



Buyers Up • Congress Watch • Critical Mass • Global Trade Watch • Health Research Group • Litigation Group  
Joan Claybrook, President

FOR IMMEDIATE RELEASE  
November 6, 1995

CONTACT: Sidney M. Wolfe, M.D. or  
Dot McDonough --202-588-1000

**Public Citizen Releases Groundbreaking Consumer Guide and Policy Report  
on Nurse-Midwifery Practices**  
*Finds Growing Role of Nurse-Midwives Increasingly Important*

Public Citizen today released the first-ever study of nurse-midwifery practices in the United States. The Public Citizen Consumer Guide to Nurse-Midwifery, *Delivering a Better Childbirth Experience*, provides descriptions of 414 hospital nurse-midwifery practices as well as practices at 41 freestanding birth centers in 47 states.

Said Mary Gabay, Principal Researcher for the Guide, "The health status of newborns in this country is a perfect symbol for what's wrong with our health care delivery system. Despite the billions of dollars we spend each year on obstetric and neonatal care, we have been unable to significantly improve the overall health of newborns over the past decade. Although infant mortality rates in the United States have declined over a thirty-year period, our relative position with developed countries has steadily worsened, moving from 12th best in 1962 to 22nd best in 1992. In many of the countries with rates that top ours, midwives are the critical link in providing much of the prenatal and labor and delivery care."

Produced by Mary Gabay and Dr. Sidney M. Wolfe, Director of Public Citizen's Health Research Group, the consumer guide and a companion policy report compare the differences between childbirth experiences during a Certified Nurse-Midwife delivery (CNM) versus a physician delivery. Said Dr. Wolfe, "For most pregnant women, CNMs are a better physical, financial and emotional alternative. With an emphasis on prevention and early detection, CNMs reduce the excessive use of medical interventions, such as cesarean sections, that are often costly, unnecessary and even dangerous. Increased use of Certified Nurse-Midwives is an excellent example of how the quality of care can be increased while saving money on health care costs."

The consumer guide reports:

- The number of in-hospital births attended by nurse-midwives in the U.S. has been increasing steadily in the past two decades, reflecting a growing acceptance of nurse-midwifery care.

-more-

Ralph Nader, Founder

1600 20th Street NW • Washington, DC 20009-1001 • (202) 588-1000

- In 1992, almost 180,000 newborns were delivered in hospitals with a nurse-midwife in attendance -- about 4.4 percent of all in-hospital births.
- Between 1990 and 1992, the number of in-hospital midwife attended births grew between 12 and 15 percent annually.
- Most CNMs who attend hospital births care not only for low-risk women but also care for moderate and high risk women through co-management with physician colleagues.
- Ninety-two percent of CNMs surveyed provide gynecological as well as maternity care services to their clients.
- Nurse-midwifery care emphasizes the judicious use of technological interventions.
- Women who are cared for by nurse-midwives can look forward to longer prenatal visits, a greater emphasis on education and birth preparation during the prenatal period, and greater emotional support.

Said Mary Gabay, "Our consumer guide dispels antiquated myths about the practice of nurse-midwifery and clearly demonstrates that it is a viable, common-sense solution to reducing medical costs while still providing quality care to pregnant women and newborns."

Both the consumer guide and companion report for policy makers, *Encouraging the Use of Nurse-Midwives: A Report for Policymakers*, are available for \$15 only through Public Citizens's Publications Department, 1600 20th Street, N.W., Washington, D.C. 20009

Public Citizen, founded by Ralph Nader in 1971, is a nonprofit, membership-supported consumer research and advocacy organization. The Health Research Group was co-founded by Ralph Nader and Sidney Wolfe in 1971 to fight for the public's health and to give consumer's greater control over decisions that affect their health.

NURSE-MIDWIFE STUDY  
PRESS STATEMENT OF MARY GABAY,  
PUBLIC CITIZEN'S HEALTH RESEARCH GROUP  
November 6, 1995

In September of last year, Public Citizen's Health Research Group sent mail surveys to almost 1600 certified nurse-midwife (CNM) practices across the country. We wanted to learn more about the impact of nurse-midwifery care on hospital cesarean rates and on the type of care women receive during labor and delivery. Over 400 CNM practices that attend in-hospital births completed and returned our survey. Based on data on number of births attended we estimate that these practices represent some 50 to 60 percent of nurse-midwifery childbirth activity in hospitals. A second survey was mailed to a selected set of freestanding birth center practices. Thirty-nine birth centers staffed by CNMs responded and data on number of births attended show they represent over half the births in freestanding birth centers. I would like to spend a few minutes discussing some key findings from these surveys.

