Approved February 28, 19[illegible]
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Vice-Chairman Ehrlich at
Chairperson

10 a.m./~~p.m.~~ on February 15, 1984 in room 526-S of the Capitol.

All members were present except:
Senator Meyers, excused

Committee staff present:
Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes Office

Conferees appearing before the committee:

Gordon Hahn, Associated Landlords of Kansas
Ray Petty, Kansas Advisory Committee on Employment of the Handicapped
Scott Nease, Topeka
Todd Sherlock, Kansas Association of Realtors
John Kelly, Kansas Department of Human Resources
Mary Adams, Chairman, Legislative Committee for Kansas Association for the Blind and Visually Impaired
Michael Byington, Kansas Association for the Blind and Visually Impaired
Don Karr, Topeka Resource Center for the Handicapped
Betty Stowers, Mental Health Association of Kansas
Bobby Gene Fisher, President, Topeka Association of the Deaf
Signe Rogers, Kansas Association on Legalization of Midwifery, Newton
Shannon Landis-Eason, Kansas City, Kansas
Peggy Hardon, RN, Wichita
Peggy Hilpman, Lawrence
Ken Kasten, Wichita

Others present: see attached list

SB 366 - Prohibiting discrimination because of a handicap

Senator Ehrlich asked Gordon Hahn, Associated Landlords of Kansas, if he had any further comments to make concerning SB 366. Mr. Hahn stated that he did not think this bill was going to solve the problems and he did not want the landlords put in a position where they were unable to cope.

Senator Ehrlich read a telegram from the Associated Landlords of Kansas urging opposition to SB 366, and asked that this be filed accordingly.

Ray Petty, Kansas Advisory Committee on Employment of the Handicapped (KACEH), testified in support of SB 366, and distributed copies of data on four Kansas surveys conducted by KACEH, addressing the needs of persons with disabilities, and explained what the findings mean. (Attachment #1)

Scott Nease, Topeka, testified in support of SB 366 and submitted a proposed amendment that a section be added to the bill requiring that at least one bathroom be made accessible in every existing building over 7,000 square feet. He also submitted a petition with 123 signatures requesting that White Lakes Mall be required to make at least one restroom accessible to the handicapped. (Attachment #2).

Todd Sherlock, Kansas Association of Realtors, testified in support of SB 366, and distributed testimony stating that KAR stands behind this bill's provisions to accommodate handicapped individuals in any form to prevent discriminatory housing practices. KAR also supports the language in KSA 44-1016(f), which forbids denial of access to real estate brokers' organizations, as well as multiple listing services to the handicapped. (Attachment #3).

John Kelly, Kansas Department of Human Resources, read testimony submitted by the Kansas Planning Council on Developmental Disabilities Services, stating that they strongly support the provision in the bill which would have the effect of including the protection of the Kansas Act Against Discrimination for persons with all types of handicaps. The definition of "handicap" in SB 366 parallels the federal definition, and will allow for consistency in terms. KPCDD also supports the provision in the bill which includes handicapped persons in the class of individuals who may not be discriminated against in housing or real estate lending. (Attachment #4).

Mary Adams, Chairman of the Legislative Committee for the Kansas Association for the Blind and Visually Impaired, testified in support of SB 366, and offered rebuttal to some of the testimony heard before. She cited several experiences of hers in trying to rent apartments, and said this bill is very much needed.

Michael Byington, Kansas Association for the Blind and Visually Impaired, distributed testimony from Judith Noeller in support of SB 366, which stated that she had had experience as a landlord, able-bodied renter, and a handicapped renter, and she felt that this bill would neither aggravate nor alleviate all of the problems, but problems must not be created where none exist. (Attachment #5).

Don Karr, Topeka Resource Center for the Handicapped, testified in support of SB 366, and distributed testimony stating that he does not feel that the Landlords Association is the appropriate enforcement mechanism with which to address housing discrimination complaints. He said discrimination does occur and this bill will extend protection against discrimination in housing. He also distributed a list of Funding Sources for Modification. (Attachment #6).

