHESIOLOGIST, DENTIST, CERTIFIED NURSE-MIDWIFE, NURSE, NURSE IN EXTENDED ROLES, RESPIRATORY THERAPIST, PHARMACIST, NUTRITIONIST, LABORATORY TECHNICIAN, CHILD-BIRTH EDUCATOR, SOCIAL WORKER.

MANY OF THE INDIVIDUALS NAMED ABOVE MAY BE COORDINATED INTO HEALTH CARE TEAMS. EACH TEAM SHOULD FUNCTION UNDER PHYSICIAN SUPERVISION.

THE FINAL POINT MADE IN THAT SECTION OF THE MATERNAL HEALTH POLICY IS A CRITICAL MATTER WHICH MUST BE CLARIFIED IF ONE IS TO FULLY UNDERSTAND THE APPROPRIATE ROLE FOR NURSE-MIDWIVES IN THE PROVISION OF MATERNAL HEALTH CARE. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AS STATED ABOVE, SUPPORTS THE INVOLVEMENT OF CERTIFIED NURSE-MIDWIVES AS PART OF THE "HEALTH CARE TEAM;" IN FACT, THE COLLEGE REJECTS ANY ACTION BY PHYSICIANS WHICH RESTRICTS OR INHIBITS THE FULL INVOLVEMENT OF NURSE-MIDWIVES IN THE OBSTETRIC-GYNECOLOGIC HEALTH CARE TEAM, OR WHICH PREVENTS THEIR ACCESS TO APPROPRIATE HEALTH CARE FACILITIES AS PART OF THE HEALTH CARE TEAM. THE TEAM APPROACH

IS ONE IN WHICH A RANGE OF HEALTH CARE PROVIDERS ARE INVOLVED, AND THE TEAM MAY INCLUDE ANY COMBINATION OF THE PROFESSIONALS NAMED ABOVE. HOWEVER, THE QUALITY OF CARE IS DEPENDENT UPON THE DIRECTION OF THE HEALTH CARE TEAM. AS STATED IN THE MATERNAL HEALTH POLICY, THE ACOG IS FIRM IN ITS POSITION THAT THE TEAM MUST FUNCTION WITH PHYSICIAN DIRECTION.

IN ANOTHER POLICY STATEMENT, "THE RESPONSIBILITIES OF THE HEALTH CARE TEAM IN MATERNITY CARE," THE ACOG HAS ADDRESSED THIS POINT STRAIGHTFORWARDLY:

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNCOLOGISTS REAFFIRMS ITS POLICY THAT THE HEALTH TEAM NECESSARY TO PROVIDE OPTIMAL MATERNITY CARE MUST BE DIRECTED BY A QUALIFIED OBSTETRICIAN-GYNCOLOGIST. FULLY RECOGNIZED IN THIS POLICY IS THE ROLE OF THE NURSE-MIDWIFE WHO, AS A MEMBER OF THIS TEAM, MAY ASSUME RESPONSIBILITY FOR THE COMPLETE MANAGEMENT OF THE UNCOMPLICATED PREGNANT WOMAN.

THIS ENDORSEMENT OF THE ROLE OF THE NURSE-MIDWIFE IN MATERNITY CARE IS BASED UPON ACCEPTANCE OF THE STANDARDS OF THE WORLD HEALTH ORGANIZATION, THE ACOG, AND STANDARDS OF THE ACNM WHICH HAVE BEEN RECOGNIZED BY THE ACOG.

IT IS IMPORTANT THAT "COMPLETE MANAGEMENT OF THE UNCOMPLICATED PREGNANT WOMAN" NOT BE CONFUSED WITH INDEPENDENT MANAGEMENT OR FINAL AUTHORITY FOR DIRECTING THE HEALTH CARE TEAM. "MANAGEMENT" IS THE DAILY, CONTINUING ATTENTION TO PROTOCOLS OF MATERNAL HEALTH CARE, WITH INDEPENDENT JUDGEMENTS LIMITED TO SELECTION FROM AMONG APPROVED ALTERNATIVES. THE MAKING OF MEDICAL DECISIONS WHICH EXTEND BEYOND SET PROTOCOLS FOR MANAGEMENT OF CARE REQUIRES THE TRAINING AND EXPERTISE OF A PHYSICIAN.

IT IS THEREFORE NOT ACCEPTABLE TO PERMIT THE PRACTICE OF NURSE-MIDWIFERY -- THE PROVISION OF MATERNAL HEALTH CARE SERVICES -- WITHOUT THE DIRECTION AND COLLABORATION OF A PHYSICIAN.

LET US DEFINE SPECIFICALLY WHAT WE MEAN BY "DIRECTION." IN THE CONTEXT OF THE HEALTH CARE TEAM FUNCTIONING UNDER THE "DIRECTION" OF A QUALIFIED OBSTETRICIAN-GYNECOLOGIST, A DIRECTED RELATIONSHIP EXISTS BETWEEN THE PHYSICIAN AND NON-PHYSICIAN (ALLIED HEALTH PROFESSIONAL) WHEN THE PHYSICIAN MANAGES AND IS RESPONSIBLE FOR A PATIENT'S CARE AND AS LONG AS THE PRESCRIBED CARE OR THERAPY CONTINUES UNDER THE PHYSICIAN'S DIRECTION. A COLLABORATIVE RELATIONSHIP EXISTS WHEN A PHYSICIAN AND A NON-PHYSICIAN HEALTH PROFESSIONAL PROVIDE DIFFERENT BUT COMPLEMENTARY FUNCTIONS RELATING TO THE PATIENT'S CARE OR TREATMENT PLAN. THE PHYSICIAN IN A COLLABORATIVE RELATIONSHIP SHOULD WHEN INDICATED BY WRITTEN PROTOCOLS PROVIDE PERIODIC RE-EVALUATION OF THE PATIENT'S CONDITION THROUGH PERSONAL EXAMINATION, SO THAT A REVISION OR CONTINUATION OF THE PATIENT'S MEDICAL TREATMENT, AS CLINICALLY INDICATED, MAY BE INSTITUTED.