I want to start by briefly describing the CNM practices that completed our surveys. The practices are located in 47 states, the District of Columbia, and the U.S. Virgin Islands. The first chart shows the number of hospital practices for the 10 states with the largest numbers of such practices in our survey. Practices that attend in-hospital births had an average staff size of 3.4 CNMs with the number of CNMs on staff ranging from 1 to 29. Thirty-eight percent of respondents (the largest group) reported being employed by a physician or physician group. Substantial numbers were also employed by hospitals and in private CNM practices. On average, practices attended 258 births in 1993, although the actual number ranged quite widely from as few as five births to as many as 3,385. When asked if their practices could increase the number of births attended without adding new CNM staff, almost two-thirds of patients reported that they could do so, suggesting that even with the recent growth in the use of CNMs we are not fully utilizing this resource. Finally, we also looked at the characteristics of the hospitals in which nurse-midwives attend births. We found that an overwhelming number of practices attend births in hospitals with large obstetric volumes -- 59 percent of practices attended births in hospitals with 1,000 or more births in 1992 and another 20 percent attended births in hospitals with 500 to 1,000 births. Fewer than 1 percent of practices attended births in hospitals with an obstetric volume of less than 100 births. Nurse-midwifery practices are more or less equally distributed among hospitals categorized by perinatal nursery level. The perinatal nursery level designation reflects the capability of the hospital and its staff to care for high risk infants.

The freestanding birth center practices had an average staff size similar to that of the hospital practices -- 3.5 CNMs. In our sample of freestanding birth center practices, about 1/2 (54 percent) also have hospital delivery privileges. The average number of births attended by birth center only practices was 204 births in 1993. The number ranged quite widely from just 21 to 930 births. Eighty-two percent of birth center practices reported operating at less than full capacity.

One of the most interesting findings from our survey concerns the risk profile of CNM patients. Our survey asked respondents to describe their patient population based on its risk status. For CNMs that attend in-hospital births, an overwhelming 87 percent of respondents said their practice cares for a patient population that is predominately low risk, but that the practice also cares for higher risk women through co-management with physician colleagues.

Only 4 percent of practices described their clients as low risk only. The remaining 9 percent reported that their patient populations were predominantly high risk due mainly to social factors. These practices care for women with low incomes, little education, and poor nutrition, among other problems. With co-management of clients there are very few women for whom nurse-midwifery care would be inappropriate.

Nurse-midwives provide not only maternity care services to their clients, but almost all practices (92 percent) provide gynecological care as well. The near universal provision of this service by nurse-midwives highlights the fact that CNMs have successfully broadened the scope of their practices to include a more comprehensive array of services for their clients.

CNM's practices have cesarean section rates that are half that of the overall national rate and because most practices care for moderate and high risk women as well as low risk women, it would appear that the CNMs' rate is not mainly due to the risk profile of the population they serve. Using data on 127,000 births provided by our survey respondents, we calculated an overall cesarean section rate for CNM practices that attend hospital births of 11.6 percent over the 3-year period, 1991-1993. That number is less than 1/2 the rate for all births in the United States over the same three year period - 23.3 percent. When looking at average cesarean rates by reported patient risk profile, the cesarean rates rise as risk status rises as expected but the numbers were too small to show significant differences. Practices caring for low risk women only had cesarean rates averaging 9.0 percent, those with predominantly low risk but also co-managing higher risk women averaged cesarean rates of 11.9 percent and practices caring for a predominately high risk patient population had an average cesarean rate of 12.4 percent.

Freestanding birth center practices with their low risk only patient populations had even lower cesarean rates. Based on data representing 8,793 planned birth center births in the years 1991-1993, freestanding birth centers had an overall cesarean section rate of 6.7 percent, 26 percent lower than the 9.0 percent rate found for CNM practices that attend births for low-risk women only in a hospital setting.

An analysis of the utilization of vaginal birth after cesarean (VBAC) by nurse-midwifery clients found much better VBAC rates among CNM practices than in the nation as a whole. On average, 9 percent of clients in a given CNM practice were women who had a previous cesarean. In most practices all or almost all women with a previous cesarean attempted a trial of labor. Of those who attempted a trial of labor, an average of 78.2 percent delivered vaginally. Thus, the average VBAC rate was 68.9 percent, a figure that is 2.8 times higher than the overall VBAC rate for the United States in the 1991-1993 period. (24.9 percent).

Our survey found that nurse-midwifery care is individualized care. Instead of insisting all women submit to the same routine during labor and delivery, women and their partners are given options (many of which enhance the likelihood of a vaginal birth) not available to non-CNM clients delivering at the same hospitals. Our survey examined flexibility of nurse-midwifery care with a question that asked respondents to review a list of 14 options in obstetric care and check those options their practices usually offer to clients. The survey then asked which of the same set of options were usually offered to non-CNM clients at the same hospital where the respondent's practice attends births. The overhead shows the results. Eleven of the fourteen options were reported to be usually offered to clients in over 90 percent of CNM practices. However, respondents indicated that non-CNM clients were offered most options much less frequently. Only 3 of 14 options were reported to be usually offered to non-CNM clients by over 90 percent of respondents. For instance, the first option listed is oral fluids

during labor: 94.5 percent of respondents reported that their practice usually offers women something to drink during labor instead of solely relying on intravenous fluids. However, only 55.8 percent of these same respondents reported that oral fluids were offered to non-CNM patients in the same hospital. The difference between these two percentages is statistically significant for this option as it is for most other options as well. There are only three options - partner in attendance during labor and delivery, rooming in, and open postpartum visitation - where the differences are not significant.

Free from hospital protocols, nurse-midwives in freestanding birth practices are even more likely to offer these options to their clients. The birth center survey added four options to our list -- light refreshment during labor, use of auscultation of fetal heart tones only, no separation of mother and baby, and unlimited family participation. All four were offered to clients by 95-100 percent of birth center practices.

