

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1416 SHESS MIDWIFERY - BATTLE STUDY 1416

statements regarding this subject. The statement is as follows:

Whereas the mortality rate of home deliveries is three times greater when compared with hospital deliveries in 1976, and whereas it is impossible to predict an uncomplicated labor, delivery and neonatal resuscitation, and whereas practitioners who have attended out-of-hospital deliveries have experienced undesirable if not potentially fatal complications, and whereas anyone undertaking obstetrical care does so with the implied goal of a successful outcome for both mother and baby, now therefore be it resolved that until further data are available, the home is not the preferred place for delivery because of the sufficiently increased risk it poses for the mother and infant, and be it further resolved that a major priority of the Colorado Medical Society should be to make all information relative to risks of home deliveries available to those persons interested in such a way they can make a rational decision, and be it further resolved that the members of the Colorado Medical Society should strive to make in-hospital obstetrical care a non-illness, family-oriented experience.

The last sentence of the State Medical Society's statement cannot be emphasized too strongly. By making every attempt to render childbirth a time of joy for the parents and family in the hospital, most of the problems we have been discussing can in all probability be circumvented.

References

1. American Med. News. August 11, 1978, p. 11.
 2. Brit. Jnl. Obs. Gyn. 84:6, 401-411.
 3. Jnl. of Rep. Med. 19:5, 281-290.
-

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

ALABAMA

(Professions and Businesses 4.34-19-1-.34-19-10)

NURSE-MIDWIFE

Requirements

Licensed registered nurse; certificate from school for nurse-midwives.

Limitations on Practice

Cases of normal childbirth; physician's supervision necessary.

Special Statutory Provisions

All deliveries must be planned to take place in hospital.

Definition:

Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.

PROFESSIONAL MIDWIFE

Requirements

Definition:

An individual who has received formal professional training as a midwife.

Limitations on Practice

Special Statutory Provisions

LAY MIDWIFE

Requirements

Definition:

Individual who practices as a midwife but has not received formal professional training.

Limitations on Practice

Lay midwives holding health department permits may continue to practice until permits are revoked by Board of Health.

Special Statutory Provisions

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CALIFORNIA

(Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)

NURSE-MIDWIFE

Requirements

Definition:

Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.

Limitations on Practice

Practice supervised by physician or surgeon (physician's presence not required); case of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortion.

Special Statutory Provisions

Requirements for censure are left up to appropriate boards and committees. In general California's statutes establish the confines of the practice.

PROFESSIONAL MIDWIFE

Requirements

Definition:

An individual who has received formal professional training as a midwife.

Limitations on Practice

Special Statutory Provisions

LAY MIDWIFE

Requirements

Definition:

An individual who practices as a midwife but has not received formal professional training.

Limitations on Practice

Special Statutory Provisions

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CONNECTICUT

(377.20-75)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	<p>Graduate of school of midwifery.</p>
	<p>Limitations on Practice</p>	<p>Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drug instruments, nor perform version or attempt to remove adherent placenta. Shall not attend a woman in labor until after seventh month of gestation.</p>
	<p>Special Statutory Provisions</p>	<p>Examination required for licensing.</p>
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

FLORIDA

(30.485.011 - 30.485.091)

<u>NURSE-MIDWIFE</u>	Requirements	
<p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	Limitations on Practice	
	Special Statutory Provisions	
<p><u>PROFESSIONAL MIDWIFE</u> <u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	Requirements	Diploma from school for midwives; sponsorship by two practicing physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	Cases of normal labor; shall not use drugs, instruments, nor assist labor in any artificial, forcible, or mechanical manner, nor attempt to remove adherent placenta. Shall not use poisonous drug or herb medicine, nor attempt treatment of disease when attendance of physician cannot be secured.
	Special Statutory Provisions	
<p><u>LAY MIDWIFE</u> <u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	Requirements	Attendance, under the supervision of a physician, at not less than fifteen cases of labor and the care of fifteen or more mothers and newborns for periods of at least ten days; sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
	<p>Requirements</p>	<p>Diploma from school of midwifery which has proper equipment to teach anatomy, physiology, hygiene, anticepsis, neurology, toxicology, and the proper management of labor; high school education; ability to read and write the English language* *There are few schools in this country which train midwives who are not nurses. Since many professional midwives were educated at foreign institutions, some states feel it necessary to require proficiency in English.</p>
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> Individual who practices as a midwife but has not received formal professional training.</p>	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	<p>(Statutes pertaining to midwifery in Indiana date to the late 1800's. Midwifery in the state is presently controlled by administrative code. Both the statutes and codes have been included.) Examination required for licensing. Gratuitous services in an emergency not prohibited by act, nor does it restrict licensed physicians.</p>
	<p>Requirements</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MARYLAND

(Art. 43.82-94)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Certified by American College of Nurse-Midwives as a nurse-midwife.</p>
	<p>Limitations on Practice</p>	<p>Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion.</p>
	<p>Special Statutory Provisions</p>	<p>Person who is not licensed midwife may practice under the personal and direct supervision of a physician. Subtitle does not restrict physician or person volunteering service in an emergency.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> Individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	<p>Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included).</p>

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MINNESOTA

(148.30 - 148.32)

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MINNESOTA (148.30 - 148.32)
<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	Requirements	Diploma from a school of midwifery.
	Limitations on Practice	
	Special Statutory Provisions	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	Requirements	Consent of seven members of the State Board of Medical Examiners given after examination of candidate.
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Certificate in nurse-midwifery from the American College of Nurse-Midwives.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

NEW JERSEY

(45:10)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Limitations on Practice</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Special Statutory Provisions</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	<p>Certificate from school of midwifery, or maternity hospital granted after 1800 hours instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician.</p>
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Limitations on Practice</p>	<p>Shall not perform criminal abortion. Normal labor cases. only.</p>
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Special Statutory Provisions</p>	<p>Examination required. Topics covered by examination specifically laid out by statute. Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's.</p>
<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Limitations on Practice</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

OHIO

(4731.30-4731.34)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Diploma from college for nurse-midwives</p>
	<p>Limitations on Practice</p>	<p>Practice under direction and supervision of physician. Shall not perform version, treat breech or face presentation, use instruments or treat abnormal condition, except in emergencies.</p>
	<p>Special Statutory Provisions</p>	<p>Examination may be required.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

UTAH

(58-44-1 - 58-44-11)

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		UTAH (58-44-1 - 58-44-11)
<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	Requirements	Completed approved certified nurse-midwifery education program.
	Limitations on Practice	Under this act, may also provide normal gynecological services.
	Special Statutory Provisions	Establishes committee to supervise practice of nurse-midwifery. Examination requirement of Act does not affect rights of parents to deliver their baby, where, when, how and with whom they choose regardless of certification.
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

WASHINGTON

(18.50.090 - 18.50.110)

NURSE-MIDWIFE

Requirements

Definition:

Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.

Limitations on Practice

Special Statutory Provisions

PROFESSIONAL MIDWIFE

Requirements

Diploma from legally incorporated school on midwifery in good standing, granted after least 2 courses of instruction of at least seven months each in different calendar years. Diploma from foreign institution on midwifery of equal requirements.

Definition:

An individual who has received formal professional training as a midwife.

Limitations on Practice

Shall not prescribe any drugs or medicine except some household remedy.

Special Statutory Provisions

Examination required. Topics covered by examination specifically laid out by statute. Gratuitous service not prohibited by chapter. Washington's midwifery laws similar to New Jersey's.

LAY MIDWIFE

Requirements

Definition:

An individual who practices as a midwife but has not received formal professional training.

Limitations on Practice

Special Statutory Provisions

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	Requirements	Graduate of school of midwifery; certified by American College of Nurse-Midwives.
	Limitations on Practice	Practice under the supervision of or in association with physician engaged in family practice or specialized field of gynecology or obstetrics.
	Special Statutory Provisions	Persons holding licenses issued before current laws enacted may continue to practice until expiration of licenses without privilege of renewal.
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

MEMORANDUM

State of Alaska

TO: Pete Jeans
Deputy Commissioner
Department of Commerce &
Economic Development

DATE: February 6, 1981

FILE NO: J-66-298-81

TELEPHONE NO: 465-3690

Thru: Harry Treager, Director
Occupational Licensing

SUBJECT: Medical Board Inquiries Re
Lay Midwives

From: WILSON L. COYDON
ATTORNEY GENERAL

By: 
Sarah T. Kavasharov
Assistant Attorney General

You have asked for clarification of conflicting opinions from this office on the question whether or not assisting at child birth constitutes the practice of medicine. The answer is, that while we might attempt to stretch the definition of the practice of medicine in the current law to cover assistance at child birth, it would be better to seek a revision of the statute.

The proposed amendment of AS 08.64.170 and AS 08.64.380(2) along with the new section 369 in the medical bill being introduced this session will cover actual assistance at child birth. Prenatal counselling already comes within the definition of the practice of registered nursing in AS 08.68.410(8) of the nursing bill which is also being introduced this session. We believe that passing these amendments is the best solution to the problem of regulation of prenatal care or assistance at child birth and should cover at least the major problems. If you have further questions on the issue, please contact our office again. We believe, also, that any further regulation of this area should be discussed jointly with the Board of Nursing.

STK:wjp

Readers
Digest
March '81

A sharp increase in the number of Caesarean sections has raised new questions—and concerns—about this “emergency” procedure

Too Many Caesarean Births?

By JOHN J. FRIED

FOR ELAINE ADAMS the first warning that she would not have a natural childbirth came shortly after her estimated “due date.” She visited her obstetrician for her regular Wednesday appointment, and he told her that two weeks overdue was too much. They could induce labor, he suggested, rather than wait until the baby became too big and risk a difficult birth. He added that inducing labor now would help to avoid the possibility of a Caesarean birth. Reluctantly, Adams decided to take her doctor’s advice.

In the hospital she was given a drug to bring on labor. For ten hours very little happened. Then, as the dinner hour approached, the doctor told her she would need a Caesarean section, an operation in which the

baby is surgically delivered through the abdomen. Adams asked for a few more hours of labor, but the physician advised against it and ordered her prepared for surgery.

Elaine Adams’s story is not unusual. Tens of thousands of women are finding themselves confronted by the possibility of a Caesarean delivery. At the end of the 1960s, only 5.5 percent of births in the United States were Caesarean. Today that rate has tripled—and in some hospitals it is as high as 32 percent.

Many women arrive at hospitals unprepared for the sequence of events that can propel them into this major surgery. First, a fetal monitoring machine (which can be misinterpreted) calls attention to some seeming liability or risk. The doctor may order drugs to regulate

and/or accelerate labor. If this results in inadequate or distorted labor, a Caesarean is called for, and the woman, exhausted from hours of labor, submits.

Many, like Elaine Adams, are disappointed about being rushed into it without proper knowledge. "In the delivery room," she told me, "strapped down for the operation, I felt angry and trapped. Later, I was in pain from surgery, while others who had had normal births were bouncing out of bed and nursing their babies right away."

"Bikini" Surgery. Just a few years ago, Elaine Adams's story would have been unusual. Women across the country, after a long struggle against medical convention, had managed to force obstetricians and hospitals to accept a host of different childbirth methods: delivery without drugs; labor assisted by husbands; even births at home, aided by midwives instead of doctors. But now, the obstetrical pendulum has swung back with a vengeance.

To many medical experts, the return of the Caesarean is a return to rational birthing. Caesarean sections, they feel, are responsible for America's decreasing infant-mortality rate. This procedure spares the premature or low-weight baby, as well as the breech baby born buttocks or feet first, from the rigors of vaginal birth. "Ten to 15 years ago, a baby weighing less than three pounds ran a high risk of dying."

*So named because Julius Caesar is supposed to have entered the world in this fashion.

says Dr. Charles Brinkman, chief of obstetrics at the University of California at Los Angeles Medical Center. "Now, in our hospital, 60 percent of the babies who weigh two pounds or the babies who weigh two pounds, or even less, survive."

Caesareans have also soared in popularity because physicians feel more at ease with the procedure. Today, many Caesareans are performed through a "bikini" cut—a small incision across the lower part of the belly, just above the pubic hairline—instead of a longer, lengthwise incision beginning just above the pubic area and extending well up over the abdomen. And instead of the general anesthesia used formerly, more than half of C-sections are now done with a spinal anesthetic that allows the mother to stay awake.

Yet the increase in the use of the technique has spawned anger and concern among many women. "There is so much emphasis on the natural experience that you feel cheated if you have a Caesarean," says Tracy Campbell, who went through a surgical birth. "Some women feel, 'I did something wrong. I ate too much. I breathed the wrong way. I am not a woman because I didn't actually give birth.'"

Almost 27 percent of the increase in the Caesarean rate can be traced to repeat C-sections—surgical deliveries in women who have undergone the procedure before. However, many physicians and the National Institutes of Health Task Force on Caesarean Childbirth point out that the adage "Once a C-section, always a C-

section" need not hold sway. The risk that an old C-section scar will rupture during a subsequent vaginal labor is small, especially in women who had bikini cuts.

No Evidence. Some doctors also feel that obstetricians are too quick to opt for a Caesarean because, with busy practices, they find it inconvenient to allow birth to come of its own volition. Thus, rather than wait out a slowly progressing labor, they will do a C-section. "A lot of people out there practice aggressive obstetrics," says a leading Los Angeles obstetrician who does not want to be identified. "They hurry things along when they shouldn't."

Many doctors believe, as well, that the procedure is a legal safeguard. Obstetricians rank fourth among physicians who are specialists as targets of malpractice suits. "The climate is such that if the physician has done a Caesarean he has done everything he can," says Dr. Thomas Garite, associate medical director for perinatology at Long Beach (Calif.) Memorial Hospital Medical Center. "If he tolerates a long vaginal birth and gets a damaged baby, it is more likely to be attributed to the physician's not doing enough." In the late 1960s and early 1970s, he adds, poor birth outcomes—including cerebral palsy, depression and neurological damage—were blamed on longer hours of labor. "So doctors won't tolerate long labors anymore," Dr. Garite says.

However, the contention that C-sections diminish the incidence of

cerebral palsy and other neurological problems among normal-weight babies carried to term is now a controversial question among obstetricians. The Task Force on Caesarean Childbirth could find no compelling evidence that babies born by C-section fare better than their vaginally delivered brothers and sisters.

Moreover, some experts believe that the obstetrician may even contribute to inefficient labor—one of the indicators used to rationalize Caesarean section—by using drugs to induce birth. "Birth is like plucking an apple off a tree," says Dr. Calvin Hobel, professor of obstetrics and gynecology at Harbor-U.C.L.A. Medical Center in Torrance, Calif. "If the apple is ripe, it will just fall off. But if you start too soon, it's like trying to pluck a green apple. You might break the branch. If you try to induce the patient before everything is ripe, you can get into trouble, and you may wind up doing a Caesarean section."

Backing Off. In a substantial number of births, the obstetrician who feels that labor is not progressing well is abetted by an electronic fetal monitor. Once the membranes have ruptured, the doctor will place two fingers in the woman's vagina, and the fingertips will touch the baby's head. Then he will pass a thin plastic-and-wire tube up into the vagina, and twist a coiled wire at the tip of the tube into the baby's scalp. Once this electrode is in place, an electronic digital readout

on a monitoring machine continuously flashes the baby's heartbeat. Ideally used, the fetal monitor can tell the obstetrician if the birth process is causing the child to suffer because his brain is not receiving enough blood and oxygen.

But the monitor itself has become a focus of controversy. Some obstetricians lack expertise in interpreting the signals. Moreover, the monitor is prone to readings that indicate problems where none exist.

In the late 1970s Dr. David Banta, a physician now with the Office of Technology Assessment in Washington, D.C., and Dr. Stephen Thacker of the Centers for Disease Control in Atlanta prepared a report on fetal monitoring for the Department of Health and Human Services. "We estimated that half of the increase in C-sections over the last ten years could be attributed to the monitoring," Dr. Banta says. "And essentially, most of those Caesareans were needless."

The goal, say some medical experts, should then be to lessen the impact of the fetal monitor. "There is no question that there has been a tremendous benefit from the increase in the Caesarean-section rate and that there have been benefits from fetal monitoring," says Dr. Hobel. "But now the question is: how much can you back off from fetal monitoring and Caesareans and maintain the success we have had in reducing infant mortality? Can we reduce the Caesarean-section rate from 25 to 10 percent and maintain

good outcomes? I think we can."

Mitigating the Effects. One reason for reducing the Caesarean-section rate is simple economics: the rocketing number of surgical births has brought immense financial burdens. In Southern California, for example, the average physician charges about \$750 for a vaginal birth—but about \$1000 for a Caesarean section. The Task Force report says that a normal birth will mean a two- or three-day stay in the hospital, but for a repeat Caesarean it will be about six days, with a net additional cost of over \$2000.

Obstetrics experts believe that in some cases the surgery may actually be harmful to the baby. Caesarean delivery is recommended to rescue a baby unable to withstand prolonged birthing. Although 20th-century technology makes it possible to determine fetal maturity, these methods are not always used or correctly applied. As a result, a scheduled Caesarean performed because the baby is allegedly overdue can bring forth a premature child subject to dangerous respiratory problems.

Caesarean sections take a physiological toll on the mother as well. In one study in New York, 25 percent of the women who had Caesareans suffered complications, including lung problems and adverse reactions to anesthetic, compared with only 15 percent for women who delivered vaginally. And the risk that a Caesarean mother will develop a pelvic

READER'S DIGEST

infection is 7 to 20 times greater.

Such postoperative complications may simply mean more time in the hospital. But in some cases the adverse reactions can increase the risk of death. "In 1978 the maternal death rate in vaginal deliveries was 9.6 per 100,000," reports Dr. Diana Petitti of California's Kaiser-Permanente group. "But for women who had C-sections, it was 40 per 100,000, or four times greater."

Women who have undergone Caesareans seem even more concerned with the psychological hurt that follows the procedure. In many hospitals the woman is not allowed to hold her child immediately after birth. "I saw my son only briefly after he was born," says Sandy Hambeck, a young Californian. "And I still feel the trauma of not being able to hold him and nurse him."

While the hurt is real, however, psychologists say they find no persuasive evidence that Caesarean mothers suffer deep or long-lasting psychological damage. "We found that Caesarean mothers often tend to be more involved with their children," says Tiffany Field of the University of Miami School of Medicine.