THE PHYSICIAN IS RESPONSIBLE FOR THE PATIENT. THE MEDICAL PROFESSION CANNOT ACT IRRESPONSIBLY BY PERMITTING NON-PHYSICIANS TO ASSUME THE LEVEL AND COMPLEXITY OF RESPONSIBILITY ROUTINELY BORNE BY PHYSICIANS. SIMILARLY, A PHYSICIAN CANNOT ASSUME THE RESPONSIBILITY FOR SERVICES OR ACTS OF INDEPENDENT NON-PHYSICIANS WHO INDEPENDENTLY PROVIDE SERVICES RELATED TO HEALTH CONDITIONS WITHIN THE SPHERE OF THEIR LICENSURE. IN ORDER TO ASSURE THE PROVISION OF QUALITY CARE, MEN AND WOMEN TRAINED IN MEDICINE AND

EQUIPPED WITH THE EXPERTISE ACQUIRED IN THE EDUCATION LEADING TO THE DEGREE OF MEDICAL DOCTOR SHOULD BE THE ONLY INDIVIDUALS UPON WHOM THE BURDEN OF FULLY DIRECTING PATIENT CARE IS PLACED. IT IS NOT RESPONSIBLE AND NOT IN THE BEST INTERESTS OF PATIENTS AND SOCIETY TO PERMIT NON-PHYSICIANS TO ASSUME PHYSICIAN ROLES WHERE AN ESSENTIAL ELEMENT OF PROVIDING CARE IS THAT PHYSICIAN TRAINING.

AS WE APPROACH THE ISSUE OF THE APPROPRIATE ROLE FOR NURSE-MIDWIVES, IT IS ESSENTIAL TO BEAR IN MIND THE CRITICAL DIFFERENCE BETWEEN "MANAGEMENT" OF CARE AND "INDEPENDENT DIRECTION" OF CARE. THE PHYSICIAN IS INVOLVED IN THE FORMER AS DIRECTOR OF THE HEALTH CARE TEAM: THE PHYSICIAN IS ABSENT FROM, AND NOT LIABLE FOR, THE LATTER.

INDEPENDENT PRACTICE IN ANY MEDICAL FIELD REQUIRES THE EDUCATION AND TRAINING OF A PHYSICIAN. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS HAVE AGREED IN A POLICY STATEMENT TO WHAT WE BELIEVE IS A CLEAR DELINEATION OF DUTIES:

THE ULTIMATE RESPONSIBILITY AND ACCOUNTABILITY FOR THE MEDICAL OUTCOME OF PATIENT CARE IS WITH THE OBSTETRICIAN-GYNECOLOGIST, BY VIRTUE OF EDUCATION, TRAINING, AND EXPERIENCE. THE OBSTETRICIAN-GYNECOLOGIST, THEREFORE, MUST FUNCTION AS DIRECTOR OF THE HEALTH CARE TEAM.

PHYSICIANS AND NURSES FUNCTIONING IN THE EXPANDED ROLE ARE INDIVIDUALS WHO ARE LICENSED AND, BY VIRTUE OF ADDITIONAL AND APPROPRIATE EDUCATION, TRAINING, AND EXPERIENCE IN A SPECIAL AREA, HAVE BEEN PREPARED TO ASSUME EXPANDED PATIENT CARE RESPONSIBILITIES.

NURSES FUNCTIONING IN THE EXPANDED ROLE ACCEPT THE PHYSICIAN AS HAVING THE ULTIMATE RESPONSIBILITY FOR THE MEDICAL OUTCOME OF PATIENT CARE. PHYSICIANS AND NURSES SHOULD COLLABORATE IN THE DEVELOPMENT OF PROTOCOLS TO BE FOLLOWED IN THE COURSE OF PATIENT CARE, AND PHYSICIANS MUST EXERCISE APPROPRIATE DIRECTION AS THEY CARRY OUT THEIR SUPERVISORY ROLE.

INDEPENDENT PRACTICE OF THE NURSE IN THE EXPANDED ROLE IS PRACTICE IN WHICH THERE IS NO PHYSICIAN DIRECTION. SUCH INDEPENDENT PRACTICE IS NOT IN THE BEST INTEREST OF QUALITY OBSTETRIC-GYNECOLOGIC CARE.

UNDER NO CIRCUMSTANCES SHOULD A NURSE-MIDWIFE ENGAGE IN INDEPENDENT PRACTICE. IN 1971, IN THE "JOINT STATEMENT ON MATERNITY CARE," THE ACOG, NAACOG, AND ACNM AGREED THAT "THE HEALTH CARE TEAM ORGANIZED TO PROVIDE MATERNITY CARE WILL BE DIRECTED BY A QUALIFIED OBSTETRICIAN-GYNECOLOGIST." THAT STATEMENT WAS SUBSEQUENTLY CLARIFIED AND EXPANDED IN 1975 WITH A SUPPLEMENTARY STATEMENT WHICH REQUIRED A WRITTEN AGREEMENT AMONG MEMBERS OF THE HEALTH CARE TEAM CLEARLY SPECIFYING CONSULTATION AND REFERRAL POLICIES AND STANDING ORDERS, AND FINAL RESPONSIBILITY FOR DIRECTION OF CARE TO BE ACCEPTED BY THE OBSTETRICIAN-GYNECOLOGIST.

