

Citizens for Midwifery

NEWS

VOLUME 9, ISSUE 1, SPRING/SUMMER 2004

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Maureen Meadows and Ridley
Photo by Steve Jones

Effects of Hospital Economics on Maternity Care

By Susan Hodges with Henci Goer

On February 26, 2004, Henci Goer and Susan Hodges presented "Economic Disincentives for Mother-Friendly Care: How economic considerations shape conventional obstetric care" at the 2nd Mother-Friendly Childbirth Forum held by CIMS near Washington, D.C. This article is based on that presentation.

When two Austin, TX, hospitals both got rid of the nurse-midwives practicing there, a news quote caught my attention:

"The closings, although not related, are being done for a similar reason:

Midwife deliveries are not big moneymakers [my emphasis], people associated with the programs said." ("Midwifery programs are closing," 05/14/02 *Austin American Statesman*.)

When many studies have shown conclusively that midwifery care is "cost effective," why are so many nurse-midwife practices being closed, and why were midwives being called "not big moneymakers?" These questions prompted me to start learning about the economics of health care, and especially of hospitals.

The Maternity Care Business

Maternity care is big business in the U.S., especially for hospitals. Of total hospital stays for women, 25% are for pregnancy and childbirth ("Care of Women in U.S. Hospitals, 2000" HCUP Fact Book No. 3). In 1999, delivery accounted for about 270 hospitalizations for every 10,000 women (Women's Health USA, 2002). Obstetricians are important to a

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The March for Women's Lives

Citizens for Midwifery generally avoids discussion of abortion which tends to be a divisive issue. However for all of us who care about maternity care and desire that mothers should be free to choose how, where and with whom they give birth, it is important to understand the problems that the concept of "fetal rights" is creating for birthing women. It is in this spirit that this report is offered, with the hope that out of understanding, solutions can be created.

April 25 was the day that thousands of women marched on Washington, DC. While such marches in the past have focused solely on abortion rights, this march began to broaden the meaning of "reproductive rights."

One organization that played an important role is National Advocates for Pregnant Women (NAPW), because this group understands that reproductive rights is about much more than rights to not be pregnant. Executive Director Lynn Paltrow spoke at the March, putting forward the message that "women who continue their pregnancies to term are also hurt by anti-abortion laws that are being used as 'weapons of maternal destruction.'" NAPW also led a contingent of marchers dressed as pregnant women. With her permission, here are excerpts of her report, and a handout provided by NAPW.

Dear Friends and Allies:

I am still feeling high from the April 25th March for Women's Lives. It is possible that my perspective is colored by the absolute thrill of being able to be on stage with my kids in front of 1 million+ people.

Our contingent in the March, led by Wyndi Anderson, carried signs and wore T-shirts calling for the government to free Regina McKnight and Angelia Kennedy – arrested for being pregnant and trying to

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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:

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CfM Board of Directors (2003-2004)

Susan Hodges, President

Paula Mandell, Vice President

Carolyn Keefe, Secretary

Willa Powell, Treasurer

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Only Part of the Story

by Susan Hodges, CfM President

Several recent birth/midwifery stories in the news illustrate again that it is essential not to swallow media coverage as "the truth."

By now probably everyone has read or heard about Melissa Ann Rowland, the mother in Utah who initially refused a cesarean section for twins. When she eventually consented and one twin was stillborn, she was blamed for the death, charged with murder, and incarcerated within 24 hours of the cesarean section. She has since pled guilty to lesser charges of child endangerment in order to get out of prison.

When the story broke, Melissa was portrayed as a selfish woman who refused the surgery for cosmetic reasons, based on quotes from hospital staff who neglected to mention Melissa's two prior cesareans or the fact she had a history of mental illness. And no one mentioned she was not offered any type of social services or other help. It is true that Rowland used cocaine; however, the idea that cocaine use causes stillbirths or causes "crack babies" has been thoroughly debunked <www.advocatesforpregnantwomen.org/articles/crackbabytr.htm>.

The arraignment of Judy Wilson on manslaughter charges in Pennsylvania recently was carried in newspapers across the country. The charges, which include Involuntary Manslaughter, Endangering the Welfare of a Minor, and Unauthorized Practice of Midwifery, were not made until more than a year after the birth in question. Judy Wilson, at the time an active CPM, attended a home birth where the baby presented as an unexpected footling breech. The parents declined transport, the baby was born at home, resuscitated, then transported to hospital by EMTs, but sadly died two days later in the hospital. News coverage did not give a complete picture, including the fact that the EMTs did not have proper equipment for providing oxygen to the newborn. As noted on the Friends of Judy website <www.friendsofjudy.org>, "Many of the statements made by the coroner's office and reported in the local media are just plain wrong. Cyril Wecht [coroner] has come under fire in the past for commenting on areas he is not

experienced in and for stating his opinion as fact." (Wecht asserted at the inquest that "laboring women are unable to think rationally and thereby make decisions about their own care.")

In Vermont newspapers carried stories about Roberta Devers Scott's legal problems. Roberta's license was suspended in February pending a full hearing before an administrative judge. The complaint was based primarily on two births, both transports. In one case the baby was delivered by cesarean section and suffered brain damage. In the other the baby was delivered by cesarean section and subsequently died. While the press reported the charges and allegations, which are public record, it is important to remember there is much more to the situation than was reported. The full story, including Roberta's testimony about the births and the political climate at her local hospital, has not been heard. She should not be tried and judged in the press, nor should homebirth be put on trial.

These recent news stories reminded me how easy it is to be influenced by these one-sided accounts to make assumptions or judgments, even unconscious ones. At best the media will report only half of the story and will focus on sensational allegations and accusations. It is up to us to actively remember that we are only getting one side. Given the attitude and power of organized medicine toward midwives and out-of-hospital birth, it is a good idea always to give the midwife and the parents the benefit of the doubt while seeking additional information.

We can also use the media to keep before the public the excellent record of midwives and homebirth in this country and elsewhere, and as midwives and midwife supporters, uphold the need for accountability mechanisms and processes that assure fair hearings for all involved. ☸

The above article is reprinted from MANA News, June 2004.

President's Letter

Dear Friends,

First of all, I want to apologize for the fact that this is a combined Spring/Summer issue, and that you are finally receiving it in July. My part-time job was full time during April and May. As the Editor, I seem to have a hard time learning that there are only 24 hours in a day, and one can only do so much in those 24 hours!

Volunteer Opportunities!

During the last six months, in addition to my job, the four current Citizens for Midwifery Board members have had children graduate from high school, given birth (congratulations Willa!), been elected to a local school board, and taken care of family elders. We are acutely aware that we have been trying to do too much with too few people. So, in the coming months the Board plans to focus on finding and welcoming more volunteers to help with the work of Citizens for Midwifery.

Some of the jobs and roles that need to be filled:

- Regional representatives for networking and news updates
- Contact person/coordinator for these regional reps
- One or several people to help keep the website up-to-date, especially the State by State pages
- Newsletter Editor

The first two would involve telephone calls and e-mail communications, as well as access to websites, and the ability to take initiative, follow through and work as part of a team.

A newsletter editor ideally would have a general grasp of midwifery issues across the country, good phone and e-mail communication skills, be able to work closely with the CfM Board members, and have some experience and/or aptitude in news reporting and editing. Ideally, the newsletter editor would have a vision for the newsletter, and would take pride in coordinating each issue.

Being "hooked up" to the Internet (e-mail especially) is a practical necessity. The work is all volunteer, though CfM expects to cover out-of-pocket expenses involved (necessary long distance phone calls, for example). As volunteers, you will have the satisfaction of making valuable contributions to CfM's efforts while getting to know some wonderful "kindred spirits" on the CfM Board!

We recognize that most of you are busy with young children and/or full time jobs. We will also be exploring ways to break down or compartmentalize some of the work so that more people can be involved with more "bite sized" tasks.

Please contact CfM if you are interested or have any questions about any of these opportunities, whether or not you think you are "qualified!" We are really interested in getting help with the work, one way or another!

Annual Membership Meeting and Elections

Mark your calendar! Citizens for Midwifery will hold our Annual Membership Meeting on **Saturday, October 2, in Albany, NY.** The meeting, including elections, will be from 5 till 6 pm, followed by a potluck and social gathering hosted by New York Friends of Midwives. This is a good chance to meet the CfM Board of Directors, as they will also be meeting together during that weekend!

Details about the Annual Meeting as well as information for voting and a ballot will be sent to all CfM members by the end of August. You do not have to be present at the Annual Meeting to vote; you may mail in your ballot or bring it with you to the Membership Meeting.