Due to lack of time, Senator Ehrlich asked remaining conferees on SB 366 to state whether they were "pro" or "con", and had them submit their written testimony to the committee.

Betty Stowers, Mental Health Association of Kansas, submitted testimony recommending the adoption of the changes proposed in SB 366, and stating that Kansas citizens who are mentally disabled deserve and are entitled to equal protection under our laws. (Attachment #7).

Bobby Gene Fisher, President, Topeka Association of the Deaf, submitted testimony in support of SB 366, which stated that it is important that all citizens be given equal rights. (Attachment #8).

Senator Ehrlich concluded the hearing on SB 366.

Senator Francisco moved that a bill be introduced to control burning of used oil. Senator Bogina seconded the motion and it carried.

SB 634 - concerning midwifery

Senator Ehrlich introduced Senator Rehorn, who gave a background on SB 634, and said the purpose of this bill is to provide safe, home delivered births. He also stated that he favored a licensed midwifery board.

Signe Rogers, Kansas Association on Legalization of Midwifery, Newton, testified in support of SB 634, and distributed testimony stating that with clear legalities established for midwives, there would be guidelines to judge one's qualifications and the midwife would be free to carry out basic emergency routines in a home setting within the scope of established procedure. (Attachment #9).

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10 a.m./~~p.m.~~ on February 15, 1984.

Shannon Landis-Eason, Kansas City, Kansas, testified in support of SB 634, and distributed testimony concerning the safety of midwifery; an article by Doris Haire discussing the trends in maternity care; and several other articles concerning home childbirth. (Attachment #10).

Peggy Hardon, RN, Wichita, testified in support of SB 634, and distributed testimony stating that birth is different from any other area of medicine, as only a small portion of it is medical. The emotional, social and spiritual aspects are stronger elements, and most doctors are unable to relate to this as well as midwives. She said midwives exist because they meet a vital need in this state. (Attachment #11).

Peggy Hilpman, Lawrence, testified in support of SB 634, and distributed testimony stating that medicine and midwifery should not be confused, and should not be defined the same. Midwifery combines skill and intelligence with dedicated work and supportive behavior. This bill should not become a battleground between the Kansas Medical Society and consumers. (Attachment #12).

Ken Kasten, Wichita, testified in support of SB 634, and submitted testimony stating that they are asking for an equal opportunity to choose an attended home birth. Three areas of concern cited by Mr. Kasten were that the midwife cannot charge for her services; physician back-up in case of complications; and insurance coverage. He stated that certified nurse-midwives cannot legally attend home births, doctors will not, and midwives are the only professionals around to fill that need. (Attachment #13).

Kris Berger, Wichita, submitted written testimony to the committee in support of SB 634, asking to be allowed the opportunity to choose qualified birth attendants. (Attachment #14).

Senator Ehrlich announced that the hearing on SB 634 would be continued tomorrow.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-15-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
TODD SHERLOCK, TOPEKA	KS ASSN OF REALTORS
HARM GORDON TOPEKA	TRLK
Rosemary Shockley "	Washburn U Sch of Nsg / KSNA
Carolyn Stewart Olathe	KALM Ks Assoc Lic. Mid.
[illegible] Topeka	K.A.C.M.
Gail Carder Hutton	K.A.L.M.
Ruth Seaton Manhattan	C.A.M. KALM
Signe Rogers Newton	KALM; PEACE'S HOME of Wichita
Peggy Hardon Wichita	
Shannon Landis-Eason K.C. KS.	
Ken Schafermeyer Topeka, Ks	Ks Pharmacists Assoc.
Don Stevens	Bd of Healing Arts
Helen Kellerman	Bd of Healing Arts
[illegible]	Bd of Healing Arts
Mrs. J. Borger	Peace & Care, Peace & Home
KEN KASTEN WICHITA	Peace & Home Assoc.
Amy Lopez	
Jason Lopez	Kansas State University
Dee Englebrecht Griffin	Kansas Univ, School of Nsg
[illegible]	K.U. School of Nursing.
Janice Mercer	K.S.N.A.
Mari Bottorff	KSNA
Rebecca Kupper	KHA