The almost universal willingness of nurse-midwifery practices, whether attending births in hospitals or birth centers, to offer these options to their clients reflects their commitment to individualized care, to facilitating the normal physiologic processes of birth, and to family-centered maternity care.

Finally, our survey revealed that nurse-midwives continue to struggle for the acceptance and autonomy needed to practice their profession. Sixty-four percent of respondents reported that their nurse-midwifery practices were restricted in some way. Among the most important restrictions: Lack of hospital admitting privileges, limits on prescribing privileges, hospital policies that assume a medical model of care for everyone, and a lack of information about CNMs in the community. Overcoming this last barrier is the goal of our Consumer Guide. Women who are unaware of nurse-midwifery as an option in maternity care cannot possibly choose CNM care. Increasing awareness can only increase utilization of nurse-midwives' services.

**Statement by Sidney M. Wolfe, M.D.**  
**Director, Public Citizen's Health Research Group**  
**Study on Nurse Midwifery**  
**November 6, 1995**

Today, we are here to present the results of our survey of U.S. nurse midwifery practices, including data from 414 nurse midwife practices that attend in hospitals and 41 freestanding birth center practices. The pendulum, with respect to midwifery in the United States, is rapidly swinging in a direction that not only has the potential to improve our still-embarrassing infant mortality record but also to provide equally safe, more patient-oriented and less expensive prenatal care and deliveries for American women.

Before 1910, there were over 3000 midwives in New York City alone, before World War I about 40% of "confinements" were attended by midwives and, even in the 1920's, there were 62,000 midwives in the United States. Unlike these earlier eras during which most of the midwives were so-called lay midwives, the study we have done and the health professionals who you will hear from are referring to certified nurse midwives (CNMs), licensed registered nurses who subsequently have completed an approved graduate level program in nurse-midwifery. At present, there are approximately 4000+ CNMs in the U.S. who offer the best of both worlds for women. They combine sensible, woman-oriented, old-fashioned care along with the latest medical and scientific expertise.

Before the recent resurgence in midwifery--especially the growth in the number of CNMs--the number of American women attended by midwives had fallen to extraordinarily low levels. In 1975, only 0.63% (19,686) of in-hospital births were attended by midwives. By 1993, as shown in the first chart, the number was almost 180,000 (178,537) or 4.4% of in-hospital deliveries.

If our three general recommendations are taken seriously, it is quite possible that not too long from now, the majority of American births will be attended by CNMs, reserving the use of obstetricians for the small fraction of deliveries which require their intervention. The recommendations are:

1. State laws and regulations governing the practice of nurse-midwifery should be reviewed to determine their impact on the provision of nurse-midwifery services and revised to better encourage nurse-midwifery services.
2. More opportunity should be made available for the education of nurse-midwives.
3. Sustained public information campaigns on the quality, cost-effectiveness, and client satisfaction ratings of nurse-midwifery care should be implemented.

Remarks of Philip R. Lee, MD  
Assistant Secretary for Health  
USPHS-DHHS

AT

THE PUBLIC CITIZEN NOVEMBER 6, 1995 PRESS CONFERENCE ON THE  
RELEASE OF "DELIVERING A BETTER CHILD BIRTH EXPERIENCE: A  
CONSUMER GUIDE TO NURSE-MIDWIFERY" AND "ENCOURAGING THE USE OF  
NURSE-MIDWIVES: A REPORT FOR POLICYMAKERS."

I am pleased to have been invited today to participate with my medical and midwifery colleagues in announcing these companion reports which recognize the care of nurse-midwives in hospitals and in freestanding birth centers. Public Citizen in collaboration with the American College of Nurse Midwives and the National Association of Childbearing Centers has assumed an important leadership role in bringing the accomplishments and promise of nurse-midwifery care to the attention of both consumers and health care policymakers.

The history of federal support for nurse-midwifery is a long one. Federal dollars sustained the growth of the profession with literally millions being allocated over the decades of the 60's, 70's and 80's through:

- . Professional Nurse Traineeships.
- . Grants for Improvement of Maternal and Child Health by the MCH Bureau.
- . Direct and specific support of educational programs by the Division of Nursing, Bureau of the Health Professions.
- . And, more recently, Medicaid and Medicare reimbursement for nurse-midwife services.

We see that this support should continue. Indeed, President Clinton's Health Security Act would have ensured that support. One of the important reasons the Act did so was because of the demonstrated success of a nurse-midwife designed and developed model of safe, cost effective and satisfying alternative maternity care, the freestanding birth center. I had the pleasure of dedicating Maternity Center Association's original demonstration of the Childbearing Center in 1975, and was also involved in the formation of the National Association of Childbearing Centers which assists interested parties in establishing centers and keeps standards high in the field.

An important contribution of freestanding birth centers is, I believe, that they have strengthened one of the fundamental values in health care; namely, freedom of choice. As we move into managed care systems we must be sure to preserve the freedom of women to choose a nurse-midwife, a freestanding birth center, or a hospital.

It is clear that childbearing centers have the potential to impact on health care costs. Indeed, some of them have already done so in significant ways. Few would question that the rising cost of health care, particularly inpatient hospital care, is one of the primary problems facing consumers, providers, policymakers and third-party payers. The childbearing center option is, I think, one such delivery innovation that can deliver high quality low cost maternity care.