Moreover, women who have had Caesareans agree that negative psychological effects can be mitigated if the woman—and her husband—retain a sense of control over their

birthing experience. Groups formed to help women suggest that:

- A pregnant woman should learn as much as she can about Caesareans so that, if the possibility arises, she will be prepared for the decisions that must be made.

- If told during labor that a Caesarean might be done, a woman should question the physician closely. "Don't accept the doctor's saying this is the only way the baby is going to be born," says Tracey Campbell, now a Caesarean-birth educator. "Find out what the problem is, whether there is something wrong with the placenta, the cord, the contractions. Have your questions ready before you go into labor, and have your husband there with you to hear the answers."

- If a woman is having a second baby after having had one by Caesarean, she may want to find a doctor who will allow a trial vaginal labor. She shouldn't agree to a scheduled Caesarean, unless her medical condition makes it imperative. Even so, she is entitled to a second opinion.

- The mother-to-be should shop carefully for a physician, and ask him what the Caesarean percentage is at the hospital where he practices. She should also ask what his own and his partners' is. "If he says, 'If that is a concern, maybe you don't want to see me,'" Campbell notes, "then maybe you don't."

THE FULL SITUATION has created another excuse for being late to work:
"Got my pant leg caught in the bicycle chain, boss."

—Wendell Trigg, Jan. 10, 1980, p. 57



Staff photo by Bruce McKim

Susan Anemone checks the vital signs of a prospective mother at the Seattle Midwifery School/Home Maternity Service.

Midwifery school helps with home-births advice

by Sheila Anne Feeney
Times staff reporter

GET "We're like snoops. Our role is to always look for something going wrong." Susan Anemone said of her vocation's curious nature.

Ms. Anemone, Margaret Mansfield, Susan Myers, and Susan Rivard are Washington state-licensed midwives who operate the non-profit Seattle Midwifery School and Maternity Service.

The service partially supports the school, and also provides the field training for students.

Rigorous, continuous screening of patients occurs continually to assure that the prospective mother is "low risk." Factors such as high blood pressure, anemia, bleeding, or malpresentation (breech or unusual birth), or even desiring a home birth for the wrong reasons, will prompt the partners to refer the client to a hospital.

The mother is speedily transferred to the hospital should a complication arise during labor, Ms. Anemone explained. This is evidence of the evolving nature of a midwife's role: the old-time, rural midwife, who once had to handle any problems that came along, has been replaced by urban specialists who handle only routine births, and refer more complicated cases to medical specialists.

Home births are less expensive (the service costs about \$500, plus mileage in some cases), however, offer women more control over the birth experience and the opportunity to have their loved ones present if they desire, Ms. Anemone said.

"This has to do with a different value system, with not being medicated and (also) having control over your own body," said Ms. Anemone. She added that the service also is a preferred alternative for women who want to be

attended by other women, and for those who dislike or fear hospitals for some reason.

Ms. Anemone said the midwife takes a back seat to the mother during the birth. "Our patients aren't sedated. They're well-prepared, with childbirth instruction."

While deliveries by midwives are a controversial topic in the medical profession, Ms. Anemone said non-nurse midwives have an advantage in a home birth because midwives trained entirely in hospitals can't be expected to do as well in a home setting.

She added that persons trained in hospitals with a variety of technology and machines at their disposal "do not develop the self-reliance and skills to know (their) limitations."

Ms. Anemone said the two-year-old school, which is independent of nursing school or hospital affiliations, is perhaps the only one of its kind in the country. Other midwifery (pronounced midwifery) schools exist, but generally are run in conjunction with, or subsequent to, a nursing program, Ms. Anemone said.

The school, which was established by Anemone, Mansfield, Myers and Rivard to train licensed midwives, accepts only six students at a time, and has a waiting list of as many as 300.

The service accepts applications from prospective mothers who would like a team of midwives (student midwives assist as part of their obstetrical training) to attend them.

Although the service has openings for pregnant women who would like to deliver at home, Ms. Anemone added emphatically that "we never tell people to have home births. They come to us after their decisions have been made."

Sept 11, 1977
Seattle Times

Giving birth: at home or in hospital?

Dear Dr. Solomon: My mother gave birth to all three of her children at home, while I had all of my children in a hospital. Now my daughter



**dr. neil
solomon**

says she plans to have her first child at home. Which would you recommend, hospital or at-home birth of a child? — Mrs. M.W.

Dear Mrs. W.: There are both pros and cons to giving birth in a hospital or at home. In the case of uncomplicated pregnancies, the evidence supporting one method or the other is not conclusive. Where complications do exist, however, a hospital setting is necessary.

Despite the recent publicity surrounding home births, they constitute only about 1 percent of all births in the United States. Those who champion this trend maintain that it provides psychological advantages to both mother and infant, as well as to any other children in the family. Some women complain that hospitals are cold and impersonal, restrict visiting unnecessarily, and interfere with the mothers' access to their babies following birth. The high cost of hospital care is another factor.

The opponents of home birth, on the other hand, say it poses unnecessary risks for both the mother and baby. While many complications of pregnancy can be foreseen prior to birth, some — such as severe hemorrhage — may not be. As Dr. G. David Adamson, an obstetrician at the Stanford University Medical Center, points out, although childbirth is not an illness, it does pose an increased risk to health.

Almost all physicians are of the opinion that women who give birth at home face risks they would be spared if they were in a hospital setting; yet, many women do give birth at home without difficulty. But concrete evidence pointing to the advisability of one over the other in uncomplicated pregnancies is still lacking.

HOME BIRTH

An Alternative on Trial

By Linda Fitzgerald

From my bed I could hear the sound of the midwife's knitting needles clicking as I rested between contractions. It had been a long and tedious labor and the strain was showing on everyone. My friend who had come to take photographs and be a labor coach lay half-asleep at the foot of the bed, my husband sat dozing beside me.

The words of my midwife drifted through my mind. "It takes a mature woman to have a home birth... After you give birth you will know you can do almost anything." She came and sat down next to me, offering me a look of understanding concern. "It hurts," I complained. "Yes I know."

she said. "But you can handle it." I gripped her hand and took my thousandth controlled breath.

Thirty-two hours after my first labor twinge, I knew the meaning of "good things come to those who wait," as a surprisingly pink, bushy little creature lay squirming on my breast. I had just climbed Annapurna and accepted the Nobel prize all in the course of little more than a day.

The birthing had not come easy but I had gotten what I wanted: to labor in my own bed and to have my baby be free from intervention and medication. I had been in control of the birth.

The desire of many women to regain control of their birth experiences created the alternative birth movement a decade ago. Although the obstetrical profession has responded by offering, in some hospitals, reduced obstetrical intervention, modified hospital routine, and alternative birthing centers, a segment of the population is choosing to have their babies at home.

In the mid-'60s, home birth was on the verge of becoming an anachronism. But during the past ten years, there has been a tremendous resurgence of interest, and a movement has developed and grown both in strength and numbers. New home birth organizations have formed, and the conferences are getting bigger.

The National Association of Parents and Professionals For Safe Alternatives in Childbirth reports that there has been a three-fold increase in the number of home births between 1973 and 1978, with hospital births declining from 99.3 percent to 98 percent during that period. In California and Oregon, home birth rates have doubled every year for several years and now represent 3 percent of all births in California, and 4 percent in Oregon.

With the renaissance of home birth, the midwife, the traditional home birth attendant, has been called back into active service. Although trained medical profession (physicians and certified nurse-midwives) do attend home births, it is the lay midwife who is present at the majority of home births. Lay midwives have acquired their skills by working with experienced midwives or doctors, studying obstetrical manuals, or by training in the few lay midwifery schools that exist. The California Department of Consumer Affairs estimates that over 400 lay midwives are practicing in that state with 9,000 babies born annually under their care.

In spite of the increasing demand for home birth, the medical establishment remains firmly opposed to its practice. The twenty-thousand-member American College of Obstetricians and Gynecologists (ACOG), home birth's most vocal critic, contends that "labor and delivery are potential hazards that require standards of safety which are provided in the hospital, and cannot be matched in the home situation." ACOG's former executive director, Warren Pease, has been known to make statements to the press such as: "Home birth constitutes maternal trauma and child abuse."

It is under the banner of "safety" that the obstetrical establishment has successfully persuaded the media and the general public that home birth is a dangerous practice. Recently, ACOG released damaging statistics on home birth, which purportedly show that home birth poses a two to five times greater risk to the baby's life than hospital birth. Home birth advocates view the study as fraudulent, claiming that ACOG never released the raw data on which the study was based, and that the spurious statistics make no differentiation between planned and unplanned home births.

Home birth advocates point to the studies done by Dr. Louis Mehl as a more reliable indicator of the safety of home delivery. Dr. Mehl's study is one of the most extensive conducted to date, comparing more than a thousand midwife-attended home births with an equal number of hospital births over a six-year period. Mehl used matching criteria among the women to eliminate any significant differences between the two groups. Mehl's findings show that the number of infant deaths were similar in the two groups, but that the hospital group showed more complications of labor and delivery, birth injuries, and a greater incidence of hemorrhage in the mothers.



Childbirth in the Courts

Home birth is not illegal in America. There are no laws in any state that outlaw the practice. However, the use of home birth attendants can be legislated. It is not illegal for parents to deliver their own baby in their home but should a friend or trained attendant assist in the birth in any way, she could be accused of practicing medicine without a license, or worse.

In California in recent years three midwives had serious charges leveled against them (two were charged with murder, and the other with a felony.)

It is not illegal for parents to deliver their own baby, but should a friend or trained attendant assist, she could be charged with practicing medicine without a license...

In the highly publicized case of Marianne Doshi, the judge's decision was a victory for home birth. The charges of second-degree murder and practicing medicine without a license for having attended the birth of a stillborn baby were unexpectedly dismissed by the judge (who was considered a conservative by the home birth advocates) with the words "I really feel that we have a segment of our society that wants to choose an alternative to what the California Medical Association, or the AMA, or the medical profession wants to provide as far as the birth of children goes. And I think these people probably have that right under our constitution. I hope the medical profession has enough maturity at this point—to say that there are alternative ways. I am convinced that had that child died in the hospital, we would have had a thousand doctors lined up between here and Los Angeles willing to testify that the doctors provided medical treatment according to the standard of care."

In another case, Jo Ann Ruiz, a midwife and registered nurse from El Dorado County, California, was indicted by a grand jury for practicing medicine without a license for having counseled a woman wanting a home birth, in prenatal care during her pregnancy. The charges against Jo Ann were ultimately dropped, the reason being, according to one doctor who attended her hearing, that "the community demanded charges."

But the most serious case still pending, that of Rosalie Tsipening, has been far more trying. Tsipening, a Monterey physical therapist, has been charged with first-degree murder for attending the birth of a stillborn baby in December of 1979. First degree murder, according to California statutes, indicates an act committed out of a "malignant and abandoned heart." Rosalie was arrested two days after the stillbirth and, with bail set at \$100,000, she was jailed for seven days. Her bail was finally reduced to \$25,000 and she was released.

At Rosalie's first pretrial hearing in February, the "first degree" was dropped from her murder charge but practicing medicine without a license and grand theft (for charging for her services) were added.

Rosalie Tsipening's right to a speedy trial has been violated by the prosecution's continual delays and postponements. All in all she has been scheduled for thirteen preliminary hearings—a

record for Madera County, where her case is being heard. So far, her legal fees have accumulated to \$30,000, and may run beyond \$50,000. Should Tarpenting be convicted, she could spend seven years or more in jail. Thus far, the causes of the stillbirth have not been fully determined, but according to an autopsy report, there were no indications of fetal distress during labor.

Rosalie's legal struggle has proved sobering for other midwives in the lay community. The unspoken legal rule of thumb appears to be: if a baby dies at home, the attending midwife will be charged with murder or a felony. If the baby dies in the hospital, it's an act of God.



Rosalie Tarpenting, charged with first-degree murder for attending the birth of a stillborn baby.

Karen Lang, a founding mother of the Santa Cruz Birth Center and midwife for twelve years, describes her own tenuous situation: "I know that all I have to do is go to a birth and have that baby not be alive when it's born, and within twenty-four hours, the police are going to walk into my house and look through my journals. My entire family will be subjected to the law" (In California, where lay midwifery is clearly illegal, if a midwife is arrested for a problem that occurs at a birth, and her children are with her at the time of the arrest, they could be taken to juvenile hall.)

Although midwives have been involved in most of the home birth court battles, doctors who have home birth practices are not immune from legal statutes. Most recently, Peter Kinn, an M.D. from Sitka, Alaska, was acquitted of the charge of "negligent homicide" for having attended the stillbirth of a baby born at home.

Home birth organizations, as well, have been subjected to legal pressures, as evidenced by the case of the State of Illinois vs. the Association for Childbirth at Home, International (ACHI).

This case began three years ago when Illinois ACHI leader Cat Feral came to the attention of the local medical community due to her role as counselor of expectant mothers. Stemming from a doctor's complaint, an investigation was begun by the Illinois attorney general, who served Cat Feral and the ACHI with two subpoenas asking for seventy-one items from the ACHI's birth records.

Included in the list of items were questions that challenge basic freedoms of individuals. The subpoena asked for the names and addresses of every parent the ACHI had trained; their phone numbers, birth dates, and work phones. Another question was phrased: "Where have the ACHI home birth series been offered in (a) Illinois, (b) the United States, (c) the world? State dates and leaders and addresses of each location."

When the ACHI refused to honor the subpoena, a lengthy court battle ensued, and the organization was charged with consumer fraud for certifying childbirth educators. The ACHI won the first battle on a technicality. The decision was appealed, dropped, and then reopened by the state. At present the case against the ACHI is being appealed to the Illinois Supreme Court.



The Source of the Conflict

Throughout the history of childbirth, an antagonism has existed between female and male practitioners. The arguments given

Suppression of female practitioners in the middle ages evolved into the witch trials, from which midwives emerged forever stigmatized...

today against midwives practicing home birth have been reiterated by doctors for six hundred years. Charges of incompetence and inexperience were as common then as they are now.

In the middle ages, restrictions were first placed on midwives during the fourteenth century, when they were compelled (in England by law), to call on the barber/surgeon to perform difficult deliveries. Should a midwife be present at the birth of a stillborn or deformed child, she could be hung as a witch.

As Europe emerged from the Dark Ages, medicine was established as a profession, and physicians sent petitions to heads of state complaining about the "worthless and presumptuous women who were usurping the profession." Licensing laws were passed to prohibit all but university trained (male) physicians from practicing the healing arts. Sure doctors did not treat the peasantry, these laws were not observed in rural areas, which remained the stronghold of the midwife/female healer. To rid the profession of its competition, physicians enlisted the aid of church and state to help them eliminate female practitioners. The suppression evolved into the witch trials, at which doctors testified as medical experts to assist in determining if a midwife/female healer had caused an affliction to befall a peasant. Said

the church: "If a woman dare to cure without having studied (at a university) she is a witch and must die." When the trials tapered off in the 1600s, midwives emerged forever stigmatized as incompetent if not malevolent practitioners who had developed a deep and lasting resentment for the medical profession. The midwife's skills and techniques that had been called sorcery were now labeled medicine when performed by a doctor.

In the seventeenth and eighteenth centuries, doctors pressed for anti-midwife laws, blaming midwives for childbed fever. Midwives, in turn, charged doctors with commercialism and the misuse of their tools.

By the twentieth century, obstetrics had come to be a recognized surgical specialty in America, and midwifery a dying art. Although a study conducted by Johns Hopkins University in the early 1900s indicated that obstetricians were less competent at childbirth than midwives, doctors, in the name of science and the improvement of maternal and child health, convinced state after state to pass laws prohibiting or limiting the practice of midwifery.

The long-standing biases and rivalries between the two practitioners cannot be overlooked in the current dispute over home birth.

Although a study conducted in the early 1900s indicated that obstetricians were less competent than midwives, doctors convinced state after state to pass laws limiting the practice of midwifery.

If you were to ask most mainstream obstetricians why they oppose home birth, you would be likely to get a one-word, all-encompassing answer—safety. Citing the higher risk factor, it poses to mother and child, obstetricians will quote a long list of unforeseen, life-threatening complications that can arise in a matter of minutes in a seemingly normal, low-risk situation.

Having received their training in hospitals which are primarily centers for treating the sick, it is small wonder that physicians view childbirth as a potential hazard. In residency programs as a whole, normal labor and delivery are given very little consideration, being described as "unremarkable birth" in obstetrical textbooks. Most obstetricians have never seen a home birth, and many have had limited experience with unmedicated births. In conjunction with being educated in a system that shows too little respect for the normal process, young doctors are encouraged to disavow the healing instinct, and replace it with the frequent application of medical technology. This fosters a belief that high-intervention type obstetrics is the only way to get out a healthy baby.

Suzanne Arms, author of *Immaculate Deception*, a book that exposes the abuses of obstetrical intervention, described the uphill battle that the home birth movement is facing. "We are confronting an obstetrical establishment that is completely sold on high technology, has brought it lock, stock and barrel from the computer and aeronautics industries, and has failed to examine its motives in buying it."

The complicated system of technological checks and balances designed for the quick and easy hospital birth cannot be transferred to the home. Home birth would prove to be a time-consuming inconvenience and an unprofitable prospect for the



One Doctor's Perspective

"I've been surprised and pleased to find that, given the current atmosphere around home birth, the opposition is not as rabid as it appears in public," says Dr. Stanley Sagov, a family practitioner in Cambridge, Massachusetts who offers home birth. Trained in South Africa, where it's a common practice, he says he began doing home births here rather naively. "People wanted birth at home and I didn't know that it was such a problem. I was not aware of and still am not aware of any statistical data that contradicts home birth on the grounds of safety in screened populations."

In spite of practicing in an area where the medical community as a whole frowns on home birth, Dr. Sagov says that, surprisingly, he feels supported in his practice. "We have made it a policy to be very public about our home birth practice. We write about it, talk about it, and let our colleagues know that we'd like to hear anything that might dissuade us from the practice."

"I find that obstetricians are often relatively uncritical of their own anti-home birth stance until they've had a chance to look at it in an unthreatened situation. I ask them when they last had an event in which it really would have made a difference not to be in a hospital, how often such events happen, and if policy should be made on the basis of such incidences."

obstetrician who is used to doing forty births a month in a central location.



David Stewart (above) of NAPSAC says, "Home births represent an enormous threat to the system. Every home birth is a loss of an average of at least \$1,000..."