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE_____

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
[illegible]	SCS
Don Kan	TRCH
KEITH LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
[illegible]	Ks Sch. Nurses' Assn.
Naomi Nibbelink	Ks State Nurses Assoc.
[illegible]	Budget
Marian Skarin	KHLA
Vionella Schneider	KHLA

H1 - 2-15-84

CONCERNS REPORT DATA FOR FOUR KANSAS SURVEYS

Research conducted by the Research and Training Center on Independent Living (RTC/IL) at the University of Kansas

Testimony Supporting Senate Bill 366

Ray Petty
Chairperson, Kansas Advisory Committee on Employment of the Handicapped (KACEH)

February 14, 1984

Attach. 1

TABLE OF HOUSING-RELATED ISSUES

COMMUNITY	N	ITEM	SATISFACTION	IMPORTANCE
Lawrence (Douglas) Spring, 1982	45	1 Affordable housing is available to all types of disabled residents.	48% (31-86)	83% (61-92)
		2 You can get help with landlord-tenant relations, utility companies, and other services when problems arise.	57% (31-86)	85% (61-92)
Topeka (Shawnee) Summer, 1982	45	3 Affordable housing is available to all types of disabled residents.	46% (42-71)	96% (83-98)
		4 Accessible houses are available at affordable cost.	45% (42-71)	86% (83-98)
		5 Acceptance into low-income housing is based on low assets and low income.	60% (42-71)	92% (83-98)
		6 Landlords respect tenant's privacy and property.	64% (42-71)	97% (83-98)
		7 There is no discrimination in housing on the basis of a person's disability.	66% (42-71)	94% (83-98)
Kansas City (Johnson, Wyandotte) Spring, 1983	75	8 Affordable housing is available to all types of disabled residents.	36% (26-71)	87% (64-93)
KANSAS Fall, 1983	1400	9 Public buildings are accessible to disabled consumers.	33% (33-66)	86% (77-91)
		10 Affordable housing is available to all types of disabled residents.	41% (33-66)	85% (77-91)
		11 Help is available for solving problems with landlord-tenant relations, utility companies, and other services when problems arise.	61% (33-66)	81% (77-91)

COMMENTS OF DISABLED CONSUMERS AT THE
TOPEKA DISCUSSION GROUP SESSION

"Managers of housing facilities put unreasonable restrictions to keep disabled people out."

"Managers may take a disabled person's application and hold it for a long time, forcing the disabled person to find other immediate housing."

"Handicapped folks are not willing to pursue the chance to live in housing that discriminates due to the fear of reprisals . . . management may delay or refuse to fix broken pipes, unhinged doors, leaky roofs, etc."

"Landlords . . . think that disabled tenants will damage apartments more thatn nondisabled tenants might."

#2 - 2-15-84

TESTIMONY OF SCOTT NEASE

Senate Bill 366

Hello, my name is Scott Nease. As you can see, I am in a wheelchair, and I have been all of my life. I have cerebral palsy. I am appearing here today because I have an issue to bring up. This is not just important to me but for the entire handicapped population of the State of Kansas. I am for Senate Bill 366, because as well as being in the wheelchair, I am learning disabled. I can not read or write. I taped this testimony and someone wrote it out for me. I have been in the recent past, discriminated against not because of my physical disability, but because the landlord did not want a mentally disabled person such as myself living in the apartment.

Because I am physically disabled as well as mentally disabled, however, I want to see 366 amended to be even stronger to help the physically handicapped. I am tired of going into large retail stores and not being able to use the restroom without asking someone off the street for help because the restroom is not accessible. With an accessible restroom, I do not need any help. There are a lot of handicapped people like me who can take themselves to the bathroom independently if the bathrooms are accessible. Therefore, my amendment I am proposing is that a section should be added to 366 requiring that at least one bathroom be made accessible according to state and federal accessibility standards in every existing building having over 7,000 square feet of retail and/or public office space. As far

Attach. 2

as I am concerned, inaccessible restrooms violate my First and Fourth Amendment rights under the Constitution. My freedom of expression is certainly limited, and also if other people have to take me to the bathroom, they have to watch me expose myself when otherwise I could use the restroom privately. In the long run, what I am proposing will make the retailers money because more handicapped people will shop in their stores.