Thank you!

Dear CfM,

I am so happy to be sending you these donations totaling \$410. When my partner and I decided to get married, we asked people to please bring a donation to CfM in lieu of gifts. Our wedding was small, but people gave generously. We are both so grateful to have had access to a wonderful midwife for the home birth of our son Rainer 16 months ago. We are happy to be able to contribute to the advocacy and protection of this precious and life-affirming art.

Yours in Peace and Love,
April & Ed Coburn (in Pennsylvania)

A heartfelt thank you to April and Ed from the CfM Board! May you have a wonderful life together!

(NOTE: The writers gave permission to publish their letter in our newsletter.)

Fundraising

The CfM Board is now developing a way for people to honor their midwives, mothers or other important people while supporting Citizens for Midwifery with a gift. Our on-going fundraising campaign: "Labor of Love: Honoring Midwives and Mothers" gives you an opportunity to Honor your Labor of Love by supporting CfM's Labor of Love — promoting the Midwives Model of Care. This will be a way to say "thank you" or remember someone special and offer a tribute to that special person while helping to make CfM stronger and more effective! Your honoree will receive a notice of tribute and, if you wish, will be listed on our web site (anonymously if preferred). Look for more information on the website and in a mailing as we develop this project in the coming months.

Hoping you are all enjoying the summer weather and keeping cool!



Citizens for Midwifery
welcomes photos to
go along with
the articles
in our newsletter!

Interested in writing a
review of a book or
video? How about a
good website you've
discovered?
Let us know!

(Economics ... continued from page 1)

hospital's financial success for a number of reasons, including the fact that they influence around 11%, or \$30 million, of inpatient charges through referrals to other physicians within the hospital (Hanold, K C, "OB/GYNs Offer a Rich Source of Referrals" MHS Fall 2002). In other words, obstetrical care is still a major marketing tool for hospitals; when a woman needs hospitalization for herself or for a family member, she will tend to stick with the hospital where she gave birth.

When we think about costs and "cost effectiveness" we usually think about the cost to us, the consumers (or to our insurance carrier or HMO). We can see that our costs will vary by setting:

Fees:	
Home Birth	\$2,300 - \$5,000
Birth Center	\$3,500 - \$8,300
Hospital	\$4,300 - \$16,000
Cesarean Section*	\$9,300 - \$26,000

*includes average 4-day hospital stay

(O'Mara, P. *Having a Baby, Naturally*. 2003. p. 322. Based on figures published in 1999.)

Consider that 99% of births occur in hospitals, of which more than a quarter are cesarean sections, and that home birth costs as little as one sixth the cost of an uncomplicated vaginal birth in the hospital.

Hospitals, on the other hand, are thinking in terms of their net income, of billings versus their costs. Every hospital needs to at least break even, but if it is a "for profit" hospital, there also are shareholders expecting a profit on their investment.

A number of economic factors affect hospitals, including some that are somewhat unique to hospitals compared to other businesses:

- High fixed costs (for expensive facilities, required staffing, special management needs for dealing with disease, etc.)
- Marketing (to attract patients who would otherwise use competing hospitals)
- Unpredictability (of medical events, use of services and facilities, etc.)
- Unpaid billings (a growing problem)
- Variable profitability among services

Illness, accidents and births are unpredictable, but a hospital must always be prepared for these. If one can make any of these events less random and more predictable, staffing can be more efficient. Childbirth has the potential for being made more predictable by manipulating labor (induction, active management of labor) or by scheduling cesarean sections. From 1989-1997 births have become more frequent on weekdays compared to weekends, and "Births delivered by repeat cesarean and vaginal births that were induced are especially likely to occur on weekdays". (Trends in the Attendant, Place and Timing of Births and in the Use of Obstetric Interventions, United States, 1989-97. Vol. 47, No. 27. 16. pp. (PHS) 2000-1120.)

Hospitals can increase their income by reducing their fixed costs (equipment, buildings, staff) and/or by increasing efficiency (more patients or billable events per unit of time). For maternity care, decreasing the amount of time each patient is in the hospital (hurrying labor along) and increasing the use of lab tests, drugs and other billable treatments are ways of increasing income for each birth. The more technology and the more tests and procedures that can be performed (and billed for), the greater the differential between costs to the hospital and what the hospital charges. In other words, as care gets more complex, the costs increase but the profit margin goes up even faster.

Hospitals compete for patients by marketing their services, and having the "latest technology" and services available around the clock is great for marketing. However, once a hospital has invested in the technology or must pay for specialized staff, there is a strong incentive to make as much use of the technology as possible, so that the fixed costs of having the technology or staff are offset by billing. For example, hospitals want to offer epidural anesthesia, so must incur the costs of having an anesthesiologist available around the clock, creating an incentive for the hospital and the staff to encourage "every" laboring woman to have an epidural whether or not she wants one. This also holds true for OBs who purchase expensive ultrasound equipment for their offices; the way to make that equipment pay off is to perform, and bill for, as many ultrasounds as possible, whether or not there is any medical need for them.

Obstetricians make the decisions about clinical care – both hospital protocols and individual decisions for each patient. Obstetricians need to maintain their hospital privileges, and to some extent the "health" of the

hospital depends on clinical practices that result in maximum billing. Obstetricians also have to pay for their liability insurance coverage, and the rates have been increasing substantially in recent years. One way obstetricians can make more money (to pay for insurance while maintaining the standard of living to which they are accustomed) is to see more patients in the same amount of time. How to accomplish this? A planned cesarean section can be performed in 20 to 30 minutes, scheduled conveniently around office hours. In contrast labor takes hours or days and is unpredictable. There is no question that planned cesarean sections are more profitable for both the obstetrician (in most states OBs are reimbursed more for a cesarean section than for a vaginal birth) and the hospital (more technology, drugs, lab work, etc. can all be billed). In addition, scheduling cesarean sections makes it possible for the obstetrician to have more patients, more births per month, more income per month.

Health Insurance and Maximizing Reimbursements

Health insurance (including Medicaid) generally pays a "global" fee to the hospital and to the obstetrician for each normal birth. This means that for many births, the doctor and the hospital are paid a set amount per birth, regardless of the amount of time. The hospital, OB, anesthesiologist and other departments (lab, radiology, NICU, etc.) each charge separately. OBs generally are reimbursed more for cesarean sections and for "high risk" patients, and can "add on" for complications (the OB decides what is a complication).

The fact that more cesarean sections are performed when reimbursement is higher, shows that this intervention is done at least some of the time for economic reasons. For example, in 2000 cesarean sections were performed on 24.4% of patients covered by private insurance (which reimburses at the highest rates), on 20% of patients covered by Medicaid, and on 18.65% of women who were uninsured ("Care of Women in U.S. Hospitals, 2000" HCUP Fact Book No. 3).

According to a CNM who has practiced for many years, in Georgia in 1987 the global fee for the OB for maternity care was about

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\$900. That amount increased quite dramatically to around \$3700 in 1993-94, but Managed Care was successful in bringing down the costs – by 1997 the global fee was down to about \$1500, but by 2003 this amount has dropped to \$900 – the same as in 1987 not counting inflation or changes in care. In the past it has been common to set fees high enough to cover not only the costs for the private patient, but to “cost share” or take up the slack for patients on Medicaid or without insurance. However, HMOs have essentially eliminated this kind of cost-sharing, plus increasing numbers of people lack any insurance and Medicaid insurance reimbursement rates have decreased. Thus many hospitals and doctors are really feeling the squeeze. When insurance reimbursements do not cover costs, hospitals and doctors are going to look at increasing the number of patients they can “process” per unit of time in order to compensate. Some hospitals will simply close down or stop providing certain services, which usually ends up decreasing access to care disproportionately for low-income people.

Hospitals and OBs have found any number of ways to maximize reimbursements. One way is to inappropriately designate pregnant women as “high risk,” based on demographics (Columbia-Presbyterian Hospital used this tactic to eliminate most pregnant women from being eligible for midwifery care at delivery) or for other reasons. Terminology also can be a tool, one example being the common use of the disease term “gestational diabetes” which “communicates the need for high-risk surveillance to providers of third-party payments” (Gabbe SG. Definition, detection, and management of gestational diabetes. *Obstet Gynecol* 1986;67:121-125.).