David Stewart, the executive director of NAPSAC, believes that the medical establishment's resistance to home birth can be reduced to the profit motive. He writes in the spring edition of the "News From H.O.M.E." newsletter: "The most efficient way to gross a lot of money in maternity care, from the economic viewpoint of the doctor and the system, is to adopt the assembly-line model from industry, to force everyone into hospitals, and to coerce the birth process into set routines. This fact is apparently well known to hospital administrators, drug companies, medical device distributors and [some] medical doctors. While the cost effectiveness to the system is maximized by such a model, the cost effectiveness to families having babies is minimized, along with the minimization of kindness and humanity in childbirth."

Stewart has found that: "Home births represent an enormous economic threat to the system. Every home birth is a loss of an average of at least \$1,000. ... 10 percent home births in the United States represent a loss of at least \$5 billion every year." Stewart points out that doctors didn't object as strenuously to home birth until the last few years when upper and middle class couples adopted it. Says Stewart: "If ACOG can manage it, the battle of home versus hospital birth will not be fought over the facts — the facts are not in their favor. Power and politics are however. Hence it is via power and politics that they will seek to squelch home birth. Thus they will do by encouraging the harassment of doctors who sympathize with home birth, by seeking restrictive legislation limiting midwives and by leveling child abuse charges against participants in home birth."

Sagov claims that an obstetrician would be hard pressed to find statistics for a strict in-hospital policy. "Birth is safe nowadays. On the basis of the data, there just doesn't seem to be a whole lot to talk about. All of the published data indicates that in screened low-risk populations the outcome is likely to be good whether one is at home or in the hospital."

In spite of the statistical data and the support he feels from his colleagues, he acknowledges that he is taking a very real, personal risk in doing home births. "We feel very vulnerable," he admits. "We feel that if there was a misadventure at home, especially a maternal death, there would be a slur cast on us for being home, even if we were completely above criticism technically. I think we would be hard pressed to find expert witnesses on our side to justify our choice of the home as a site. Though we have not let that deter us, we're afraid of it. It's a recurrent nightmare that something might happen that would be judged unavoidable if it happened in the hospital, but would incur a very harsh reaction from the medical profession if it happened at home."

Dr. Sagov feels that the question of home versus hospital is basically a straw issue, one which has come to encompass larger questions of freedom of choice and the right to self-determination. Though this has helped raise public debate, it ultimately clouds the real issue: finding ways to get together to make available the safest and most satisfying range of birthing choices.

He finds a sole focus on site to be one of the greatest obstacles. "If your orientation is that the home is the best place or vice versa, and you are not looking at the larger picture of what's really desired here — namely, satisfaction and safety for as many people as possible, then you're going to be spending your energies struggling with side issues and miss the point."

Birth can be a beautiful, meaningful experience wherever it happens. "I've seen people have just the most rich and transcendent experiences in the hospital in all sorts of circumstances, with Caesareans that they didn't anticipate, or having spontaneous vaginal deliveries that were with friends, other siblings and family members. They've been wonderful experiences where everyone has felt all of that excitement that makes us want to be a part of childbirth."

No matter how great an experience may be possible in a hospital setting, however, there will always be women who will choose home birth. Dr. Sagov says he wishes the obstetrical community would just accept this and get on with fulfilling their responsibilities as physicians providing safe care. "If our orientation as doctors is, 'How can we make it safe and how can we maximize consumer choice in a way consistent with our concerns for physical safety,' my own sense is that we can do a great deal that will relieve everyone's worries."

— P. T.



Midwifery and the Law

The status of the law varies widely from state to state. Many states have no legislation or case laws covering midwifery. In some, the practice is considered illegitimate but not illegal. Other states make the practice clearly illegal. Lay midwives have been prosecuted in California, Kansas, Florida, Illinois and elsewhere.

Following is a cross section of how the individual states rate.

The Western States

As a whole the west has a favorable midwifery and home birth climate. Oregon, Texas, and Utah are so-called free states, where there is no legislation governing the practice of midwifery, and midwives can openly practice without a license.

Oregon: The state attorney general has stated that as long as midwives use hygienic methods to insure the home birth will be clean and safe, there is no reason to regulate the practice. Oregon is a very progressive, individual-rights oriented state. Midwives can have a business license, charge for their services and advertise. Doctors are generally open to home birth and will do postpartum check-ups in the home if asked. Midwives can file birth and death certificates.

California: This state has one of the worst legal situations, but it has a strong home birth movement pushing for better legislation.

Texas: Texas has no regulations governing midwifery except in the border area near Mexico, where the local public health department supervises the practice of lay midwifery. Sixty percent of all births take place in the home.

Utah: Utah is a Mormon state and midwifery fits into their beliefs. A year ago nurse-midwifery legislation was passed which could have restricted rights of parents, but it was amended by pro-home birth legislation.

Washington: In Washington a midwife can practice without a license if she does not advertise or charge for her services. The state has recently revived old licensing laws for midwives. Midwives and state officials are in the process of updating the licensing procedures.

Arizona: Arizona is very similar to Washington where old midwifery licensing laws have been revived. The first midwifery exam was given a year ago.

Alaska: Allows home birth and midwifery, although a general preference is to have a physician.

The Southern States

Most of the old licensing laws remain intact, although some have been updated. Some states require that public health department supervise training, examining and licensing.

Virginia: There are two or three licensed midwives practicing in this state. License regulations are very restrictive. The public health department follows up on each delivery.

Florida: Under the old licensing act, a lay midwife must attend fifteen births under a doctor's supervision. If the doctor recommends her for a license and the county health department director agrees, she is eligible for the midwifery exam. In a 1975 decision in St. Augustine the 1931 Florida statutes for licensing lay midwives was declared unconstitutional, in the case of *Carole Baya*. If the decision is upheld in Florida's Supreme Court, Florida law will change.

Kentucky and Tennessee: Both states allow midwifery, especially nurse midwifery, with the Frontier Nursing Service.

Arkansas: Allows lay midwifery, but is phasing it out by not renewing licenses of those who have practiced for years.

The Problem of Back-Up

The increasing difficulty of obtaining adequate back-up assistance from the medical community appears to be the most dangerous problem facing home birth in this country. The denial of back-up and prenatal care is the medical establishment's most effective means of penalizing midwives and women wanting home births. Midwives who have been practicing during the last decade report a gradual tightening up of doctors' attitudes toward home birth.

According to midwife Raven Lang, "Things are worse now, in a way, because twelve years ago, physicians didn't really know what home birth was all about, and they'd say, you can call on me if you need transportation or back-up. Now they are clear and precise, they do not want to be involved."

In Santa Cruz, California, as in parts of Illinois, Colorado and other states, midwives have reported that obstetricians have banded together and pressured their colleagues into refusing prenatal care and back-up to persons involved in or having a home birth. This is even a problem in Oregon and Washington, two states which have a favorable climate for home birth. Says Oregon midwife Shari Lauer, "I have to search for doctors to do back-up because they are filled with scare tactics from their peers." Lauer also claims that women who choose to come under a midwife's care, after having seen an obstetrician, are often in for a fight just to obtain the prenatal records that are legally hers.

Lauer does all of her own prenatal care, and receives emergency help from doctors on a good Samaritan basis. For her clients in Washington, she has only two doctors who will back her up. She reports that, in one instance, she had to drive a woman needing a Caesarean section out of her own city (population 100,000) to a rural area forty minutes away to get emergency care. Said midwife Raven Lang about the situation in her area: "There is no back-up except from other midwives. If you have to go to the hospital, it's take who you get."



Tonya Brooks, head of the Association for Childbirth at Home, International.

This "pin luck" state of affairs can prove to be dangerous in some circumstances. Two Kentucky midwives, having to transport a laboring woman with a prolapsed cord, were greeted at the hospital by an uncooperative staff of medical personnel, who paid little attention to their repeated pleas for a surgeon to do a Caesarean section. As one midwife struggled for half an hour to keep the baby's head off its cord, she was told there was no surgeon in the whole county, and they would just have to wait. The midwives put the woman back in the ambulance and drove

to another hospital, twenty minutes away, where the woman was finally given a C-section.

"If a doctor delivers at home and there is a poor outcome, ... no one will testify in his defense."

Tonya Brooks, head of the ACHI, calls the back-up situation a "national scandal." Says Tonya, "In the last fourteen years, I have not seen improvement in back-up. Everywhere we make strides, there are other hospitals that are nasty about it."

Suzanne Arms believes that in refusing prenatal care to women wanting a home birth, and by cutting off back-up to midwives, doctors are hoping, in effect, to prove that out-of-hospital birth and the use of midwives is a dangerous practice.

Physicians justify their reluctance to provide back-up by citing the legal risks that could arise with their assistance. In a recent *Los Angeles Times* article on home birth, a Santa Barbara physician complained about midwives bringing in patients in emergencies. "The physician who tries to bail that situation out is the one who has to go to court if there's a suit, because he's the one who has the insurance. The lay midwife doesn't have the insurance." Although there are few, if any, instances where doctors have been prosecuted under such circumstances, they are in the letter of the law legally responsible for the welfare of whomever they treat. In a state like California, malpractice lawsuits are a prominent fear. Says an obstetrician who backs up home births but refuses to attend them: "If a doctor delivers at home and there is a poor outcome, whether or not there could have been anything that could have been done about it in a hospital, that doctor's name is on the line, no one will testify in his defense."

Doctors with the courage or conviction to attend home births often find malpractice insurance hard to come by. ACHI President Tonya Brooks explained, "In the United States now, insurance companies often will not give malpractice insurance to physicians who do home deliveries or will raise the rates so high for those physicians that they are prohibitive."

Norcal Mutual, the insurance company of Northern California physicians, informed its clients two years ago that doctors attending home births would no longer be covered by malpractice insurance. "The lack of insurance can mean an end to a doctor's hospital privileges, thus limiting his or her ability to provide emergency care. Doctors wanting to maintain a home birth practice will find it necessary to meet clear of the physician-united barriers that put restraints on their right to practice at their homes."



Midwives Unite

Increased harassment, concurrent with increased demands for their services and the desire to upgrade their education, has pushed midwives to band together. They are becoming better organized, with grassroots support groups often forming into strong organizations complete with newsletters, bulletins, and t-shirts. Many midwives are coming to believe that public involvement and legal action are necessary skills that must be learned if the age-old practice is to survive.

Some midwives, who have come to the practice from a personal point of view, at first think involvement in politics is a pipe dream.

Midwest

Illinois: Presently has an archaic licensing system for certified nurse midwives and lay midwives, and requires the presence of a physician. New legislation has been proposed and is in the lengthy hearing-debate stages.

Wisconsin: Recently passed legislation allowing home births under lay midwives.

Ohio: Allows home births under lay midwives and physicians.

East

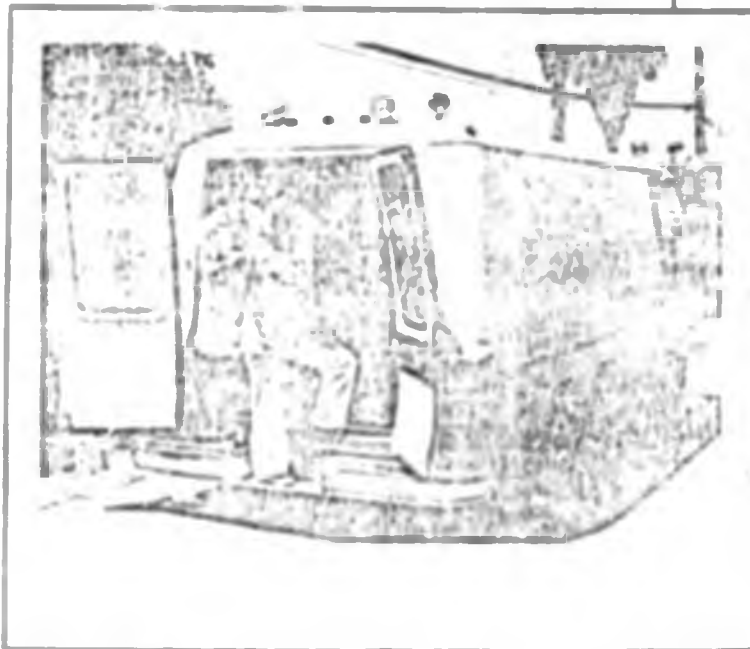
New Jersey: The attorney general has proposed regulations that would allow only hospital births, doing away with midwifery in the state.

Maryland and Washington D.C.: Both allow the practice of midwifery and nurse midwifery.

Maine: Allows the practice of lay and nurse midwifery.

Massachusetts: Lay midwives may attend home births without a physician.

Connecticut: State legislators, nurse-midwives and lay midwives are working to replace the old licensure board with a safe certification process and to have medical back-up assured.



The Baby Buggy, a fully equipped paramedical vehicle, stands outside a home nurse-midwives from the A. R. E. clinic in Phoenix, Arizona do home births.

Tools for Birth

Lay Midwifery Schools

The Seattle Midwifery School, 1624 44th Ave., Seattle WA 98122

The Maternity Center of El Paso, Texas
Association for Childbirth at Home, P.O. Box 1214, Corona CA 92701

The Woman-Care Midwifery Program, Santa Cruz CA

There is also training available for nurse midwives at Georgetown University, Yale University and one or two other medical schools.

Home Birth Organizations

The Association for Childbirth at Home, International (ACHI), P.O. Box 1219, Cerritos CA 90701: Third largest childbirth organization in the United States. The ACHI is also an international training and research organization that has trained over 800 childbirth educators and 10,000 couples.

NAPSAC, P.O. Box 267, Marble Hill MO 63764: NAPSAC publishes a directory of alternative childbirth issues, and has compiled data on home birth.

Informed Home Birth, P.O. Box 788, Boulder CO 80306: sponsors midwifery workshops.

Home Oriented Maternity Experience, 311 New York Avenue, Tacoma Park, Washington DC 20012: A national consumer group with branches in at least twenty states. H.O.M.E. publishes a list of 1,500 birth attendants throughout the U.S. and a book titled *A Comprehensive Guide to Home Birth*, also a quarterly newsletter, "News From H.O.M.E."

Peace and Home Association of Wichita, MaryEllen Jordan, 2730 Thistle, Rose Hill KS 67133. A group working for midwifery legislation in Kansas.

International Childbirth Education Association, P.O. Box 20852, Milwaukee WI 53220: The biggest childbirth education association.

Washington State Midwifery Council, Ann Younis, 1512 Langridge Ave., Olympia WA 98502

The California Association of Midwives, P.O. Box 3306, San Jose CA 95116: A group of a hundred and fifty practicing home birth attendants including lay midwives, nurse midwives, and licensed physicians who are working to get midwifery legislation passed, provide guidelines for midwifery, and working for midwifery concerns.

The American Foundation for Maternal and Child Health, 251 Nottingham Way, Hillside NJ 07035

The Farm Midwives, 152 Drake Lane, Summertown TN 38485

New Mexico Lay Midwives Association, Box 2104, Taos NM 87571

Family Birth Associates, Arlington VA

Maine Arrow to Alternatives in Childbirth Care, c/o Arlet Walton, RFD 1, Box 74, Durham ME 04432

Birth Options, 1492 River Road, Teaneck NJ 07666

Institute of Feminine Arts, P.O. Box 2774 East Side Station, Santa Cruz CA 94062

Home Opportunities for the Pregnancy Experience, P.O. Box 78, Wauconda IL 60084

C-Sec., Inc., 140 Valley Rd., Needham MA 02192: Nancy Weather Cohen founded this organization for two purposes: to offer support to women who have undergone Cesarean sections and to begin for their future birth options.

Home Birth Supplies:

Birth Center, P.O. Box 603, Summit City CA 94389: provides a list of least-expensive suppliers of birth equipment.

Mountaincrest Birthings & options, 1644 S. Downing, Denver CO 80210: Carries dispensable home birth kits and midwife supplies.

Home of St. Augustine, RFD 1, Box 12, St. Augustine FL 32086: Carries home birth kits.

are, but as Raven Lang says, "You can say, well, I don't believe us that [politics] and meanwhile you're getting handcuffed and taken off to jail—you get politicized fast."

According to California registered nurse and midwife Mickey Selwin: "It's very difficult for midwives to be good practitioners and good politicians at the same time. Babies come first. Every time we try to get organized and set a meeting, the people aren't there, and it's for good reasons. We need people who know how to organize, and that's a skill most midwives don't have."

Getting together on basic issues and arriving at standards for their profession is a hurdle that lay midwives have yet to jump. Paramount among their concerns are issues involving training and legalization. Many fear that in order to practice legally, they will be obligated to receive their training in a hospital under the supervision of doctors, and be transformed in the process into medical technicians. Raven Lang is of the opinion that if midwives become state-approved practitioners, they will lose the art of serving women in childbirth. Says Raven: "If everyone is certified, midwives are not going to make beds and take home the laundry, and bring the dinner the next day."

In training lay midwives, she teaches them to trust their God-given instincts, rather than focus entirely on acquired medical skills. She thinks hospital training should be limited, and that a midwife can gain most of her knowledge by watching normal births.

The consensus among the lay community appears to be that basic emergency training is essential, but that abnormal conditions in birth should be taught primarily by midwives, with some hospital training interspersed with normal home births.

The concept of "spiritual midwifery" may have been misunderstood by a segment of midwives, who interpret it to mean that the atmosphere created at a birth is of greater importance than technical skills. ACHI Vice President Linda Bennett takes issue with this point of view, contending that it is imperative that safety be given top priority in the home birth situation. Says Bennett: "You cannot jump over the physiological concerns and say, 'well I'll just skip all that.' You are not free to handle the emotional and spiritual aspects of birth until the physical ones are handled."

Establishing protocols and guidelines has been difficult for the community of midwives. At the heart of the matter is the question of what really constitutes a midwife's responsibilities. Susanne Arms and others in the home birth movement have proposed a tiered system of midwifery practice, a sort of career ladder whereby a midwife could train to practice at a certain level of expertise. Should she want to practice at another level, she could take additional training. "I hope lay midwives set their standards for themselves and that the state uses the one when it comes to writing the law," says Arms. "If midwives don't do it, the state is going to do it, under pressure from the mainstream medical community and national lobbying groups."