Attached, please find a petition with 123 signatures on it of handicapped people and their friends who wanted one particular shopping center to do my proposal. I think all such places should have an accessible restroom.

PETITION

William Woerner
White Lakes Mall
P.O. Box 5574
Topeka, KS 66605

We the undersigned feel that the White Lakes Mall is a good place for handicapped people to shop. Everything is convenient and accesible. It is not good, however, if a handicapped person has to go to the bathroom. We the undersigned thus urge and petition White Lakes Mall management to make at least one restroom fully accessible to the handicapped.

NAME	ADDRESS
1. Ruth Powers	Rt 2 Box 37 Carbondale Ks. 66414
2. Mary Goodell	R#1 Hoyt, Kansas 66440
3. Mary T. Bartel	1241 Bel Air, Topeka 66604
4. Judy Hall	2934 Lydia 105 Topeka 66612
5. [illegible]	3520 E. 7th Topeka
6. [illegible]	243 [illegible] Dr, Lawrence, KS 660[illegible]
7. Betty C. Powell	2055 Clay St. Topeka, KS
8. [illegible]	1930 [illegible] Topeka KS
9. George Berens	1000 [illegible] Topeka Kas.
10. Vanda Palmer	201 N. [illegible] Topeka Ks
11. Don Karr	931 Centennial Dr
12. Gail Price	2107 Potomac Dr Topeka, KS.
13. Karen Scates	2524 Golden Topeka K
14. Mary Umscheid	155 Willoughby Topeka K
15. Karen Gustafson	2507 Golden Topeka K
16. Kelley Fogle	2920 W [illegible] Topek
17. Linda Peak	3133 Bryant La
18. Simon McGregor	724 Island

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	NAME	ADDRESS
1.	Michael G Byington	706 Buchanan, Topeka.
2.	David Rogers	3003 Powell # A 66605
3.	[illegible]	2709 W 10th 66604
4.	Erma Curtis	431 Litchfield
5.	Sharon Walker	R.R # 2, Berryton 66407
6.	[illegible]	237 SE Fr. Ter 66607
7.	Laura McMains	1116 Louisiana Lawrence, KS 66044
8.	Cindy Zeuber	1815 Naismith Dr. #214 Lawrence KS 66045
9.	[illegible]	4845 W. 17th #2 66604
10.	Edhelma Bracy	2006 W 27th Ter # 7 Lawrence Ks 66044
11.	Izetta Paulson	2433 Kentucky Topeka, KS 66605
12.	David Hayes	1711 Central Park Topeka Ks.
13.	Angela Johnston	700 E 21 Topeka KS
14.	Lee Anne Pepperd	905 Orleans Topeka, KS 66606
15.	Rhonda Underwood	4203 Rochester Rd. Topeka, KS. 66617
16.	Robert Miller III #2	Berryton Rd 66409
17.	Robert L Tabor	2509 W 10th 66604
18.	Annie June Ramsey	631 Jewell Pl.

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	NAME	ADDRESS
1.	[illegible]	[illegible]
2.	Chrystal Dye	806 SE 20th
3.	[illegible]	1012 Taylor #1
4.	[illegible]	2312 S.W. Hodges Rd
5.	[illegible]	[illegible] Silverton Ks 66537
6.		
7.	[illegible]	[illegible] Bankbank
8.		
9.	[illegible]	1253 Collins
10.	Kathy Martin	[illegible]
11.	[illegible]	1808 West 1st
12.	[illegible]	[illegible]
13.	[illegible]	5232 W. 12th St. Terr.
14.	[illegible]	Rt 6 Topeka
15.	[illegible]	1614 Jewell Topeka KS
16.	[illegible]	1201 Chandler St Topeka, Ks
17.	[illegible]	3500 N. 10th Topeka
18.	[illegible]	