THE ACOG CONTINUES TO SUPPORT AND ENDORSE THE REASONING REPRESENTED IN THE STATEMENTS QUOTED TO THIS POINT. THE ACOG CANNOT ACCEPT A RECENT DRAFT STATEMENT BY THE ACNM THAT DESCRIBES NURSE-MIDWIFERY PRACTICE AS "THE INDEPENDENT MANAGEMENT OF CARE" OF ESSENTIALLY NORMAL NEWBORNS AND WOMEN. THIS STATEMENT IS PART OF A LARGER STATEMENT CALLING FOR ACCESS TO HOSPITAL FACILITIES FOR NURSE-MIDWIVES TO RESPOND TO CONSUMER DEMAND FOR THEIR SERVICES. THE ACOG SUPPORTS HOSPITAL ACCESS FOR CERTIFIED

NURSE-MIDWIVES WHERE THEY ACT WITHIN THE HEALTH CARE TEAM WITH PHYSICIAN DIRECTION. REGARDLESS OF CONSUMER DEMAND, IT IS NOT PROFESSIONALLY RESPONSIBLE, NOR IS IT HUMANELY REASONABLE, TO PERMIT INDEPENDENT PRACTICE BY CERTIFIED NURSE-MIDWIVES OUTSIDE THE HOSPITAL SETTING OR WITHIN IT. TO SACRIFICE QUALITY FOR POPULARITY IS OUT OF THE QUESTION FOR THIS PROFESSION.

THE ACOG CALLS UPON THE CONGRESS TO RECOGNIZE THE KEY CONSIDERATION OF QUALITY OF CARE, TO RECALL THE HISTORY OF MEDICAL PRACTICE FROM ITS ORIGINS WHEREIN THE PHYSICIAN HAS BORNE THE PERSONAL AND PROFESSIONAL RESPONSIBILITY FOR PATIENT OUTCOMES, AND TO RESPOND TO WHAT MIGHT APPEAR TO BE A POPULAR CALL FOR ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS AS BEING IN ACTUALITY AN ATTEMPT TO RE-ORDER THE PRACTICE OF MEDICINE, LOWERING STANDARDS OF ENTRANCE TRAINING, AND INCREASING THE RISK TO THE PATIENT BY PERMITTING LESS THAN ADEQUATELY TRAINED INDIVIDUALS TO INDEPENDENTLY MANAGE AND DIRECT THE MODALITIES OF CARE.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS SEEKS TO COOPERATE WITH OUR AFFILIATE ORGANIZATION, THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND THE AMERICAN COLLEGE OF NURSE MIDWIVES OR ANY OTHER GROUP, AS WELL AS THE CONGRESS, IN RESOLVING THE ISSUE OF CERTIFIED NURSE-MIDWIFERY SERVICES. THIS ORGANIZATION CANNOT, HOWEVER, BE A PARTY TO A DELIBERATE REDUCTION IN THE STANDARDS OF QUALITY THAT PATIENTS CAN EXPECT FROM THEIR HEALTH CARE PROVIDERS.

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Mr. GORE. We can go right to your statement. We don't have to do that. You say on page 8 of your statement that you cannot accept the American College of Nurse-Midwifery practice as the independent management of care.

Then at an earlier point in your statement, on page 6, the first full paragraph, you say, "Let us define specifically what we mean by direction. A direct relationship exists between the physician and nonphysician when the physician manages and is responsible for a patient's care."

Dr. PEARSE. Then I go on to talk about the collaborative relationship which is, I would say, how we view the association with the certified nurse-midwife.

Mr. GORE. But this is not an inconsequential point. I made the point earlier that this debate takes place on two levels: (1), out in the country, at the gut level where the studies and experts are not involved, but it is just an economic clash oftentimes.

Now we are at the point where the associations are involved and the experts from the respective associations are involved, so these definitions are important, and you were defining a moment ago independent practice.

I had thought that your definition of independent practice was consistent with an absence of direction and that mere association with physicians was something that was not acceptable to you.

Dr. PEARSE. Let me provide a two-part answer, if I may.

Mr. GORE. All right.

Dr. PEARSE. The first I think is very positive. We are clear in our own mind, along with the American College of Nurse-Midwives, that the semantics of these are not totally clear. The presidents of these three organizations meet together regularly. We met in November, we are meeting again on January 22, of next year in Chicago, in the attempt to develop a clearly worded statement that relates both to direction and reimbursement.

The second part would be that I think—

Mr. GORE. Here it is, the top of page 5: "As stated in the maternal health policy, ACOG is firm in its position that the team must function with physician direction." So mere association is insufficient, there must be physician direction before it is acceptable under your policy.

Dr. PEARSE. Let me define direction.

Mr. GORE. That is the key point. What does direction mean?

Dr. PEARSE. Direction means—and I have a practicing nurse-midwife next to me who may want to add to this as well. Direction means that there are written policies, procedures and protocols for the function of the certified nurse-midwife together with the physician in providing maternity care to a patient.

Within the bounds of those procedures and protocols, the nurse-midwife may have independent and complete management of the maternity patient. When a point is reached where the procedure or the protocol says, "if *x* occurs, the physician should be consulted," then the physician is consulted at the point that the post partum hemorrhage reaches 500 milliliters of blood.

Mr. GORE. All right now, what happened in Nashville, Tenn., what happened to Susan Sizemore in Nashville, Tenn., was wrong, in my opinion. Do you agree that it was wrong?

Dr. PEARSE. I would say first that my only knowledge of what happened in Nashville, Tenn. has been what I have heard here this morning and I have heard one side of a story. Whether or not there is another side, I am not sure.

If what I heard today is the entire and whole truth, then that would not follow the joint statement and policies which our organizations have adopted. In other words, it is not correct.

Mr. GORE. In preparation for this hearing, which you knew was going to be chaired by a Member of Congress from Tennessee, did you or a member of your staff contact members of the American College of Obstetricians in Nashville?

Have you received communications from Tennessee in regard to this case involving Dr. Martin and Susan Sizemore?

Dr. PEARSE. We have made no contacts. We have received no communications and we did not attempt to investigate prior to this hearing.

Ms. MIKULSKI. Dr. Pearse, having now heard the testimony of Susan Sizemore and Dr. Martin, will your organization organize an investigation into this situation to see if, No. 1, this is so, and how they did comply with the stated policies of your organization, and take appropriate redress?

Dr. PEARSE. Our functions, Congresswoman Mikulski, are much less extensive than those of the American College of Nurse-Midwives. We are a 501(c)(3) educational organization. In our standards the clear statement is made, and I would quote: Our standards are "recommendations and general guidelines rather than a body of rigid rules. They are intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice."

