Citizens *for* Midwifery news

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Inside this Issue

Midwives Model of Care™ SUPPORTER

Do You Know Where Your Information Came From?

By Carolyn Keefe, MLS, BirthNet, Albany, NY

As birth activists have developed an understanding of the role of evidence-based care, and have become more aware of the importance of educating the public and legislators, we've come to understand the importance of having references available to support our statements about birth and midwifery.

We must at the same time, however, ensure that the statistics and references we use are accurate and can be examined by others. Only by using recognized and accessible sources can we develop and maintain our credibility. The evidence is in our favor, but no one will believe us if they can't examine it for themselves.

I've recently become concerned about this, as I've researched the cost of maternity care relative to other types of healthcare. Most of us have seen or heard the statement that "maternity care constitutes 20% of all health care costs." I wanted to see what that relationship has been historically, so I began to research this statistic. Susan gave me the original reference she had been given for this number, and I went to work tracking down the source used for it. I learned that the original source did not say anything of the sort and, in fact, didn't even address the issue of this relationship.

I later found the Healthcare Cost and Utilization Project (HCUP) at the Agency for Healthcare Research and Quality (AHRQ), an agency of the federal Department of Health and Human Services (HHS). Using HCUPNet, I discovered that, for hospital expenses at least, maternity care constitutes about 4 or 5% of healthcare costs. Although we are still talking about $28 billion dollars in costs and "Pregnancy, Childbirth & The Puerperium" is the fifth or sixth largest category, cardiac care is four times higher and around 20% of costs.

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Reading Scientific Birth Studies Critically:

Washington State Home Birth Study

By Susan Hodges

Carolyn Keefe has pointed out the importance of getting your information from authoritative sources. (See adjoining article.) In addition, we also need to develop the ability to assess the validity and meaning of studies and information even when they are published in respected journals.

In the Summer 2002 *Citizens for Midwifery News* we mentioned publicity about a study using Washington State birth statistics that purported to show that babies born at home are more likely to die than if they are born in the hospital. At the time we could only guess about flaws in the methodology.

The study was published in the August 2002 issue of the *Journal of Obstetrics & Gynecology*: "Outcomes of Planned Home Births in Washington State: 1989-1996" by Pang, Heffelfinger, Huang, Benedetti & Weiss. You can read a press release by the American College of Obstetricians and Gynecologists (ACOG) on their website: "Home Births Double Risk of Newborn Death" at <http://www.acog.com/from_home/publications/press_releases/nr07-31-02-3.cfm>. For a copy of the original article, click on "August Issue of Obstetrics & Gynecology" in the text; those words link to a PDF file of the paper.

Now CfM and several other organizations and individuals have critiqued the studies (see box for links).

This study provides a good example of the necessity for reading original papers, and not just accepting what is said in news coverage. It is also necessary to read any

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Citizens *for* Midwifery

Who Are We?

CITIZENS FOR MIDWIFERY, INC. is a non-profit, grassroots organization of midwifery advocates in North America, founded by seven mothers in 1996. CfM's purposes are to:

- *promote the Midwives Model of Care.*
- *provide information about midwifery, the Midwives Model of Care, and related issues.*
- *encourage and provide practical guidance for effective grassroots actions for midwifery.*
- *represent consumer interests regarding midwifery and maternity care.*

CfM facilitates networking and provides information and educational materials to midwifery advocates and groups. CfM supports the efforts of all who promote or put into practice this woman-centered, respectful way of being with women during childbirth, whatever their title.

CfM News welcomes submissions of articles, reviews, opinions and humor. Please contact us for editorial guidelines and deadlines. We plan to publish our newsletter quarterly.

If you have questions about the group, feel free to drop us a line: Citizens for Midwifery, Inc., PO Box 82227, Athens,GA 30608-2227. You can also reach us at (888) CfM-4880 (ET) (toll free), or e-mail <info@cfmidwifery.org>.

Be sure to check out our web site: <http://www.cfmidwifery.org>.

As always, we want to hear your comments and suggestions!

CfM News Credits:
Editor: Susan Hodges
Editorial Review: Susan Hodges and Paula Mandell
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New Zealand College of Midwives Adapts CfM's Brochure!

In August a representative of the New Zealand College of Midwives (NZCM) contacted CfM with a request to adapt our Midwives Model of Care brochure. The College is preparing "an information brochure for women to promote midwives and midwifery care," and wrote, "You have produced a great pamphlet and … we think you have some great ideas."

After substantive e-mail discussion with Sally Pairman, Projects Officer for the NZCM, CfM has given permission for the adaptation, and will be credited in the brochure!

The adaptation reflects some substantial differences between maternity care in the US and in New Zealand. For example, Sally wrote to us that in New Zealand all women can access continuity of midwifery care, and "over 70% of women here have a midwife who is their sole caregiver throughout pregnancy and birth to six weeks after the birth."

Sally also wrote: "All midwives who provide this care have contractual service specifications they must meet that reflect a midwifery model of care. Whilst not all midwives will practice the same, the College of Midwives does promote midwifery care as outlined on the brochure. That is, the College says if you have a midwife this is the kind of care you should expect as this is what midwives do." Typically, "women check out several midwives before deciding who they want to have."

Sally also described the Midwifery Standards review process "that most midwives undertake annually (and from next year, all midwives will be required to undertake)." She wrote: "Our review panels consist of two midwives and two consumers who have been specially trained to conduct reviews. The midwife presents annually with her outcome statistics, her self-evaluation against the NZCOM Midwifery Standards for practice and with any practice issues she wants to discuss. The panel has had access to her written material prior to the meeting, and also has access to the consumer feedback forms that have come directly to them from each midwife's clients. The panel can ask the midwife about anything, ask to see her notes or information she gives to women and they also feedback to her about the consumer evaluations. This process is very successful in getting midwives to move in their practice."

Wow! Talk about "partnership with women!" CfM is proud that the New Zealand College of Midwives found our brochure of such value!

If you want to hear more about how New Zealand achieved this level of autonomous midwifery and continuing input from consumers, be sure to attend the MANA 2002 conference near Boston October 24-27, where keynote speakers will be New Zealand midwives and activists! (Registration information at <www.mana.org>; special low rate for midwifery advocates.)

"Free Issue" Postcards are Here!

CfM has produced postcards offering a free issue of Citizens for Midwifery News *that midwives, doulas, childbirth educators and people who have contact with pregnant women can hand out or include in client packets. Recipients just fill out the card and mail it in for their free sample issue.* ***This is an easy way to introduce clients and friends to Citizens for Midwifery!***

The more women and families know about Citizens for Midwifery, and the more that join ... ***the more CfM grows, and the more we can do to advocate for the Midwives Model of Care!***

Postcards and CfM brochures are available free of charge, although a donation to cover costs is always appreciated! We encourage you to order both postcards and brochures to hand out together (a suggested donation for 25 of each is only $6). Send in your order today!

President's Letter

Dear Friends,

I was just sitting down to write this letter when the latest issue of *Midwifery Today* arrived in the mail. The article *The Assault on Normal Birth: The OB Disinformation Campaign* caught my eye immediately. Henci Goer, author of *The Thinking Woman's Guide to a Better Birth* has written an important article, making a well-supported argument that the American College of Obstetricians and Gynecologists (ACOG) has mounted an effective PR campaign to do away with normal birth. The article is available online at <http://www. midwiferytoday.com/articles/disinformation. asp>. The well-publicized Washington State home birth study by Pang et al (see page 1) is just one example of the way ACOG "spin doctors" subvert research and evidence. As Henci writes: "You can't begin to craft a strategy to fight back until you know what you're up against." Do read this article!

"Listening to Mothers" Survey and Forum

On October 24 the Maternity Center Association will reveal the results of their *Listening to Mothers* survey. The questions were designed to elicit factual information about what actually happens and what women experience during childbirth and after – the first national survey of this kind. Read more about this important project at <www.maternitywise.org>, where the results, executive summary and more will be posted starting October 24. If you are in the New York City area and can't go to MANA 2002, do try to attend the forum (details on the website)!