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	NAME	ADDRESS
1.	Marsha Price	440 S. Winfield
2.	Jeanette Eckhardt	614 Roosevelt
3.	Tina Hoover	440 S Winfield
4.	Melissa Smith	440 S. Winfield
5.	Roberta R. Walton	440 S.E. Winfield
6.	[illegible]	440 S. Winfield
7.	Vicki Lynch	201 N. Linn
8.	Donna Hoffmeister	3330 Virginia
9.	Herald Gold	2416 Evans
10.	Jarene Chastie	1238 Pines
11.	Jean Eckhart	1515 Kansas Ave. S.
12.	Bill Counter	10835 Sx Dawn
13.	Beth McPheeters	426 SE arter
14.	Mike Peterson	3 [illegible] 10 St
15.	Jim Sandusky	1435 Wayne
16.	[illegible]	617 N 4th Carbondale Ks
17.	William L Harris Bus. Mgr. Cayuga Foundation	Oskaloosa, Ks.
18.	James L Ware	

19. Ted Deeken — Topeka Wheelchair Bs.
Team (Player & Treasurer) 705 W.

Steven H. Swafford — 4126 Tw. 55

Dianne Dollarhide — 3315 S.W 10th #6

Lord Stockman — 3600 West 10th St

Barry Mounce — 2925 SW Maupin Lane

Frank McGrath — 839 Parkview Topeka

[illegible] — 5134 S.W. Aylesbury Rd.

	Name	
	Cecelia Stirl	3500 W. 10th 2646 S.E. 29th, Topeka, Ks. 66605
	Steve Hyten	5613 W. 19th, Topeka
2.	Mark Nicks	5613 W. 19th, Topeka
3.	Anna Evans	2520 S.E Golden Topeka
4.	Cyol McPhail	3473 Clare, Topeka
5.	Liz Gentry	5817 SW 22nd Terr #4 Topeka KS 66614
6.	Eric Schumon	
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	NAME	ADDRESS
1.	[illegible]	2416 Deane
2.	[illegible]	2420 Deane
3.	Chelli Schafer	2420 Duane
4.	Annabelle Ce Yoho	2416 DUANE
5.	Marian Gabehart	710 N Michigan
6.	Michael D Fryer	1514½ Grace
7.	[illegible]	2419 Duane
8.	Mr. & Mrs Bill W. Sapp	2415 Duane
9.	Judy Sapp	2415 Duane
10.	Max Yoho	3013 Quail Creek dr. Topeka
11.	[illegible]	3013 Quail Creek Dr.
12.	Terry Anderson	1217 Clay St.
13.	Susan Warden	1732 Fillmore
14.		
15.		
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18.		

H 3 - 2-15-81

KANSAS ASSOCIATION OF REALTORS®

Executive Offices:
3644 S. W. Burlingame Road
Topeka, Kansas 66611
Telephone 913/267-3610

REALTOR®

SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

Madam Chairperson and members of the Committee, I am Todd Sherlock and I represent the Kansas Association of REALTORS. I come before you today in support of Senate Bill 366, and act concerning the Kansas act against discrimination.

Our Association agrees with your definition of 'handicap' in this bill, and we stand behind this bill's provisions to accomodate handicapped individuals in any form or fashion to prevent discriminatory housing practices. We are aware of the difficulties of the handicapped in finding housing appropriate to their specific needs. We also recognize actions already taken by state governments to reduce impediments to handicapped individuals in the acquisition of housing and urge the real estate industry and government to cooperate in continuing to provide guidance for needed, cost-effective solutions to the housing problems of the handicapped.

Our parent organiztion, the National Association of REALTORS, has worked with state governments throughout the country in an effort to make housing discrimination at any level an idea of the past. For more information of the National Association of REALTORS anti-discrimination projects, please let me know and I will see to it that you receive such information.

In short, we are very much in favor of Senate Bill 366 as it applies to handicapped individuals obtaining decent and safe housing. We also very much support the language in KSA 44-1016 (f) which forbids denial of access to real estate brokers' organizations as well as multiple listing services to the handicapped. I very much urge you to support this worthwhile bill.