Birth Centers have also demonstrated the ability to provide quality health care for families of all socio-economic levels.

One dimension of quality that seems important to me is the notion of the family's involvement in childbirth; and, in fact, the involvement of a whole social network - not just the family from the very first stages of prenatal care up to and including delivery, but also including the care of the infant and the whole family following birth. In fact, birth centers have opened the doors to the importance of the whole social network in many areas of service delivery, such as the care of the elderly.

Another important dimension of the quality of birth centers is the model they provide for collaboration and cooperation between institutions and practitioners. These characteristics are necessary to facilitate cost-effective delivery systems and assure access to acute care, not only for birth centers, but also in other areas of primary care where it is necessary to assure prompt access to secondary and tertiary levels of care.

Finally, informed consent procedures followed by the childbearing centers are likely to be used by many other health professionals and institutions. To a growing degree, patients will demand, and the courts will require, that this kind of full disclosure be provided all patients in order to assure that informed consent is in fact "informed".

The childbearing center model is being watched and will continue to be watched with interest by those responsible for the delivery of maternity care and prenatal care. It will also be watched by those concerned with broader dimensions of health care. Those in the birth center movement have designed and developed a model of care in which physicians, nurse-midwives,

nurses and other health professionals and non-professionals can work as a real team in collaboration with families. It is a model in which women can assume increasing responsibility for their own health and learn to appropriately use all of the resources within the system. This partnership between health care providers and patients needs to be adopted more widely in all health care delivery.

As you can see, I have been a strong supporter and advocate of nurse-midwifery and the birth center concept and congratulate Public Citizen on the release of these two valuable reports.

Statement by George Huggins, M.D.  
Interim Director, Department of Obstetrics and Gynecology  
Johns Hopkins University School of Medicine  
November 6, 1995

For the past 25 years, since 1969, I have been involved in training and working with certified nurse midwives (CNMs). There is a large CNM service at Johns Hopkins Hospital and at Johns Hopkins Bayview Medical Center. Our experience with CNMs has been uniformly positive over the years.

I am familiar with the studies showing a difference in the cesarean section rates of women cared for by CNMs compared to women cared for by physicians. Certified nurse midwives in this country function in a medically-directed system. That system results in a lower c-section rate than the system which is managed independently by physicians.

I support all three policy recommendations made in the Public Citizen Health Research Group reports. They include:

1. State laws and regulations governing the practice of nurse-midwifery should be reviewed to determine their impact on the provision of nurse-midwifery services and revised to better encourage nurse-midwifery services.
2. More opportunity should be made available for the education of nurse-midwives.
3. Sustained public information campaigns on the quality, cost-effectiveness, and client satisfaction ratings of nurse-midwifery care should be implemented.

Remarks of Ruth Watson Lubic, CNM  
Maternity Center Association

AT

THE PUBLIC CITIZEN NOVEMBER 6, 1995 PRESS CONFERENCE ON THE  
RELEASE OF "DELIVERING A BETTER CHILD BIRTH EXPERIENCE: A  
CONSUMER GUIDE TO NURSE-MIDWIFERY" AND "ENCOURAGING THE USE OF  
NURSE-MIDWIVES: A REPORT FOR POLICYMAKERS."

I am and have been a nurse-midwife for more than thirty three years. Twenty-five of those years I served as the General Director of Maternity Center Association, where I have observed my profession struggle for the opportunity to provide care to childbearing families according to the needs of the pregnant and parturient woman, rather than the needs of a particular professional group, be it obstetricians or nurse-midwives. I saw that we in the United States have not fashioned our care systems on the needs of those we purport to serve, but rather more often than not, have devised our patterns based on the needs of the serving professions. In so doing, we have emphasized the authority of the professional groups in power rather than on evidence of need and needs based models. Other countries in which I have had the privilege to observe, manage much more effectively. For example Sweden, which ranks consistently in the first five nations with best maternal and infant outcomes, has a ratio of 15 obstetricians to every 85 nurse-midwives, a situation which reflects the needs of the Swedish childbearing population (85% of women anticipate healthy physiologic pregnancies and 15% complicated.) The exact percentage of American families who could be seen through pregnancy and birth by nurse-midwives is not known exactly, but certainly it is more than the ~~1~~% who

currently are. When collaborative management of women with complicated childbearing is added, virtually all women can benefit from midwives' emphasis on prenatal education and the support afforded to achieve confident newborn care and parenting.

In 1975, in an effort to meet the needs of American families, Maternity Center Association, the 78 year old voluntary health agency which initiated prenatal care, preparation for labor, and the first school of nurse-midwifery in the United States, through its nurse-midwifery leadership devised a model to meet the needs of childbearing families and to answer their complaints about the conventional maternity care system. That model, now 20 years old, is the freestanding birth center we see surveyed by the Public Citizen. Both the Maternity Center Association (MCA) and National Association of Childbearing Centers (NACC) are very grateful to Dr. Wolfe, Mary Gabay and the staff for the fine work they have done to bring the safe, sensitive and cost effective care available to families utilizing such centers to the attention of both the public and policymakers. NACC estimates that five billion dollars each year could be saved if only 50% of women wanted and had access to midwifery care as provided in freestanding birth centers. Even many families living in low income areas are eligible for and want birth center care. MCA demonstrated that fact in the Southwest Bronx over the protestation that all such families are high risk by virtue of their addresses alone.