New Board Member

We welcome to the CfM Board Carolyn Keefe, of Albany, New York. After many months of being short one board member, the Board appointed Carolyn to fill the vacancy at the September 10 Board meeting. Carolyn is active with New York Friends of Midwives and with BirthNet, an Albany-based organization that she co-founded in 2000 to focus on public education programs about maternity care. She is also a member of the International Cesarean Awareness Network, and serves on two committees of the Coalition for Improving Maternity Services. With her Library Science Masters degree, Carolyn also brings to the CfM Board special and greatly appreciated research skills. We are happy to have her join the Board!

Annual Elections and Membership Meeting

By the time you receive this newsletter, every CfM member should have received a ballot and biographies of the candidates to elect for the 2002-2003 Board of Directors.

The Annual Membership Meeting will take place Friday, October 25, 1:00 - 2:45 pm, during the MANA 2002 Conference. There is still time to register for this outstanding conference, which will include a series of workshops especially for consumer advocates! Get the complete registration packet at <http://www.mana.org/mana2002/index.html>, or, if you need a paper copy, contact Atmakaur Khalsa at <MANAboston2002@aol.com> or (508) 429-8911 (EDT). If you want to attend only the CfM Membership Meeting, please contact CfM at (888) 236-4880 (EDT).

Funds Still Needed

CfM, Massachusetts Friends of Midwives and MANA invited three midwifery activists from New Zealand to be keynote speakers at the MANA 2002 Conference. (Read about them at <http://mana2002.mfom.org/speakers.html>.) The three organizations made a commitment to raise the needed funds for the airfares. So far, we have gratefully received donations for about one third the cost of the tickets; as of late September $2,400 is still needed.

Why is New Zealand so special? Women and midwives worked together to make sure that women could have midwives in whatever setting was best for them, including at home. Today, midwives are autonomous, all women have access to midwives, and midwives work in partnership with women. (see page 2)Isn't that what we need here?

This is an investment in the future of midwifery! Consider a contribution (of any size) from your state midwifery or "friends of midwives" group, or make a donation yourself. You can send a check for the "MANA 2002 New Zealand Fund" to CfM, or conveniently pay by PayPal at <http://mana2002.mfom.org/nzmidwife.html>. All donations are tax deductible.

Looking forward to seeing many of you at the end of October at MANA 2002!

Midwifery Advocates: Sign Up NOW to ReceiveThe Grassroots Network Messages!

We have updated the Grassroots Network so you can sign up directly and receive the messa-ges directly, not through a state contact.

This national e-news list is **a simple way to find out about late-breaking news, new resources, and up-to-date information** related to advocating for midwifery and the Midwives Model of Care.

To sign up, visit the News & Resources section of our website <http://www.cfmidwifery.org/gm.asp>. Find the Yahoo! box at the bottom of the screen. Simply **enter your e-mail address, and you're ready to go! It's that easy!**

This is the same one-way communication as the old Grassroots Network, just a new way to sign up. **Your e-mail box will not be flooded with mail!** In the past, there have been an average of two to four messages per month. As before, the messages (selected by the gatekeeper) will focus on midwifery advocacy, including legal and political issues and news, useful resources, research that supports natural birth and the Midwives Model of Care, and closely related information.

If you discover news or information you think should be posted, please send it to <info@ cfmidwifery.org> with "For the Grassroots Network" in the subject line.

Let your friends and clients know about the new Grassroots Network e-list!

Information continued from page 1

Furthermore, while the 4-5% figure is based on hospitalizations, non-maternity health care probably takes up an even larger chunk of health care costs than maternity care. Maternity care, while including some procedures, prescription drugs, provider time, and technology, may use far fewer resources than care for the elderly, for instance, or for those with cardiac illness, cancer, or diabetes. Also, maternity care rarely involves home health care (unfortunately) or transfers to skilled nursing facilities (thankfully). I haven't fully embraced that 4-5% number and plan to do more research, but I think it's pretty clear that the 20% figure is unlikely to be accurate.

Unfortunately, this 20% figure has been circulating and may cost us credibility with legislators or reporters who decide to track it down. We can still make the argument that the costs are too high, that there are too many surgical procedures related to birth, and that these issues affect large numbers of women, without overreaching based on questionable, if truly well-meaning sources.

During my training as a librarian, I was taught how to evaluate information and recognize authoritative sources – authoritative as in author, not necessarily authority. In other words, it's always important to know where the information is coming from and whether or not the source is reliable (or indeed the best source). This is even truer in the age of the Internet. Evaluating sources involves four basic criteria:

Author – Can you determine who the author is? Can you determine her or his background and level of expertise on this topic? Does he or she seem objective?

Publisher/Sponsor – Do you know who the publisher is? Is the publisher familiar and credible?

Currency – How dated is the information? Is there a more current source?

References – What references is the author using? Can you access them? Do you trust them? Would they be better (or primary) sources for the information you're seeking?

I also learned in library school that the US government is the largest collector and publisher of information and statistics in the world. Of course, you always have to "read the fine print" to understand what data was actually collected and how, in order to interpret the results. However, while no source of information is flawless or totally comprehensive, several things make using government information desirable.

First, it is free and easily accessible via the Internet. Second, it is a widely respected, relatively impartial source of information; so all parties can be on the same page. Finally, it's fairly consistent historically and geographically — so the data can be compared using these criteria as well (though you may need to track down paper copies in depository libraries if you want to go back before 1994). As I said, it's not perfect or complete, but it's often a great place to start. Also, if you need help tracking down information, the authors of these publications are often happy to help.

Another good source of information can be associations or organizations, like Save the Children or the World Health Organization. Here we need to be careful however, because, as we know, some organizations and associations have distinct biases, which can make their information suspect. Professional organizations, for example, are best at providing information about the practitioners of their professions, but may not be as reliable as sources for information about which their members have a financial stake.

We've learned to mistrust ACOG largely because our experience has shown that some of their information is inaccurate and self-serving. Unfortunately, they are still the authority for most people in this country. To counter that situation, we must be even more scrupulous about ensuring that we know what we're talking about and can back it up.

Some Good Sources for Research and Information:

Agency for Healthcare Research and Quality
<http://www.ahcpr.gov/>
Includes information about the Healthcare Cost and Utilization Project, Evidence-based Practice, and Quality of Care.

National Center for Health Statistics
<http://www.cdc.gov/nchs>
Primary Publications – Final Birth Data, Final Death Data, National Hospital Discharge Survey, Mortality and Morbidity Weekly Report, Vital Statistics Reports, and various other studies.

National Library of Medicine
<http://www.ncbi.nlm.nih.gov:80/entrez/query.fcgi?db=PubMed>
Source for citations of journal articles and other medical research. Includes some abstracts and includes links to some journals.

Save the Children –
<http://www.savethechildren.org/mothers/sowm02/index.shtml>
Publishes the annual State of the World's Mothers report, which has good maternal mortality rate info, among other data.

World Health Organization –
<http://www.who.int/research/en/>
Research tools include the Library Database and Statistical Information Service.

My alma mater's library also happens to have a great web page on this topic (as I'm sure many other libraries do). You can get more information or do an online tutorial at <http://library.albany.edu/usered/evalsup/main.html>.

Citizens for Midwifery has a vision:

The Midwives Model of Care is universally recognized as the optimal kind of care for pregnancy and birth, and is available to all childbearing women and their families. To achieve this vision, CfM promotes the Midwives Model of Care by providing public education about midwifery, the Midwives Model of Care and related childbirth issues, and by encouraging and supporting effective grassroots action.

Reading Studies continued from page 1

"scientific" paper critically, because medical and scientific journals do sometimes publish papers of dubious quality.

When I finally got my hands on a copy of the Pang study, I read it with pencil in hand to note all my questions. I kept in mind what I know about home birth, and especially aspects of home birth about which the researchers (all of whom are medical doctors) were likely to be ignorant and which might affect the data and conclusions. I looked for statements that were based on assumptions, rather than data, and I questioned the assumptions. More difficult, but also important, is looking for what is NOT included in the study. It is more important to ask the questions than to answer them; asking questions will help you think about the study and what it actually shows and doesn't show.