Other Ways to Increase Hospital Income

Increasing cesarean sections is another way to increase revenues, and performing fewer cesareans loses money. In the 1980’s, Mt. Sinai hospital instituted a program that successfully cut the cesarean rate from 17.5% to 11.5% in two years. However, “The drop in cesarean sections cost the hospital and physicians approximately \$1 million in lost revenues over the two-year program” (Koska MT. Reducing cesareans—a \$1 million trade-off. *Hospitals* 1989;63(5):26). According to one

mother-friendly obstetrician, who works to help her patients NOT end up with a cesarean section, it is relatively easy for an OB to “set up” a patient so she will end up with a cesarean without even realizing she was set up.

Admitting babies to Neonatal Intensive Care Units (NICUs) is a money-maker, especially if the babies are not very sick. A Ross planning associate said: “We can do a better job of budgeting our staff with these longer stays and increased numbers of patients. . . . And we’re doing procedures—highly technical procedures that cost a lot and can generate higher revenue based on the same occupancy.” (Shearer MH. The economics of intensive care for the full-term newborn. *Birth* 1980;7(4): 1980. p 235) In fact, data on newborns in intensive care shows that primarily only very low birth weight babies, about 3 to 4 percent of babies, actually benefit from NICU admission; about 60 % of NICU admissions are low risk or mildly ill and unlikely to benefit. In the 1990’s in one academic NICU unit newborns admitted for “evaluation” accounted for 2% of work hours in the unit, but for 7% of its revenues. (Perkins BB, *The Medical Delivery Business*. Rutgers University Press, 2004. P 130).

Increasing the use of epidurals increases profits by increasing billing, both for the procedure itself and for the increased needs for tests and treatments due to complications from the epidural itself.

Hospitals also work to increase market share. Having the latest technology is a marketing tool, but once the technology is in place, there is a strong incentives to use the technology as much as possible in order to cover its costs.

Maximizing patient flow also helps profits. For maternity care, this includes having prenatal visits of minimal length, inducing labor, and scheduling cesarean sections. As Dr. J Caillouette commented on a study of the merits of elective induction: “It is no longer feasible for individual physicians who have invested 12 years in training at a cost of hundreds of thousands of dollars to dedicate extended periods to observing one normal woman in labor.” (Macer JA, Macer CL, and Chan LS. Elective induction versus spontaneous labor: a retrospective study of complications and outcome. *Am J Obstet Gynecol* 1992;166:1690-7.)

Hospitals can also try to save money by reducing staff costs. Induction of labor, epidural anesthesia and scheduled cesarean sections

can help. Electronic fetal monitoring, especially where one staff can keep an eye on multiple monitors at a central location, also reduces staffing needs. “Active management of labor” calls for artificial rupture of membranes for all women to speed up labor; oxytocin if progress is not at least “average”, and a cesarean section if dilation is not complete within 10 hours of admission. “The newfound ability to limit the duration of stay [on the labor and delivery unit by using active management of labor] and therefore to quantify the number of patient-hours to be serviced has transformed the previously haphazard approach of planning for labor.” (O’Driscoll K and Meagher D. *Active Management of Labour* 2nd ed. London: Bailliere Tindall, 1986. p 101) Recently, some hospitals have eliminated lactation consultants to “save money.”

Results and Conclusions

The results of all these economic factors leaves us with the following anomalies and paradoxes:

- Fully 85 percent of U.S. Women enter labor at “low-risk” for problems (Healthy People 2010), but virtually 100% of U.S. women have at least one intervention. (*Listening to Mothers Survey*. Maternity Center Association 2002)
- There is no justification for cesarean section rates over 10 to 15% (*Recommendations* WHO Consensus Conference on Appropriate Technology, 1985), but the U.S. Cesarean section rate is 26.1% (National Center for Health Statistics, June 2003).
- WHO recommends an induction rate of 10% or less, but in the Listening to Mothers Survey, induction was attempted 44% of the time (and worked more than 1/3 of the time).
- Continuous electronic fetal monitoring (EFM) does not improve outcomes in either low risk or high risk births, but in the Listening to Mothers survey 93% of women had continuous EFM.

Compared with women seeing only obstetricians, women receiving hospital-based midwifery care spent less time in the facility, experienced fewer cesarean sections, experienced fewer vacuum or forceps assisted vaginal deliveries, had fewer episiotomies, were

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(Economics ... continued from page 5)

less likely to be induced, and experienced less technical intervention. (Jackson et al. "Outcomes, Safety, and Resource Utilization in a Collaborative Care Birth Center Program Compared With Traditional Physician-Based Perinatal Care." *Am J Pub Health* 2003; 93:999-1006.) Given these results, midwifery care clearly would result in less income for the hospital which would lose billings for epidurals, cesarean sections and other interventions, and would have fewer babies going to NICU. Care that is "cost effective" is less expensive for you, but almost always hurts the hospital's bottom line.

Given these economic considerations, should it come as any surprise, therefore, that some hospitals have: refused permission for CNMs to attend births; counted CNM births as doctor-attended, then argued that midwives didn't do enough births to make the program

cost-effective; or created hospital rules that made CNMs "too expensive," such as requiring an OB and anesthesiologist to be present at each CNM birth (doubling professional charges)?

Hospitals and obstetricians are making clinical and management decisions for economic reasons, which is neither honest nor good medical care. When a pregnant woman in labor goes to a hospital and is told she needs this procedure or that intervention, how is she to know if the treatment is actually being recommended for real medical reasons? Or for purely economic reasons? No agency or government authority is asking any questions such as "Has the increase in cesarean sections resulted in better outcomes for mothers and babies?" There is an unspoken assumption that physicians' decisions should not be questioned, so there is no regulation by disinter-

ested parties. There is virtually no consumer pressure. There are no restraints on anti-competitive practices. There are no meaningful consumer protections. There is no accountability for the health and well-being of mothers and babies.

The end result is that women are being cut and drugged and their babies harmed every day for economic and other non-medical reasons. How much longer are we going to tolerate a health care system that allows doctors to perform unnecessary cesarean sections and other interventions for economic reasons, while withholding access to preventive care (like midwives and lactation consultants) that improves the health and well-being of mothers and babies???

If you found this article interesting or provocative, be sure to read the review of The Medical Delivery Business: Health Reform, Childbirth and the Economic Order on page 17 of this newsletter.

New Booklet Now Available

Helping Women Make Informed Decisions About Cesarean Section

From the Maternity Center Association

Endorsed by Citizens for Midwifery and over 20 other national non-profit organizations

Informing Women • Securing Rights • Protecting Mothers • Protecting Babies

What Every
Pregnant Woman
Needs to Know
About Cesarean
Section

2004

MATERNITY CENTER ASSOCIATION

be informed

know your rights

protect yourself

protect your baby

Exposing the Myths, Reducing the Risks

- relative safety of vaginal and cesarean birth for dozens of outcomes
- results of systematic review
- close look at pelvic floor and planned cesarean controversies
- evidence-based tips to avoid unnecessary cesareans

How To Order

This booklet is available in two forms: as a bound, color version with an at-a-glance insert comparing the risks of vaginal and cesarean birth, and as a PDF file (insert not included). You can order both forms by visiting www.maternitywise.org/cesareanbooklet/, by emailing info@maternitywise.org or by calling 212-777-5000.

To learn more about the process and sources used to draw conclusions, go to www.maternitywise.org/cesareanbooklet/.



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(March for Womens' Lives ... from page 1)

carry those pregnancies to term in spite of their drug problems.

Among those marching with us were John and Amber Marlowe. Although as a matter of religious faith they oppose all abortions, they joined us because they understand from personal experience how antiabortion laws hurt women who seek to carry their pregnancies to term. Amber Marlowe was nearly forced to have a totally unnecessary c-section by a hospital that obtained a court order to cut her open based on claims of fetal rights. The Marlowes escaped and gave birth to a perfectly healthy baby without the c-section. They marched with us. ... Among those marching were also members of a variety of drug policy reform groups.

For those along the march route who could not quite figure out why many of us were dressed as pregnant women, we were ready with flyers explaining our work and our commitments. [See box.]

As a long time reproductive rights activist I know how far that movement still has to go. To the extent I could hear the other speakers, many of them continued to focus only on abortion. Yet, I also knew how incredibly different this march was from the last two in 1989 & 1992. Extraordinary commitment and hard work, particularly by women of color organizations, succeeded in changing the march from one limited to "choice," to one for Women's Lives, that includes the lives of women and families affected by poverty, racism and the war on drugs. Having women of color including Loretta Ross, Center for Human Rights Education and Sister Song Women of Color Reproductive Rights Collective, and Luz Alvarez Martinez, National Latina Health Organization and Sister Song in major leadership roles is a sea change for a movement that in the past has too often excluded key allies and connected issues. From the feedback I have been getting and from much of the media coverage it is clear that we have taken a great step forward in building alliances and making the connection between reproductive rights and other social justice issues.