We are not an investigatory agency.

Ms. MIKULSKI. You are a doctor and you are a human being, and you have delivered 2,000 babies. I think both as a person and as an organization, you would want to stand for fundamental fairness. It would seem that you would want to then go back to Tennessee and see if in fact they are complying, not with the rigid set of bylaws or whatever, but with the spirit that the organization stands for.

Dr. PEARSE. I suggest the alternate route, Congresswoman, which is what more usually happens. We don't go out looking. People come to us. And if anyone in Tennessee, Dr. Martin or anyone else, had written a letter to the college describing what the difficulties were in Tennessee, if we had been contacted by anyone concerning this issue, we would have provided the necessary policies, we would have initiated some inquiries and attempted to reach a satisfactory solution.

Mr. GORE. Now wait a minute, doctor, before you get too far, if my colleague will yield.

Ms. MIKULSKI. I would like to yield back. I am sure you saw what I did, which was Dr. Martin signaling to us that he did write such a communication.

Mr. GORE. Yes, he did contact the American College, and beyond that, let's go back to your response to my earlier question. I asked you did you or a member of your staff contact members of the American College—ACOG—in Nashville about this case?

You may not be familiar with the contacts, but I am informed that such contacts were in fact made, that indeed Dr. Ervin Nichols—what is his position?

Dr. PEARSE. Director of practice activities.

Mr. GORE. He is director of practice activities—made such contacts personally at our request. We knew that we were going to want to ask you questions about what went wrong in Nashville, so we asked you specifically to look into what went on down there.

Now, for you to come and say that there may be another side, is one thing, but if you don't have the other side, then I am forced to conclude that the facts as they have been presented on this record and as they have been checked into by the national organization, are as stated.

Now, based upon your knowledge of the events in Nashville, Tenn., is it your testimony that that was a violation of the maternal health policy of the American College of Obstetricians & Gynecologists?

Dr. PEARSE. To respond directly, it is a violation, it is in disagreement with the joint policy statement of the three organizations.

Mr. GORE. OK.

Dr. PEARSE. Dr. Nichols is here if you would like him to testify. I can only testify to what I know.

Mr. GORE. That is fine. Dr. Nichols, would you come forward and be sworn, please?

[Witness sworn.]

Mr. GORE. You are the director of practice activities for the American College of Obstetricians & Gynecologists?

TESTIMONY OF DR. ERVIN E. NICHOLS

Dr. NICHOLS. Let me give you a little explanation of the sequence of events, because Dr. Pearse is absolutely correct as far as his knowledge is concerned.

Mr. GORE. I suspected that was the case.

Dr. NICHOLS. And the issue is between me and your counsel, so that you know that I am stationed here in Washington, my office is here in Washington, and Dr. Pearse was in Chicago.

Mr. GORE. OK.

Dr. NICHOLS. So it was those negotiations that got Dr. Pearse down here. We prepared most of this testimony in the office here in Washington, so that was prepared following a visit with Mr. McLain. Following the visit with Mr. McLain, I did contact one of our people in Nashville—not one of the principals—to see if I could get a general idea. I was informed by Mr. McLain of sort of an outline and it was my impression that he was asking me questions, was sort of the way it went, and I did call and I did talk to one of the people down there who was extremely supportive of the program that was going on.

The question came at that time, in my own mind, should I talk to Dr. Martin and try to get more information or any of the others, and it was my opinion that I should not do that. The information, as I say, was prepared and this was never discussed with Dr. Martin.

Mr. GORE. Dr. Martin wrote the American College of Obstetrics & Gynecologists. I have a copy of the letter dated June 14, 1980. In

fairness to your organization, it is directed to the Nashville Academy of Medicine, and a copy of it is sent to the American College, is sent to ACOG. It is directed to you, Dr. Pearse. As I say, it is dated 6 months ago. It outlines all of these problems. It is signed by Dr. Martin and Susan Sizemore and Victoria Henderson.

Now, as I said before, this debate takes place on two levels. It takes place at the gut economic level out in the countryside, and it takes place at the more sophisticated logical argumentative level, among the associations and the experts. But I think it is awfully significant that here we have the official spokesman for ACOG who says based on the facts as known to ACOG, be they limited or not, this is contrary to the policy of ACOG. I think that is very, very significant, very significant.

Now, it may be that we are making progress in many parts of the country in improving cooperation between the certified nurse-midwives and obstetricians. It may be that in many parts of the country they are becoming accepted and are free from restraint of trade.

But it is also true, as evidenced by the testimony that we have heard all day today, that in many parts of the country they are facing restraint of trade, they are facing unfair intimidation, that is preventing them from responding to the consumer demand for their services.

Now, the issue that is immediately raised is, what does the ACOG do about that?

You say in your statement, Dr. Pearse, that ACOG rejects any—let me see—"the college rejects any action by physicians which restricts or inhibits the full involvement of nurse-midwives in the obstetric-gynecological health care team or which prevents their access to appropriate health care facilities as part of the health care team."

What are you going to do about it?

Dr. PEARSE. Mr. Chairman, let me first apologize. I did not search my facts back a long time. As you can well imagine, we are presented with a great many problems everyday and I did not go back to look, nor did I recall a copy of the letter which had gone to the National Academy of Sciences and testified on the basis of that belief.

When we have been contacted on similar instances, and I can cite, for example, problems involving privileges for family physicians in the State of Connecticut, we have gone, as indeed Dr. Nichols began to do in this instance, through the local obstetrician-gynecologists, asked how the situation was perceived, tried to get as much information as we could and then tried to see if there was any way at the national level to encourage local solutions to the procedure. In general, I think we have been successful in some instances.

Mr. GORE. What are you going to do with this travesty of justice in Nashville, Tenn.?

Dr. PEARSE. We, I think, should follow that same procedure as far as Nashville is concerned, and I gather that Dr. Nichols has already begun it.