Att. 3

H4 - 2-15-84

KANSAS PLANNING COUNCIL on DEVELOPMENTAL DISABILITIES SERVICES

JOHN CARLIN
Governor
RICHARD MORRISSEY
Chairperson
JANET SCHALANSKY
Executive Secretary

Fifth Floor North
State Office Building
Topeka, Kansas 66612
Ph. (913) 296-2608

TESTIMONY PUBLIC HEALTH AND WELFARE

On behalf of The Kansas Planning Council on Developmental Disabilities, we appreciate the opportunity to address our concerns related to S.B. 366 concerning the Kansas Act Against Discrimination.

The Kansas Planning Council on Developmental Disabilities was created by K.S.A. 74-5501-06 in response to Federal Legislation. The Council's Mission is to improve the quality of life, maximize the developmental potential, and assure the participation of the Developmentally Disabled citizens in the privileges and freedoms available to all Kansans.

The Council is composed of 15 members, one-half of whom are either Developmentally Disabled themselves or are parents or guardians of the Developmentally Disabled.

We strongly support the provision in the Bill which would have the effect of including protection of the Act for persons with all types of handicaps. Currently, by definition only those individuals who manifest a physical disability would be protected from discrimination. Many of the Developmentally Disabled citizens who we advocate for are not physically handicapped, but are mentally retarded. We feel these citizens should be protected from discrimination. The definition of handicap contained in S.B. 366 parallels the Federal definition found in Section 504 of The Rehabilitation Act; and, therefore, will allow for consistency in terms.

In addition to the change in definition of handicap, we also support the provisions in the Bill (Section 8, Line 0524 and Section 9, Line 0565) which include handicapped persons in the class of individuals whom may not be discriminated against in housing or in real estate lending. Both of these provisions extend to the handicapped the same protections afforded all Kansans.

Thank you for the opportunity to share our concerns with you; and we urge you to support these amendments to the Kansas Act Against Discrimination.

Members
Kansas Planning Council on
Developmental Disabilities

JS:jmr

Topeka, Kansas

#5- 2.15-84

My name is Judith Noeller. I'm a member of the largest, or the smallest (which ever way you care to look) group -- the concerned citizens.

I can say that I have experience on all sides of this question. I have been 1) a landlord, 2) an able-bodied renter and 3) a handicapped renter. Without a doubt, problems can be cited for each position now and bill #366 will not totally agrivate or eleviate all of them. The direction I feel must be taken here is not to create problems where none exist.

This is not to say that there are some very prominent problems. One of these is definitely accessability. As a landlord, I did not even think about this and as an able-bodied renter, it never concerned me (I thought). Now, having to use crutches/wheelchair, I'm hit hard with the reality of being denied the ability to enter certain areas. Believe me, experience can be the nastiest of teachers. I can understand that, to the landlord, the expence of making a place accessable can seem "frightening" drain on them financially. This is where we come upon the first of those created problems.

"Who is responsible?", is the question I hear. I see this "responsibility" basicly as a one time thing - not on going. Possible answere are already at our disposal. Various organizations presently assist with monitary outlay for such - the multiple sclerosis society, for example. It is quite possible for the landlord to make a place accessable without that large (one time) outlay so abhored. Then, though the landlords say they think the topic is overworked, there is that tax credit ($10,000) available to virtually recoop expenses incurred. Another feared cost is said to be increased insuranne. Looking at this from the purely practical point of view, a house, apartment, etc., modified in this manner could only be safer for any and all concerned. Fire safety, the largest cause of increased insurance, would be inhanced for all. Though it should, this would, in all probability, not lower insurance, but, neither should is cause an increase.

I've heard statements meant to be in reference to the mentally and psychologically handicapped. One such was about a "2nd or 3rd time child molester". I think this question is almost self explanitory. How many potential renters (able-bodied or handicapped) would you say approach a prospective landlord - "I'm so-in-so. I'd like to rent your place. I'm an ex-con for such-and-such offense." That's rather a rediculous idea. I'm quite certain, of the numerous people released from prison, on probation or parole, an extremely small number have landlords who even know they had the slightest trouble with the law. That is not a subject generally "bragged" about.