Here are some of the kinds of questions one can ask when reading this type of paper:

- Did the authors refer to and discuss all or most of the published articles on the same or related topic?
- What is the stated objective of the study? Does the study or experiment actually answer this question?
- Read the materials and methods section carefully. What is the source of the data and is it of good quality? (Has it been verified? How inaccurate can it be?) Are the data categories adequately defined so you can tell exactly what is included and what is not? How have the authors manipulated the data? Have they made assumptions? Have they justified their assumptions and shown that they are reasonable to make? Do you think their assumptions are reasonable and valid for this study? Why or why not?
- When data from two or more groups are compared, have the authors demonstrated that the groups, and the data from each, are essentially the same except for the aspects being compared?
- Do the results (what was found out) make sense? Are the numbers large enough so that inaccuracies in the data collection will not affect the statistical significance of the results?
- The discussion (or conclusions) should include the authors' interpretations of their results. What do the results mean? What can and cannot be concluded? What are the strengths and shortcomings of the methodology? What problems occurred and could those problems affect the results? How do the results compare with the results of other related or similar studies? How are similarities or differences in results explained?

This study on Washington State home births has many flaws and problems, many of which become obvious when read critically (i.e., questioning everything). Without going into great detail, here is an example. The title reads: "Outcomes of Planned Home Births in Washington State: 1989-1996," but the authors write in the Materials and Methods section that "Because Washington State birth certificates do not identify which home births were planned, we defined planned home births…." This sentence alerts us to the fact that the authors were using inadequate data, and we had better look very carefully at the assumptions they used to decide which home births were "planned." Here is what they tell us – they included:

- "singleton newborns" – okay, since this helps to make the home and hospital groups equivalent.
- "of at least 34 weeks' gestation" – not okay since babies born "at home" at 34-37 weeks are likely to be unplanned, precipitous births, at higher risk due to prematurity. Experienced home birth midwives would not plan to attend at home at less than 37 weeks so these should not be included (although later in the paper they claim that omitting births prior to 37 weeks did not affect the relative rates of neonatal mortality).
- "who were delivered at home" – maybe OK, but we do not know how this is designated on the birth certificates, and whether or not it includes unplanned out-of-hospital births (in the car, on the way, etc.).
- "and who had a midwife, nurse or physician listed as either the birth attendant or certifier on the birth certificate (if an attendant is not listed on the birth certificate, then the person listed as the certifier attended the delivery)" – we know that those babies born "on the way" would then go to the hospital where someone would sign the birth certificate – NOT a planned home birth.

We don't even have to go any further in the study to be certain that at least some unplanned, unattended, even premature births will have been incorrectly included in the cohort of "planned home births." Any neonatal deaths, postpartum bleeding, need for resuscitation for more than 30 minutes (all outcomes included in the study) associated with these high risk births would be wrongly attributed

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On-Line critiques of the Washington State planned home birth study by Pang et al:

Citizens for Midwifery 'fact sheets' covering the main points of criticism are posted on our website <www.cfmidwifery.org/resources/cfm/item.asp?ID=31>.

Henci Goer, author of *The Thinking Woman's Guide to a Better Birth*, has written a critique *Homebirth: Is it really a safe option?* that is posted on ParentsPlace.com (where she is the Birth Guru). Go to <www.parentsplace.com>, click on "Birth Guru" under Ask The Expert, scroll down to "articles by subject."

MAWS (Midwives Association of Washington State) has written a response at: <http://www.washingtonmidwives.org/releases/20aug02.shtml>. Their statement includes a good list of references.

Faith Gibson has written a detailed commentary and critique at <www.collegeofmidwifery.org>.

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For an excellent and more thorough look at the topic of home birth safety than the Pang et al. study, using much higher quality and more detailed data, more births, and logistic regression analyses to show interactions of risk factors, see Peter Schlenzka's dissertation *The Safety of Alternative Approaches to Childbirth,* (available in PDF file at: http://www.vbfree.org/docs/meadsum.htm> – located toward the bottom of the page.

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to the "planned home birth." Even the authors acknowledge later in the paper that this is a problem that could skew the results to make "planned home birth" appear more dangerous.

The authors chose to look primarily at neonatal deaths, even though the rate is very low for healthy normal pregnant women regardless of where they give birth. The study reports neonatal mortality rates of 1.5/1000 (hospital) vs. 3.5/1000 (home). The study offers no basis for knowing the magnitude of misclassifications of births in the "planned home birth" category; it is possible that eliminating wrongly classified births would diminish the difference to the point of statistical insignificance.

What about information and data that are not included but should be? For example, there is no mention made of unpreventable neonatal deaths, i.e., when the cause of death was unrelated to the intended or actual site of birth (congenital anomalies incompatible with life, for example). In addition, we cannot know from this paper how many of the neonatal deaths occurred in the unknown number of unplanned/unattended "home births" that were wrongly included as "planned home births."

Addressing another outcome, the authors claim that women "intending a home delivery were more likely to have prolonged labor." However, we know that there can be substantial differences between home and hospital regarding when the beginning of labor is counted, and that typical hospital protocols call for interventions to speed or augment labor, so one might anticipate that hospital births would be less likely to have "prolonged labor," yet this is not discussed. In fact, medical interventions that impact on outcomes for both mother and baby, such as episiotomy, epidural and other drugs, induction, augmentation of labor, forceps, vacuum extraction and c-section, are not even mentioned, let alone discussed in relation to this study.

Finally, even if the findings of the study were "true," not even the authors claim anything more than an observation of an association in this set of data shaped by their assumptions. In other words, this study in no way was designed to show, and does not show, a causal relationship. The results cannot legitimately be used to predict even the risk of neonatal death as a result of planning a home birth. One should also note that while the original study, with all its flaws, at least has a neutral title, the ACOG press release overstates the study's findings with an inflammatory and misleading headline, and fails to even mention the shortcomings and limitations of the study.

These are just a few of the flaws that can be found by simply reading the study with a critical eye. However, while the Pang study provides a good exercise for critical reading, you do not have to figure it all out for yourself! CfM has prepared two fliers, one with the key criticisms of the study and the other quoting the authors' own words, in the study, regarding its problems and limitations. In addition excellent and thorough critiques can be found on-line (see box on page 5).

If this study comes up in your newspaper, or among legislators, use these resources to show up the flaws of the study. The CfM fliers in particular are designed with press and state officials in mind.

> ***"Children thirst to hear where they came from ... they need to know that they were desired, that their birth was a wonder, and that they were always the object of love and care."***
>
> ***— Marcelle Clements***

"Childbirth May Not Cause Incontinence"

This was the Reuters headline for a study that looked at the incidence of urinary incontinence in post-menopausal nuns – women who had never born children. They found the same incidence of incontinence that has been reported in other studies – of women who HAVE born children!

The study, *Prevalence of Urinary Incontinence and Associated Risk Factors in a Cohort of Nuns*, by Buchsbaum, Chin, Glantz, & Guzick (*Obstetr & Gynecol* 2002;100:226-229) was published in the same issue of the same journal as the flawed Washington State home birth study (see page 1), but ACOG did not draw attention to it with a press release.

What does this study have to do with midwifery? Over the last few years, the president of ACOG and other obstetricians have actively promoted "patient choice c-section." One of the main reasons given was that vaginal birth causes urinary incontinence later in life – avoid vaginal birth with a c-section, and you won't face this problem.

In fact, these representatives of ACOG were once again putting forth opinion as fact. According to the introduction, even though it is estimated that 35-45% of women, especially elderly women, suffer from urinary incontinence – "the eighth most prevalent chronic medical condition in the US" – little is known about its causes. The few studies that have been carried out are conflicting and have not established any association between "obstetrical trauma and urinary incontinence."

To be fair, this was a small preliminary study based on questionnaires; such results can be imprecise. However, the authors conclude, "These findings appear to be contrary to the conventional wisdom that nulliparity protects against stress urinary incontinence." The authors are planning "ongoing studies on the relationship between vaginal delivery and subsequent pelvic floor dysfunction." One hopes that they will distinguish between natural vaginal births vs. those treated with medical interventions.

NARM Receives Accreditation!

The following article is reprinted from The North American Registry of Midwives News, *July 2002. NARM is is the organization which administers the Certified Professional Midwife (CPM) credential.*

NARM is pleased to announce that we have received accreditation as a certifying agency from the National Commission for Certifying Agencies (NCCA). The NCCA is the accrediting body of the National Organization for Competency Assurance (NOCA).

To receive the accreditation, NARM submitted an extensive application demonstrating compliance with the strict standards set by NCCA for verifying professional competency. This evaluation included every aspect of the NARM certification program, including: administrative procedures, job analysis, test development, test security, standard setting, eligibility criteria, board responsibilities, ongoing review of all policies and procedures, and verification of reliability and validity of the credential.