Mr. GORE. Does that mean that you are going to investigate and seek to reverse the outcome in Nashville, Tenn. insofar as it is possible?

Dr. Martin has had to leave the State.

Dr. NICHOLS. We recognize that, Mr. Chairman, and again I would like to come back to the statement, because the hypothetical question was asked by Mr. McLain how we would react to this kind of thing, and I believe that he would say that we said when we met with him here, that we would be opposed to any kind of obstruction of that kind.

We can approach our fellowship in Tennessee through the local chapter, we can approach it through education within our newsletter, we can approach it by direct correspondence, but we don't control those individuals.

Mr. GORE. I understand, but you speak for them and you present a very respectable and positive, aggressive image for all obstetricians. Now, that carries some responsibility, it seems to me.

Dr. NICHOLS. We attempt to fulfill that responsibility and I think that by making that very public and very well known what our position is—there are always going to be people who are opposed to any particular policy, and we are opposed to home deliveries, but there are still people of our fellowship who participate in home deliveries. We can't arbitrarily dismiss them from the organization on the basis of that even though that is not a college principle, and the question—we can get into other areas—the real issue if we want to get down to a tough one is abortion.

You know what the law of the land is, and we have 30 percent of our people that are on one side of the fence and some on the other—

Mr. GORE. I prefer not to get into that.

Dr. NICHOLS. I was trying to use it as an illustration.

Mr. GORE. I understand. I get into that issue all the time. That is fine. But I want to keep this hearing focused on this issue.

What about Marian McCartney, Dr. Pearse? What happened to her was wrong. What is ACOG going to do about it, the same thing? Investigate, try to persuade the principals to reverse their decision?

Dr. PEARSE. Yes, sir. I would say that we would prefer that wherever possible, these problems be brought to our attention rather than us having to go out and seek them out.

Mr. GORE. What about Lonnie Holtzman Morris, she was denied hospital privileges. Will you look into that in the same manner?

Dr. PEARSE. Yes.

Mr. GORE. All right, fine.

And the problems with the Maternity Care Association are somewhat different, it is a different concept, it is somewhat different facet of the issue, and perhaps my colleague will have some questions about that, but let me conclude my portion here before turning it over to my colleague, by pinning you down on the policy itself, because this has such an impact on how the arguments go in the rest of the country.

It all comes down to what you mean by direction. As I analyze the issue, there are two ways you can go. You say there is some uncertainty about this. The way I have mapped out this logical

argument here, you have two options. You may say this. And I am interested in whether or not you do.

Is it your position that the physicians in designing the protocol, the formal agreement between the physicians and the certified nurse-midwife, is free and should be free to outline the parameters of discretion allocated to the certified nurse-midwife?

Do you want to answer that or do you want me to give you an example?

Dr. PEARSE. Yes.

Mr. GORE. If the doctor in the written protocol says that the certified nurse-midwife will have responsibility for the pregnant woman along with the pregnant woman herself, and have responsibility for determining whether and when the doctor is brought on the scene as an active member of the team, is that all right?

Dr. PEARSE. Yes sir.

Mr. GORE. Well now, it seems to me that if that is all right, at least at this level of debate, on this facet of the issue, the argument is essentially over?

Dr. PEARSE. Mr. Chairman, if I could simply read to you from the statement itself?

Mr. GORE. Yes.

Dr. PEARSE. I think it would serve to answer your question.

Mr. GORE. Well, OK.

Dr. PEARSE. This is the joint statement on maternity care.

Ms. MIKULSKI. What page?

Dr. PEARSE. The joint statement on maternity care, 1971.

Mr. GORE. That is not your testimony?

Dr. PEARSE. This is not testimony. This is the joint statement. This is two sentences. "There must be a written agreement among members of the team clearly specifying consultation and referral policies and standing orders. The representatives of each practice discipline should participate in the development of and be signatory to the agreement."

Mr. GORE. Yes, but that is not all it says. You go on and you say that the team must function with physician direction, and then you define what you mean by direction and that definition appears to include periodic reevaluation of the patient's condition through personal examination by the physician.

Let me ask you a point blank question. Does the doctor have to be in the delivery room?

Dr. PEARSE. Absolutely not.

Mr. GORE. Does the doctor have to periodically see the patient?

Dr. PEARSE. The statement which we read earlier says not.

Dr. NICHOLS. Yes.

Mr. GORE. On one level it seems to me the argument is over and the issue then becomes to what extent is it possible, is it appropriate, and to what extent are you willing to communicate that fact, the facts we have just outlined, to your membership, so that we don't get an inconsistent result based upon the inappropriate use of raw economic power?

Dr. PEARSE. The statement obviously is not a new statement, it was distributed to all of our fellows in 1971, distributed again in 1975. There are obviously new members of the college since that time and it can certainly be pointed out again in an educational

fashion. But additionally, we certainly are willing to investigate problems that are brought to our attention. We are not, however, an organization which deals in expulsion or punishment.

Mr. GORE. I understand.

Congresswoman Mikulski.

Ms. MIKULSKI. I am recovering from the flu and this will be a hell of a time to need a doctor.

Mr. NICHOLS. Is that good or bad?

Ds. MIKULSKI. I would like to deliver my germs in my own home.

Dr. PEARSE, I would like to thank you for coming and I think you understand that many of our questions are not directed at you personally but at some of the institutional problems that we have run into. And we thank you, Ms. Lenker; you are doing an outstanding job in your national association and community.

I had some questions earlier, one of which was to clarify the difference in terms of the kind of process between what a patient receives when she consults with a nurse-midwife and what happens when that same patient consults on OB-GYN, and I talk about prenatal care and delivery. Could both you and/or Ms. Lenker outline that for me?

Dr. PEARSE. I have been accused of not giving simple answers to anything. I will do my best.

Ms. MIKULSKI. You could run for Congress if you talk like that.