It should be noted that there is no such thing as risk free

childbirth. MCA's position is that families should have the privilege and authority to decide, after being fully informed which risks they would like to undertake. At MCA's Childbearing Center (CbC), families are informed fully, including about complications which are possible to occur and, as well, the position taken by professional groups vis a vis the nurse-midwife designed birth center. Families are given consent forms and glossaries to study at home in order to assist their decision making. This is an empowering activity for families, one of several which occur in the Childbearing Center experience. Others include performing the weight and urine screens done at prenatal visits, including recording the results in their own record, which is fully available to every family. In other words, families are considered partners with professionals in monitoring their health. As one mother put it --"the nurse-midwives are the specialists in normal childbirth, the obstetricians (4 of whom serve as consultants to the CbC and back-up to families) are the specialists in complicated childbirth, but I am the specialist in how I feel." I submit to you that if that final third of the equation is not taken into consideration and valued, the care will not achieve its potential. Yet another empowering facet of birth center care is early discharge, which has for 20 years occurred in from 4-12 hours following birth. The key to the success of this practice lies not in the length of stay, but in the prenatal preparation for maternal and infant care and the follow-up system in place.

The postpartum stay in the center following a labor and birth in which pain relief is provided through non-chemical means, is used to reinforce the teaching which took place in prenatal education. In MCA's opinion, insurers should be covering that preparation and follow-up rather than another 24 hours in an institution during which teaching may or may not occur and the mother may or may not be ready to return home with her newborn.

I want to thank especially the courageous physicians who have supported MCA's innovations and the work of nurse-midwives over the decades. Dr. Lee is one, as you have heard, and there are many others. But the people who deserve the ultimate credit for the success of childbearing centers are the families who trusted us as we broke conventional molds and the Board of Directors of MCA for providing fearless and confident leadership. That leadership now moves into the future as MCA seeks to collaborate here in the District of Columbia with the aims of improving some of the country's most regrettable infant outcome records and at the same time empowering families to bring about not only improved health, but also social change as we saw happen in the South Bronx. There are many strong families living in low income areas. We need to partner with them to facilitate change in our inner cities and childbearing centers give us that opportunity.

✓  
Statement of Lisa Summers, CNM  
Delivering a Better Childbirth Experience: A Consumer's Guide to Nurse-Midwifery  
November 6, 1995

I am a nurse-midwife who has spent all of her career in major teaching hospitals caring for both public and private patients, most recently at Johns Hopkins. I believe that my response to the Public Citizen report is in many ways typical of hospital-based CNMs in this country. I appreciate the opportunity to highlight a few points:

**The last decade has seen an exponential growth in nurse-midwifery. Why? Women want a better childbirth experience.**

When I completed my midwifery education at Yale University in 1983, there were about 2000 CNMs in practice. The membership of the American College of Nurse-Midwives now exceeds 5000. I had about 20 schools to choose from; there are now 46. The number of midwife-attended births has almost quadrupled in the same period, exceeding 200,000 in 1993. Women in this country have discovered a system of care that addresses women's needs the world over: midwifery.

What is valued in our health care system -- which is really an illness-care system -- is the latest, cutting edge technology and most novel intervention. The U.S. leads in curing disease and developing new technology. However, most of the four million women who have babies every year in this country *don't need any of that*. Unfortunately, the U.S. system provides way too little of what healthy childbearing women **do** need.

What healthy childbearing women do need nurse-midwives have been providing for 50 years. First, we served poor women in urban and rural communities where there were no other providers. That continues to be an important part of the work we do. More recently, women with resources have sought out nurse-midwives. What do all of these women appreciate? They appreciate prenatal care in their communities. They appreciate care providers who speak their language, in the literal and figurative sense. They appreciate the time we take: When we ask if they have any questions, it is not with our hand on the doorknob. In labor, we are truly "with woman" from beginning to end. Traditional hospital practice treats pregnancy as an illness and childbirth as curative surgery; the growth of midwifery shows women's desire for a different approach.

**For years, studies have shown that nurse-midwifery care is safe, satisfying, and cost-effective. The research of Public Citizen contributes to a body of knowledge that is helping us understand why and how the *process* of nurse-midwifery care leads to those outcomes, particularly how it may contribute to lowering the C-section rate.**

Our focus is on the woman and facilitating her ability to birth her baby. This report documents some of the ways in which we do that, and how that sets us apart from traditional hospital practice. Sometimes facilitating one woman's ability to birth her baby requires something that makes it hard to run a busy hospital -- like having her husband and her mother

and her sister and her aunt all present to wipe her brow and offer encouragement and rejoice with her. It's easier to restrict visitors and limit traffic, but that's not what it takes to birth some babies. It is easier on *my* back for a woman to birth her baby lying flat with her legs up in stirrups, but she is more likely to be able to push her baby out if she can assume whatever position makes that easier for *her*. An epidural is one commonly offered option for providing pain relief in labor, but there are a host of other options that, when used in place of the epidural, provide pain relief and a significantly increased opportunity for vaginal delivery.