So for those of you who marched, thank you for being there. And Thanks to all of you for your support and for making our presence possible.

Lynn M. Paltrow
Executive Director
National Advocates for Pregnant Women
<www.advocatesforpregnantwomen.org>

The National Advocates for Pregnant Women handout:

Why We Are Marching Dressed As Pregnant Women

Each year 6.3 million women become pregnant. The vast majority continue those pregnancies to term. These women are not celebrated or supported by our government. From employment discrimination, to lack of paid parental leave, to state scrutiny and possible punishment, pregnant women and mothers face a wide array of state policies that undermine them and their families. NAPW wants to make the point that reproductive rights also includes the right to continue a pregnancy to term without fear of discrimination or arrest.

As a result of anti-abortion efforts to establish fetal rights separate from and hostile to those of the pregnant woman, more and more pregnant women are being treated as criminals. NAPW seeks to highlight the fact that if fetuses are "legal persons" then a pregnant woman who refuses a cesarean section against her doctor's wishes can be treated as a child abuser. If fetuses are "legal persons" pregnant women can be arrested and jailed as criminals if any aspect of their lives or health is deemed to pose a risk to fetal health. NAPW research shows that close to 300 women have been arrested based on claims of fetal rights. Low-income pregnant women, particularly those of color, have been targeted for criminal searches and arrest based on the claim that their drug use or other health problems are a form of child abuse.

The debate about abortion in this country is deliberately manipulated to keep us from focusing on the lack of commitment to America's mothers and their children. NAPW marchers hope to draw attention to the fact that 11 million children lack health insurance, that 25 percent live below the poverty line and new EPA regulations will permit Mercury emission particularly toxic to pregnant women and fetuses.

NAPW is Marching:

IN MEMORY OF Angela Carder, a 27-year-old pregnant woman who in the name of fetal rights was forced to have a cesarean section that resulted in her death and the death of her fetus.

IN SUPPORT OF Regina McKnight and other women who instead of having access to drug treatment and compassionate health care have been targeted for criminal investigation and arrest based on the argument that the fetus is a person and their drug problems during pregnancy is a form of child abuse.

IN DEFENSE OF all families but particularly families of color who in the name of fetal rights are having their children removed at birth based on nothing more than a single unconfirmed positive drug test.

National Advocates for Pregnant Women website:
<www.advocatesforpregnantwomen.org>

State by State

CONNECTICUT

Two ongoing legal actions involving four midwives

In June, 2002, Barbara Soderberg, CPM, and Bea Arzt, CPM, were sued by the Connecticut State Health Department, and later charged with practicing medicine without a license. In the most recent hearing (May 19), the Health Department refused to negotiate an agreement to drop the complaint of practicing beyond the scope of nursing, unless the midwives agreed to wrongdoing (acting as nurses, not independent midwives). The midwives refused to agree, even though it meant ongoing hearings with resultant time and financial duress. Currently, neither Barbara nor Bea hold nursing licenses. The two midwives appreciated the many clients and families who came to the hearing. The next hearing is tentatively scheduled for November 19.

Around the same time, Maryellen Albini, CPM and Joan Mershon, CPM, were charged with practicing medicine without a license, their case to be heard by the Medical Examining Board. On May 14 the last defense witnesses testified and the defense rested. In a surprise turn of events, the State's attorney asked to call rebuttal witnesses, including Maryellen and Joan to rebut their own testimony! The Medical Examining Board is considering the request. A date for the next hearing has not been set.

Midwifery supporters in Connecticut have been raising funds, but legal costs to date far exceed the amount raised. To make a donation, send a check to: United Families for Midwifery Care, Midwives Legal Defense Fund, PO Box 460, Colchester, CT 06415. Please write "Legal Defense Fund" in the lower left corner of all checks.

Provided by Angelina Kendra <angelina@snet.net> of United Families for Midwifery Care and Joan Mershon, CPM.

MAINE

Celebrating Midwifery Week in Maine: Peaceful Birth, Peaceful Earth Picnic and Rally in Augusta

Maine Midwifery Week was celebrated for the 19th time this year!

In recognition of Maine Midwifery Week, a picnic was held on May 8 in Augusta. The event was co-sponsored by Midwives of Maine, the Maine chapter of ACNM, and

Peace Action Maine, to create greater awareness and understanding of how healthy childbirth and parenting choices can lead to a more peaceful community and world at large.

About 40 families enjoyed beautiful weather, great music, and informational exhibits from organizations committed to providing holistic care and peaceful solutions for Maine families. Speakers addressed a variety of topics, including growing concerns over exposure to neurotoxins during pregnancy and in breast milk, the importance of engaging in activism for what you believe in, and the need to change our culture of birth and how it is related to our culture of violence.

Maine midwives meet regularly and have a website <www.midwivesofmaine.org>.

Provided by Midwives of Maine.

PENNSYLVANIA

As reported in the Grassroots Network, long-time Pennsylvania midwife Judith Wilson has been charged with involuntary manslaughter.

The charges stem from a November 2002 home birth, a surprise footling breech. The parents declined to transport; immediately following the birth baby Isaac was transferred to the hospital, where he died two days later.

While the parents, Heather and Jon Daley, strongly support Judy and do not wish to file charges, the Allegheny County Coroner held an inquest into the death of the baby and recommended that charges of involuntary manslaughter be filed against Judy. At the inquest Coroner Cyril Wecht asserted that laboring women are unable to think rationally and thereby make decisions about their own care.

Following a search and seizure visit from homicide detectives, Judy turned herself in on Friday, April 23, and was held in jail through Monday, April 26, long after bail was posted.

Starting last fall, local supporters organized Friends of Judy and also the broader-based Pennsylvanians for Birth Options. In short order they set up an e-list and website, and had plans and press releases in the works. A petition drive and letter-writing campaign asked the prosecutor to drop the charges.

An initial hearing was held June 6. Hundreds of mothers, fathers, babies and other supporters, along with busloads of Amish supporters, attended, holding a vigil around the courthouse in support of Judy. While the magistrate upheld the charges (meaning Judy will stand trial), the press coverage was remarkably good; thoughtful and strategic planning for the press release and good press contacts resulted in some reporters beginning to understand the issues.

Friends of Judy is organizing an e-bay auction as a fundraiser for Judy's legal defense. Watch the Friends of Judy website <www.friendsofjudy.org> for details.

Information provided by Vicki Pasterik <vicki@pasterik.com>.

TEXAS

It looks like in our next legislative session, we will have a big battle on our hands trying to protect DEMs (in Texas we are called "documented" midwives) as well as the hard work being done for CNMs who have been fired across the state.

There is a systematic attempt on behalf of the Texas Medical Association to end midwifery, specifically homebirth, in Texas. As

“*The effort to separate the physical experience of childbirth from the mental, emotional and spiritual aspects of this event has served to disempower and violate women.*”
— *Mary Rucklos Hampton*

you may or may not know, Texas trains the majority of midwives in this nation, so what happens to midwifery in Texas is essential to our national look at midwifery.

An interesting side note about the connection between the DEMs and the CNMs here in Texas is that last year the DEMs were writing new rules under which to practice. There were several doctors on the rules writing committee. Two physicians in particular were very unsupportive; one was a doctor at Brackenridge Hospital, (one of the hospitals that fired their CNMs due to "financial" reasons), and the other was on the Health and Human Services committee in the Texas House of Representatives (which made several attempts to move the midwifery board under the Board of Nurse Examiners in an attempt to have more control over midwives in Texas). It was in the middle of this rules writing process that CNMs across the state were fired.

Texans for Midwifery, The Association of Texas Midwives and The Consortium of Texas Certified Nurse Midwives are all working hard on behalf of all the midwives in Texas. Please forward this information on to anyone who you think might be interested.

For an excellent article detailing the challenges in Texas, read "The Birth Battle: Doctors, Midwives and the Politics of Pregnancy" by Kim Pleticha in Parent:Wise Austin, April 2004, on line at <http://parentwiseaustin.com/Archive/2004/04_April/Cover_Story.html>.

Laurie Fremgen, CPM
<lauriemidwife@yahoo.com>.