Dr. PEARSE. The American College of the Nurse-Midwives has stated earlier, and I believe they do believe that the standards for ambulatory obstetric care, which we have set forth and which were developed in conjunction with nurses and midwives, are accepted by both organizations. I made a note before to point out nutrition is an important component of that document. The college, for example, has developed a questionnaire to be administered to pregnant women by the provider to determine their state of nutrition, and we have published three parent education booklets on nutrition, the last updated about 1 year ago.

I would hope that in most instances in which we are talking about a health care team that the physician and the certified nurse-midwife working together might each bring something different to the parent. It is, I would hope in many instances, not an either/or but a cooperative effort in which each could bring expertise to the parent care, both during prenatal care and during delivery, and I think the chairman made that point very well in terms of parent observations during labor in talking with Dr. Miller.

Ms. LENKER. I would like to add to that the fact that when parents come into my practice, I also tell them who my medical backup is, the physician who is with me, who the alternate is when he is out of town. I think that is a parent's right to know that at the very beginning. She may have disfavor with my backup, she also knows what the protocol is when I go for consultation and at what point the doctor will intervene.

Ms. MIKULSKI. I guess what I am trying to get at, thank you very much, what I am trying to get is a picture just in my mind, I have an office visit, there would be the difference. I am in my third month of pregnancy, I walk into my OB-GYN, what happens to me?

When I see my OB-GYN, what actually occurs in a routine OB-GYN?

Then I want to hear, Ms. Lenker, if I walk in my third month of pregnancy in your office.

Dr. PEARSE. I have not practiced now for 5 years' time.

Ms. MIKULSKI. I have never had a baby.

Dr. PEARSE. If we are assuming at this point a repeat prenatal visit, there are a set of history items which would be gone into at this time which help to define first whether or not the parent is low-risk or has developed any high-risk factors, and in addition to explore with the parent any personal or paramedical problems which may have arisen.

There would be at the third month a number of physical measurements as well, and laboratory tests, if they have not been carried out, and these are detailed at some length in the document itself.

The added dimension here is the education and parent counseling if a parent is in a practice which has no certified nurse-midwives associated, then generally the physician would develop some protocol for parent's education and direct the parent to that or carry it out in his or her own office and provide the necessary counseling.

Our statement and our maternity health policy lists 15 different providers who may be responsible for the pregnant woman and many of these may be involved in the care.

Ms. LENKER. The third month, which is usually about the second visit, I would follow exactly what Dr. Pearse has outlined, I would also add the fact we do most of our own patient education and nutritional counseling. We also review at that time the things that we have gone over the first time related to what they expect to have as the outcome of their pregnancy, their alternatives reinforced, make sure they are sure this is the practice they want to be in.

Ms. MIKULSKI. I see. That answers my question.

I don't have any further questions. Thank you very much.

Mr. GORE. Let me pin down one other point.

In requiring direction, your policy does not require that the economic relationship between the certified nurse-midwife and the doctor be structured in such a way that the money goes first to the doctor and then to the certified nurse-midwife, is that correct?

Dr. PEARSE. That is correct. I had begun to testify to that when the questions came up.

We initially testified against Congresswoman Mikulski's proposal last year; this year we changed our position to support it because our initial concern was about physician association and direction and we thought that had been satisfactorily answered.

As you may be aware, the medicaid legislation as it finally passed says something rather unusual about this, and in reading one sentence to you would you say this called for certain rights for midwives? This is the wording itself, it says the State shall be required to reimburse under medicaid for services furnished by a nurse-midwife whether or not he or she is under the supervision of or associated with a physical or health care provider. So as the

legislation finally emerges from conference, I think it is something we would not care to have seen.

Mr. GORE. So, the protocol that all parties assume will be involved is all right even if the doctor is technically an employee of the certified nurse-midwife?

Dr. PEARSE. Or the other way around.

Mr. GORE. Either way is fine, is that correct?

Dr. PEARSE. Yes, sir.

Ms. Lenker could describe her own circumstances which I think are acceptable.

Ms. LENKER. I think protocols have to be established between you and the physician that you are working with. In my case, my reimbursement is 100 percent of my services, the overhead, minus the overhead I incur.

Mr. GORE. Fine. Back to the relationship between the national society, the national organization which you represent, and members of the organization, what role do chapters play in this structure? Are your chapters autonomous, do they receive policy direction from the national organization? How does that operate?

Dr. PEARSE. We actually have sections which function at a state or substate or provincial level. We also represent Mexico and Canada. The sections are integral portions, parts of the national organization. The sections serve primarily as educational sections to provide educational programs at the State or at the substate level. On occasions, State sections or substates have made pronouncements which are in conflict with national policy. We can't stop people from doing that, but we can tell them once they do it that that has to be retracked because that is not permissible.

Mr. GORE. No, in New Jersey, the section, section 3, is that New Jersey?

Dr. NICHOLS. New Jersey is a section and it is a piece of the third district; there are three states in that district.

Mr. GORE. Is this a chapter involved?

Dr. NICHOLS. No.

Mr. GORE. District 3?

Dr. NICHOLS. New Jersey section.

Mr. GORE. The New Jersey section formally supported the Board of Medical Examiners in opposition to certified nurse-midwives. Will the national organization investigate that matter insofar as you do have somewhat more control, as I understand it, over policy set by sections as opposed to control over individual members of the organization?

Dr. PEARSE. The New Jersey section is, I think, more complex than Nashville and involves a whole series of restrictions on the practice of nurse-midwives which were set which the American College of Midwives does not agree with. It also involves the question of independent practice outside physician association or direction, as I understand it.

Mr. GORE. Outside physician association or direction? Or outside physician direction?

Dr. PEARSE. Both.

Mr. GORE. Both? I think there is some disagreement about that.

We will hold the record open for further inquiries on this.

Dr. PEARSE. I am not totally conversant with all of the situation in New Jersey; I know it is a very complex situation.

Mr. GORE. OK, I certainly appreciate the candor of your presentation here this morning, all three of you. As I say, I think it is extremely significant that you have made a judgment you have.