While the hallmark of midwifery care is an individualized approach that focuses on facilitating an inherently natural process, **nurse-midwives are not anti-science, anti-technology, or anti-medicine. We advocate the individualized, judicious use of science, technology and medical care.**

I appreciate researchers creating new therapies, I value the availability of fetal monitoring and ultrasound, and I greatly respect the skills of the perinatologists with whom I work. *What saddens me* is our tendency to place greater emphasis on creating new science than on solving old social problems. *What frightens me* is our tendency to think that the technology that serves the high-risk pregnancy can safely be applied to all pregnancies. *What frustrates me* is a system that rewards the perinatologist for the amniocentesis but doesn't allow time or reimbursement for education and emotional support.

It is a tremendous privilege to practice midwifery; to be a partner with women in the provision of their health care and to have a role in the creation of strong and healthy families. What I try to model, as a midwife in a medical school, is the ability to say "no" to inappropriate technology and intervention that doesn't work, even if it pays well or makes us feel better. To create an environment where a woman's natural abilities are recognized and strengthened is the challenge of midwifery today. This report has validated the importance of those struggles. I am grateful to Public Citizen for this work and look forward to the implementation of their recommendations and a truly better childbirth experience for families.

Lisa Summers, CNM  
Johns Hopkins School of Medicine  
Department of Gynecology & Obstetrics  
410-955-8496

STATEMENT BY LORRAINE McCORMACK  
PATIENT OF CNM LISA SUMMERS  
November 6, 1995

I had my first baby in March 1985. My husband and I took the traditional hospital sponsored LaMaze classes and were told all we had to do was breathe and have a focal point and labor would be almost painfree. I went into early labor at about four in the morning. The doctor was at the hospital having just delivered another baby and he recommended that we come right in. As soon as we arrived, the maternity ward was extremely crowded and two women were in every labor room. There was no privacy and no place to walk around. The nurses made me lay down flat on my back immediately. Because I was not very dilated, they started pitocin IV and fetal monitoring. They were not encouraging at all and one even told me I was not going to be able to handle it. For the rest of the morning the doctor only stopped in occasionally and I was just left to lie there. By 10 or so in the morning, they started pressuring me to have an epidural anesthetic, even though I told them I did not want any drugs. At one in the afternoon, when I was alone in the room, the epidural came out, but since that doesn't usually happen, no one believed me and no one would even check it until the drugs had completely worn off. Then they had to reinsert it. I remember pushing for four hours, mostly all by myself, with no idea what I was supposed to be doing since I couldn't feel anything. At 6 p.m., during a push, the monitor showed the baby was in distress. The doctor said the baby was "too big" and that he would have to do a cesarean. The surgery went well and he was born at 7:10 p.m. weighing eight pounds, four ounces. I was told the reason for the c-section was cephalopelvic disproportion (CPD - in which the pelvis is too small for the baby's head).

Four years later, during my next pregnancy, I switched to a midwife, after the doctor kept talking about doing a scheduled cesarean, even though I was telling him I wanted to try for a vaginal birth after cesarean section. The midwife told me I could try for a vaginal birth and she encouraged me to try. I went into labor at around noon, I called the midwife at the hospital, and she said to come on down and let her check on me. It was again very early in labor, but we were already at Johns Hopkins Hospital which was very far from my home, so she thought I should stay there, but walk around and relax. We could walk anywhere in the hospital, not just the maternity ward, and every once in a while I would have to lay down for a fetal monitor check, but mostly I was on my feet as long as I could be. The midwife was with me the whole time and she was very encouraging and positive, even when I would scream a lot during contractions. She said it was okay, and she kept repeating "You can do this." We used no drugs, I pushed for two hours, and by 4 a.m. I delivered a eight pound, nine ounce baby with no episiotomy.

## PRESS STATEMENT OF KAREN KENNY

November 6, 1995

As the mother of three small children I have experienced the practices of both an OB and a CNM. My first two children were delivered via c-section after what I call medically managed labors. My third was born with the help of a CNM. The biggest difference I see between the practices is that CNM's trust that a woman's body can do the job and OB's feel that they need help.