VIRGINIA

To honor local midwives and celebrate International Midwives Day, Virginia Friends of Midwives (VFOM) and the Commonwealth Midwives Association (CMA) joined together for the first annual "Honor a Midwife Month." We selected a wonderful CPM as our first recipient, but due to the current legal situation cannot publicly print her name. However, we did not let this stop us from honoring her!! Past clients provided her some home cooked meals and the VFOM Board and her colleagues at CMA are sponsoring her trip to the

MANA 2004 conference. We thank this wonderful woman, teacher and midwife for all that she does and hope that she knows how much we all appreciate and support her!

Visit the VFOM website
<www.vfom.org>!
Information provided by Sara Fariss Krivanec <doulabelly@yahoo.com>.

CfM is looking for photos to include with the State by State articles.

Do you have photos from your conferences or local gatherings?

Maybe a good baby photo for the front page?

Send them along!

"Free Issue" Postcards

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 to interested individuals 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!

Born in the USA Video *is now available!*

This is the made-for-public TV version of the popular documentary!

Special offer for CfM members only!
\$89 ~ includes free shipping!

See page 17 for more information.

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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.

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100% Coverage: My Struggle Having a Homebirth Paid for by the Insurance Company

By Karen E. Wallace

The most stressful part of my recent pregnancy was dealing with my insurance company. My husband, Jeff, wanted the insurance company to cover the cost of the prenatal care and birth. My priority was having a homebirth with caring, competent, normal birth oriented midwives of my choosing. After many time-consuming letters and telephone calls, our health insurance company finally reimbursed us 100% for our homebirth midwives. Our perseverance paid off, but was emotionally very difficult.

We now know the six-step process in getting the insurance company to pay for a procedure. I would suggest trying this for reimbursement for homebirth, a doula, and for childbirth education classes. Our insurance company booklet, the representatives on the telephone, and the letters that came to us always covered the procedures of the appeal process.

1. Call the representative on the telephone, who will say “no.”
2. Ask to speak to a supervisor, who will say “no.”
3. Appeal in writing. This is the first formal level of appeal.
4. Appeal again in writing. This is the final appeal to the insurance company. They will respond with their final decision.
5. Get the benefits department of the employer who is paying for the insurance involved.
6. Contact the state division of insurance enforcement.

What is essential in this whole process is the paper trail. On April 18, 2002, I sent a letter appealing the denial of pre-certification for coverage of homebirth midwifery services by a CNM. I selected an out of network CNM/CPM because the insurance company had no in-network midwives who attended homebirths.

The bottom line is to be persistent. Appeal and grieve at all levels and document all conversations and keep copies of all correspondence. Although homebirth midwifery

care is worth the money to pay for it out of pocket, take the effort to try to force the insurance company to pay for it. All insurance companies should pay for all homebirths at 100% because in the end, it saves them many thousands of dollars.

Some details from our story ...

We select our insurance coverage annually, after carefully considering what medical needs we may have in the coming year. The only big one we plan is pregnancy and birth. In October of 2001, Jeff went to his company's benefits fair. He talked to the representatives of the health insurance companies. His key question was “will your health insurance company cover a home birth midwife?” One health insurance representative said “Yes, all you have to do is get a physician to refer you.” This health insurance company wishes to be known for accepting alternative medicine, so we enrolled with them for 2002.

In February I went for my pap smear and while I was there had my initial pregnancy blood work done since I was pregnant. When I received a letter from the insurance company that said they would not cover the prenatal aspects of my appointment, I realized that working with this company could be very difficult.

I managed to get the initial prenatal costs paid, and then began the challenging task of getting a homebirth midwife pre-approved. We learned two major lessons from this exercise: 1) Insurance company employees believe that all midwives attend births at home, and 2) How to navigate through the appeal/grievance process.

I decided that before getting any more prenatal care, I would get my homebirth midwife pre-approved by our health insurance company. The first representative with whom I spoke asked me, “Do you actually need to have your baby delivered at home?” He told me that my plan allowed me to have a house call by a physician. He said I could have “any in-network surgeon deliver the baby at home as covered by the home visit benefit.” He did not understand that I did not want a surgeon, but a competent attendant in “normal” birth.

My request was for pre-certification from the insurance company stating that it would pay for a homebirth midwife to provide my prenatal, delivery, and post-partum care 100%.

The fee was \$4000. An insurance company representative told me that the usual and customary fee that the insurance company paid the obstetrician and hospital was \$6000 which did not cover the anesthesiologist and newborn care.

The insurance company initially denied my appeal in a letter dated April 22 because of their "provider available" clause. They listed the names and telephone numbers of three CNMs. After trying to make contact, we discovered that two of the midwives did not attend home births, and the third phone number had been disconnected. Immediately, I appealed again in writing, saying that the insurance company did not have participating midwives that attended homebirth. I again requested pre-certification of out of network coverage by the practice I had chosen.

On May 6 I sent the insurance company a grievance letter which appealed the denial of pre-certification of homebirth midwifery services. I requested antenatal, birth, and postnatal care by an out of network CNM/CPM/MSN of my choosing since no participating midwives or physicians attended births at home. I discussed the safety, statistics, cost, and made special request for an out-of-network provider since I had no freedom in my HMO.

A letter dated May 23 stated that the grievance review board had completed its review of the grievance and, "... After thoroughly considering all of the information available to it, the Board has determined that although Oxford does have certified midwives in your area, we are unable to provide you with a participating midwife who performs home birthing services. As you do not have coverage for out of network providers under your current plan, reference number XX will be updated to allow antepartum, postpartum and home birthing services with [my midwife] on an in plan basis."

On September 26 my son, Seth Phillip Dean, was born at home attended by my midwife and her partner. My midwife sent the \$4000 bill to the insurance company with all the correct codes and pre-certification information. We received a partial payment the next month. We knew that our work was not yet done.

After cashing the check, I called the insurance company. The representative said that the bill was processed correctly. "Midwives are only reimbursed at 65% because they are not OB/GYNs and the reimbursement was based on the geographic location (zip code) of the provider not the residence where the care was given." Catherine Taylor's *Having a Baby Today* says that Medicaid reimburses midwives 65%, which makes me think that is where my health insurance company came up with that percentage.

On November 7 I sent the health insurance company a letter in an attempt to appeal the amount of the coverage. After several attempts to get this settled, the insurance company said I would never get more than 65% paid. They said my only other recourse was to contact our state Division of Insurance Enforcement.

I referred back to a brochure from my husband's employer who paid for our insurance. The brochure said that after trying and failing to resolve an issue on your own, call the Benefits Express and ask a representative for assistance.

My husband called his Participant Advocacy Service. After explaining the situation the ombudsman said that, without a doubt, our homebirth should be covered 100%.

On February 5, 2003, approximately one year after my first prenatal appointment, we received a check from the insurance company for the balance due for all services. After a lot of hard work, frustration and uphill battles, we finally got the insurance company to do what they said they would do in the beginning .. cover the services of a home birth midwife. 🌸

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When you join CfM, you will receive the quarterly *Citizens for Midwifery 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™.

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How it works:

- ▼ Your state organization should use copies of the **Special Membership Form** to the left, which may be personalized with your state organization name at the top and the name and mailing address at "Thank you!" box near the bottom.
- ▼ Fill out this form, in addition to whatever forms your organization uses for memberships, and **give these forms and the membership fees to your state organization.**
- ▼ Your state organization must collect the **CfM special membership forms and payments.** (Regular CfM membership forms may also be used, but must be labeled with your organization name and submitted by the state organization to take advantage of this special offer.)
- ▼ Your organization can collect a separate check for each CfM membership, or write one check to CfM for the collected CfM memberships.
- ▼ Your state organization forwards the CfM membership forms with payments to CfM.

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(order forms are available).*

*State organizations may request a
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Please contact CfM if you have any questions
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We want to make it easier for people to belong
both to their state organizations and to CfM!

An Essay about “Risk”

By Susan Hodges

In maternity care we hear a lot about “high risk” and “low risk,” the risks of various interventions and the risks of various conditions. A lot of the time it seems that being at “high risk” for something is interpreted as meaning that it definitely will happen. What does “risk” mean? How is “risk” dealt with in decision-making during pregnancy and child-bearing?

Risk refers to the likelihood or chance that some event or outcome will happen in a population, usually expressed as a percentage. For example, when we hear that the cesarean section rate is 26.1%, we mean that for every 100 pregnant women, about 26 will end up with a cesarean section for one reason or another, or, in other words, a pregnant woman has approximately a one in four chance or risk of having a cesarean section. Just because an individual is “at risk” for something does not mean that this will happen to them; it only means that there is a chance of it happening.