NARM has always believed that midwives should be the ones to define their job and to set the standards for demonstration of competency. From the beginning, NARM has sought input from a wide variety of midwives (indeed, from all midwives) in establishing the criteria for certification. NARM was created by and for midwives to maintain the heart of midwifery, while establishing a fair way to measure the demonstration of skills and knowledge defined as essential to competent practice. A key component of this process has been the preservation of multiple routes of entry into the profession and the validation of the apprenticeship model of adult education.

It is a milestone in the validation of the CPM credential to receive this designation from NCCA, a highly respected organization whose purpose is to promote excellence in competency assurance. As midwives and midwifery advocates, we are aware of the uphill struggle to receive recognition for the honorable profession to which we dedicate our lives. It is with great pleasure that we share this honor with all the midwives who have contributed to the development of the Certified Professional Midwife credential.

About NOCA

The mission of the National Organization for Competency Assurance (NOCA) is to promote excellence in competency assurance for practitioners in all occupations and professions. Their accrediting body, the National Commission for Certifying Agencies (NCCA) was created in 1987 by NOCA as a commission whose mission is to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs or organizations that assess professional competence. NCCA uses a peer review process to: establish accreditation standards, evaluate compliance with these standards, recognize organizations or programs which demonstrate compliance, and serve as a resource on quality certification. NCCA accredited organizations certify individuals in a wide range of professions and occupations. Of NOCA's 300 members, only 47 have reached the status of accreditation by NCCA.

Regardless of the type of profession, the NCCA certification indicates that the credentialing program meets or exceeds the standards set for the development and administration of a valid and reliable credential.

Letter to the Editor

Dear Susan,

Thank you for writing your article "Medical Model Maternity Care and 'Violence Against Women.'" I am thrilled that you have brought to light this way of looking at the problem of medicalized birth and that you are encouraging women to speak up about the aspects of their births that were unacceptable.

As you know, I did just what you have suggested following the birth of my son in 1995. I researched what happened and eventually filed complaints against my CNM and two OBs from the backup practice who did my unnecessary cesarean. My complaints were fully investigated, and the board found no evidence of medical malpractice. Of course that result was depressing considering the truth of what had occurred, but I knew I had done the right thing in letting my story be known.

Now I want to write in to CfM and encourage all women who have experienced violence in their births to report those people involved. In the aftermath of my son's birth, we attended a meeting with the hospital staff, and in that meeting and the replies the OBs made to the Medical Board, it was clear that they were flabbergasted that I was displeased with the care I was given. They were completely unused to being questioned and of course highly offended that I had complained to the Medical Board. One physician wrote in his reply to the Board that I was "mentally unstable" and the other that I cared "not a whit" for the health of my child. The surgeon actually complained in his reply to the Board that if he had used a vertical uterine incision on me I would have also complained about that, to which I could only say, you bet I would have!

If other women will file their complaints, no longer will the individual who has an educated opinion seem so bizarre. A few complaints every couple of years isn't going to change anything. But a hundred? A thousand? Yes, that will make a difference. Remember that the tidal wave that gets immediate attention starts way out at sea underwater where no one can see it. But it has to start somewhere. Please do what you can to change medical care in birth; speak up for yourself.

Sincerely,

Jennifer L. Griebenow
Kentucky

CfM President Speaks in Mexico

By Susan Hodges

In June I traveled to central Mexico to participate in the International Conference about Professional Midwifery and Self-Regulation, held at the CASA Professional Midwifery School in San Miguel de Allende. Speakers and attendees included midwives and midwifery students, educators, physicians, and representatives of government health ministries as well as of national and international organizations (ICM, WHO, ACNM, MANA, NARM, etc.) from the Americas. It was amazing and eye-opening to see and to hear from midwives of all kinds, from above the Arctic Circle to Chile.

The last panel of the conference was *Politicking and Policy Implications*, and I gave the last presentation in the panel. As President of Citizens for Midwifery and the only presenter who was speaking for women ("consumers"), I addressed the need for policymakers to listen to women, not just to professionals, and I emphasized the importance of respect – for birth, for the mother, for the baby and family – as the foundation for all the elements of good midwifery care (already described in other presentations). I stated that the current maternity system in the US is not a good model, and that it is very difficult to regain birth knowledge once it is lost. Not only are midwifery skills and knowledge lost, but, when birth moves to the hospital, women themselves can no longer acquire an intimate knowledge of normal birth as they grow up, and thus lose their own knowledge of birth, what to expect, and that birth works. Finally I pointed out some of the challenges we face in the US, and some of our strengths.

Overall, I don't think a single person was left unaffected by the conference. I became aware of how Eurocentric most of us in the US tend to be, largely unaware of our neighbors to the south. In many of these countries the vast majority of women give birth at home with traditional midwives, often with very little access to any other health care even when needed. For example, Quechua midwives from Bolivia noted that 80% of the population there is Quechua, and they primarily use their own traditional midwives at home. Traditional midwives at the conference all expressed a desire for more knowledge and education so they might be better able to deal with complications as there often is little practical access to doctors and hospitals. The concept of the CASA Professional Midwifery School, where students learn from both modern professional midwives as well as from local traditional midwives, really made sense as one model for carrying midwifery into the 21st century, a model that could have real promise for Mexico and maybe for other countries and locations as well.

I took part in countless conversations and discussions that all served to stretch my mind. I became acutely aware of the tremendous loss in the US since the continuity of culture-based birth knowledge and traditions have been pretty much broken for almost all cultural groups that were here or came here. In a way, direct entry/home birth midwives are each attempting to create a new "tradition" of midwifery and birth practices, but because we don't have a common and continuous cultural tradition of midwifery and childbirth, each individual midwife is trying to do this individually. Perhaps this lack of common tradition and the broken continuity partly explain the disunity that seems to plague midwifery in the US. The diversity and lack of a common tradition can be liberating and a source of richness and strength if we can rise to the challenge and do the work of understanding that there can be more than one "right" way to do things, whether one is talking about protocols or credentials.

On the last day, I had the wonderful opportunity to join a small group to visit Dona Guadalupe, a traditional midwife about an hour away from San Miguel de Allende. This 80-year-old midwife has been catching babies since 1979, as many as nearly 100 per year (after she had had her own 11 children). Now people come to her – she has a one-room "birth center" building. I saw only two cars in the village, and one of them was at her house.

photo courtesy of Ken Johnson

Susan Hodges (r) visits with Viviana Lina (l), partera, of Bolivia, a birth activist with RELACAHUPAN, a Latin America/Carribean organization for the humanization of childbirth.

Good nutrition is difficult, as during parts of the year fresh fruits and vegetables are only available in San Miguel and are expensive. Dona Guadalupe has the absolute minimum of equipment. She has never lost a mother. This is one of several traditional midwives with whom students from the CASA School spend several weeks as part of their studies. I left humbled, both by her skills, unrecognized by our "medical world," and by a new awareness of how out-of-touch our own US culture is in so many ways with the those outside our beliefs and conveniences.

I left Mexico with marvelous images and memories – the beautiful architecture and colors of the town; the smiling faces of all the young volunteers at the CASA School; the marvelous building and the unique curriculum of the midwifery school; delicious food and live mariachi music; a one-of-a-kind performance of the *Vagina Monologues* starring some of today's midwifery heroines as well as local ladies; the opulence of parts of San Miguel contrasting with poverty, hard work, and extremely low-tech living in the rocky, hilly, near-desert countryside.

I am proud to have been part of this conference, and look forward to all of us in the Americas learning from and helping each other in the process of holding on to midwifery in all of its forms for the sake of mothers and babies, families and communities.

Excerpts from Susan's Presentation "Listen to Women!"

The most important element is RESPECT – for birth, for the mother, for the baby and family. **Respect is the foundation of all the elements of good midwifery care** that have been mentioned by the speakers – things such as personal attention, information, continuous, one-on-one mother-centered care, and access to medical attention when needed.