It has been a long day. Again I want to thank you for rearranging your schedule in going to special effort to be here. I think it is an important subject and I think that it will become increasingly important as more and more consumers ask for other choices such as those provided by Ms. Lenker and the other certified midwives who testified here today.

With the thanks of the subcommittee to you and all of our witnesses today, I declare this hearing adjourned.

[Whereupon, at 2:50 p.m., the hearing adjourned.]

[The following correspondence was submitted for the record:]



DEC 30 1980

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

444 North Capitol Street, Suite 408 • Washington, D.C. 20001 • Telephone (202) 638-4860

December 22, 1980

The Honorable Albert Gore, Jr.
United States House of Representatives
1417 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Gore:

The recent hearing on nurse-midwifery practice raised a number of issues which will require the attention and efforts of all concerned parties for some time to come. This communication is the first of several which you can expect from the American College of Obstetricians and Gynecologists, regarding the hearing itself, the testimony of all the witnesses, the apparent need for further elucidation of the ACOG position on the role of the nurse-midwife, and our expectations for the future.

At the outset, I would like to request that this letter be included with our statement for the hearing record. During the course of the hearing, you stated that the record would be held open for additional statements or clarification, and request that this statement be included.

The American College of Obstetricians and Gynecologists is pleased that Congress values the opinions and official positions of its representatives and the organization itself. I was impressed by the concern shown in your initial contacts with this office regarding our participation in the hearing, as evidenced through contacts by your counsel, Patrick McLain, and your persistence in requesting the presence of our Executive Director, Dr. Warren H. Pearse. At all times, we remained satisfied that your approach to the hearing was to be as represented to us by Mr. McLain: a general overview of the status of nurse-midwifery in the United States, with attention to ACOG's view of the appropriate role for their participation in health care delivery and our response to a perceived public demand for nurse-midwife services. Mr. McLain did describe in relatively general terms the experience of Dr. Darrell Martin in Tennessee and asked if I had any knowledge of the circumstances there. I did not, and so told him, but then (at his request) made a telephone call to a physician in the Nashville area, one not associated with the Martin affair, to clarify (1) which hospitals were involved and (2) if there was any reasonable amount of truth in the hearsay shared by Mr. McLain. I learned which

hospitals were involved, and felt at that time that two of the three had at least reasonable sounding explanations, as related to me by the physician contacted, but it also appeared that there was some credibility to the story told by Mr. McLain. However, at no time did Mr. McLain request that ACOG formally investigate the situation; in fact, if he had, I would have explained that the College does not have a policy of investigating such allegations since we do not dictate to any physician or hospital the manner in which he or she or it must manage their/its affairs.

On subsequent occasions, Mr. McLain was told by my staff that we would not be able to comment on the Tennessee matters because we were not fully aware of the facts. Mr. Congressman, we entered the hearing room expecting you to ask at most the personal opinions of our witnesses based upon what we heard that day, but were appalled and, I think rightly, confused and frustrated when we were apparently expected to not only explain and defend, but also repair, the damage done to Dr. Martin's practice in Nashville. If you wanted an explanation and defense of that action, why did you not call the physician parties to testify? And why did you not at least extend to us the courtesy of forewarning us that we would be questioned as hostile witnesses on the matter? Your approach impressed us as less than that which we have come to expect from the Congress and the Interstate and Foreign Commerce Committee in particular. In future dealings, I hope that you will make it clear when explaining your expectations in the interest of efficiency and efficacy throughout the hearing process.

At this point, I would like to clarify certain issues which might have been misconstrued in light of Dr. Parse's comments in response to the obviously prejudiced approach taken in questioning:

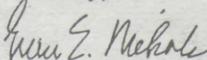
1. The position of the ACOG is stated in the written testimony submitted for the record and any inconsistency which was perceived in oral testimony should be dismissed in favor of the written statement.
2. The ACOG maintains that the health care team is responsible for maternal health services and that team must function with the direction of a physician. Direction, in this sense, is defined as: "guidance or management of conduct and performance within written protocols of medical care;" direction includes responsibility and liability for the outcome of that care.
3. The ACOG remains unalterably opposed to independent practice (i.e., practice without physician direction) by nurse-midwives.
4. The ACOG approves of reimbursement to the health care team for midwifery services if those services are rendered by a member of a health care team directed by a qualified obstetrician-gynecologist.

On January 22, 1981, the leadership of ACOG, NAACOG, and the American College of Nurse Midwives will meet to review and consider our past and

present positions on the various concerns of the professions. If the record can be held open until that date, I request that our statements resulting from that meeting be included in the record. If that is not possible, I can assure you that you will receive the information from us in a timely fashion in any case.

Again, I thank you for your invitation to the College to participate in the hearing. I am disappointed and regret that the hearing first described to be a fair and unbiased investigation became quite clearly an exercise in abuse and castigation of the entire profession and specialty based upon the alleged behavior of a relatively few individuals not under the control of the College and without a defense or explanation by any of the accused. I do hope that our basically good working relationship will not be impaired by this unfortunate experience.

Sincerely,



Ervin E. Nichols, M.D., FACOG
Director - Practice Activities

cc: Warren H. Pearse, M.D.
Rosanna Lenker, C.N.M.
Sally Tom, C.N.M.
Judy Norsigian, C.N.M.
Susan Sizemore, C.N.M.
Darrell Martin, M.D.
Lonnie Holtzman Morris, C.N.M.
Ruth Lubic, C.N.M.
Marion McCartney, C.N.M.
C. Arden Miller, M.D.
Judith Rooks, C.N.M.

ALBERT GORE, JR.
FOURTH DISTRICT
TENNESSEE

1131 LONGWORTH OFFICE BUILDING
TELEPHONE, (202) 225-4231



COMMITTEES:
ENERGY AND
COMMERCE
SCIENCE AND
TECHNOLOGY

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

March 6, 1981

Dr. Ervin E. Nichols, M.D.
Director, Practice Activities
American College of Obstetricians
and Gynecologists
444 North Capitol Street, N.W.
Suite 408
Washington, D.C. 20001

Dear Dr. Nichols:

I would like to take this opportunity to respond to your letter of December 22, 1980 and offer some comment upon our meeting of January 28, 1981. Initially, let me say that at your request, your letter as well as this response will be included in a hearing record as additional statements, but certainly not as a recantation of the prior sworn testimony of your Executive Director, Dr. Pearse.