The percentage of risk predicted for a given outcome or situation is statistically more accurate if it is based on data from a large population. On the other hand, pooling the data from a large population for one kind of outcome tends to overlook many factors that may influence the occurrence of the outcome of interest. Knowledge of such factors can give a better idea about risks for an individual, as well as indicate how an individual might act to minimize risks. For example, we can look at birth outcome data and determine the overall percent of babies that are born with low birth weight. One could say then that for pregnant women, there is a certain risk of giving birth to a low birth weight baby. However, we know that maternal factors such as nutritional status, overall health, infection and smoking can affect the baby’s birth weight. Therefore, the risk for having a low birth weight baby is relatively greater for a pregnant woman who smokes and is not healthy and relatively lower for a well-nourished non-smoking pregnant woman.

A key point, often forgotten, is that no one, absolutely no one, can predict with any degree of certainty which specific

individual(s) within a population definitely will experience the particular outcome or situation in question. We are hearing more and more frequently of women being told by their obstetricians that their baby is or will be “too big,” that the baby and mother “will die” if they don’t agree to induction or cesarean or some other intervention to make the baby come before it gets any bigger. Some mothers are told categorically that they will not be able to deliver “such a big baby.” Such a prediction is false – the doctor absolutely cannot know for certain what this particular mother/baby is capable of with this pregnancy, or what the outcome will be. However, such a prediction can become a self-fulfilling prophecy with the doctor effectively undermining any confidence the mother may have in her ability to birth her baby. And of course, this leads to unnecessary inductions, epidurals and cesarean sections.

Recently the mother of a Pennsylvania family having their seventh baby was told absolutely that the baby was “too big” for a vaginal delivery (despite the fact that this mother had previously given birth vaginally to several babies over 10 pounds). While the family left that hospital and the mother eventually gave birth vaginally with no problem, the first hospital was successful in obtaining a court order for a cesarean section in order to “save the baby.” However, even if that hospital felt that a vaginal birth included some risk, they could not say with certainty that this particular baby would be harmed by vaginal delivery. This is an example of both hospital personnel and a judge apparently not understanding the nature of “risk” and the impossibility of predicting any particular outcome.

Childbirth involves risks. Some of those risks can be quantified, some cannot. A very important aspect is the meaning of the various risks to parents. Personal beliefs and values, the mother’s age, how many children she has or plans to have, all play a role in how risks are assessed and what they mean for parents. Beliefs and values also are important in the decision making process regarding any medical interventions that may be recommended. No obstetrician, judge, nurse or other outsider can possibly weigh all these aspects – only the parents can, and they are the people who have to live with the outcome, whatever that may be.

Another aspect of risk is that if the risk does happen to you, it happens 100%. What risks are you willing to take? What risk is too

great and who decides? Can a mother be charged with a crime if she makes a decision about risk and the result is harm to her baby? What about all the other mothers who make the same decision but are lucky and their babies are fine?

Risks are also a consideration in birth setting decisions. Some health conditions, such as pre-eclampsia and high blood pressure, and some infections are associated with high risks of serious or life-threatening complications for mother and/or baby. These risks can be minimized (but may not be eliminated) in the hospital setting. A huge problem in making good decisions about the birth setting or transport has to do with the kind of care a mother will receive in the hospital, including interference with labor and complications caused by unnecessary procedures and interventions typically imposed in hospital-based births.

Lots of attention to a particular risk can make it seem much more significant than it really is. An example would be the “risk” of uterine rupture for vaginal birth after cesarean section (VBAC). Research has shown that the use of drugs to stimulate or augment labor significantly increases the risk of rupture, while VBAC without labor-stimulating drugs has no more risk of uterine rupture than a first vaginal birth, a risk so small that it is almost never mentioned to non-VBAC pregnant women. (Lydon-Rochelle M, Holt VL, Easterling TR, Martin DP. Risk of uterine rupture during labor among women with a prior cesarean delivery. *N Engl J Med* 2001;345:3-8).

Another important point is that parents cannot really weigh the risks unless they have the best information available. A friend’s friend recently gave birth, and had an epidural. The mother ran a fever, so the hospital did a septic work-up on the baby, including a spinal tap. The mother and baby were separated, and the mother was not able to initiate breastfeeding until the third day. The mother was upset by the treatment of her baby and the disruption of the first few days. Neither her OB nor her anesthesiologist had told her of her chances of running a fever as a result of the epidural, nor of the consequences for her

(continued on page 18)

The following article can be found at the CfM website <www.cfmidwifery.org/resources/cfm/item.asp?ID=54>.

Unhappy With Your Maternity Care? File a Complaint!

Disclaimer: This document does not constitute legal advice. It is merely intended to be a starting point regarding your right to complain. Filing a complaint is not the same as filing a medical malpractice suit.

What do we do when obstetricians or other hospital staff treated us rudely, abusively or violently? Do they ever hear from us afterward? Abusive behavior toward women, especially in childbirth, is unacceptable and harmful and can cause Post Traumatic Stress Syndrome. Abusive or unacceptable behavior can include threats, scolding, coercion, yelling, belittling, lying, manipulating, mocking, dismissing, refusing to acknowledge, treating without informed consent, omission of information, over-riding your refusal of a treatment, misrepresentation (of medical situation, of interventions, of reasons they “need” you to do something or not do something), etc. For a raised consciousness on this topic, read: Violence against women in health-care institutions: an emerging problem. by A. F.P.L. d’Oliveira, S.G. Diniz and L. B. Schraiber *The Lancet*, Vol. 359. May 11, 2002.

The idea is not to complain about things just for the sake of complaining or just to be nitpicking (for example, if overall the care was very good, but one person under unusual circumstances was less than satisfactory, a friendly, informative note to that one person might be more effective than a full-blown complaint). The idea is to put the provider and the Medical Board on notice that these kinds of behaviors are serious and harmful, especially a pattern of them, and are not acceptable even if there have been few complaints in the past. While single complaints probably will be ignored, I think if enough women actually formally complained about abusive treatment of any kind and asked for changes, the medical establishment would have to start listening. Also, by sending

copies of the complaint to other potentially interested individuals and organizations, the complaint can also serve an educational and consciousness-raising purpose for more women. Here are steps you can take:

1. **Write (handwritten is best) a narrative report** of everything you remember from the situation – with dates, what people said and did (including as much as possible names of anyone involved, dates and times), etc., and **sign and date that narrative**. The sooner you write all of it down, the better. Such a dated, personal, written narrative will stand as evidence in a court of law. Even better, have your statement notarized by a notary public, which will establish the date by which you wrote the statement. Your narrative (and those of others, see #2) help establish the facts and keep your memory fresh. They would be especially useful IF your complaint eventually resulted in some kind of formal hearing or legal action; it may be that you don’t use the narratives at all, but if you need them later, you will wish you had taken this step. Your dated, notarized first-person written account is much stronger than someone else’s memory months or years later.
2. If you can get **anyone else who witnessed the behavior(s) to write a narrative describing the same incidents**, that would be very valuable. For example, is there a nurse who would do that? Did your husband, a friend, or a doula come to any of your office visits or to the birth, where incidents occurred? Did you complain to family members or to a friend right after one of these run-ins with the doctor? Ask those people to write down in detail what they heard and saw, or they heard you say at the time and how you were acting (ie, upset? in tears? etc.). **DO NOT** coach them on what to write. Each one should also date and sign their narrative, and mention that this was their personal experience and memory of the events.
3. **Composing a formal complaint.**
 - Use the internet or get help from a library to find **a website or contact information for your State Medical Board** (name may vary). The website <http://www.citizen.org/hrq/forms/medboardALL_action.cfm?View+All+States> has direct links to EVERY state’s medical board website. Each of the Medical Board

home pages I looked at had something for “consumers” or “complaints” or “patients rights” leading to information on how to file a complaint. (For other medical staff or the hospital itself, you may have to complain to another board, and use their complaint procedure, state statute, etc. depending on your state.) Every state has a procedure for filing a complaint about a physician; for most states information about how to do this is on-line. If the formal complaint process does not allow for attaching statements (a copy of your dated narrative or those of others), you can at least mention in the complaint that you have these statements.

- **Look up your state’s Medical Practice Act** and locate the section that describes “unprofessional conduct” – the behavior you are complaining about is likely to fall into this category, and it is more powerful if you can cite the section of the statute. A public library librarian should be able to help you, or your local legislator.
- Download **ACOG’s** (American College of Obstetricians & Gynecologists) **ethics statement** from the ACOG website <www.acog.org> (search for “ethics” on the ACOG website and you will get the pdf file of this statement to print out). It is actually pretty good, except that it is ignored. The ACOG ethics statement is not legally binding unless specifically referred to in your state statute; however, this document constitutes the professional guidelines for OBs and again, you can strengthen your complaint by pointing out (quoting from it) the ways the OB violated the profession’s standard for ethical practice.
- ACOG has separate statements regarding **informed consent** (also available on their website) and **informed refusal** (see below). Many abuses and unnecessary interventions are associated with a lack of or inadequate informed consent process, or the refusal of the

physician or staff to honor your informed refusal of treatment.