Respect also means that midwives and government agencies and doctors should listen to women! Even though this makes some of them nervous! But here are some reasons:

- **"One size fits all" care doesn´t work.** Each woman is unique and brings her beliefs, values and culture to the life-changing experience of giving birth. Midwifery care reflects this, and policies should also. Different women perhaps do better with differently trained midwives.
- **Women are pregnant and give birth** – they alone, not caregivers, must live with the results of the care they did or did not receive – they should have a say in it.
- Government policies and laws, and the policies and actions of professional organizations, determine the nature and availability of maternity care – who will be cut and who will not, what choices are available or not, etc. **Women should be involved in every aspect of legislation and policy-making because they are directly affected by those decisions.** This includes education requirements [for midwives]. For example, requiring too much education can reduce access to midwives, because a midwife who has had to travel a long way from home for several years and invest a lot of money in her training is unlikely to return to practice in her rural hometown.
- Women have perspectives and concerns regarding maternity care that are different from those of caregivers and can contribute to maternity care development and midwifery.

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Women need midwives, and midwives need women – not only for births, but also for political action to preserve and nurture women being with women in childbirth.

Listen to women!

Midwives and The Law

In addition to investigations, arrests and ongoing legal cases in Connecticut (page 10), Ohio (page 11) and Illinois (*Citizens for Midwifery News* Summer 2002), midwives have also been investigated, arrested and/or jailed in other states and in Canada.

"Gloria Lemay – grandmother, childbirth educator and midwife with 20+ years experience – was convicted of 'criminal contempt of court' for practicing 'midwifery' in British Columbia, Canada, a province where 'midwifery' is a word and practice owned and controlled by the provincial government. She is appealing this conviction, as well as the five month jail sentence and 12 month probation the judge handed to her on July 24." (Leilah McCracken) Find out more about Gloria's situation and case, and how to contribute to her legal defense, at Leilah McCracken's website: <http://www.birthlove.com/gloria/defense_fund.html>. LATE BREAKING NEWS: Gloria was released from prison on Friday, September 20, to serve the rest of her sentence under probation.

"On July 6, 2002, **Nan Koehler** of Sonoma County, California – mother, grandmother, geriatric caretaker, herbalist, agronomist, author, midwife (traditional birth attendant) – was arrested and jailed for 'reckless child endangerment,' 'practicing medicine without a license,' and 'administering a controlled substance to a minor' (oxygen), carrying a maximum sentence of four years, in connection with a birth she attended on February 28, 2000. Tragically, three months after the birth, the baby was diagnosed with cerebral palsy." (friends of Nan Koehler website) A Preliminary Hearing is scheduled for November 15, 2002 at 10 am. Nan's friends have organized an informative website, including information about a legal defense fund for her at <www.friendsofnan.org>.

The continuing saga in Illinois: The Illinois State Supreme Court has agreed to hear **Yvonne Cryns'** civil case, while **Valerie Vickerman Runes** still awaits word on her similar civil case. Yvonne's criminal case is still on appeal (she was acquitted on one manslaughter charge, but had a hung jury on the second. The state is ready to retry the second charge, but Yvonne's attorney has objected that a second trial (same evidence) would be double jeopardy. The Illinois Board of Nursing filed to remove Valerie's nursing license, because she used to be a midwife. This case, which was "tried" before a judge hired by Illinois Department of Professional Regulation (IDPR), has been completed; the judge has not yet made a recommendation (although the Director of IDPR has complete discretion to follow the recommendation or not). In the middle of all these cases, the Director of IDPR has resigned; a new director has been appointed, but is a lame duck, since a new governor will be elected in November who is expected to appoint new directors of state agencies including the IDPR.

In South Dakota, **Judy Jones**' legal case (practicing midwifery without a license) has been dragging on for years. South Dakota laws do not address the legal status of direct entry midwives. Recently, in a favorable ruling, the trial judge decided that certain facts (that Judy had an injunction at the time of the birth, that the child died a week and a half after it was born) were not relevant to the charge that Judy is practicing midwifery without a license. The prosecution appealed that ruling to the South Dakota Supreme Court, which heard the appeal on August 26 and has six months to make their decision. Then the case will go back to the trial judge; the actual trial could then take place sometime between March and October 2003. In another development, Judy's name has been found on another birth certificate. A hearing was scheduled for September 20. This could begin a whole new round of charges, or she could simply face jail time for (allegedly) disobeying the injunction against her. In South Dakota, any birth certificate not signed by a doctor or CNM is sent to the medical board to investigate. Most homebirth parents usually just say that the father was the attendee.

Also in South Dakota, another experienced midwife, **Margo Wyatt**, has just been charged similarly to Judy Jones – practicing midwifery without a license. Margo's supporters have set up a legal defense fund. Find out more by contacting Annie Thorstenson at <annieandy@rapidnet.com> or call (605) 745-6614, or contact Bob Fletcher at <mod70xtr@inetnebr.com> or (605) 376-3407.

State by State

CONNECTICUT

Four CPMs are under investigation by the Connecticut Department of Public Health (DPH). Two are being charged with practicing medicine without a license, while two are being asked to turn over a mother's chart as part of an investigation of *possible* violations of nursing and/or nurse midwifery regulations. (The mother objects to her chart being turned over to the DPH.) These separate but simultaneous investigations were prompted by births that occurred over two years ago, which involved appropriate transfers from home to hospital and good outcomes. They are not being initiated by the families involved, but appear to be administratively and/or politically motivated. Hearings are being scheduled for the fall.

These cases are reminiscent of Donna Vidam's case in 1996, in which she was accused of practicing nurse midwifery without a license. During that case, Donna's attorney convinced the hearing officer that the type of midwifery she was practicing is distinct from the practice of nurse midwifery and was therefore not prohibited – or regulated – by Connecticut's nurse midwifery statutes. The DPH was advised that if it wanted to regulate direct entry midwifery, such regulation must be pursued through the state legislature.

In early August, the Alliance of Connecticut Midwives (ACM), together with United Families for Midwifery Care (UFMC), mailed a detailed letter to nearly 700 consumers apprising them of the situation and asking for letters of support to the Governor, the Commissioner of Public Health, and the state's Attorney General. The DPH has responded to consumers with a letter indicating that the provision of services by these homebirth midwives "is governed by statute and falls within the scope of the practice of medicine or nurse midwifery. Thus it is a healthcare practice for which a license is required." In other words, it reads as if the 1996 ruling never took place.

Pam Maurath of the Midwifery Task Force met with us in July to help plan our media/PR campaign. Our message will include the following basic points:

- A better use of the DPH's resources would be to work with the midwifery community to pursue legislation rather than continue to prosecute direct entry midwives who are not practicing unlawfully.
- Consumers and midwives support a regulatory process by which direct entry midwives can function as licensed practitioners in Connecticut.
- This is not just a Connecticut issue, but a national one. We can point to other states in which licensure programs for direct entry midwives have been implemented and learn from their experiences.
- All families must have access to the Midwives Model of Care.

Connecticut midwives are seeking donations to help cover legal costs. Donations may be sent to: United Families for Midwifery Care, Attn: Midwives Defense Fund, P.O. Box 460, Colchester, CT 06415. Thank you for your support!

Submitted by Sharon Reilly <fomct@attbi.com>.

LOUISIANA

The Louisiana Midwives Association recently submitted potential candidates for the Advisory Committee on Midwifery to the governor for approval. The candidates were approved and the first committee meeting was scheduled for Friday, September 6. At the meeting, the committee discussed several proposed changes to the rules and regulations before submitting a proposal to the State Board of Medical Examiners.

Some of the major proposed changes include adding the CPM credential as having met all requirements for licensure, adding well-woman care training, adding pharmacology and microbiology, and acknowledging that midwifery care occurs within a variety of settings, including homes, birth centers, clinics, and hospitals. We hope this last change will open doors for midwifery care within hospitals. Probably the most crucial and vital change is reducing the number of visits a woman must make to an obstetrician and taking midwifery care out from underneath the supervision of a physician. This will allow the midwife to maintain her autonomy of practice while still being able to collaboratively work with physicians/obstetricians should the client's risk status change or a potential situation for risk arise.

We do not know how these proposed changes will be accepted by the State Board of Medical Examiners (the licensing board for direct entry midwives in Louisiana), but feel we have no other choice than to at least make the proposal and give testimony. Louisiana currently has only two home birth midwives practicing within the state, and numerous women are being forced to choose between a hospital birth or an unassisted home birth. This is not an ideal situation for a woman who wants a midwife-attended home birth, and we are going to everything we can to ease the minds of the select group of women wanting a home birth.