If their practice is to be regulated, the majority of midwives would want to see a control board composed primarily of their peers, with representatives from the medical community. California midwife Karen Chelak explained the problem. "We midwives have great fears of having an organization like the A.M.A. ruling us. We don't want to get so powerful without the commonsense that we are underwriting people around and denying others the right to what we have."

But many midwives believe that standard setting is necessary. As Susanne Arms says, "I think anybody practicing and all wants to practice to a certain standard and wants to know if they state achieved the best facilities."

Lani Rosenberger, a member of the California Association of Midwives, explains that her organization would like to see certification of lay midwives as a protection for the public: a practitioner's certificate would show she had gone through a specific training program, or had otherwise demonstrated proficiency in her work.

At present, the CAM, one of the best-organized midwife groups, is working to define the lay community's goals. Through networking and lobbying efforts, they are preparing to take on the California Medical Association's lobby in order to get midwifery legislation passed.

Midwifery legislation is now being written or is coming up for consideration in a number of states. California, at this point, probably has the best chance of getting favorable legislation passed. If the adage is true, "As California goes, so goes the country," the hope is that in the next ten years other states will follow suit. Two bills in the past made it halfway through the legislative process in California, the most recent having been defeated by only one vote in subcommittee. In the four hours of testimony on the Midwifery Practice Act, only the California Medical Association and the local chapter of ACOG argued against the bill.

In trying to gain support for and push through the next piece of legislation, the CAM will switch its focus from debating health and safety with physicians, which has proved to be a no-win situation, to placing the emphasis on the right of consumers to choose the type of health care they want.

Although she supports efforts to legalize midwifery, ACHI Vice President Linda Bennett cautions that the standards set by licensing do not necessarily guarantee competency, as has been clearly demonstrated in the case of medical peer review boards. "The key," says Linda, "is informed health-care consumers." Parents must decide what constitutes a good midwife.

The home birth movement is in the process of gaining control over parents' rights to a free choice concerning where, how and with whom birth should be experienced. It is in the hands of the parents that the future of that free choice now lies. The medical establishment will respond accordingly, if it is faced with a determined segment of society that demands home birth as an option. Changes that have occurred so far in childbirth have come about because of consumer demand. Midwives will be at the forefront of the home birth controversy, but without the parents they cannot bring about the changes that are necessary to continue. Says midwife Abbey Selwin, "In the United States, where money speaks louder than words, consumer demand is ultimately the loudest voice."

"The home birth situation today is not hopeless at all," concludes Suzanne Arms. "It is as demanding a situation as the Vietnam war was, where you literally had to drop out of the system in order for the system to change. All the movement has is the decision-making power of the women themselves. All they have is the power in people's feet to walk out and say 'Hell no, we won't go.' As long as there are people to keep alive the knowledge that birth can be a wonderful, magical event, you will never drive it underground."



Linda Fitzgerald, a California licensed nurse-midwife with first-hand home birth experience, is active in the West Coast home birth movement.

Books

Immediate Deception by Suzanne Arms, (Bantam, \$2.50). The seminal book on the childbirth revolution, it exposed the abuses of medical technology.

Commonsense Childbirth by Lester D. Hazell Berkley Publishing Corp., \$2.95). One of the most comprehensive home birth guides. She provides an excellent description of labor and delivery in the home birth situation.

Childbirth at Home by Marion Sousa (Prentice-Hall, \$7.95). Explains why home birth is a good alternative to hospital birth, and also contains a superb chapter on complications in labor.

Birth at Home by Sheila Kitzinger (Oxford University Press, \$11.95). The most up-to-date guide to birthing at home, it contains valuable information on arranging a home birth and the safety factors involved.

The Birth Book by Raven Lang (Available from Science and Behaviour Books, Inc., P.O. Box 11457, Palo Alto CA 94306, \$7.95). One of the first books on home birth to appear, it helped kick off the home birth movement and has many birth stories of interest.

Newsletters, Bookstores and Films

Birth Notes, the ACHI Journal, P.O. Box 1219, Centris CA 90701.

Birth Family Health Bookstore, 3440 B West Orange Avenue, Anaheim CA 92804. Comprehensive list of books on birth and health related issues. Also has t-shirts, calendars, and other items.

Birthing, c/o Box 415, Winona Lake IN 46790.

The California Association of Midwives Newsletter, c/o Claudia, P.O. Box 512, Penngrove CA 94951.

The Federal Monitor, 710 Bullsneck Rd., Drawer Q, McLean VA 22101. A newsletter on legislative and regulatory activities relating to the health of women and children.

Mothering, Dept. W, P.O. Box 2046, Albuquerque, NM 87103.

The Practicing Midwife, 136 Drake Lane, Summertown TN 38483 (The newsletter of the Farm midwives).

The Penny Press, 1100 24th Ave. E. Seattle WA 98112. Carries pamphlets on obstetrical information.

Birth and Life Handouts, P.O. Box 70423, Seattle WA 98107. Offers a comprehensive selection of books on pregnancy, child birth, and early childcare, as well as offering IMPRINTS, a quarterly newsletter.

Midwifery and home birth t-shirts. Janice Ashworth, 8200 Oak Ave., Ben Lomond CA 95005.

Cinema Media, 2335 West Foster Ave., Chicago IL 60625. Carries a wide range of childbirth films including some on midwifery and home birth.

News from H O M E, 511 New York Ave., Takoma Park, Washington DC 20012 (newsletter of H O M E) offers information and the Andrea baby pack, a front carrier for nursing infants.

NAPSAC and ACHI. Listed in Organizations publish good newsletters.

Other sources include the Women's Health Care Collective which publishes the book *Our Bodies, Our Lives* among others, local chapters of La Leche League, local family practice physicians, and local bookstores that focus on women and youth.

THE Caesarean Epidemic

Who's Having This Baby, Anyway—You Or The Doctor?

By Gena Corea

Photograph by I'main Hill

Don't go to the hospital," Julie Olsen tried to warn her pregnant sister, Laurie, when she heard that, though Laurie's labor had not yet begun, her membranes had ruptured. Too late. Laurie had left.

Independently, Kathie, another sister, attempted to reach Laurie to tell her: "Don't let them give you Pitocin." But by that time, the Pitocin drip had already been started.

Karla, eldest of the four sisters, also tried to protect Laurie that day—the day Laurie's first baby, Jesse, was born—delivered by Caesarean section.

Laurie's is a close family with an extraordinary mother, Tillie Olsen, author of the feminist classic, *Tell Me A Little*, and more recently, *Science*. Laurie's father, Jack Olsen, teaches labor history and is a former union organizer. The work of the three elder daughters is concerned with childbirth and feminist health. Perhaps these are reasons why they understood, and were especially outraged by, what happened to Laurie.

A policy researcher and a writer who at one time worked with *The Feminist Press*, Laurie is the youngest Olsen daughter. When she became pregnant, she and her husband Michael Margulis, a musician, began voraciously reading books and articles on childbirth. They took Bradley method childbirth classes and talked extensively with midwives. Though they would have preferred a midwife-attended delivery, they felt confident they could handle the birth in the hospital facilities offered by their health plan. After all, they were prepared and Laurie was in excellent health.

Laurie's waters broke at five a.m. and three hours later, on July 25, 1979, she and Michael were at their hospital in Oakland, California.

The doctor there told them that the hospital had a policy on ruptured membranes: the baby must be delivered within 24 hours because of the danger of infection. The membranes of the "bag of waters" that surround a fetus protect it from any bacteria that might come up the vagina and into the uterus. So if Laurie's labor did not begin soon, the doctors wanted to induce it intravenously by giving her Pitocin, a drug that stimulates uterine contractions.

By 10 a.m. Laurie was hooked up to an electronic fetal monitor (EFM) and an intravenous feeding tube. She was lying on her back in deference to the machine's needs and could hardly move. The EFM made Laurie uncomfortable. The EFM, a key part of this story is a large machine which is wheeled to the bedside of a woman in labor. An audio device, a screen like that of an oscilloscope and a steadily unrolling paper tape record the heartbeat of the fetus and the strength of the mother's contractions.

At 11 a.m., the resident physician came in and said that Laurie's labor would be induced by Pitocin. "It's policy," she explained.

Laurie and Michael decided not to enter into an adversarial relationship with the doctors. They did not want to fight alone against the hospital, especially when they were not confident they knew enough to challenge its policy. But for all their awareness of the complexities of birth, they were not prepared with practical alternatives when the hospital's rules began to work against them.

If Laurie and Michael could have gone to a medical library, this is what they would have found:

In order to avoid the danger of infection associated with

Engineering A Caesarean

SCENARIO NO. 1: "We're going to make your contractions more effective," the doctor announces to the woman in early labor. He ruptures her membranes prematurely. Then he orders the nurse to give the woman Pitocin.

The Pitocin-induced contractions come much stronger and more frequently than normal ones. Each contraction cuts off the oxygen supply to the baby. During natural labor, the baby has time to "catch its breath," but between the artificial contractions, the baby has less time to get oxygen. This causes fetal distress, an indication for Caesarean delivery.

Dr. Peter Dunn writes in the British medical journal *The Lancet*: "The increase in Caesarean section following failed induction is well known."

Variation: When the doctor ruptures the membranes, the fluid in which the umbilical cord floats spills out of the sac. The cord drops down before the baby's head does and is squeezed, blocking off the baby's oxygen supply. This condition, a prolapsed umbilical cord, is a severe complication. Emergency Caesarean follows.

SCENARIO NO. 2: The doctor inserts the internal electronic fetal monitor (EFM) into the woman's body. Piercing the scalp of the baby, he attaches an electrode to its head. The procedure frightens the woman. Later, she feels uneasy at the strange sounds issuing from the machine. Or she may panic when, as frequently happens, the EFM malfunctions and records "fetal distress," which later turns out not to have been there. In her fright, her body releases catecholamines, a substance which can lead to a slowdown of the baby's heart rate and a lowered fetal blood pressure. This reduces the baby's oxygen supply and brings on fetal distress.

Variation: Wired up to the monitoring machine, the woman cannot walk around. The immobility, along with the supine position she is obliged to take in deference to the machine's needs, results in "supine hypotension," a condition which involves lowered blood pressure. With less blood getting to the fetus, its oxygen supply is reduced. Later, the woman's supine position leads to compression of the umbilical cord. In order to rescue the distressed fetus, the doctor calls for a Caesarean.

SCENARIO NO. 3: A nurse shaves off the laboring woman's pubic hair and gives her an enema. The doctor inserts an I.V. into her arm and the EFM through her vagina. Strangers (residents and medical students) repeatedly give her vaginal exams, sometimes when she is in the middle of a contraction. These procedures frighten the woman, and the fear stops her labor.

The doctor gives her Pitocin to force the resumption of labor. The Pitocin-induced contractions go out of control. The doctor administers another drug to stop the contractions. Later, he restarts labor again with Pitocin. The woman gets very tired and discouraged. She loses all confidence in the ability of her body to bear her child. With more drugs, the doctor slows the contractions. Then he diagnoses "failure to progress" and does a Caesarean. The woman is grateful.

Variation: The Pitocin-induced contractions remain in control but are much more painful than natural ones. The doctor gives the woman pain-relieving drugs. He does not explain that the drugs can slow labor and lead to a condition called "uterine dysfunction." Eventually, he sections the woman for "dystocia" (impaired labor), or "failure to progress."

the breaking of the waters, or premature rupture of the membrane (PROM), midwives and conservative obstetricians refrain from examining the woman vaginally with their hands. It is just such examinations that could lead to infections.) They take the woman's temperature frequently. Only if a sign of infection develops do they intervene in the birth.

The more aggressive doctor-in-control approach to PROM calls for delivery of the baby within 24 to 48 hours of rupture through induction of labor with drugs. If that fails, the doctor performs a Caesarean.

About 15 years ago, the time limit following PROM was 72 hours. Then, in some hospitals, it dropped to 48 hours. Now, in some places, it is only 12 hours.

In 1979, Dr. Kenneth Kappy and colleagues from the Tufts University School of Medicine Affiliated Hospital in Boston reported on their own work practicing the conservative approach to PROM. If there were no signs of infection, they waited while the women went into labor spontaneously. They did not examine such women manually.

Of 166 women studied who had babies under 37 weeks gestation, more than half waited longer than a day, and 19 percent went longer than seven days, before labor began. One woman waited 58 days. Despite the higher potential for infection at delivery, there was no significant illness among mothers, and no deaths among them or their babies.

LOSING THE WAR

At the hospital, Pitocin dripped steadily into Laurie's vein. The contractions came on strong and suddenly. Unlike normal contractions, there was no buildup to them. Laurie concentrated on her breathing exercises and Michael supported her intently. They felt good about the labor. They felt they could handle the experience.

When Karla, Laurie's eldest sister, learned of the induction, she was worried. Karla, who teaches exercises to pregnant women, knew that labor induction was frequently the prelude to Caesarean section.

She called the hospital several times and finally reached Michael. "What is the hospital doing to Laurie?" she asked, frantically. "Try to get her off the Pitocin. Try to walk her around to bring on her labor."

Instead, the doctors upped Laurie's dose of Pitocin. At one point, the baby's heartbeat accelerated too much. The drug was stopped for a while.

Laurie's parents, Michael's parents and an 18-year-old niece, Encka, arrived at the hospital in the afternoon. Hospital rules allowed only Michael in the labor room, but 67-year-old Tillie half-charmed, half-sneaked her way to her daughter's side.

It was the electronic fetal monitor she saw first. The machine's presence filled the room. At a time when Laurie needed to concentrate on what was happening inside her body, her attention, and that of everyone in the room, was diverted to the machine. Laurie and Michael were staring directly at it, their eyes glued to the graph that showed every tiny variation in the beat of their child's heart.

Tillie Olsen did not let herself feel her outrage over that machine until later. She had come to be of use. She immediately set to work putting pressure against Laurie's back to relieve some pain. The labor, she saw, was arhythmic. It was

not labor as Tillie had both experienced and observed it.

Labor wasn't going well, Jack Olsen told his daughter Kathie over the telephone. Laurie wasn't dilating. Kathie called sister Julie. "Let's go to her," she said.

As they set off in the car for the two-hour drive to the hospital, Julie said, "Well, do you want to know the scenario?"

"What do you mean?" Kathie asked.

"They're going to have her hooked up to the fetal monitor by the time we get there. They may let her off the Pitocin for as much as two hours. And at one o'clock in the morning, she'll be having a C-section."

Kathie laughed. "Julie, how can you say that?"

"They change shifts at midnight. The Pitocin is going to fowl her up so seriously that she won't be able to go into active labor. They'll realize that late in the evening. They'll wait for the next shift to operate."

Julie's analysis of the ordeal her sister would go through at the birthing proved not far wrong. Many observers, like Julie, have noted that people seem to be undergoing more Caesarean sections these days. But it is not until you start examining statistics that you see how sudden and extreme a trend it is. As recently as 1968, the overall rate for Caesareans in the United States was only 5.0 percent. By 1978, that had shot up to an estimated 13.9 percent. And in some hospitals today, the C-section rate has reached 25 percent of live births.

This leap in the rate of C-sections comes at a time when women are winning many battles in their struggle to regain control over childbirth, a normal process which physicians have defined as a medical event. In many parts of the country, women have won the right to give birth in a conscious state, without heavy medication; the right to bear their children in an upright position rather than flat on their backs, bound to delivery tables; the right to give birth in the presence of a loved one rather than totally among strangers; and the right to see and hold and nurse their babies immediately after birth. All these changes center childbirth on the woman; Caesareans put it back in the hands of the doctors.

THE DOCTOR AS GOD

From the figures alone it seems clear that the C-section delivery is no longer being used as an emergency birth method to save the life of mother or child. Rather, the demands of birth technology and the medical technocracy are now taking precedence over the best interests of mother and infant. As one critic of the rise in Caesareans put it, "The mother is 100 percent out of control of the birthing, and the obstetrician is absolutely in charge. The Caesarean is the obstetrician's last opportunity to play God."

Changing terminology reflects this. "The chief of ob gyn [obstetrics and gynecology] won't let us answer the phone 'Labor and Delivery' anymore," says obstetric nurse Betty Wood of Vanderbilt Hospital in Nashville, Tennessee. "We have to say 'Fetal Intensive Care Unit.'"

Indeed, so enthusiastic are some doctors about doing Caesareans that they talk as if there were something wrong with women who want to have their babies the old-fashioned way. "It may well be that during the next 40 years the allowing of a vaginal delivery or attempted vaginal delivery

Four obstetricians suggest in an article that an "occult reason" may lie behind a woman's refusal of a Caesarean.

may need to be justified in each particular instance," write Drs. John Sutherst and Barbara Case in the April 1975 issue of the British journal *Clinics in Obstetrics and Gynaecology*. And in an American journal last year, in an article entitled "The Fetal Right to Live," four Israeli obstetricians suggest that an "occult reason" may lie behind a woman's refusal of a Caesarean section. "It is probably that the patient hopes to be freed in this way of an undesired pregnancy," they write. Other possible reasons for this strange reluctance to undergo a C-section, the doctors speculate, may be "fear of surgery, prejudice, ignorance, difficulty with the language or inadequate rapport between doctor and patient."

Physicians refer to C-section deliveries as "from above" and vaginal deliveries as "from below." Dr. Helen Marieskind, author of a report prepared for the Department of Health, Education and Welfare (HEW), relates that while she was conducting interviews for her study on the rising Caesarean rate, obstetricians repeatedly asked her: "What's so great about delivering from below, anyway?"

To be sure, there are sometimes valid medical reasons for "delivery from above." An estimated seven percent of the Caesareans now being performed are for conditions that endanger the baby's life, such as *placenta previa*, in which the placenta covers the opening to the birth canal; or *abruptio placentae*, in which it tears from the uterine wall, cutting off the baby's oxygen supply. But these are unusual birthing conditions and have been rare throughout history. As recently as 1965, doctors who exceeded a five-percent C-section rate were generally suspected of gross incompetence. For, though Caesareans can save lives, they also can pose serious risks to the mother. Some are these:

- Death during childbirth. Caesareans, like any form of surgery, occasionally can result in fatal complications.
- Inevitable separation of the infant and mother after delivery. This can lead to difficulties in emotional bonding between mother and child and in breast-feeding.
- Pain, gas, weakness and difficulty in movement after surgery. According to one report, half of the women who undergo a C-section suffer serious side effects like hemorrhage and infection.
- Infection of the respiratory or genitourinary tract. In one study, Caesarean mothers had a 20.4-percent rate of uterine infection after birth, while mothers who delivered vaginally had only a 1.4-percent rate of uterine infection.