- Using all this material (quotes are good!) and the formal complaint procedure, **write the formal complaint and keep copies.**
- You should **include what you want the Medical Board to do** that is realistic within their authority per the statute (such as reprimand the physician? Have the physician make a formal written apology to you? Require the physician to get sensitivity training? Etc.)
- You can also use this general process to file complaints about any other health care providers or a hospital to their respective state boards.

4. **Compose a cover letter** explaining briefly why you were moved to complain – ie, you felt so outraged, betrayed, violated, abused, damaged etc. by the doctor’s behavior etc. and how the experience affected you (rage? Loss of confidence? Distraction? Sleeplessness? Post traumatic stress syndrome?) – with cc’s indicated for all the other places and people to whom you decide to send the letter (see #5). Include again what you want to come from this complaint (what you want the Medical Board to do, etc.). You might want to have one or two other people review your draft and make suggestions so your letter and complaint will be as clear and effective as possible. Send that cover letter with the formal complaint to the Medical Board by “certified mail return receipt requested,” so you have proof that they received the complaint (also, it makes them take it more seriously).

5. Make copies of your formal complaint and **send it** (regular mail is okay) with a cover letter (vary the cover letter as needed for the various audiences) **to as many other individuals and organizations as you want.** For at least some of these, you might want to include a specific request for action on their part, as appropriate. Suggested individuals and organizations:

- Your HMO or Insurance Company
- Your State Insurance Commissioner (if insurance coverage is an issue)
- The Hospital Board (as a whole, or each individual member)

- Public Relations person, consumer relations person, etc. at the hospital
- Any appropriate midwifery board (for CNMs and/or licensed midwives)
- Any women’s organizations, local and/or state, such as NOW Chapter, groups working on prevention of violence against women, rape prevention, etc.
- An attorney – this can be a friend or any attorney who agrees to be listed; you just want the Medical Board and others to see that you are talking with an attorney. This may be more important for some situations than for others.
- National organizations like ICAN and Citizens for Midwifery <www.cfmidwifery.org>.

By sending your complaint to a whole array of people, more people will know about it, and it is less likely to be ignored. You are also educating women’s groups and others about abuse against pregnant women and in childbirth. If nothing comes of your complaint, you will at least have documentation to use to take any further actions you may feel moved to take (writing to the newspaper, writing an article for a women’s magazine, etc.). If you have a means of collecting such complaints locally, that might give impetus for collective action locally regarding a specific physician or hospital, or targeting hospital policies.

6. **Follow up!** Bug the Medical Board until you get a response. Follow up with the hospital people. If you are unhappy about the response you get, let them know, let your State Representative know what is going on, tell the hospital people that you are dissatisfied and may take further steps. Depending on the original situation, you can consider a number of possibilities, from consulting with an attorney, to writing an article for the local paper or a Letter to the Editor, to speaking to womens’ groups in your town, to deciding to let it go.

Filing a formal complaint is NOT guaranteed to “fix” the situation. However, if enough of us complain, it should get others thinking about changes in the future. ☺

Resources:

American College of Obstetricians & Gynecologists Code of Professional Ethics in Ethics in Obstetrics and Gynecology 2002 http://www.acog.org/from_home/publications/ethics/ (go to the last item on the list for a pdf file of the Code of Ethics)

American College of Obstetricians & Gynecologists Ethical Dimensions of Informed Consent in Ethics in Obstetrics and Gynecology 2002

American College of Obstetricians & Gynecologists. ACOG Informed refusal. Committee Opinion No 237, June 2000. Not available electronically. Reads in part: “Once a patient has been informed of the material risks and benefits involved with a treatment, test, or procedure, that patient has the right to exercise full autonomy in deciding whether to undergo the treatment, test, or procedure or whether to make a choice among a variety of treatments, tests, or procedures. In the exercise of that autonomy, the informed patient also has the right to refuse to undergo any of these treatments, tests, or procedures. ... Performing an operative procedure on a patient without the patient’s permission can constitute ‘battery’ under common law. In most circumstances this is a criminal act. ... Such a refusal [of consent] may be based on religious beliefs, personal preference, or comfort.” [In other words, women don’t have to have what an obstetrician would consider a good reason. All they have to do is decline.]

Also see:

“Midwives Model of Care” <http://www.cfmidwifery.org/mmoc> Citizens for Midwifery

“Rights of Childbearing Women” <http://www.maternitywise.org/mw/rights.html> Maternity Center Association.

“Mother-Friendly Childbirth Initiative” <http://www.motherfriendly.org/MFCI> Coalition for Improving Maternity Services.

About the author:

Susan Hodges, a birth activist for more than 15 years, is President of Citizens for Midwifery, a consumer-based organization promoting the Midwives Model of Care and representing consumer interests regarding midwifery and maternity care. Find out more about Citizens for Midwifery at their website <www.cfmidwifery.org>.

Resources

Informative Birth Websites

www.midwifeinfo.com

This site was created and is maintained by Nancy Sullivan, CNM, recently retired from a position as assistant professor in the nurse-midwifery education program and coordinator of the midwifery faculty practice at Oregon Health & Science University in Portland, Oregon, where she was on the faculty since 1986. While the site appears oriented primarily for midwives, it includes specific sections for parents, although I would think that many parents will find useful information throughout the site. While some items are links to information on other sites, there are also quite a number of well-written and well-documented articles written just for this site.

www.birthingnaturally.net

The webmaster of this site is a childbirth educator and doula. She maintains the site "to be a source of information and an exchange of ideas about pregnancy and childbirth." The site includes articles written specifically for parents in an easy to read style with great information. These are written "to" the reader, and made me feel as if I had clicked into a really interesting childbirth class with a warm and knowledgeable teacher. This site also includes information and resources for natural childbirth with a Christian perspective.

www.childbirth.org

Started by Elise Weiss, this website is run by a group of women including doulas, childbirth educators, midwives (both CNMs and direct entry), and others. Some articles are original with this site, but many others are on other websites, and some are abstracts of published studies. A broad range of topics is included, not just specifically childbirth topics, but also parenting, infant feeding, fertility, and other related topics.

Help for Depression After Delivery

www.depressionafterdelivery.com/

Depression after Delivery (DAD) is a wonderful nonprofit organization devoted to helping women overcome postpartum depression and other postpartum disorders. DAD gets 400 requests for information a month from women and sends out free information packets to any who request them.

At this time DAD is struggling financially. You can find more information about DAD on its website and a link to an article which discusses the financial situation more fully.

Cesarean Section Information Booklet

In early April the Maternity Center Association (MCA) of New York City unveiled their new booklet *What Every Pregnant Woman Needs to Know About Cesarean Section*. Finally, women have a way to be truly "informed" before "consenting" or getting talked into a cesarean section!

Initiated after the American College of Obstetricians and Gynecologists came out in support of "patient choice" cesarean sections, the booklet has been endorsed by many organizations, including Citizens for Midwifery.

Like other MCA projects, the booklet looks thoroughly at the evidence, while at the same time being readable and accessible. The text provides a synthesis of virtually ALL the research about cesareans, providing women with information on the risks and benefits of cesarean sections, short term and long term, for mother and for baby. Fully informed, women can then make up their own minds (and question their doctors). In addition, the booklet includes information about what women can do to lower their chances of ending up with a cesarean section.

The booklet is available free online as a .pdf file, along with a complete bibliography, description of how MCA went about this project, and evidence tables showing the results of studies on which the booklet is based. Printed copies can be ordered in bulk.

Find the booklet and additional information at: <<http://www.maternitywise.org/mw/topics/cesarean/booklet.html>>.

This is well worth printing out!

From Calling to Courtroom: A Survival Guide for Midwives

www.fromcallingtocourtroom.net

Now finally completed, this book is a fantastic (and FREE!) resource for anyone associated with midwives, especially direct-entry midwives, and especially those in states without legislation that specifically protects and recognizes direct entry midwifery. While the book was conceived to be particularly for midwives, there is a lot of information that consumers should also know.

The almost 300-page book includes chapters entitled "Why You Aren't Safe," "Organizing Support," "Understanding The Legal System," "Looking for a Lawyer," "After the Dust Settles," "Taking the Next Step: Mainstreaming Midwifery" and an extensive "Resources" section.