We will keep CfM readers updated. I ask that anyone who has had or knows someone who has had an unassisted home birth because they were unable to secure attendance by a midwife please contact Misty Richard at <rdrunr7@juno.com> or (225) 667-1210.

Submitted by Misty Richard <rdrunr7@juno.com>.

MINNESOTA

The first freestanding birth center has opened in Moorhead, Minnesota, a town that borders nearby Fargo, North Dakota. Opened by Jill Kent CPM, LM, her first birth was in July. Grassroots efforts of longtime out-of-hospital birth families donated goods and services to help Jill in her efforts to get the doors opened. The Stork's Nest director is Sue Amick, a Bradley teacher and homebirth momma of three children. Part of the appeal of The Stork's Nest location is that there is a large conference room where classes in belly mask making, children's knitting, yoga and doula training services are available. Besides the beautiful birth suite, massage therapists and a Chinese herbalist use space at the center. We hope more women hear about this new option and choose to birth in such a lovely, and safe environment!

On a less happy note: The problem facing clients interested in birth center or homebirth in Minnesota or bordering states is

the reluctance of insurance companies to welcome the cost savings and routinely cover out-of-hospital births. A few midwives do insurance billing, but the results are spotty. Some companies are good and others are a struggle for each and every claim. Blue Cross and Blue Shield, as well as MEDICA, continue to be a thorn for families and midwives. For example: BC/BS said they would cover homebirths if midwives were certified. Even with the CPM credential BC/BS refused. Next they said midwives need to be stated licensed. We got that licensure up and running and started billing BC/BS again. With virtually every claim families face denial or a long appeal process to get their claims to fruition. MEDICA used to pay partial for out-of-hospital birth, but have since stopped. Midwives can only do so much; individual families must address the issue with their insurance providers. With enough pressure on these conglomerates change can happen!

Minneapolis Star & Tribune is currently researching an article on water birth. The author wants to know if this is a growing trend? My reply is that it is no longer a trend, but just one of the many options available to women I serve. Peace to all the volunteers and workers who are changing the world through gentle birth.

Submitted by Kerry Dixon, CPM, LM <kdmidwife@aol.com>, Secretary of Minnesota Council of Certified Professional Midwives (MCCPM).

NEW YORK

Consumers in New York are beginning to mobilize in some new and exciting ways. New York Friends of Midwives (NYFOM) has recently identified some of the most restrictive barriers imposed upon midwives and the families they serve by the Professional Midwifery Practice Act, the law in New York under which we have been laboring for the past 10 years. These barriers have been printed and distributed to members of our State Board of Midwifery as well as to consumers and the public at educational and political action events. Please contact me at <tgnyfom@aol.com> for a copy.

Though this law clearly imposes restrictions on midwives, the trickle down effect is that consumers in many communities across this large state are left with very few options and very limited access to the Midwives Model of Care that they demand and deserve. Because the diverse credentials, educational and practice backgrounds of midwives have historically obscured the common ground upon which we might all stand to move midwifery forward, consumers in New York are poised to take matters into their own hands. We are beginning to frame the issues, the challenges, the barriers and the solutions specifically from a consumer perspective rather than a practice perspective.

NYFOM serves to inform the public about the Midwives Model of Care and works to secure the availability of more midwives in more settings for more consumers. We also serve to inform our State Board of Midwifery about national developments in midwifery that New York has been oblivious to, namely the recent recognition by the American Public Health Association of Certified Professional Midwives (see <www.cfmidwifery.org/cfm/item.asp?ID=9> and access to out-of-hospital birth services, as well as the Federal Department of Education's recognition of MEAC approved midwifery schools and programs. At the last two State Board of Midwifery meetings, NYFOM presented packets of information to each Board member and delivered a prepared presentation on how consumers are specifically affected by some of the barriers the law creates. Both the packets and the presentations were well received. Dialogue with the Board was continued on September 12 in Albany.

In addition to working with the Board on issues affecting consumers, NYFOM is planning a large, statewide event for Saturday, November 16, 2002 in Albany, New York, titled *(brain)Storming the Barriers to Birth Options in New York*. This forum will examine the effects of the first decade of the Professional Midwifery Practice Act on consumers and chart a course for the next decade. We will have panel discussions on birth options, the law, and stories and reports from women around New York. The afternoon will be devoted to learning how to change public policy and breakout groups to develop strategies and goals. The emphasis will be on consumers and our concerns, with input and support from midwives.

We are planning our event and developing our brochures for a September mailing. Included in that mailing will be petitions that will circulate throughout the state to solicit a strong consumer constituency for challenging barriers and changing the law and regulations.

Consumers have been working diligently with midwives in New York for 10 years. We still have a long way to go to provide broader access to the midwifery services we want in the settings of our choice. As we get ready to enter our second decade of advocacy, we want midwives to now work with consumers. These laws affect US, our bodies, our options, our families.

It is WE, the consumers, who will ultimately be responsible for changing them.

Submitted by Tisha Graham, <tgnyfom@aol.com>.

OHIO

The Spring 2002 *Citizens for Midwifery News* (page 10) reported about the March 1 arrest of Mennonite midwife Freida Miller of Holmes County, Ohio, on three felony charges in connection with an appropriate transport for post partum hemorrhage.

On May 1, 2002, Freida accepted a plea bargain and plead guilty to Possession of Dangerous Drugs, two counts, misdemeanors of the first degree and Attempted Unauthorized Practice of Medicine, a misdemeanor of the first degree. Terms of her plea bargain/sentencing included: (1) A fine of $3,000, plus court costs; (2) 360 days in jail, suspended, but three years probation; (3) 200 hours of community service; (4) a letter of apology for her crimes in two newspapers; (5) agreement to not possess any controlled substance or dangerous drug; (6) have high risk protocols applied to her practice and (7) cooperate with all federal, state and local authorities in any investigations.

On August 31, Freida arrived at a birthing mom's home to find the baby's position was a footling breech. She transported to the hospital per her agreed "high risk protocols"... this was the same hospital and the same doctor that helped bring the original

Texas: Possible Legal Action Against Insurance Companies for Not Paying Midwives

In Texas a lot of midwives (and their clients) have been having difficulty with Aetna Insurance Company lately. The scenario goes like this:

1. Client comes to midwife for a home birth.
2. Midwife or client calls Aetna for pre-certification and are told that home birth is covered.
3. Prenatal care, delivery and postnatal care are provided.
4. Claim is sent to Aetna.
5. Claim is denied. Birth at home is not covered.
6. When claim is appealed, Aetna says, "Phone log of representative makes no mention of your inquiry regarding a HOME birth."

Aetna has an Internal Coverage Policy Bulletin #329 that states they will not pay for home births for policies on which they are the primary insurer OR if they are doing claims processing and either the employers benefits statement says that home birth is covered or the state in which the insured delivered MANDATES that home birth be covered. (In other words, Aetna's denial overrides policies, state mandates and employers' benefits statements!)

Obviously it is difficult for policyholders to determine that home birth is not covered, because that information is normally not in any plan description. It is only in an Aetna Internal Coverage Policy Bulletin. The end result, for home birth clients, is that Aetna avoids paying for either a hospital birth (client did not know that was the only covered option) or a home birth.

My wife, Gail, has had several clients that have had this experience. We have received e-mails that indicate that it is not an isolated occurrence – not only here in Texas, but nationwide as well. We have filed a complaint with the Texas Insurance Commission for three of Gail's clients. Aetna's initial response was that home birth was never specifically mentioned in pre-certification calls. (Note: Aetna does not provide written pre-certification because, "Written pre-certification for obstetrical care is not required.")

Aetna justifies their position based on GUIDELINES by ACOG and AAFP and on ONE study done in Australia from 1985-1990. That study showed that in Australia risky birth at home has poorer outcomes than risky birth in Australian hospitals. However, what Aetna failed to note was that home birth in Australia during that period was still twice as safe as hospital birth in the US at the time. A 1994 Washington State home birth study and our Texas statistics for home birth demonstrate the safety of home birth. Obviously the physicians and insurance companies want to use a single set of data to justify their position. We want to use at least two decades of data to justify our position that home birth is safer.