Your letter indicates several areas in which you take issue with or with which you seek to clarify concerning either the preparation or conduct of the hearing concerning nurse midwifery. I would like to address some of those areas. First, as I stated in my office, the suggestion that some of the matters discussed at the hearing, particularly those relating to the situation which existed in Nashville, Tennessee came as a surprise to the College, I believe is totally without foundation and represents an extreme in naivete. You indicated quite correctly that Subcommittee Counsel Patrick McLain discussed this issue well in advance of the hearing and indicated to you his full knowledge of the facts as they existed in Nashville and further requested that you make an effort on your own to determine the nature of the situation in Nashville and the reasons for the action which was taken by the various hospitals against Dr. Martin and the nurse midwives. Later Mr. McLain was informed that you had in fact looked into the situation and that it was virtually as he had described it to you.

Additionally, you failed to mention the letter dated June 14, 1980 from Ms. Sizemore, Ms. Henderson and Dr. Martin to the Nashville Academy of Medicine which was also copied and sent to Dr. Pearse, as the Executive Director of ACOG, detailing the situation. Further, your staff was informed in advance of the hearing of the witnesses who were to appear with Dr. Pearse, including Ms. Sizemore and Dr. Martin. Lastly, let me suggest as I did at the hearing that the fact that you knew this hearing was to be chaired by a Member from Tennessee should have given you a clear indication that matters of substantial interest to me and to my State would be discussed at that hearing.

You indicate that ACOG witnesses were expected to "not only explain and defend, but also repair the damage done to Dr. Martin's practice in Nashville." I can assure you, Dr. Nichols, that the Subcommittee did not and does not expect the College to explain or defend the actions that have been taken solely by others. However, to the extent that actions taken by individual doctors or hospitals are endorsed or fostered by the policies, practices, or attitudes of the American College of Obstetricians and Gynecologists, we would expect representatives from the College to explain and defend your positions. Prior to the hearing and the ACOG testimony, we did not know whether that would be the case regarding the incidences described by those witnesses appearing before the Subcommittee. As such, there is no way we would know whether ACOG was to appear as, using your words, a "hostile" witness. Obviously, such a position is of your choosing and not that of the Subcommittee.

I believe that the most troubling issue raised in your letter is the implication contained in your statement that "the position of the ACOG is stated in the written testimony submitted for the record and any inconsistency which was perceived in oral testimony should be dismissed in favor of the written statement." I am prepared to accept that none of the statements made by Dr. Pearse in his testimony were inconsistent with his written statement, since my initial reading of that statement led me to conclude that when such generalities of "supervision," "direction," "guidance," and the like phrases were applied to specific factual situations, those words could take on any meaning that the reader sought them to take.

If, on the other hand, your statement had the intended implication that certain statements of Dr. Pearse do not represent the correct positions of the College, and you now seek to recant those statements, such a position would be totally unacceptable to the Subcommittee. It has been the experience of the Subcommittee in the past that often a witness under oath, subject to public scrutiny and cross-examination by Members of Congress, reveals interesting inconsistencies with a prepared statement that has been subject to careful message and proves to be merely a self-serving, defensive vehicle. It is quite understandably, I believe, an attempt to avoid public embarrassment by not stating a position which even the most casual of observers would consider indefensible. I believe such a position would exist should one try to defend the actions restraining the trade of those individual nurse midwives who appeared before the Subcommittee.

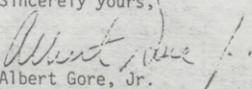
Once again, let me state that I am prepared to accept the fact that none of those statements made by Dr. Pearse were inconsistent with the written testimony. Should any real inconsistency exist, let me state emphatically that the sworn testimony would take precedence over any inconsistent statement contained in prior written testimony. If this statement in your letter is to suggest that any statements during the course of the hearing by Dr. Pearse, or any representative from the American College of Obstetricians and Gynecologists, did not represent a fair and accurate statement of the truth, I believe that to be a matter of the greatest importance and would urge that witness to contact me immediately to discuss what action might be taken by that witness and the Subcommittee, including the possibility of further hearings to more fully and adequately develop an accurate record.

When we met on January 28 we discussed several matters which I would now like to address. First, I appreciate the effort which ACOG undertook to meet with the cross section of local, State, and national officials and individuals familiar with the Nashville situation and to review and comment on the specialties position regarding the practice of certified nurse midwifery in Tennessee. While I appreciate that there are many diverse and often complex reasons which may be stated for the denial or the acceptance of a nurse midwifery practice within a given hospital, I fully expect a national organization such as ACOG with the prestige which attaches to your standing to exert whatever influence you may possess to encourage individual physicians and hospitals to adopt the positions approved by ACOG in your joint statements as well as those of Dr. Pearse in his testimony before the Subcommittee. I trust that you will continue in those efforts.

Of particular importance at the meeting I believe was your desire to discuss with me the fact that there do exist many successful programs of nurse midwifery associations with physicians which bring about an enhanced quality of care to childbirth. Dr. Nichols, I assure you that I am aware that such programs do exist and the staff of the Subcommittee did encounter them in preparation for this hearing. I also know that many of those programs do exist in large part with the backing and the encouragement of the American College of Obstetricians and Gynecologists. I commend you for that effort and encourage you to sustain your support for programs of that type.

Let me thank you and Mr. Raines once again for taking the time to meet with me and share your report from your meeting in Nashville of January 7, 1981. I hope that you will feel free to continue to inform me of the activities of the College as they relate to certified nurse midwifery practice.

Sincerely yours,


Albert Gore, Jr.
Member of Congress