Here is the official announcement for this information-packed book, the result of a remarkable collaborative effort:

It is with delight, pride, and more than a little relief that we announce to you the final release of the book *From Calling to Courtroom: A Survival Guide for Midwives*. We began work on the book early last fall, and have put a tremendous amount of time and effort into it...at times we have struggled, but we believed that the final product would be a gift to U.S. midwives. I hope you agree that we have succeeded.

This book is a result of the experience and talent of many people – midwives, attorneys, and midwifery advocates – all of whom volunteered their time and energies. From the beginning, our plan was that all those who worked on the book would do so without cost, and the book would be available without cost. You may find it at:

<www.fromcallingtocourtroom.net>.

You can read it online, or you can download the entire book as a .pdf file.

You may also order a hardcopy at cost.

Pay us a visit ... sign our guestbook. Let us know what you think!

Valerie Runes, Acting Editor
From Calling to Courtroom

Book Review

The Medical Delivery Business: Health Reform, Childbirth and the Economic Order

by Barbara Bridgman Perkins
Rutgers University Press, 2004
ISBN: 0813533287
List Price \$42.95. 252 pages

Reviewed by Carolyn Keefe & Susan Hodges

Barbara Bridgman Perkins, an independent scholar and one of the authors of the original *Our Bodies, Our Selves*, has written a carefully documented book of great importance, laying out how we have ended up with a health care system whose primary focus is on making money rather than improving health outcomes.

The first section of the book explains the rise of medical “specialism” and how maternity care in particular was “industrialized.” In the early 20th century capitalism and the organizational ideas that developed out of industrialization were considered the height of modernism and efficiency. Perkins documents how these ideas were increasingly used for organizing and administering health care and managing hospitals. Division of labor, a kind of assembly line for health care with a hierarchy of workers, each with the expertise and responsibility for particular aspects of care, came from this industrial paradigm. In addition, these developments occurred in the context of a class system where different classes of people received different kinds of care, reflecting their ability to pay.

The second section documents the development of regionalism and the dominance of specialties, which developed in the context of competition, between institutions and between the different specialties. With quotes and references Perkins shows how these developments and economic organization of hospitals have affected what care is available and how health

outcomes, evidence-based practice and equal access to basic health care have all taken a back seat to the primary focus of making money.

For midwifery advocates, the last section, *The Economic Production of Childbirth*, may be of greatest interest as she writes about more recent developments in maternity care. While most of us are aware of those developments, Perkins provides a startling new analysis by looking at these developments in terms of economic organization and in relationship to the historical precedents. The information about Neonatal Intensive Care Units is fascinating and illuminating – an example of competition, specialization, and capitalization, leading to overuse and over treatment of infants many of whom will not benefit at all from the intensive care. Sound familiar?

Having finished reading this book, many aspects of today’s hospital-based maternity care are making more sense to me. The bottom line is that hospitals and doctors (especially obstetricians) make money from illness, complications, tests, ICU use, and NOT from natural, drug free childbirth or healthy mothers and babies. The entire system is set up this way, with really huge conflicts of interest built in from the beginning. It feels powerful to now have so much documentation about the economic and capitalistic nature of medical care.

Reading all the way through this book that validated many of my suspicions was exciting and fascinating. My only disappointment came at the end. I was hoping Ms. Perkins would have a solution, a plan, a strategy to bring about change, but she did not. As she puts it, “the hegemony and momentum of a given economic order make it difficult to develop alternatives.” She does “hold out the hope that we can scientifically and democratically match health care delivery to known needs.” She has shown us what went wrong in the twentieth century and raised important questions, but it will be up to all of us to figure out how to reform the system. First, it is important to understand it, by reading this book! 🌸

Consider ordering your books online from Amazon.com through the CfM website <www.cfmidwifery.com>.
(Scroll to the bottom of the homepage and look for the Amazon icon.)
Every item you order generates a small donation to CfM!

Born in the USA Special for CfM Members!

Through a special arrangement with Fanlight Distribution, we have the made-for-public-TV documentary *Born in the USA* for sale to CfM Members at the special price of only \$89! This is a tremendous savings over the list price of \$199. The special offer is available through December 2004.

Use the order form on the last page of this newsletter, or print out an order form from the CfM website, and send your check or money order. Remember, you must be a CfM member in order for us to accept your order; including membership (form and check) with your order will qualify you for this special.

For those of you not familiar with this film, *Born in the USA* (released in 2000) was created by a home birth couple who are professional documentary film-makers.

Read a CfM review at <http://www.cfmidwifery.org/resources/cfm/item.asp?ID=6> or more descriptive information at http://www.fanlight.com/catalog/films/297_bitusa.shtml.

Born in the USA is just as timely and effective now as it was when it first came out. It is a very effective educational tool, great for public meetings as well as classroom use.

Mark your calendar now!
Annual CfM Membership Meeting and Elections
October 2 in Albany, New York!

(Risk Essay ... continued from page 13)

baby. She did not have the opportunity to weigh the various risks and benefits (for her and her baby) associated with the epidural, but might have made a different decision had she known.

The bottom line is that childbirth does involve risks. We live in a culture that believes that at least if we do everything “right,” every birth should be perfect, and if the baby is not perfect, then it is someone’s fault. But birth is not a mechanical process, and it is not a totally predictable process, in any setting, with or without interventions. The best we can do is to try to minimize risks for our babies and for ourselves, but we cannot eliminate them altogether. Sadly, some babies die, and we may never know exactly the reason why, and it may be no one’s fault. Just as no one can predict with certainty the specific outcome of a particular birth, no one can say with certainty what “might have been” had the birth taken place with different circumstances or had some intervention been applied.

By understanding the nature of “risk” and by examining our own beliefs and values, we can come to decisions that we can live with. We can also remind others that no one can predict individual outcomes or prevent all bad outcomes. Life is a gift. Treasure it, enjoy it, protect it. Understanding the nature of “risk” can help us not take life for granted and can keep us humble. ☘

**Midwifery Advocates:
Sign Up NOW to
Receive The Grassroots
Network Messages!**

The Grassroots Network: 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 the CfM 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!

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. 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 “Grassroots Network” in the subject line.

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

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.

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> <info@meacschools.org>

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!*

Send to (PLEASE PRINT):

Name _____
 Street Address _____
 City _____ State & Zip _____
 Home Phone _____ Office Phone _____
 Fax _____ E-mail address _____
 CfM Member? _____ Yes _____ No

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.

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)	\$ _____
_____ 25 CfM brochures and 25 "Free Issue" postcards	(suggested donation \$6)	\$ _____
_____ 25 CfM membership fliers (2-color flier – great alternative to brochure)	(suggested donation \$3)	\$ _____
_____ 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:

_____ 100 MMofC brochures (or .30 ea + shipping) [] English [] Spanish	(\$38 includes postage)	\$ _____
_____ <i>Born In the USA</i> video ~ Special offer for CfM members only!	(\$89 ~ free shipping!)	\$ _____
_____ <i>Midwives: A Living Tradition</i> video (1998, 68:30 min.)(see <i>CfM News</i> 4/99)	(\$30 includes postage)	\$ _____
_____ "Liberty & Justice" advocacy buttons	(\$2 each or 10/\$16)	\$ _____
_____ Other advocacy buttons (call or e-mail for available selection)	(\$2 each or 10/\$16)	\$ _____

_____ **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

PO Box 82227 • Athens, GA • 30608-2227

*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!*

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.

<input type="checkbox"/> Student	\$20	<i>I am a (check all that apply):</i>	<input type="checkbox"/> Concerned Citizen	<input type="checkbox"/> Parent
<input type="checkbox"/> Suggested	\$30*		<input type="checkbox"/> Childbirth Educator	<input type="checkbox"/> Doula
<input type="checkbox"/> Supporter	\$50*		<input type="checkbox"/> Midwifery Student	
<input type="checkbox"/> Best Friend	\$100*		<input type="checkbox"/> Midwife (<input type="checkbox"/> CPM <input type="checkbox"/> CNM <input type="checkbox"/> LM <input type="checkbox"/> DEM)	
<input type="checkbox"/> Guardian Angel	\$500*		<input type="checkbox"/> Other (_____)	
<input type="checkbox"/> For overseas addresses, add	\$10			
<input type="checkbox"/> Additional donation	\$ _____ *			
TOTAL ENCLOSED	\$ _____			

* Your contribution is tax deductible except for your newsletter subscription valued at \$20 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