We have asked the Texas Insurance Commission to request that Aetna (and all other insurers) to pay for home birth based on the Texas Midwifery Act. For more information and a form for reporting your insurance experience (good, bad or indifferent), go to <http://www.texasmidwives.com/possiblelegalaction.htm>. "If you live in the State of Texas, have insurance and have had or are planning to have an out-of-hospital birth, we need your help. Whether your experience has been good, bad or in between, we need to hear from you. All information can be helpful in the investigation and preparation of a possible legal action against insurance companies who refuse to pay midwives. Persons from other states are certainly requested and in fact encouraged to send information; however, at this time the investigation into possible legal action is restricted to Texas." If you live outside Texas, your information will be held by Gail Johnson with the hope and expectation that a future, similar, legal action will be national in scope.

Submitted by Earl Johnson, husband of Gail Johnson, CPM <midwife@gte.net>.

State News continued from page 11

charges against her. A c-section was performed on the woman, who suffered a very severe hemorrhage (transfused with many pints of blood). The MD was quite upset, and registered his "complaint" with her probation officer. Within a day or so, the county health department appeared at Freida's home asking to view all of her current client charts ... she cooperated ... they made a report/list of all her clients. It is unclear what they plan to do with that information.

Freida was ordered to appear at a "questioning" in early September. She was asked to reveal her source for the pitocin, but she steadfastly declines to do so. She was advised that this put her in violation of the terms of her probation, and would lead to contempt of court proceedings. Her probation officer later contacted her to meet and "answer some questions." The next steps are likely to be a grand jury investigation, where refusal to answer under oath will result in contempt of court charges; she would be jailed and/or fined until she cooperates.

Freida is probably the busiest midwife in the state, with many Amish and Mennonite families as clients. Many families are rallying to her support, but there seems to be little that they can do. Some feel that her legal representation has left much to be desired, plus Freida's own beliefs lead her to not "fight back." Supporters are holding prayer meetings near the courthouse on Thurdays.

More information can be found at <www.ofom.org> (click on "action alert"), the Ohio Friends of Midwives website, including how to contribute to a legal defense fund for her case.

Information provided by Pam Kolanz <ohpam@juno.com> and Pat Brown.

VIRGINIA

Notes From Around the State

The last of Virginia's "grannied in" Health Department registered midwives, Adella Scott-Wilson, has packed her bags and moved "to North Carolina" (further details unavailable at this time). Adella's departure, coupled with the untimely retirement of Cynthia Caillagh several years ago, leaves heavily populated Virginia Beach and all of Virginia east of Richmond without a home birth midwife. Several folks from that area have contacted Virginia Birthing Freedom (VBF) recently and pledged to work harder to support midwifery legislation this fall and winter.

The Virginia MOM group (Midwifery Options for Mothers) continues to hold regu-

lar meetings, classes and special events in the Northwest and Shenandoah region. Visit <www.VirginiaMOM.org> for details.

The Commonwealth Midwife Alliance (CMA) has been meeting regularly this year, discussing a wide range of issues, conducting peer review and workshops, and adopting bylaws.

The VBF Board of Directors elected new officers and named a new Director at their September meeting. The new officers are, Tammi McKinley, President; Ellen Hamblet, Vice President; Sara Krivanec, Secretary; and Bonnie Matheson, new Director and Treasurer.

Organizing grassroots involvement and fundraising are VBF's top priorities this fall. Last year's bill(s) fared better than previous efforts despite an apparent decline in the number of calls and letters to legislators. With the number of home birth midwives at an all time low – and falling – more consumers should begin to realize that the ball is in their court.

In many ways, it seems like we've been trying to buy midwifery a ticket to sail on the Titanic.

VBF will hold a benefit concert featuring the South American folk/rock/dance/romance band Solazo, at Northern Virginia Community College in Annandale on November 19. Visit <www.Solazo.com> and <www.VBFree.org> for details.

Finally, with VBF in good hands, I'm taking a half step back and searching for ways and means to address the broader fundamental problems of the way that Virginia and other states go about regulating health professions and institutions. In many ways, it seems like we've been trying to buy midwifery a ticket to sail on the Titanic. Virginia's Department of Health Professions is a scandal of conflicts of interests from top to bottom, and many members of the media and the legislature are insisting that a major overhaul is long overdue.

Nosocomial (hospital-caused) infections are the fourth leading cause of death in the US, but far more money and attention is being given to fighting the West Nile virus. The state with the lowest hysterectomy rate in the country, New York, is the only state with mandated and prescribed informed consent for the procedure.

Virginia's Department of Health Professions is a scandal of conflicts of interests from top to bottom, and many members of the media and the legislature are insisting that a major overhaul is long overdue.

Across the board, I think that the public needs to be enabled and encouraged to play a greater role in their own health care and in regulating health professions and institutions. I'll still be focusing a lot of attention on midwifery, while I try to weave together some of these other loose ends on The CommonHealth website at <www.HealthFreedom.org>.

Submitted by Steve Cochran <SteveCochran@HealthFreedom.org>.

Free Materials to Promote the Midwives Model of Care!

Planning an educational event? Need professional looking presentation folders for state legislators or the local press? The following items are available to midwives and midwifery advocates **free of charge**. (Display boards are on loan and are shipped with return mailers.)

- Midwives Model of Care Press Folders and Press Packet Items
- Midwives Model of Care Postcards
- Safe Motherhood Quilt Project Brochures
- Quilt Project Brochure Display Board
- CPM Brochure Display Board
- Midwives Model of Care Brochure Display Board

Interested parties should contact Pam Maurath at <info@midwivesmodelofcare.org> or (866) 439-4837 (toll free) to make arrangements. Please allow 1-2 weeks for shipping.

Midwives Model of Care™

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes. The Midwives Model of Care includes:

- monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- minimizing technological interventions; and
- identifying and referring women who require obstetrical attention.

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

Resources

Book Review

Giving Birth: A Journey Into the World of Mothers and Midwives

By Catherine Taylor

Perigee Trade Paperback, Penquin Putnam Inc. NY 2002

Reviewed by Susan Hodges

Like several other recent autobiographical books about being pregnant (see reviews in *CfM News*, Fall 2001/Winter 2002), Catherine Taylor's *Giving Birth* is organized around the sequence of pregnancy and giving birth, but there the resemblance stops. This book is a wonderfully readable narration of the author's research and learning about birth and midwifery. Written during the time of her own second pregnancy and birth, it is personal and informative, but neither didactic nor judgmental.

A writer and editor, Catherine Taylor undertook to write about childbirth and midwifery, "for both personal and professional reasons." Already a mother of a seven-year-old, and wanting another child, she set out to explore and understand midwives and midwifery, not by just reading or through interviews alone, but by actually spending days with a variety of individual midwives as they went about their work. The process eventually led her to undertake doula training, and to spend time with both hospital-based nurse-midwives and direct entry midwives. In addition, the author researched her topic thoroughly, and her factual statements are referenced in "Notes" at the end of the book.

Written in the first person (and sometimes in the present tense), she reports her observations and experiences with an intimate and conversational style. In a very natural way, she has interwoven research and facts, related to the narrative by her own observations or subsequent knowledge: "At the time, I knew nothing about…" or "I later learned…." or "Now I know that…."

Taylor started out following midwives that were part of an HMO hospital where 80% of deliveries were with nurse-midwives. Along with her, we discover how individual each midwife is and their differences in practice, as she observes the midwives at work with women who permitted her presence. We learn about the frustrations, politics, pressures and compromises involved with practicing midwifery in the hospital. Taylor is not passive in her thoughts. "I am a bit surprised by…." Or "I don't understand why…" pop up frequently. In addition, Taylor draws the midwives out with questions, getting them to talk about how they practice and about the political/professional aspects of their work. The result is a broad-spectrum picture of "nurse-midwives," including their relationships with their "patients" and with each other, and their vulnerability in the hospital system. In addition, the reader can't help but get an understanding of why, even though the nurse-midwives are doing their best, mothers frequently get shortchanged when giving birth in the hospital, even when attended by a nurse-midwife. Because Taylor is observing as neither "patient" nor midwife, she notes when, for example, the supervising doctor makes a decision, but the midwife persuades the mother on a course of action (intervention) without letting her know that the doctor, not the midwife, actually made the decision.