To sum it up, a C-section is *major* surgery. "People have the idea that a Caesarean is a simple little operation," says Dr. J. R. McTannan, chief of obstetrics at Community General Hospital in Reading, Pennsylvania. "But it's a

major operation. There are all sorts of complications and problems than can develop." The risks present with any operation—*anesthesia effects, shock and hemorrhage, emotional trauma*—are inherent with a Caesarean. Should hemorrhage occur, there are then complications associated with the necessary blood transfusions—*hepatitis or other, adverse transfusion reactions*. And, during surgery, doctor-induced injury to organs near the womb is possible. There is also a disfiguring scar left from the operation, depression and a sense of failure, all of which would not otherwise be associated with the birth of a child.

For the infant, there are different hazards:

- Respiratory Distress Syndrome and hyaline membrane disease. Both of these lung problems are more frequently

found in infants delivered by C-section than by normal birth. C-section infants also have more mucus in their lungs, leading to the conclusion that there is something about the normal labor process, not thoroughly understood, that clears a baby's lungs.

- Drug reactions. From Pitocin, used to induce labor, to pain-killers to anesthesia, the long-term effects of drugs on a newborn infant are not well known. They look worse with every passing study. More and more women refuse to subject their fetuses to the damaging effects of caffeine, alcohol or nicotine, only to have their about-to-be-born children bombarded with pharmaceuticals which the women never even heard of before labor began. A study in the British medical journal *The Lancet* found that infants born after a Pitocin-augmented labor were six times as likely to be admitted to intensive-care nurseries as infants whose mothers had not been given Pitocin.

The key to resisting a Caesarean is understanding how the operations are engineered by doctors and grasping exactly when those rare occasions do occur when a C-section is necessary to save lives. If you are a pregnant woman or think you might ever become one (or are the husband, friend or lover of a pregnant woman), you should be informed (see box, page 35). If you are giving birth in a hospital, be sure to have a well-informed ally with you who can argue with the doctors if it turns out to be necessary.



Chart by David Reardon. Photo by Dwight Sorenson

THE SCENARIO ENDS

At the hospital, nurses came in, checked Laurie and warned her that her cervix was not dilating enough. She was not "progressing in labor."

Tilje Olsen was aware of the intimidating atmosphere in the labor area. Time and again, the nurses and doctors entered the room, looked first at the machine, examined Laurie, called attention to her failure to dilate and said they were going to increase the Pitocin.

Each time, Laurie and Michael questioned the need for a larger dose. Each time, doctors asserted it was essential.

Right after one of the examinations, a nurse who had been gentle with Laurie came to check the Pitocin. It looked like the flow was blocked. The nurse pugged the bottle. Large doses of Pitocin sped into Laurie's vein, she had a massive contraction lasting what seemed to be between five and ten minutes.

The baby's heartbeat on the electronic fetal monitor dropped from 160 beats per minute to 40. Within seconds, the room filled with doctors and nurses. They cut off the Pitocin and gave Laurie another drug to stop the contraction.

The doctors said Laurie might have to have a Caesarean. It was an emergency. Michael could not be present. But the baby's heartbeat was beginning to climb again. Michael said no. They would accept a Caesarean only if it were absolutely necessary.

All right, the doctors said, losing some of their urgency. But Laurie and Michael would have to sign a consent form in case a Caesarean was necessary later.

The doctors brought the form. Michael read it to Laurie between contractions. As he went through the long list of things that could go wrong and things the doctor had a right to do during surgery, they felt increasingly powerless to resist

the hospital and its authority. One provision on the form gave the doctors authority to remove any of Laurie's organs when they opened her up to do the Caesarean.

They did not want to sign it, but Laurie was in labor, in pain, exhausted. They did not know exactly how to word what they were willing to sign. Should they cross out some items or write in qualifications?

They decided: we cannot deal with this now. What is happening now is labor, getting through the labor. They set the form aside. Tillie pressed against her daughter's back to try to ease the pain of the contractions.

In the waiting room, Julie Olsen watched a man she had not seen before make a phone call. His wife was having a Caesarean. According to Julie's count, there were five births going on at the hospital that night. Four were Caesareans.

At midnight the doctors announced that a Caesarean was probably necessary for Laurie. They said, "You're only five centimeters dilated and you've been in labor for 13 hours. You're going to be exhausted with another 13 hours of this. Your baby is probably not going to make it because he's in distress already."

Laurie knew it was wrong to assume that because it took her 13 hours to get to five centimeters, it would take her another 13 to get to ten. Natural labors do not work that way. She could be at ten centimeters in another hour or two. But maybe artificially induced labor was different. Maybe the baby was in danger.

A doctor said, "Let's give it another hour."

Tillie watched Laurie and the doctor. Laurie, exhausted and in pain, was bargaining not to be put out, bargaining to be conscious during the birth and to preserve her right to have Michael with her.

Laurie went into surgery at 1:30 a.m. She kept saying to herself, "Laurie, your baby is being born." But she could not pay attention to the birth. She could not even look over at Jesse, her new son. She was vomiting severely now, from the anesthetic.

Sister Julie's scenario of the engineered C-section had been off by only ten minutes.

Recovery from the C-section shocked Laurie. She had no idea she would be so sick, so debilitated by the surgery. She was in great pain. In her hospital room, several television sets blared on different stations, and nurses left ringing bells unanswered for what seemed like hours. It was so difficult to rest that she checked out of the hospital after three days, "against medical advice." It was seven weeks before she felt she had her body back.

As her strength returned, Laurie felt angrier and angrier about the Caesarean. Some of the reasons for her anger seemed trivial to her. Like the scar. The realization that she had a tremendous scar for the rest of her life. It itched. It hurt. She felt it disfigured her.

Other reasons seemed more important. Many of the hospital procedures, she thought, probably created the need for the Caesarean. As the doctors acknowledged, the drug-induced labor put extra stress on the baby and, through the abnormal contractions, on her.

She was angry, too, with the way people reacted to her Caesarean. They treated her as though she had had less than a birth. They pined her. Their comments made her feel terrible about herself. Women said, "How awful that you had

**Why are physicians— who
once saw the knife as a
last resort—so anxious
to wheel American mothers
into the operating room?**

to miss the thrill of pushing your baby out of your body." She began to feel she had missed out on a terribly important occasion in life. But at the same time, this feeling became mixed with another: she found herself feistily defending her experience. She wanted people to know that, Caesarean or not, it was still a birth.

FOR A PRICE

Laurie Olsen's story is one of many thousands. The rising Caesarean rate, as yet, shows no signs of leveling off. What has changed over the last ten years to push the C-section rate higher? Why are physicians—who once viewed birth by knife as a technique of last resort—now so anxious to wheel American mothers-to-be into the operating room?

There are many reasons, all interrelated. Dr. Helen Marieskind, in her study *An Evaluation of Caesarean Section in the United States*, has given the most complete picture of the problem. (Anyone interested should read her findings, available from Clara Schiffer, Room 723, E-2, Hubert H. Humphrey Building, Washington, D.C. 20201.)

One reason for the increase in C-sections is greed. In 1963, the ratio of live births to obstetricians was 261 to 1. By 1975, the number of births had dropped as the number of obstetricians increased, and the ratio shrank to 145 births to one ob-gyn. Yet, astonishingly, the after-tax income of ob-gyns as a group rose dramatically, passing the median incomes of even general surgeons and psychiatrists, to establish the field as the highest-paid medical specialty.

"This is a remarkable accomplishment in view of the dramatically falling birth rate," observes Dr. C. Arden Miller, a public health physician at the University of North Carolina. "It seems to me," Miller adds, "that in order for those obstetricians to maintain that sort of livelihood, they are forced to resort to more expensive and elaborate technologies, of which, I think, Caesarean section is one." (The cost of a Caesarean—including increased physician fee and hospital stay—is about three times greater than the cost of a vaginal delivery.)

A study by Dr. Andrew Fleck, director of the Division of Maternal and Child Health in New York State's Department of Health, shows widely diverse Caesarean section rates around New York state—from two percent in one hospital to 22 percent in another.

"What we've been able to show is that Caesarean section is a provider attribute and not an attribute of the woman," Fleck explained in an interview. "If you go to a doctor who likes to do Caesarean sections, you're going to get sectioned. In other words, snake-bite poisoning is a function of the kind

A Feeling Of Being Raped

BETH SHEARER, Boston, Massachusetts: The first thing I said to the doctor when he told me I was going to have a Caesarean was, "You're not going to put me to sleep are you?"

The anesthesiologist told me, "Let me know if you feel some discomfort." I didn't want to go to sleep because I was still hoping to feel and see my baby.

At one point I said, "It really hurts." The next thing I knew, with no warning and no explanation, there was a mask coming down on my face. I couldn't talk. It was over my head. I was trying not to breathe in.

I wanted to pull my hands up to shove the mask away, to get rid of it, to say, "I don't want to go to sleep. I'll take the pain." But when I went to lift my arms, they were tied down.

I thought, "I can't move! I'm going under." It was terrifying.

Finally, I shook my head vigorously and he took it off. But by that time, I was already very groggy.

Afterward, I thought that the feeling of powerlessness I had then may be the same feeling women have during rape.

KATHY HERWALDT, Chicago, Illinois: I wanted to be awake for the birth. But I was so spaced out during the contractions, I don't remember too much. They said they were going to do a general anesthesia, and I guess I said O.K. I must have.

Right before I went out—I remember this so clearly—the surgeons started talking about their weekends.

When I woke up in Recovery, someone said to me—it was a man's voice—"You have a girl." I was just coming out of the anesthesia. My eyes were still closed. And I said to myself, "I really don't give a hoot. I could care less if the baby lives or dies."

From that minute on, I was depressed. In the middle of the night, I woke up with a nightmare. It was about a pagan ritual. A male priest was holding a knife. Then he cut a baby.

After six weeks I went to see a psychiatrist. I said to her, "I had a feeling that I didn't want my daughter, but I also had a feeling that I didn't have my daughter either."

EUNICE BRINKLEY, Plainfield, New Jersey: Shortly after I arrived in the hospital room, the doctor entered. He said, "Let's get this over with before your husband comes in." I said, "What are you doing?" He said, "I'm breaking the bag of waters. This will improve the quality of the contractions."

The contractions tripled and quadrupled. I was shaking in the bed. It was the kind of pain that shoots through and vibrates in your body.

At about a quarter to six, I began to push. I was absolutely thrilled. It felt so good to push—almost orgasmic. I was having such a wonderful time pushing; then they announced that I was going to have a Caesarean.

I started hollering that I was *not* going to have a Caesarean. What could possibly be wrong? They said, "Mrs. Brinkley, your baby's heart rate is slightly affected. We classify him as distressed."

I said, "But I'm pushing! I'm having this baby now!"

No one responded to me. They just started carrying out a big rush and taking off all the monitoring wires and instruments and taking off all my clothes and shaving my stomach, and the whole time I was protesting.

I protested all the way as they rolled me through the hall—naked on the table—into the operating room. I protested up until the very moment they put me out with anesthesia.

of snake which bites you. The data in my report offers indirect evidence that the performance of a Caesarean section is unrelated to the woman's condition.

Convenience, as well as greed, may be a motivation of doctors who perform Caesareans frequently. One would expect first-time Caesareans, which are supposed to be emergency operations, to occur randomly around the clock. But when an associate in Fleck's office looked at the statistics of five New York hospitals in 1978, he found that 62 percent of the first-time Caesareans took place during working hours—between 7 a.m. and 6 p.m. Only 33 percent occurred between 6 p.m. and 7 a.m.

Some doctors, in fact, openly defend the practice of scheduling births at their convenience. Dr. R. E. Hall was quoted in a congressional hearing as having written to his fellow obstetricians: "It is high time we shed our shame over preferring to practice obstetrics in the daytime." And two British physicians argue the same thing in a recent article. "If planned induction for nonurgent reasons increases," write Drs. John Setherst and Barbara Case, "the work load of a busy maternal unit can, possibly, be spread evenly throughout the week. It might even be possible thereby to completely minimize the performance of Caesarean section at, for example, weekends or holidays, when medical staffing can be a difficult problem."

Just as the economics of delivering babies has changed since the beginning of the '70s, so too has the emphasis of birth shifted from physician concern over the mother's well-being to what could only be called a baby-as-product mentality on the part of the doctors. They argue that they are getting "better babies" with the increased use of Caesarean section, but when asked for evidence, they cannot point to studies that support their contentions that normal birth is in any way detrimental to infants.

Dr. Saul Lerner at the University of Massachusetts Medical School is a great believer in C-sections. He asserts that in 20 years, most women will deliver babies by surgery. Lerner is also one of the doctors who claim normal birth is a dangerous process for babies.

"There's a lot of force there," Lerner hypothesizes. "Babies can be battered by labor. Sometimes you get a 'football baby,' squeezed out of shape. That's not good for the baby. We're trying to avoid brain damage."

Lerner could supply no citations, however, for studies supporting his belief that C-sections could reduce the number of brain-damaged infants. The studies are, in fact, not on his side. Several recent studies indicate there is no evidence whatever that liberal use of the C-section has done anything to raise the mental performance of children. "Neither is there conclusive proof," the authors of a Brown University paper add, "that Caesarean section has been able to reduce the incidence of neurological disorders in our population."

A condition frequently mentioned by ob-gyns like Lerner, who believe normal birth can lead to brain damage or neurological difficulty, is that known as breech birth. A breech birth occurs when the baby is positioned to exit the womb in any way other than head-first. As many as four percent of births are breech deliveries. Though many ob-gyns now insist all breech births should be delivered by C-section, medical studies do not support this practice.

A retrospective review of 457 breech deliveries at the Medical Center Hospital in Burlington, Vermont, revealed no significant improvement in death and morbidity rates for breech babies delivered by C-section over those born vaginally. In some breech births, a C-section may be warranted, especially if the infant is of very low birth weight. But prevention may ultimately be the solution to the breech birth problem, not surgical intervention. One breech birth study found that a simple exercise performed twice daily by the mother actually changed the baby's position from breech to head-first in 88.7 percent of the women who tried it.

TECHNO-CURE

The role of medical technology in the rising rate of Caesareans cannot be underestimated. The chief instrument of that technology—the machine that so dominated Laurie Olsen's birthing—is the electronic fetal monitor. With the EFM has come a "diagnosis" of something called "fetal distress" and a cure for the condition—Caesarean section. Before the fetal monitor took over the watchful role once performed by human beings, fetal distress was rare.

Most reports indicate that the fetal monitor gives a high number of false positives—indicating babies are distressed when they are not. Dr. H. David Banta and Dr. Stephen Thacker coauthored a federal report on the EFM. Banta and Thacker cite four studies which compared groups of EFM-monitored mothers with those monitored by nurses. The EFM group showed no benefit attributable to the machine. Banta and Thacker conclude that the "EFM has, if any, proven benefit not given by the regular auscultation [human monitoring with a stethoscope] and it is a costly and dangerous procedure."

Yet in a discussion of the EFM published in February 1978 in *Patient Care*, obstetricians agreed that it is advisable to monitor every mother in labor and that women who refuse the machine may be uninformed or simply selfish. Dr. Ronald Chez, professor of ob/gyn at Howard University College of Medicine said: "Our task is to help these patients recognize that they are introducing their own hedonism into a 12-hour event that may affect the 70-80 years of life of the infants they bear."

If the fetal monitor is mostly wrong, dangerous, expensive and uncomfortable to the mother, who must lie immobile during her labor, why is it used? Doctors most often cite the fear of malpractice suits as the chief reason. They are afraid that if they do not perform a C-section when a baby is actually distressed or when the operation is necessary for the mother's health, they will pay for it in court. Even physicians who do not believe in the EFM—and one, Dr. Albert Huerkamp, who authored a study which found that use of the monitor made no difference in fetal outcome—still use the machine because of a fear of lawsuits.

But Dr. Helen Maneskind thinks that, based on the findings of her HEW study, malpractice suits are not valid fears. "There have been one or two really whopping suits," she says. But she adds that most malpractice suits involving Caesareans refer to events that occurred during the C-section, not to a failure to perform the operation.

Maneskind also discovered that physicians are no longer being taught how to handle a complicated vaginal delivery, like a breech birth, without resorting to the knife. Others

admit they are now reliant on the fetal monitor for tuning into the fetus and birthing mother during labor, having lost the skill of manually listening to the baby's heartbeat. One ob-gyn said he felt "naked" now without the machine, even though he admitted that use of this machine has undoubtedly led to some unnecessary Caesareans. As with any technology, once physicians are hooked up to it, it is often difficult to kick—even if the hardware proves undesirable in the end.

CHILD ABUSE

Ultimately, the justification for the rising Caesarean section rate rests on a devaluation of the woman and a glorification of the baby. Some physicians would have this view embodied in the legal code. The four Israeli obstetricians who authored the article "The Fetal Right to Life" declare that if a pregnant woman refuses to submit to a Caesarean section which the physician deems essential to save the fetal life, "the doctor

—Continued on page 42

Stopping That Knife

THE EPIDEMIC of Caesarean sections will not go away until there are considerable changes in the power structure of American medicine. But in the meantime, there are some things you can do to avoid having an unnecessary C-section. One is to have a midwife attend your baby's birth. If, however, an obstetrician will be delivering your child, choose your doctor carefully and have some clear understanding with him or her *before* labor begins. "It's through this kind of direct political action—women taking the situation in their own hands—that the C-section rate is going to drop," says Dr. Sidney Wolfe, director of the Health Research Group in Washington, D.C.

Here are some questions to ask the doctor at the beginning of your pregnancy:

QUESTION NO. 1: What percentage of deliveries does he or she do by C-section? This is the most telling fact. "If it's over ten percent," says Wolfe, "then he or she is one of the doctors who is keeping the average up. Watch out." Other critics would set that percentage lower.

QUESTION NO. 2: What does the doctor feel are legitimate reasons for a Caesarean? If the physician answers that all breech deliveries, not just complicated ones, justify the operation, beware. Ditto if he or she says that all women who have had a Caesarean must have repeats for subsequent pregnancies. If you have had a previous C-section, you probably had a "lower-segment section," and this does not necessarily mean that you can never deliver vaginally.