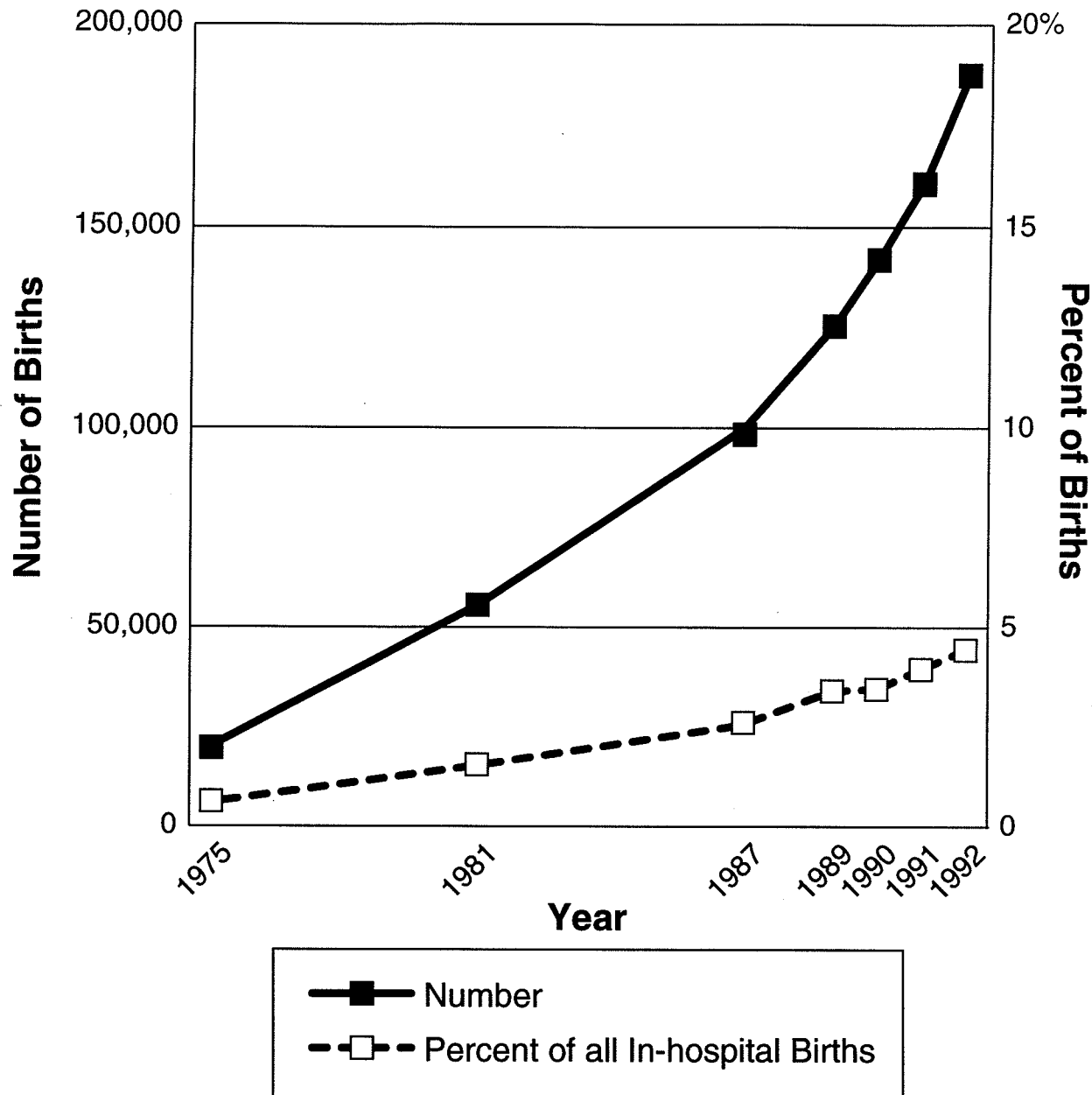
When I was in labor with my first I told my doctor that I thought I wanted an epidural. I was told I was going to have one so I could enjoy it. Then I was told I needed pitocin to regulate my contractions. I was put on a monitor and not allowed to get out of bed again. When it was time to push I was told how and when. After a certain amount of time I was told I needed a c-section.

When I became pregnant with my second I told my doctors that I wanted to have a VBAC. I asked what their VBAC rate was and was only told that if I wanted a VBAC I would have a VBAC. I never considered that I would have another c-section, I also knew I did not want any pitocin. My labor was pretty much the same as my first except that my water didn't break at the onset. Once again upon arriving at the hospital I was put on a monitor and not allowed to get up. My contractions were very strong and I thought everything was going great. My doctor however wanted to give me pitocin. He kept telling me that my contractions weren't strong enough and showed me the tape from the monitor. Even after telling him I didn't care what the monitor said he insisted on pitocin. After 20 minutes of arguing I finally gave in. It was the biggest mistake I could have made. Sometime later the doctor discovered that the monitor was put on wrong and my contractions were on top of one another. My son could not handle the contractions and went into fetal distress. An emergency c-section was performed. I will never forget the sight of my baby being pulled from me, totally blue, no movement and not a sound. Even then I was told my babies were too big. I knew the next time would be different.

Before I became pregnant with my 3rd I did as much research as possible on VBAC, c-section and certified nurse-midwives. I talked with anyone I thought might have information that could help me have a natural birth without medical intervention. I had a number of questions for my doctors when I became pregnant with my third. I knew I had to find someone else when not one question was answered with the answer I should have heard. As I was leaving the final straw was when I was told my chances of a VBAC were slim to none.

Before making the decision to go with a nurse-midwife we not only talked to midwives but with other OB's that were more willing to let nature take its course. I liked the approach that the midwives would take: Listening to the type of birth I hoped for and also helping me deal with my fears. When I went into labor I stayed home but in contact with them. Once we arrived at the hospital my water broke and I was already 9 1/2 cm. I could no longer walk but not once was I told to lie down and put on a monitor. I labored in any position I could choose and began pushing when I felt I was ready. I pushed in any position I could and when I wanted to, for as long as I wanted. The midwife allowed my body to be in charge of my labor. When my son was crowning it took a very long time. She was patient and didn't do an episiotomy to speed things up. My son was born alert and screaming. I had finally done what I always knew my body was capable of doing. All I needed was someone to believe in me and help me believe in myself.

**Table 3**  
**Growth in In-Hospital Midwife Attended Births**



Source: National Center for Health Statistics. Advance report of final natality statistics, 1992. Monthly Vital Statistics Report; vol.43 no. 5, suppl.