Recognizing that one of the problems is that nurse-midwives in the hospital often simply cannot be with a woman during labor (a situation she experienced in her first labor), Taylor not only read about doulas, she completed doula training with Pam England (author of *Birthing From Within)*. By this time Taylor was happy to be pregnant, and she also continued to follow midwives around and be at births. In addition, she became interested in home birth as a possibility, and observed several home births with different direct entry midwives. Does the setting affect childbirth? The stories and information in *Giving Birth* makes a strong case that it does.

If there is a weak part of this book, it is the brief conclusion. The issues and problems are well summarized, focusing on the need for respectful treatment of mothers, for recognition of birth as a normal process, and for attention to the spiritual, transformative and empowering aspects of giving birth. However, less than a page is devoted to "what can we do to change the system." Unlike the rest of her book, this section reveals a lack of understanding about the political and economic challenges involved, with rather vague "we can support" suggestions and no mention of the need to coordinate efforts if we are to effectively change maternity care in the US. She does, however, include a useful "resources" section, with lists of books, publications and organizations (including CfM). To be fair, "what can be done" is not the focus of her book, and she has otherwise addressed birth and midwifery admirably.

Catherine Taylor has beautifully crafted a tapestry of birth stories, birth facts, midwives and midwifery, the needs of mothers, and maternity care realities. I highly recommend this eminently readable book to anyone who wants to learn more about pregnancy, the realities of maternity care in the US and the midwife/birth setting choices that may be available.

Required Reading!

ACOG's "Code of Ethics" and "Informed Consent"

Last issue's article about violence against women in the medical model of maternity care (*CfM News* Summer 2002) proposed the idea of filing complaints when obstetricians or other medical care-givers are abusive or behave unprofessionally. If you read ACOG's Code of Ethics, you'll know the professional standard to which obstetricians are accountable.

Steve Cochran discovered that the Virginia Code (statutes) § 54.1-2914. "Unprofessional conduct" references "the standards of ethics of his branch of the healing arts." Steve has linked the ACOG Code of Ethics PDF file and related documents specifically about informed consent. You can find these at: <http://healthfreedom.org/acog>.

Let's make use of this document to educate women about the ethical standards to which obstetricians in particular should be held, and let's encourage women to make formal complaints when their obstetricians fail to live up to these ethical standards.

Alphabet Soup Directory

Following is a brief listing of common terms and groups whose focus includes midwives and midwifery care. Time zones are listed, along with the telephone numbers for each organization.

***CfM* Citizens for Midwifery**
P.O. Box 82227, Athens, GA 30608-2227, (888) CfM-4880 (ET) (toll-free), <www.cfmidwifery.org> <info@cfmidwifery.org>

***CIMS* Coalition for Improving Maternity Services**
P.O. Box 2346, Ponte Verde, FL 32004, (888) 282-CIMS (ET) (toll-free), <www.motherfriendly.org> <cimshome@mediaone.net>

***MANA* Midwives Alliance of North America**
4805 Lawrenceville Hwy, Suite 116-279, Lilburn, GA 30047, (888) 923-MANA (CT), <www.mana.org> <info@mana.org>

***MEAC* Midwifery Education Accreditation Council**
220 West Birch, Flagstaff, AZ 86001, (928) 214-0997 (MT), <www.meacschools.org> <meac@altavista.net>

***NARM* North American Registry of Midwives**
PO Box 140508, Anchorage, AK 99514, (888) 84BIRTH (888-842-4784) (CT), <www.narm.org> <info@narm.org>

***CPM* Certified Professional Midwife** (direct entry credential administered by NARM)

***ACNM* American College of Nurse-Midwives**
818 Connecticut Avenue NW, Suite 900, Washington, DC 20006, (202) 728-9860 (ET), <www.midwife.org> <info@acnm.org>

***CNM* Certified Nurse-Midwife** (advanced practice nursing credential administered by ACNM)

***CM* Certified Midwife** ("direct entry" credential administered by ACNM; also used to designate midwives certified through state midwifery organizations in some states)

***DEM* Direct Entry Midwife** **(not a credential, designates midwives who came directly to midwifery, not through nursing)**

Order *CfM brochures and packets!*

Use this form to order brochures in bulk.
• For a single brochure, please call toll-free or e-mail your request.
• The packets contain tips and "how to" information that you or your organization may find useful.
• You are welcome to reproduce packets for use in your area.

Send to (PLEASE PRINT):

Name _____

Street Address _____

City _____ State & Zip _____

Home Phone _____ Office Phone _____

Fax _____ e-mail address _____

CfM Member? _____ Yes _____ No

CfM brochures and packets are available to you free of charge. However, if you would like to help make CfM's funds go further (printing and postage do cost money), a donation to cover costs is always appreciated!
Contact CfM regarding prices for other quantities.

_____	Packet of 25 CfM brochures (Send SASE for sample copy)	(suggested donation $5)	$ _____
_____	Additional brochures, same order	(our cost $.10 each)	$ _____
_____	Packet of 25 CfM brochures and 25 "Free Issue" postcards	(suggested donation $6)	$ _____
_____	Organizing Packet, including legislative hearings and presenting testimony (approx 50 pp)	(suggested donation $5)	$ _____
_____	Public Education Packet (approx 25 pp)	(suggested donation $4)	$ _____
_____	Using the Media Packet	(suggested donation $4)	$ _____

FOR SALE:

_____	50 Midwives Model of Care brochures [ ] English [ ] Spanish	($20 includes postage)	$ _____
_____	100 MMofC brochures (or .30 ea + shipping) [ ] English [ ] Spanish	($38 includes postage)	$ _____
_____	Pocket Guide to Midwifery Care (see *CfM News* 4/99)	($9 includes postage)	$ _____
_____	Midwives: A Living Tradition (1998, 68:30 min.)(see *CfM News* 4/99)	($30 includes postage)	$ _____

_____ **TOTAL ITEMS ORDERED / AMOUNT ENCLOSED** *(Check payable to Citizens for Midwifery)* $ _____

Please mail this form, with your check or money order to: Citizens for Midwifery, PO Box 82227, Athens, GA 30608-2227
Citizens for Midwifery · (888) CfM-4880 · info@cfmidwifery.org · www.cfmidwifery.org

Citizens *for* Midwifery
Learn, Connect and Take Action

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Members, have you moved?
Please let us know of any address corrections!

If your name is not followed by a six-digit number, you are not yet a member, and have received a complimentary issue.
Please join CfM today!

Citizens *for* Midwifery
Learn, Connect and Take Action

Yes!

I want to help promote the Midwives Model of Care.

Please mail this form,
with your check or money order to:

Citizens for Midwifery
PO Box 82227
Athens, GA 30608-2227

Name _____

Street Address _____

City _____ State & Zip _____

Home Phone _____ Office Phone _____

e-mail address _____ Fax _____

I originally learned about CfM from: _____

CfM may occasionally make its list of members available to other midwifery-related organizations. (___ I do NOT want my name released.)

Contact CfM regarding special rate when you join or renew CfM and state midwifery or midwifery advocacy group memberships at the same time.

___ Student	$15	*I am a (check all that apply):*
___ **Suggested**	**$25***	___ Concerned Citizen ___ Parent
___ Supporter	$50*	___ Childbirth Educator ___ Doula
___ Best Friend	$100*	___ Midwifery Student
___ Guardian Angel	$500*	___ Midwife (__ CPM __ CNM __ LM __ DEM)
___ For overseas addresses, add	$10	___ Other (_____)
___ Additional donation	$ _____ *	
TOTAL ENCLOSED	$ _____	

** Your contribution is tax deductible except for your newsletter subscription valued at $15 annually.*

Membership in Citizens for Midwifery: When you join CfM, you will receive the quarterly *CfM News*, keeping you informed on midwifery news and developments across the country. Your membership also helps to pay the costs of maintaining our toll-free hotline and supplying information and brochures to the public. Your contribution will be used responsibly for carrying out CfM's mission. A financial report is available on request. CfM is a grassroots, tax-exempt organization meeting IRS requirements under section 501(c)3, and is composed of volunteers who want to promote the Midwives Model of Care.

How can you help? Join today. Volunteer with CfM. Become informed!
By joining CfM you are helping to make a difference! Thank you for your support.

Getting in touch with CfM: Call: (888) CfM-4880 E-mail: info@cfmidwifery.org Visit our website: www.cfmidwifery.org