QUESTION NO. 3: What does the doctor know about the policy of the hospital where you plan to deliver your baby? In what percentage of pregnancies does the hospital use the fetal monitor? If the answer is more than 20 percent, the chances are higher you will have a C-section. Also ask whether the hospital will allow patients to be conscious during the C-section and what its policy is on other medical problems, such as ruptured membranes.

QUESTION NO. 4: What is the physician's opinion on drugs used to induce labor and how long would he or she wait before starting labor induction? The drugs used for inducing labor are coming more and more into question. In the case of Laurie Olsen, they contributed to the need for a Caesarean section. □

Caesarean Epidemic

—continued from page 35




because it's what it takes for consistently pure water.

Tall is nature's way of cleansing the earth's water, and it's ours, too. Tall is what it takes to separate pure water from the many impurities in today's tap water.

The New World® Distiller II, with its tall 25" steam rise, assures you of consistently pure water, because only the purest steam is condensed. Satisfaction is guaranteed, or your money back.

- High output—14 gallons in 24 hours
- Economical—less than 1¢ a gallon
- Quiet—No moving parts
- Quality stainless steel—Engineered to last a lifetime
- Efficient—Seldom needs cleaning
- Five year warranty

Call 800-643-3510 Toll Free. Send for free brochure



NEW WORLD DISTILLER CO. P.O. Box 2700, Gravelly Hill, AL 36730

Please send me a copy of your free brochure.

NAME _____

ADDRESS _____

CITY/TOWN _____

STATE _____

must be legally entitled to warn the woman that she is committing a felony."

Their article, which appeared in 1979 in *Obstetrics & Gynecology*, is published at the same time abortion opponents are using the fetal right-to-life argument to justify compulsory pregnancy. Such arguments turn the woman into mere housing for a fetus whose rights and personhood are given more value than the woman's, and in the name of whose welfare the woman's body can be manipulated, probed and invaded with impunity.

So today, while women are accused of murder for having abortions, some obstetricians are charging women with felonious behavior (for refusing Caesarean sections), hedonism and ignorance (for refusing the electronic fetal monitor) and child abuse (for resisting tech-

nological hospital deliveries and bearing their babies at home). "I think home birth is child abuse," Dr. Edward Hon, developer of the EFM, said in an interview. "If my daughter wanted to have a baby at home, I would say in no circumstances should that be done. I would tell her very plainly that she does not have the right to make that decision for the unborn child."

These arguments reduce the woman to a vessel, an object. That is the view women have been so forcefully challenging for the past ten years. As Tillie Olsen, who watched in suppressed rage the events leading up to her daughter's Caesarean section, observes: "The stunning rise in Caesareans at this particular time has a great deal to do with sexism fighting for its continuance."

Gena Corea writes frequently about medical subjects.

NEW OFFERINGS

Roughly 800,000 people will read Gena Corea's "The Caesarean Epidemic" in this issue of *Mother Jones*. Eight hundred thousand is a lot of people, but it's only a fraction of those who should know what's happening in America's maternity wards. That's why we offer inexpensive reprints of this and other important *MJ* articles.

The Caesarean Epidemic by Gena Corea (JULY 1980)

At a time when the movement toward more natural childbirth has won several victories, doctors are asserting their control over the birth process. The result: an incredible rise in the rate of surgical deliveries.

Running in Reverse by Karen Branan (JULY 1980)

When Karen Branan's Ford Galaxie slipped from park into reverse and raced backward for two blocks, sideswiping five cars, she decided to do some digging. Every Ford owner in America should read what she learned.

The Silent Party by Deborah Larned Romano (JANUARY 1980)

A visit from a deaf neighbor who needed assistance in making a phone call introduced the author to the unfamiliar, often misunderstood—and sometimes militant—world of the deaf.

PRICES: 2 copies (minimum order) \$1 + \$5 shipping/handling, additional copies .50 each. California residents add appropriate sales tax. Please allow four to six weeks for delivery.

MOTHER JONES Reprint Service
125 Third Street
San Francisco, CA 94103

"5-standards for safe
childbearing"

\$9.50

3.00 for airmail

David Stewart
Exc. Director

NAPSAC

no nat'l statistics

11 states - birth cert - ^{full} where
birth was

article → Dec. 19, 1980
Journal Am. Med. Assoc.,
N. Carolina - Home birth Study
homebirths in N.C.

"NAPAC"
publication

(Sitka & Anch.)
chapters

"21st Century Obstetrics"

Lewis Mehl mehl

page 199 summary

poor data - - causes on unplanned

homebirths - folks that can't
get to the hospital

Juneau Health Center - Margaret Crawford 58-3736

Dorothy Rice

(301) 436-7016
(301) 436-8500+
436-8884+

3/4/41
Info. Systems

BATTELLE

STUDY

Nancy

PRELIMINARY SUMMARY COMMENTS: PUBLIC MEETINGS

Alaska Comprehensive Health Care and Financ Study: Battelle Report

January 11-15, 1982

Nome, Fairbanks, Teleconferene Sites, Anchorage, Juneau

1. The challenge is to make the state's health dollars stretch as far as possible by maximizing the federal subsidy.
2. Extension of Medicaid coverage to groups currently covered only under the General Relief Medical Program - G.R.M., would seem to be the most logical and cost effective mechanism for accomplishing this.
3. The state might consider using Medicaid funding to ensure transportation of needy patients to Indian Health facilities where the 100% reimbursement is in effect.
4. If this 100% federal reimbursement policy continues efforts should be made to make sure that the Indian Health clinics in Juneau, Fairbanks, Kodiak, Ketchikan, etc. can recover that 100% reimbursement and that the rural hospitals are retained in Indian Health Service ownership, even if operation has been contracted to a native health corporation or local governments.
5. The two groups to whom I would recommend extending Medicaid coverage are:
 - a. Needy families according to the Medicaid income standards with both parents in the home, using any existing insurance as a prior resource. The current policy of linking Medicaid eligibility with AFDC and thereby covering only single parent families has been destructive to family structure in Alaska.

b. The medically needy using a "spend down provision.

6. Additional services to be covered under Medicaid:

a. Physical therapy, occupational therapy and prosthetic devices.

b. Prescription drugs might be included if some agreement could be reached with Indian Health Service to make sure that their current excellent pharmacy service to rural Alaska would continue since it would be difficult to duplicate in the private sector.

c. Institute some cost sharing mechanism such as a \$2 per visit copayment, if such a program would not be too difficult to administer.

d. Develop prospective reimbursement system for nursing homes.

7. The above listed suggestions for broadening Medicaid eligibility are contingent upon the accuracy of the statement on pg. 23 that the "freedom of choice" provisions have been narrowed federally so that the state could adopt "cost effective arrangements" that could link eligible natives to certain IHS facilities where 100% reimbursement would be realized, and could also lock overutilizers to a single provider.

* 8. The Handicapped Children's Program has not even been mentioned in the Battelle report even though it is an important resource for subsidizing medical care for high risk, low income children about whom the Battelle report is concerned.

9. The Battelle report has failed to consider the current Catastrophic Illness Program which also provides coverage for some of the needy "uncovered".

10. In considering the potential state saving by broadening Medicaid eligibility, the saving in these two programs should be considered as well as the savings in GRM funding.
11. In order to provide more comprehensive planning for the Medicaid eligible children, I would recommend that the coordination of the children's portion of the Medicaid program be placed in the Division of Public Health so that a close coordination could be achieved with the EPSDT and HCP Programs that are currently administered by the Division of Public Health. With waiver authority to overrule the "freedom of choice" provision of this would now be possible and would undoubtedly be cost effective for the state.
12. Before unconditionally recommending the extension of Medicaid eligibility is the possible effect of the (federal) cap on Medicaid funding in the state. Specifically, every attempt must be made to exclude the 100% reimbursement to IHS facilities from being included in the Medicaid funding cap.
13. There is an important assumption underlying the entire Health Insurance section that may not be valid, i.e., that the 29,000 uninsured non-Native Alaskans would avail themselves of health insurance if it were offered to them; there has not been enough effort expended in finding out why the uninsured do not have health insurance.
14. There are two groups of people that are apt to be risk takers and accident prone, and for that reason are likely to incur large medical expenses related to accidents both for themselves and for other Alaskan residents. For this reason I would suggest a scheme aimed at subtly mandating insurance coverage for these people, i.e., that proof of both liability and health and accident insurance be mandated prior to issuance of an Alaskan motor vehicle driver's license, including motorcycles.

15. In regard to extending insurance coverage several suggestions:

- a. Some form of state sponsored incentive to small businesses to offer health insurance to employees might be a helpful plan, if indeed this is a problem group. However, before designing such a program, I would suggest survey of small businesses in Alaska should be made rather than making the assumption on the basis of nationwide trends that their employees are in need of health insurance. A problem may also exist in cases where the bread winner is self-employed.
- b. Some investigation might be made to see whether it would be possible and advantageous to link some health insurance benefits with the collection of Unemployment Insurance in order to cover the temporarily unemployed rather than mandating a complex scheme of exit lags.
- c. Rather than devising a statewide insurance plan with a subsidy arrangement that sounds too complex to be administered effectively on a statewide basis with a highly mobile and diverse population, I would suggest that certain homogeneous population groups be encouraged to enter into group plans for their own constituencies. Examples might include:

The Old Believer villages around Katchemak Bay where most of the families are large and the fathers are self-employed fishermen.

Some of the Native Health Corporations, like KANA in the Kodiak area, where medical care is available through the private sector but the Indian Health beneficiary population is resistant to paying for their private care or arranging their own insurance coverage thus rather than instituting a parallel system of free care for the Native population.

16. The Report, on page 125, states that the plan "could include a provision with respect to limiting coverage of pre-existing conditions". One of the problems with many current private

insurance plans is that pre-existing conditions are not covered under GRM, HCP, or Catastrophic plans. It is also hard to see how excluding pre-existing conditions and subsidizing high risk patients are compatible concepts.

17. An effort should be made to educate Alaskans in general and Natives and rural inhabitants in particular about how to utilize health insurance. Currently many Alaskans who do have insurance have very little concept of what services are actually covered, and many of the Natives with coverage through regular employment plans do not even know what company insures them.
18. Providers also need education regarding utilization of insurance. There are cases in which insured individuals have personally pocketed up to \$18,000 because providers neglected to secure assignment of benefits. Rural clinics have resisted the bother and paper work necessary to collect from private insurance which, unfortunately, must be done in order to remain economically viable especially when dealing with rural non-Natives a large percentage of whom already have good health insurance coverage through their employment.
19. The Battelle Report has missed the boat regarding "Rural Health Care" although it has pointed out some important facts that, if accurate, may well point the way to a logical evolution of the rural health care problem. Problems are:
 - a. The way in which "rural" is defined to include areas such as Kodiak, the Kenai Peninsula, the Mat-Su valley, and the South Eastern cities outside of Juneau and Ketchikan.
 - b. The emphasis on the rural non-Native population as being a primary target group. There is an inconsistency in the preoccupation with this group, particularly since the report states on page 178 that all but 2,000 of the 36,500 rural non-Natives live in South and Southeast Alaska and yet does not identify these as being problem areas.

- c. The Battelle Report focuses far too much on the rural non-Native population on the great majority of which really does not have much of a 2,000 non-Natives that do live in primarily native areas served by IHS hospitals could be better accommodated if a means could be devised by which the IHS facilities could and would collect health insurance.
 - d. If contracting management of IHS owned hospitals and clinics to Native Health Corporations or local governments would indeed allow for the recovery of health insurance payments while still allowing collection of 100% federal reimbursement for Medicaid eligible natives, it would appear that this would be the most beneficial type of administrative arrangement for the state to encourage.
 - e. The unqualified acceptance of the State Health Plan's designation of Level I and Level II communities which in several cases does not fit currently reality. Some of the communities designated as Level II and capable of supporting at least a mid-level practitioner are not assessed by a sufficient population through readily available ground or boat transportation.
 - f. In designating appropriate staffing for Level II communities, I would suggest a careful review of the medical care history in the communities such as Aniak where over the past 15 years unsuccessful attempts have been made to place a physician, a physician's assistant and a public health nurse. Experience in this particular community emphasizes the fact that a practitioner of facility should not be imposed upon a community without adequate evidence of full community support.
20. Current Indian Health care system and state public health nursing systems should be preserved and built upon. In no way should the services that these systems now provide be circumvented by the Native Health Corporations even though they may assume some of the management functions.

21. Local responsible governments should be involved whenever possible and assumption of health service functions by local governments should be encouraged through a realistic level of state revenue sharing. Local governments should provide a stability that may not exist with the Native Health Corporations. Furthermore racial bias would be eliminated if health service were linked to local government.
22. The state should attempt to take maximum advantage of Medicaid funding for coverage of the native population and should also consider covering travel of Medicaid eligible adults to IHS facilities.
23. Maximized private reimbursement should be developed through education as well as through other than direct federal management.
24. Resent the implication that there is a lack of cooperation between the state and the Indian Health Service; for 15 years a close cooperative relationship has been developed especially in regard to the state public health nursing and Handicapped Children's Program.
25. The state should design an organized and fund a grant program for primary health care facilities in rural areas similar to the currently existing Community Mental Health Center program and the Infant Learning grant programs. A specific amount of money should be allocated for such a program for which interested local governments and/or Native Health Corporations could apply.
26. The state itself should not assume the responsibility for provision of primary medical care as distinguished from the primary prevention health that it now provides for the rural or native population only, but rather should aid local "entities" (what ever they are) to provide facilities and arrange for appropriate medical care provision. By instituting a well designed state sponsored grant or loan program, the state might better and more comprehensively serve rural areas than through the current legislative "Christmas

Tree" approach whereby funds are allocated to communities like Cold Bay in which there is no existing responsible government "entity".

27. There is no mention of the possibility of augmenting the current Catastrophic Illness Program and perhaps allowing for some preauthorization of financial support under that program.
 28. There has been no mention of the possibility of developing a mechanism whereby pioneer funds could help to subsidize the care of pioneers, natives and non-natives in nursing homes.
 29. The state should direct its efforts towards maximizing the benefits of the dollars that are already being spent for medical and health care in Alaska rather than spending additional money.
-
-

30. The existing rural health problems are not simply a result of lack of resources but also of a lack of mechanisms for coordinating and allocating existing resources, endorse the establishment of a coordinated planning authority which would include federal and state activities.
31. If the state opts to encourage planning efforts of the Regional Corporations (page 201) in order to expand their perspective and role to encompass the non-native rural population, it should support it financially as that function was one of the first to be dropped with loss in Federal funding.
32. The staffing requirements recommended by South Central Health Planning for Level II are considerably less than recommended by this study and the IHS Resource Allocation Criteria. We have found those criteria to be unusually generous as well as rigid in their adherence to the traditional medical care model. We are concerned that the operational costs of such a staffing configuration would be financially unfeasible.

33. On page 195 and 196 there are several inaccuracies with regard to physician's assistants and nurse practitioners, i.e.,
- a. nurse practitioners are licensed under the Nurse Practice Act, not the medical licensing act,
 - b. nurse practitioners practice on their own license associated with a physician in a collaborative but not supervisory capacity, physician assistants practice on an associated physician's license,
 - c. the number of currently licensed nurse practitioners is 60.
34. Our support (Health Systems Agency) is given this effort by the State. A great many complex issues have been covered in this study and presented in a clear and concise manner.

35. Page iii - The Alaska Native population is given as 65,000. On page 7, the figure 70,000 is used. Since the IHS figure is 64,047, (1980 census) it would be better to use 65,000.
36. Page 13, A. Medicaid - The last sentence of the introductory paragraph should be modified to explain that the federal government will pay 100% of the Medicaid bill of a Native American in IHS facilities as a part of non-Medicaid legislation related to improving the health system serving Native Americans.
37. Page 170 - The term "rural health authorities" is used several times in the document without being clearly defined. It has the connotation of an enforcement agency. Perhaps "representatives," or something of that nature, would be a better term to use.
38. Page 175 - There are several mistakes in Table XIII-1. The corrections are as follows:

Under Census Areas, add Yukon Koyukuk. Across from this, and under the Community column, add Tanana.

Under the hospital column, please correct these names:

Bethel PHS should be Yukon-Kuskokwim Delta Regional Hospital (PHS)

Kanakanak should be Bristol Bay Regional Hospital (PHS)

Norton Sound should be North Sound Regional.

Under the hospital column, add the following:

Faith (Glenallen)

Petersburg General (Petersburg)

Wrangell General (Wrangell)

Tanana PHS (Tanana)

Seward General (Seward)

Kodiak Island (Kodiak)

39. Are the figures given in the population column for the communities or census areas? This should be designated in the column heading. The population totals of 52,000 in this table conflict with the 57,500 figure of table XIII-3 on page 178, and the narrative on page 177.

40. Page 180, C - Please insert AANHS after Indian Health Service for clarification. It would be better to use the term Native Health Corporations, both here and throughout the document, to distinguish them from the profit Native Regional Corporations.
41. Page 180, #1 - Clarify the first sentence by saying "The AANHS....provides health services to Alaska Natives and non-Native spouses". Please clarify the third sentence by saying, "Use of the AANHS system by non-Natives not eligible for services is very small".
42. Page 182 - Table XII: - 5 does not list data source. All tables in the study should reference the data source.
43. Page 182 - The following breakdown would probably best describe AANHS health program.

Inpatient Services

Ambulatory Care Services =

Medical Care

Dental Services

Optometry Services

Audiology Services

Community Health Services

Public Health Nutrition

Mental Health

Social Services

Health Education

Environmental Health Services

Appropriate adjustments would then have to be made in the narrative which follows.

44. Page 183 - a. Please insert the following paragraph which should help to explain the IHS arrangement with Bristol Bay:

"Direct care program funds are a major source of support for the operation of the Bristol Bay Area Hospital by the Bristol Bay Area Health Corporation, under the provisions of P.L. 93-638. See further discussion of P.L. 93-638 programs under Native Corporations on page 186.

In the last sentence, change "Funds for travel have been..." to "Funds for travel are..."

45. Page 183 - b. Move the two sentences beginning "In the future" through "...desire and qualify" to page 186 (2. Native Corporations).
46. Page 184, c. Second paragraph - Add Tanana to the list of hospitals and omit Tanana from the sentence which follows it.

The third sentence should read, "Hospitals and clinics are manned..."
Under the Service Unit column,

#3 should be Bristol Bay Area

#4 should be Yukon-Kuskokwim Delta Regional Area

#8 should be Interior Alaska.