Hyattsville, Maryland: Public Health Service. 1994 (and previous reports).

Notes: Data represents all births attended by midwives in hospitals regardless of the classification of the type of midwife. With the revision of the U.S. birth certificate in 1989, a more detailed classification of attendant at birth is now possible. However, some births attended by CNMs are classified in the "other midwife" category. According to NCHS, it can be assumed that almost all births attended by "other midwives" in hospitals were delivered by CNMs.

**Table 7**  
**Top 10 States by Respondent**  
**Location for Survey of**  
**Nurse-Midwifery Practices That**  
**Attend In-Hospital Births**

<b>State</b>	<b>Number of Respondents</b>
California	44
New York	41
Pennsylvania	22
Florida	20
Arizona	19
Michigan	17
Massachusetts	16
Washington	16
Ohio	16
North Carolina	14

**Table 14**  
**Practice Characteristics:**  
**Patient Risk Profile**

<b>Patient Risk Profile</b>	<b>Number of Practices</b>	<b>Percent of Practices</b>
Practice cares for low risk women only, referring moderate and high risk women	17	4.1%
Practice cares for predominately low risk, but also co-manage higher risk women	365	87.1%
Practice cares for a predominately high risk patient population	37	8.8%

**Table 12**  
**Practice Characteristics:**  
**Patient Care Services Provided**

<b>Patient Care Services</b>	<b>Number of Practices</b>	<b>Percent of Practices</b>
Antepartum (prenatal) care	419	100%
Intrapartum (labor and delivery) care	419	100
Postpartum care	412	98.3
Gynecological care	384	91.7
Well baby care	57	13.6
Family planning services	387	92.4
Other services	82	19.6

**Table 7**  
**Hospital-Based CNM Survey**  
**Respondents' Utilization of Cesarean Section\***

	1991 (n=129)	Year 1992 (n=151)	1993 (n=186)	All Years (n=187)
Total Practice Births	36,729	42,585	48,014	127,328
Number of Cesarean Births	4,240	5,057	5,445	14,742
Overall Cesarean Section Rate	11.5%	11.9%	11.3%	11.6%
Overall National Cesarean Rate**	23.5%	23.6%	22.8%	23.3%

*\*Practice birth data was included if it was clean, complete, and covered a full calendar year.*

*\*\*Source: CDC. Rates of cesarean delivery—United States, 1993. Morbidity and Mortality Weekly Report. 1995;44(15):303-307.*

**Table 24**  
**Average Cesarean Rates by Patient Risk Profile**

<b>Patient Risk Profile</b>	<b>Number of Practices*</b>	<b>Average Cesarean Rate</b>
Practice cares for low risk women only, referring moderate and high risk women	5	9.0%
Predominately low risk women, but also co-manage higher risk women	174	11.9%
Predominately high risk patient population	14	12.4%

*\*To be included in this analysis, the practice had to have clean and complete data for at least one year and had to have at least 20 practice births between 1991 and 1993.*

**Table 22**  
**Utilization of Vaginal Birth**  
**After Cesarean (VBAC)\***

	<b>Practice Average</b>
Percentage of patients with a previous cesarean	9.0%
Percentage of patients with a previous cesarean who attempt a trial of labor	88.1%
Percentage of patients who attempt a trial of labor who deliver vaginally	78.2%
<b>VBAC Rate</b>	<b>68.9%</b>

*\*Data based on 143 survey responses that reported clean and complete data and indicated the data were based on practice records.*

**Table 28**  
**Flexibility in Obstetric Care**

<b>Options</b>	<b>Percent of practices in which option is usually offered to CNM patients*</b>	<b>Percent of practices that indicated option is usually offered to non-CNM patients at the same hospital**</b>
Oral fluids during labor	94.5%	55.8%***
Room to ambulate during labor	97.8%	76.4%***
Alternative birth rooms	92.2%	86.7%***
Partner in attendance	100.0%	99.5%
Friend(s) in attendance	98.8%	85.6%***
Use of shower, bath, or hot tub	93.5%	53.9%***
Encouragement of alternative positions for delivery	96.9%	27.9%***
Use of intermittent rather than continuous monitoring	94.4%	34.9%***

*\*Percentages based on 413-415 non-missing responses.*

*\*\*Percentages based on 390-403 non-missing responses.*

*\*\*\*CNM clients statistically significantly more likely ( $p \leq .05$ ) than non-CNM clients to be offered this option.*

## Table 29

### Restrictions on Nurse-Midwifery Practices

**Survey Question:**

---

Do you feel your nurse-midwifery practice to be restricted in any way?

**Survey Responses:**

	Number of Practices*	Percent of Practices**
Yes	269	64.2%
No	141	33.7%

**Survey Question:**

---

What are the sources of these restrictions?

**Survey Responses:**

	Number of Practices	Percent of Practices***
Hospital policy	159	59.1%
Physician policy	133	49.4%
State law	83	30.9%
Other sources	80	29.7%

*\*Based on 410 completed responses to this question.*

*\*\*Percentages do not add to 100 due to missing responses.*

*\*\*\*Percentages based on the 269 practices reporting restrictions. Some practices reported more than one source of restrictions.*