Changes should be made on page 185 accordingly.

Please correct the hospital names, see comments for page 175.

47. Page 186 - The first sentence should use Interior Alaska Service Unit not Tanana. The last sentence should read "...Native Corporations to deliver various levels of health care services in the region.
48. Page 198 - The first sentence would be more accurate: "Generally, community health aides are employees of the regional health corporations. CHA's are not employed by the AANHS."
49. CHA's record the names of people to whom they deliver care, including non-Natives; therefore, the available information is more than anecdotal.

50. Suggested rewording for the first factor under Accessibility: "The distinction between what is permitted and what is practiced."
(Standard operating procedures are "official".)

51. Page 199 - First paragraph, fourth sentence - This is not true, the third party payers do reimburse for non-Native medical care.

Second paragraph, First sentence - Insert rural before "non-Natives", insert in remote rural villages before "do not".

52. Page 206 - c. last paragraph - Again, the AANHS is able to collect from private insurers.

53. Page 207 - b. First paragraph, first sentence should read "...government providers for care provided to subscribers who are also eligible for AANHS services (i.e. Alaska Natives and non-Native spouses)."

c. Perhaps the state could work with the Native Health Corporations to develop a model for involving non-Natives on their boards.

54. Page 208 - First paragraph - Because the future funding of HSA's is "hazy", perhaps the best approach would be a coalition of State, HSA, Native Regional Health Corporations and AANHS planners.

55. Appendix L3 - First complete sentence - "Relationship" would be a better word to use than "importance".

56. In Alaska there are currently 60 Nurse Practitioners authorized to practice. While the educational preparation does vary between certificate programs and programs conferring a Master's Degree, the minimum requirement in Alaska is one (1) academic year of preparation. Because of some of the programs do not lead to an academic degree, requirements for entrance vary and Bachelor of Science in Nursing Degree is not always required. Nurse Practitioners also must be certified by a national certifying body in their speciality area.

57. Nurse Practitioners are authorized under the Nurse Practice Act not the Medical Licensing Act. Nurse Practitioners are licensed Registered Nurses who are authorized to practice acts of medical diagnosis and prescription of medical, therapeutic or corrective measures. The Nurse Practitioner regulations (12 AAC 44.400 to .490) do require a collaborative relationship with a physician. This relationship is a collegial one rather than a supervisory relationship.

58. The Board of Nursing also notes that none of the authorized Advanced Nurse Practitioners are practicing in a hospital setting.

59. As a citizen of Alaska for only three plus years I have watched with awe and amazement at how the billions of dollars available in this state have been leading many Alaskans to want the State to provide everything - food, clothing, housing and how even free or subsidized health care. Organizations and private individuals are fighting to be the next in line to receive some of this State's wealth. The attitude seems to be: well, if my neighbor or business associate can get dollars for this or that project, why shouldn't I get my share also? This attitude is appalling to me.

60. I was an observer at the Statewide teleconference yesterday to discuss this study, and was shocked that no one presented any concerns about the section of the study discussing implementation of a statewide health insurance program. At the end of the teleconference yesterday my question to myself was: does the average citizen of Alaska really want Alaska to become a socialized state?

61. By implementing either a subsidized health plan for small employers or a statewide health delivery system (which I realize this study is not recommending), you get the same results more people expecting handouts without working for them.

62. I believe my company is representative of small employers in Alaska (9 employees). We are forced to offer health care in order to compete with the State, Federal and Municipal governments for workers. This is not as true in other states. The Battelle study states that nationally 50% of the firms with fewer than 10 employees offer group health. I believe this to be 75% or higher in Alaska. Alaska is not like outside.
63. I believe that implementation of the subsidy program for small employers will cause them to cancel their present policies to obtain "free" money from the State. What's the incentive for them not to! After all, they, like my small company, have other ways to spend the money that goes toward health care premiums for our employees.
64. One question which I had in reviewing the subsidy section was what would happen if the small employer applying and qualifying for the subsidy program suddenly (6 months into the program) had a large increase in business and thus an increase in employees, which would increase his payroll to bring him above the limits to qualify for the subsidy?
65. One of the other areas of concern: the suggestion of exit lags. When the length of unemployment in Alaska is longer for a larger percentage of the unemployed population than it is nationwide (as your study indicates), what is the incentive for the unemployed to really make an effort to get a job when not only do they receive an extremely high weekly unemployment check but now also will get health care benefits for themselves and presumably their families for 6 weeks after they terminate their jobs? Doesn't this encourage some employees to quit their jobs for a paid vacation and paid health care for 6 weeks before looking for another job?
66. Suggestion: a questionnaire to all small employers in Alaska to see how many do offer group health to their employees, the number covered and not covered, the premium, and if not coverage is offered, would they be interested in a state subsidy. Make it short and simple so they will all take the time to respond and maybe even enclose a stamped envelope.

67. Additional observations on the first section of the study pertaining to health care for the needy: First, several of the options suggested would add an unproportionally large cost per eligible for a few to be added to the Medicaid or GRM rolls.

As examples: Option 5, the spend down for GRM, is estimated in the report to annually cost the State \$5.8 million for only 550 new coverages. This breaks down to \$10,545 per new coverage. Option 1, the spend down for Medicaid, is estimated by the study to cost \$12.4 million and adds 1,650 new coverages--a cost of \$7,515 per new coverage. It appears other options would cover a greater number of people and at a lesser cost.

Another item in the Needy section which I strongly favor (because of my basic philosophy that one shouldn't ever get something for nothing) is Option 7 - the patient cost sharing. The estimated net savings of \$680,000 seems minimal compared to the millions to be expended but I firmly believe it causes the consumer to be more cost conscious and thus reduces unnecessary utilization.

68. The advisory committee's policy guidelines to the Department of Health and Social Services are the following:

POLICY GUIDELINES

The committee agreed to a set of general policy guidelines (listed below) for use in formulating an initial set of options:

1. Cause minimal disruption of the existing health care system.
 2. Minimize-direct-state participation in the delivery of health care.
 3. Improve the economic efficiency of the health care system, i.e., discourage people from seeking unnecessary health care and include cost containment incentives for third party payers and providers.
 4. Yield the greatest improvement in the health status of the state population: i.e., focus on groups which are at highest financial and health risk and are the most needy.
-
-

69. A review of the Rural Health section of the Alaska Comprehensive Health Care financing study researched by the Battelle Institute leads me to make the following observations. The thrust of the message in this section states that the State of Alaska seeks to improve "rural health care" in Alaska. However, it states that the problem derives from (1) resources and (2) organizations. It should be noted the IHS has a system in Alaska that has been here for many decades, and it does the job with scarce financial resources. Now, the state comes in and says we're going to improve the health of rural Alaskans, and that begs the question of how they are going to improve it. The only way is to provide additional financial resources. My contention is that there is not the political will in the State to fund rural Alaskan health systems which serve predominately Alaska natives. It should be noted that the State spent 60 million dollars on a sports stadium in Anchorage, and I do not foresee the State providing in excess of 55 million dollars per year for rural health. The IHS system has the organization in place, it is a good one, it merely requires the financial resources to be able to carry out its full program.
70. As to the establishment of rural health authorities. I think this establishes another layer of bureaucracy, and drains precious financial resources from the operating health entities in Alaska. There is a similar situation in the Indian Health Service Area Office in Anchorage where the program formulation branch does essentially planning activities, and the regional corporations are concerned that this is merely another meaningless bureaucracy in the IHS system. I feel that the State should deal directly with regional corporations, and deny the establishment of rural health authorities.
71. I believe that freestanding regional entities with their own planning systems should take precedence over any centralized rural health authority, or any other type of health planning authority. This would encourage better inter-staff, inter-regional cooperation rather than spending large sums of money on programs that would not be truly cost-effective to the people of rural Alaska.

72. The report states that the State of Alaska and Department of Health & Social Services encourage regional administration and local control of health programs, and they cite the Mauneluk Association assumption of Public Health Nursing program. I fully support the concept of local control, and I urge the State of Alaska to foster the mechanisms by which this can be accomplished by limiting the regulatory and administrative road blocks to such an concept.

73. Limited funds for Community Health Aide Training represents a real and continuing problem for the rural areas. Reduction of funding to the Indian Health Service is creating major problem in basic training and for inservice training.
74. Health Aide Training is available only in three locations: Anchorage, Fairbanks and Bethel. More training centers are needed. Now some of the training is available only once in two years; the Aide often with little or no training; turnover for aides is very high.
75. The 40 clinics mentioned on Page 193 should be reviewed: the selection criteria should be explained and defended.
76. More work is needed with regard to the mid level practitioner.
77. Non emergency travel for medical services should be provided in the rural areas.
78. Possibilities for the native tribal organizations to operate the IHS facilities.
79. Not enough emphasis was given in the report to mental health and alcoholism issues.
80. Certain additional topics should be addressed in the Rural Health section of the report:
Health education in schools;
Local control of health services;
Community responsibility for alcohol problems;
Improved health aide programs;
Improved health planning and resource development efforts.
81. University of Alaska should improve opportunities for health aide training as a university responsibility.
82. Misconception is abroad that the Indian Health Service is always primary health provider in the rural area.
83. Accessibility to health care was not stressed enough in the report.
84. Medical travel for both emergency and non-emergency needs attention and provisions made for such.
85. Eligibility guidelines should be changed for GR Med and raise income level for eligibility test for medically needy.
86. Benefit suspension by Division of Public Assistance (GR Med /Social Security) after denial and while case is pending appeal
87. Methodology in developing 44,000 not covered persons need statement and explanation.
88. Cost sharing, if adopted, would have very wide effect both for public programs and throughout insurance industry; less utilization of services.
89. More information needed on how uninsured persons receive services for medical care.

90. More attention should be given to Catastrophis Illness program; very important program and very much needed.
91. State should be concerned about those with deep and genuine medical needs and who have not been given services under workmen's compensation programs even though many individuals dropped from workman's compensation benefits are disabled and have increasingly difficult time in proving their desability to an insurance company representative . Such persons should at the least be targeted for ehlp under the 'medically needy' program.
92. Closer cooperation and coordination needed between the state and the Indian Health Service.
93. Cost sharing would add dignity and respectability to Medicaid and GR Med program if it can be wored out. The treatment of the topic in the report is rather confusing and needs more clarity.
94. The Medicaid and GR Med Program should be combined into a single assistance program for the poor.
95. Long term care, while utilizing a major portion of state medical care funds is not treated very well in the report.
96. The use of the 1976 data should be explained especially as to the adjustments which can be made to make the data valid for consideration at the present time.
97. The Rural Healthsectior: needs the most work and it should provide more specific options for improvement to be considered by the policy makers.
98. Clinic operational funds support/ source/problems need treatment in the report;
99. telecommunications utilization should be treated;
100. more attention to travel for medical services in rrural areas needed.
101. 'tribal specific" issues from native non profit health organizations should be considered more carefully.
102. The designation of native corporations status of non-profit and profit needs more careful useage.
103. need exists for definition of levels of benefits available from the IndianHealth Service.
104. statement of mail use by non-natives of IHS facilities and programs not accurate

ALASKA COMPREHENSIVE HEALTH CARE FINANCING STUDY

Health Surveillance Coverages

D R A F T

John Middaugh, M.D.
State Epidemiologist
May 6, 1981

Prenatal:

Complete assessment and counselling on risk factors
Rubella blood test
Syphilis and gonorrhoea screening
Hb (blood count)
Urine analysis
Blood group Rh type
Blood pressure

Infants: (birth-17 months)

Immunizations appropriate for age
Well baby assessments (4 weeks, 2 months, 4 months, 6 months,
12 months, 18 months)
Phenylketonuria (PKU) and hypothyroidism screening
Hb (blood count) once by age 17 months

Children: (18 months-15 years)

Vision - 2 years, 5 years
Hearing - 2 years, 5 years
Immunizations - 18 months, 5 years
Dental exam - annual

Adults: (16 years and older)

Blood pressure - annual
Dental exam - annual
Immunizations (diphtheria/tetanus every 10 years)
Breast self-exam instruction - annual
Mammography - yearly between ages 50-59
Vision - every 5 years
Hearing - every 5 years
Pap cytology - annual when sexually active,
then every 3 years after 2 negative exams between ages 20-65
Stool for blood - annual > 50 y.o.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MURKAY BUILDING
139 DENALI STREET
ANCHORAGE 99501

June 19, 1981

*For your information:
J. M. Quinn*

Representative Thelma Buchholdt
 Representative Terry Gardiner
 Representative Don Clocksin
 Alaska State Legislature
 Pouch V
 Juneau, Alaska 99811

Dear Representatives Buchholdt, Gardiner and Clocksin:

Your thoughtful response to an editorial in the Anchorage Daily News (May 12th edition entitled "Health Care Plan Can Wait for the Facts") has been read with a great amount of interest. It continues to be encouraging to know that members of the Legislature are addressing with courage and determination the difficult and important problems of health care and health financing for Alaskans. Our department has appreciated the opportunity to work with members of the Legislature and to keep all of the members advised fully as to the status of the assignment given to the Department of Health and Social Services to provide for a study of health care issues including access, financing and other important facets related to health care for the future.

As you know, the work of the Battelle Human Affairs Research Centers has been underway and continues by contract with the Department of Health and Social Services. The need for such a comprehensive, fundamental and basic study of all health care services provided by government and the financing of that health care with implications for the future all have been of deep concern to and under consideration by the department for about three years. With the appropriation by the last session of the Legislature in May of 1980, it was possible for the department to move forward and to provide for the first basic phase of the study during the fiscal year ending June 30, 1981. The cost estimates for FY 1981 were worked out with as much precision as possible and with very close projections. The requirements for the basic research contract with Battelle, expenses of the Advisory Committee's work and other expenses such as printing, related to such a major project were developed for the fiscal year in which the obligations were made, the present fiscal year. The Battelle contract was to be carried out across two fiscal years, 1981 and 1982, for the work envisioned under the project. From the outset, including the departmental preliminary reviews, the development of the Request for Proposals, and finally the contract itself, the department took into account that it was not possible to determine all the data already available from all sources which would assist in the project. For that reason the original contract with Battelle included the following required work provision: (2-4 i.e)

"A description of the types of data not available at present but needed to decide which alternative health care provision and financing approaches would be desirable and feasible for the State of Alaska to pursue, and the cost of obtaining those data."

Those determinations have now been made and the department is able to identify for the first time the additional research that will be needed in order to complete the study as was anticipated all along.

On December 17, 1980 a "Status Report" was sent to every member of the Legislature from the department, detailing the progress of the project as of that date. Battelle contract activities and schedule of the study was detailed in that report. In April of 1981, the department again transmitted materials to every member of the Legislature regarding the status of the project including two basic Interim Reports prepared by Battelle Institute for Human Affairs Research detailing the progress and developments on the study as of April, 1981.

While the department concurs with some of the observations made in your Forum article prepared for the Anchorage Daily News and which appeared on Wednesday, June 17, 1981 under the heading "More Health Care Facts", there are parts of that presentation which could very easily mislead the public and I am sure you would not wish erroneous impressions to grow out of your presentation. For that reason, I would like to make the following observations:

1. Your presentation of the "first phase of the study" as consisting of "documentation about the current state of health care financing in Alaska" is oversimplified, limited and, to that extent, inaccurate. As you will see by referring to the Request for Proposal as well as the contract with the Battelle Institute, Section 2-4 requires work related to at least twenty topics separate even though at times interrelated. While it is true that Battelle has presented, as required, two Interim Reports, they are precisely that and intended to be such Interim Reports. You have indicated in your letter that "Battelle's contribution to current knowledge.....is already done". That statement could seriously mislead legislators and the public. While the first two interim background reports to the Department of Health and Social Services have been completed, that does not mean that the present and continuing work under the contract into the next phase and in FY 1982 will be of no value or unnecessary in order to do the thorough job planned from the beginning.
2. When the Request for Proposal was developed and the contract entered into there was and currently is a very significant and crucial reality faced. It will be found in Section 2-4 of the RFP as set forth above.

The Interim Reports and further conferences and correspondence with the Battelle Institute have indeed identified requirement for additional facts which as far as we know, and as far as they know, are not available from any source at the present time. Examples of these include but are not limited to the following:

- A. Alcoholism Care: Alcoholism has been repeatedly identified as perhaps the major health care problem in Alaska. HB 41 mandates alcoholism treatment benefits in the state employees' health plan, and a number of other states have also mandated such benefits. Alcoholism treatment consumes a significant share of the state health budget. The questions which arise are: Does broad scale private coverage of alcoholism care truly reduce alcoholism? What is the return on the state's current investment in alcoholism care? How significant is the problem that treatment is often available only at sites distant from home - can such programs be successful?
- B. Private sector insurance coverage: Knowledge about existing coverage levels for different types of benefits is important to the evaluation of several of the options. The profile generated thus far has relied upon data from the principal insurers, and upon some national level data. While this has been sufficient for interim purposes, much better information could be derived through a scientific sample survey of the coverage offered by employers in this state. This would also permit linking coverage information to characteristics of business and employees, and permit a more thorough analysis than currently existing data would allow of issues which affect employment related health insurance.
- C. House Bill 41: HB 41 is a package which combines components of several different options, including a state sponsored plan, mandatory benefits, and expansion of Medicaid. Taken as a package what does HB 41 imply about the demand on health care resources, costs to the state, incentives created for changed private sector behavior? What are the principal implementation issues implied by the bill?
- D. Long term care: Long term care is the principal component of Medicaid costs, due primarily to price, since the size of the elderly population is small in Alaska. But during the next 20 years the number of elderly could grow by 125-210% according to the Bureau of the Census projections for Alaska. Furthermore, recent congressional interest has suggested that federal Medicaid contributions for long term care may be capped, even if other elements of the program are not. What does this imply for the State budget? Can the state take steps to try to reduce the bill? What are the problems of integration of the long term care industry, which is principally private and for-profit, with the state's system of Pioneer Home care?
- E. Physician distribution: Recent research from RAND has suggested that physician availability in rural areas is improving, purely as a result of market forces. What does this imply for Alaska

with respect to the projected size, specialty mix, and geographic distribution of the physician population? What does it imply for the use of non-physician providers? What have been the recent trends in this area, and to what extent can we expect them to continue?

- F. An analysis and evaluation of the present status of native non-profit health corporation assumption of responsibility for health care from Federal Government and from State Government; current and/or potential capacity for assumption of more local control; financial implications both present and and in the future under a greater assumption of local control of health care and financing by the native corporations.
- G. A thorough analysis of the possibility under current federal and state programs and the implications of mandating a "cost sharing" or "deductible" provision in the publicly financed health programs.
- H. The implications of federal fund reductions for health financing on state options and state budgets as an outgrowth of federal congressional changes and initiatives as well as changing federal policies with regard to Medicaid financing which will be mentioned later.

These additional data gathering projects are included in the work program anticipated as a large part of the requested FY 1982 appropriations for the FY 1982 part of the study. These were not included under the current contract provisions but represent statistics and data anticipated under Section 2-4 I e of the Request for Proposals and the contract.

- 3. Your letter leaves the impression that the three areas being pursued in the second phase of the project necessarily will become recommendations from the Department of Health and Social Services or the Governor to the State Legislature. That may be the case but it is not necessarily the case. At this stage Battelle and the Department are probing, in as much depth and breadth as possible the problems and possibilities for changes and improvements. The final report of Battelle in December 1981 will indicate to the Department of Health and Social Services the costs and the benefits involved, the values and the limitations. Whether to proceed with the recommending to the Legislature that any or all of the options or alternatives be adopted will be decisions of the Department of Health and Social Services, its broad-based public Advisory Committee, and the executive branch of government. It is anticipated that clear alternatives, undergirded with as factual a base as possible, will be available at the beginning of the next session of the Legislature.

The focus of your letter seems to concentrate on "health care financing in Alaska". That is one emphasis and responsibility of the study. It is by no means limited to that concept. The scope of the study includes: (1) The present health care delivery; (2) The present health care financing systems in

the State of Alaska; (3) Identification of existing potential funding sources; (4) An examination of improvements to the present systems and, (5) Exploration of alternative methods of providing for health care and cost distribution in Alaska; (6) Design proposals for the implementation of potential new systems or methods. I think you will agree that the requirements under the current research and the work yet to be accomplished by December extends far beyond that which is presented in your letter.

4. Your letter leaves the impression that the Battelle study is being extended in time or that Battelle is not providing the originally anticipated information. On the contrary, it is anticipated that the original time schedule will be adhered to with the completion of the study in December of 1981. It is true as we all know that the study is to be carried out within parts of two state fiscal years. The department requested funds in fiscal year 1981, ending this June 30, for the actual obligations made and necessary to carry out certain planning and research for 1981 fiscal year. That budget was submitted and administered related precisely what was anticipated for fiscal year 81. Additional funds are being requested to carry out and to complete the study in fiscal year 1982 as was originally intended. Those funds in 1982 fiscal year, beginning July 1, will be used for: the investigation of the issues not originally foreseen in detail but thought to exist as indicated above; the expenses of travel and per diem of departmental personnel attributable to the study and for the statewide Advisory Committee representing a broad spectrum of the public; the expenses connected with holding of public hearings in at least four locations in Alaska between now and December of 1981, as required under the contract and set forth in the Request for Proposals and the incidental costs of the study project such as printing, required telephone and so forth. The fiscal year 1982 phase of the work is extremely important and considered absolutely necessary for the maximum advantage to the State of Alaska for this project. None of the funds requested in the 1982 budget overlap, duplicate, or substitute for the work required by the Battelle Institute within their contract during the FY 1981 budget year and part of their work in the 1982 budget year. Additional payment to Battelle for the 1982 fiscal year will be for those activities beyond the scope of the original contract but which could not be foreseen until all the existing and available data could be gathered and analyzed in order to determine what statistics, what data, what facts were not available in usable form from any quarter. You indicate correctly in your letter that "the rest is to pay for more research and documentation".

The Department of Health and Social Services, the Battelle Institute, and the Alaska Comprehensive Health Care and Financing Study Advisory Committee all have been aware of the provisions of House Bill 41. It is acknowledged that in its current version there could be some overlap between the goals and provisions of House Bill 41 and what might emerge from a longer term more fundamental and more extensive study of the facts and data that we believe to be required to arrive at sounder public policy decisions. The Department concurs with the editorial in the Anchorage Daily News to which you refer entitled "Health Care Can Wait for the Facts". Reasons for the agreement are outlined above. In

addition to those facts the following developments are emerging among others on a current basis with a possible strong impact on a re-designed health care and financing policy for the State of Alaska:

1. The U.S. House of Representatives is considering HR 850, an act entitled "National Health Care Reform Act of 1981". That national bill addresses (a) need for structural reforms; (b) specific deficiencies in the present method of delivering and financing health care with problems identified as lack of coordination and continuity of care, excessive government regulation, third party payment system problems, reasonable cost reimbursement, government as third party payer issues, lack of competition. Other congressional initiatives currently underway include a bill to be introduced immediately by Senator John Heinz of Pennsylvania entitled "Competitive Health and Medical Plan Act of 1981". That bill if enacted provides an important alternative in the form of a variation of health maintenance organization which would encourage and stimulate competition among alternative systems of health care delivery. If enacted, it will, or could have, an impact on Alaska. If it is not enacted, some of the strengths and values identified therein should be considered in the process of the final design of a revised system for Alaska. While that bill has specific advantages and relations to the elderly population, it is not limited to the elderly population and the Medicare program.
2. Discussions between the Battelle Institute researchers, myself, and members of the U.S. Department of Health and Human Services' Health Care Finance Administration last week explored in some depth the relative value of the State of Alaska seeking Medicaid waivers in order to retain any reasonable portion of the federal Medicaid funds for Alaska in the event the final design of a program for Alaska, under the comprehensive study, might impact on the Medicaid funding in such a way as to create a potential loss of part of the federal Medicaid funding. The current federal Medicaid initiatives as you know include strong proposals that likely will be enacted soon to put a ceiling on the growth of the Medicaid program within states and limit the rate of growth of that program. The exact Medicaid ceiling decisions of the federal congress are not known at this time but doubtless will come into clear focus, if not finally determined, before January 1982. Those decisions will have strong implications for federal funds available for health care in Alaska as well as new flexibilities in using Medicaid funds within any state. They certainly should be taken into account prior to the enactment of any major or new programs adopted by the Alaska Legislature.

For all of the above reasons, I would urge (1) that the prime sponsors of House Bill 41 and other interested Legislators, await the completion of the Alaska Comprehensive Health Care and Financing Study; (2) strong support to the departmental budget request for the \$150,000 needed for adequate financial undergirding for that effort after July 1, 1981; (3) that a fresh look be taken in the new legislative 1982 session with regard to the important issues involved in these public policy questions. The issues surrounding health care and health financing from public funds is of growing concern throughout the nation and within Alaska. As early as three years back, the Department of Health and Social Services did anticipate some of the questions

Representatives Buchholdt,
Gardiner and Clocksin

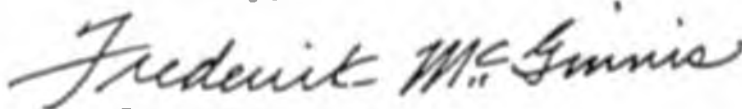
7

June 19, 1981

which have more recently been raised and began then to make provisions for a thorough analysis of the issues involved including health care, health financing, access to care, barriers to care, benefits, coverage and who properly should pay for benefits expected.

The prime sponsors of House Bill 41 are to be congratulated in turning their attention to some of the issues involved in the health care area. The Department is pleased that the work of the department and the Battelle Institute for Human Affairs Research has been of value to date. We believe that the value level and contribution can strongly be improved and extended following the outcome of the second phase of the work now underway and scheduled for completion in December of 1981.

Sincerely,



Frederick McGinnis
Deputy Commissioner and
Project Coordinator for the
Alaska Comprehensive Health
Care and Financing Study

We are writing in response to an editorial, "Health care plan can wait for facts," that appeared in the May 12 edition of the Daily News. The thrust of your comment is that passage of HB 41, the health care financing bill, should wait for final publication of a state-funded study of health care financing in Alaska performed by the Battelle Research Center for the Department of Health and Social Services (DHSS). We disagree with your assessment.

We have followed the work of the Battelle study closely this session. The first phase of the study consisted of compiling documentation about the current state of health care financing in Alaska. The report describing this research has already been completed and Battelle plans to do no further work on it. Thus Battelle's contribution to current knowledge about existing services in the state, and about what services are lacking, is already done. The House has had access to those facts, and has used those facts, in its deliberations over HB 41.

The second phase of the study group's work consists of formulating recommendations to the legislature for action that can be taken to improve health care financing in Alaska. At first, the study group identified 17 options for improvement of health care financing. However, time and funding constraints as well as the availability of needed expertise have narrowed those options down to three.

At the study group's last meeting on May 1, the three options were identified as: (1) a comprehensive state health care plan similar to that embodied in HB 41; (2) improvements in rural health care delivery; and (3) seeking waiver authority from the federal government to consolidate the Medicaid and General Relief Medical (GRM) programs into one plan. Clearly, recommendation 1 coordinates well with HB 41. Recommendations 2 and 3 could easily be enacted in legislation, if indeed legislation is needed, next year. HB 41 already paves the way for recommendation 3 by including most components of the current GRM program in the insurance plan of section 1.

Since we have made a continuous effort to follow Battelle's work, we have been able to take it into account in the design of HB 41. Passage of HB 41 this session would not preclude utilization of information included in the December report and would not require revamping of HB 41. In fact, coverage under the insurance plan called for in section 1 of the bill does not begin until July 1982. This is to give the state time necessary to gear up to offer insurance, and to allow Battelle's findings, and those of other research projects, to be used extensively in implementation of the bill as a whole.

By the way, the state's funding for the Battelle study was not for three years, but only for one year. The Department of Health and Social Services apparently does not plan to finish its work in December though, because it has asked for another \$150,000 to continue working with Battelle in FY 82. Despite several inquiries, the legislature was not given any details of the department's plans to spend the \$150,000 until (the month of May), even though the request for funding was submitted in January. Much of the money that is sought is to complete payment of items that should have been paid for with the first \$175,000. The rest is to pay for more research and documentation, the compilation of

contingent upon the study's completion. So much attention has been forced on the insurance portion that we wonder if people know that the bill includes funding for alcoholism treatment of state employees, an attempt to improve the provider reimbursement system for government health care programs, expansion of Medicaid coverage, and a study of how the state can complement Public Health service and Medicare. All of these services are greatly needed to provide more and better health care to Alaskans.

HB 41 does not attempt to take care of every health need of every Alaskan with 100 percent state money. We are attempting, instead, to assure that 40,000 Alaskans who currently have no health care financing plan are able to afford health crises and provide for their basic health care needs; that more attention be paid to our obvious and collective alcoholism; that comprehensive health care be available to those who are least able to afford it; and that the state consider partial funding of the health needs of rural Alaskans and older Alaskans.

All of these goals should be attained as soon as possible. Any future recommendations of the Battelle study, and the recommendations of others knowledgeable of Alaska's health care needs, should be considered. This is not, however, a valid reason to postpone action on some of the problems that can be addressed now.

— Rep. Thelma Buchholdt
— Rep. Terry Gardiner
— Rep. Don Clocksin
Prime sponsors of HB 41

Anchorage Daily News · Wednesday, June 17, 1981

forum

MAY 12 1981

Anchorage Daily News

Winner, 1976 Pulitzer Prize Gold Medal for Public Service

Katherine Fanning
Editor and Publisher

Stan Abbot
Executive Editor



Gerald E. Grilly
General Manager

Howard Weaver
Managing Editor

Lawrence Fanning, Editor and Publisher 1967 to 1971
Alaska's Only Morning Newspaper • Founded in 1946 by Norman C. Brown

Health care plan can wait for facts

American efforts to develop the finest in health care are the envy of the world; in technology and training our medical community offers abilities that are first rate.

Health care capability does not, however, insure health care delivery. And despite widespread and expensive efforts to provide assistance to all, there still are many citizens who fall between the cracks in the myriad of federal, state and private programs that are available.

In Alaska, estimates indicate at least 10 percent of the population does not have health coverage — a situation that has drawn the attention of legislators concerned over the devastating expense of emergency and long-term services. Like everything else, health care costs more here, and the state House has approved legislation meant to provide the unprotected a state-sponsored option for health coverage.

Such coverage quite properly should be available in a state awash in unprecedented revenues; health care is a basic, quality-of-life issue that concerns everyone at one time or another.

But the House apparently has acted too soon on the initiative. The state already has funded a three-year study into health care financing, the results of which are not due until December. The study presumably will be of great value in determining the best shape of a health care strategy for Alaska. Legislators would do well to wait for it.

Waiting another six months, to be sure, will mean added difficulty for those who suffer most during the interval. But the payoff will be worthwhile if the delay ultimately results in a plan that is secure, affordable and well-suited to the needs of Alaskans.

Let health care remain in the political agenda until the next legislative session — and let it move even higher on that agenda once the necessary information is at hand.

House Research Proposal for interim study

Preventive Health Care

There are many approaches to preventive health care. These can be divided into three general categories: 1) health education and community information programs; 2) screening and early diagnostic programs; 3) alternative treatment programs, usually involving mid-level practitioners. Given the staff time which we have available during the interim, we can address only one of these categories in depth. The second--screening and early diagnostic programs--could be treated most efficiently by our staff. We envision addressing the following questions:

- 1) What is the relationship between the State's major health problems and preventive health care services?
 - We would identify the state's major health problems and attempt to determine how these problems could be addressed through preventive care. This section would include an overview of the various approaches to preventive care outlined above.
- 2) What are the primary benefits of screening and early diagnostic programs?
 - This component of the study would address both the health and cost benefits of the early diagnostic programs, e.g., likely effect on health care insurance premiums; possible effects on other state programs.

3) What screening and early diagnostic programs currently operate in the state? Who has access to these programs? How many people have these programs served?

- Programs to be examined would include: Medicaid and the EPSDT program; Public Health Service; Indian Health Service.

4) Are there innovative screening and early diagnostic programs which have been initiated in other states? How are these programs structured and funded? Is there any information available on program effectiveness?

5) How might screening and early diagnostic programs be expanded in Alaska through legislative action?

Any research that we would undertake on the subject of preventive health care would be intended to complement the Battelle study now underway.

**Health, Education and
Social Services Committee**



Official Business

Alaska State Legislature
Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4908

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

MEMORANDUM

TO: Charlie Parr
FROM: Rocky Plotnick Weller *Rocky*
DATE: April 30, 1981
RE: The Alaska Comprehensive Health Care Financing Study

You have asked for the current status of the Alaska Comprehensive Health Care Financing Study. I have outlined the study's purpose and schedule below:

- I. The study's purpose is to explore health care financing in Alaska, explore alternative means of expanding health care coverage, and improve physical and financial access to health care services.
- II. Phase I of the study was completed by Battelle on March 30, 1981. It describes the present methods of public and private health care delivery, access, coverage and financing in Alaska. Also, it presents alternative approaches to reshape health care coverage and financing, and to a lesser extent, delivery and access.
- III. The Advisory Committee will meet May 7, 1981 to consider the alternative approaches addressed in Phase I and decide which approaches Battelle should develop.
- IV. Phase II will provide a complete plan for implementing and financing each of the alternative approaches selected. The deadline for the

draft is September, 1981.

- V. The final document should be completed and submitted to the Department of Health & Social Services, the Governor and the Legislature by December 11, 1981.

NEWS & VIEWS

Battelle Study

Early this year, DHSS contracted with Battelle Human Affairs Research Center, to do a comprehensive year-long study of the delivery and financing of health care in Alaska.

They have delivered two interim reports, the first an analysis of health care resources and financing, and the second, some options for state action.

The analysis found:

- a higher-than-national-average death rate for every age group
- a unique pattern of disease and injury highly related to lifestyle and behavior
- shortages in practitioners and clinics in villages and difficult access to acute care in remote areas
- shortcomings in behavioral health services, emergency medical transportation and village sanitation in some communities

According to the study, the total health care bill in Alaska in 1979 was \$480 million, financed 14 percent by state and local government, 31 percent

by federal government and 55 percent by the private sector. It found that 44,000 Alaskans, nearly all of them non-Native civilians under the age of 65, have no health care insurance coverage of any kind. For those with coverage, significant gaps in benefits were found for newborn and well baby care, extended care, mental health care, dental care, vision care and hearing care.

The study produced a spectrum of alternative actions the state could take. An advisory committee chose three basic packages which Battelle will study in further detail for a report due September 15.

One package looks at redesigning a health care program for the poor. Actions which Battelle may address include the following:

1. allowing two-parent families to be eligible under current Medicaid/General Relief Medical eligibility
2. making all households eligible if their incomes are less than 150 percent of the federal

poverty level guidelines for Alaska

3. withdrawing from Medicaid if restrictions which accompany participation threaten key aspects of the program

A second package includes a state-sponsored comprehensive health insurance plan open to all Alaskans, possibly with subsidized premiums for low income groups not covered by Medicaid. It would be designed to complement private health insurance plans, not replace them.

The third package looks at improved access to health care for rural Alaskans, including coordination of activities of the state, Indian Health Services, Native corporations and the private sector.

The state could choose a combination of actions from all 3 packages.

A final report is scheduled to be in the hands of DHSS, the Governor, legislators and other interested persons by December 15. Deputy Commissioner Frederick McGinnis is coordinating the study project.

Primary Prevention

Promoting good health
Elimination of environmental pollution
Prevention of accidents
" of occupationally-related diseases
Worksite safety
Health education (alcohol, drugs, smoking, tobacco
nutrition, stress).

Secondary Prevention

Reducing morbidity
Earlier diagnosis of disease
Preventing early signs of disease

Tertiary Prevention

Rehabilitation for chronic illness

Battelle

Human Affairs Research Centers

4000 NE 41st Street

Seattle, Wash. 98105

Meeting June 15 - Lunch

(Coord. - Dept Comm. Fred McKeen)

handouts mtg

278-4668

Issues that all the work / policy analysis
last meeting identified:

1. Rural health delivery
2. State health insurance
3. Health care for needy (Medicaid / Medicare)

Issues subject area not chosen:

Education will be addressed
in next mtg.

Dr. Johnson has attended

Meeting on June 15 - Major issues:

1. Health Insurance - 30% Health Planning

2. Health Insurance - Coverage

1980 - 85 major issues

1980 - 85 major issues

National activities

Dr. Johnson - Lic. of Nursing (State)

Issues regarding...

physicians - issues regarding...

June 15