Another mentally handicapped refered to were those suffering the problems or the retarded. Take a 20 year old man with the mental age of about 8. I have heard landlords say they "must provide for all" who live in their housing (apartments specifically mentioned). Yes, there is still the old predjudice that abounds saying that such a one should most definitely be kept seperate from children - mothers won't permit "different thing" to even talk to little "Susie". If a fully qualified physician has allowed a person so vulnerable to live independently, can it not be assumed that the training received by that

Att. 5

person has shown to that doctor an ability. If granted this small "freedom", it seems, to me, more than prejudical for untrained people to say, "Oh no you can't. Not near me, you can't."

A physical problem treated in this same manner is epilepsy. Old wives tales even today pour fire to stigmas associated with this problem. Many ways have been shown to deny things to these people without hurting our own prideful feelings (concerning such as unprejudice). A person with epilepsy tends to isolate himself a great deal because he fears the seizures themselves and the reactions of those around him. It is therefore extremely painful when further isolation is forced of him.

It is my opinion that testimony and written information I have read concerning opposition to this bill seems to be trying to do what they say they don't want to do. As they state, "We are not qualified" to make decisions made, usually, by physicians, psychologist, or psychiatrist. But, I have heard statements made that clearly show them to be making instant I.Q. evaluations and, also, making the decision that a person, psycholicly handicapped, will always remain unable to live with "normal" people. My one question concerning this is, are those "normal" people any better a risk?

Judith A. Noller

#6 - 2-15-84

TESTIMONY OF DON KARR

Senate Bill 366

While I have had frequent, though not weekly, contacts with the President of the Topeka Landlords Association, as regards the availability of rental units and the transmittal of information concerning the Kansas Tax Credit, Section 8/Moderate Rehabilitation loans, etc., I do not feel that the Landlords Association is the appropriate enforcement mechanism with which to address housing discrimination complaints. I, therefore, do not notify Mr. Hahn of discrimination complaints as the Landlords Association cannot serve as a mediating body; void of special interests.

Discrimination does occur.

Senate Bill 366 will extend protection against discrimination in housing to handicapped persons. The law will prohibit landlords, real estate agents and people who sell homes from unfairly excluding handicapped people from housing opportunities.

There is no freedom without opportunity. Can a price be placed on rights and freedom? (insurance costs to landlords)

Consumers often are denied housing by uninformed landlords who do not understand that these persons are capable of living independently.

Funding for housing adaptation work and materials is available (to landlord or consumers).

If rental units incorporate accesibility elements, e.g., a ramp, and the landlord is just renting space, not conducting an ongoing business, e.g. charging for Personal Care Attendant services, there will be no change in the liability insurance rate.

Att. 6

H-P-2-15-84

COMMITTEE ON PUBLIC HEALTH & WELFARE

Testimony on Senate Bill 366

BY: Betty Stowers,
President Mental Health Association in Kansas
February 14, 1984

I would urge, on behalf of the members of the Mental Health Association in Kansas, that you members of this committee recommend the adoption of of the changes proposed in Senate Bill 366.

The Mental Health Association has long fought against the stigma suffered by those who are victims of mental illness. As the number one health problem in our nation today, these people have endured for too long discrimination and segregation directed against them. It is high time that Kansas, long a leader, even a center for the treatment of mental illness, act to end such discrimination, segregation, or separation in all areas. These Kansas citizens who are mentally disabled, deserve and are entitled to equal protection under our laws.

Attach. 7

Funding Sources for Modifications

Agency	Eligible items	Type: loan/grant	Contact, Address & Phone #	Process	Process Time
1. Kansas Crippled Children	Orthopedic: Braces, splints, etc. Limited PT Housing adopted on case by case basis, i.e. stair-glide	grant	K.C.C.P.-Doris Bearsley Forbes Field 862-9360 ext. 583	contact Doris or County Health Department	3-4 days
2. Easter Seal Society of Kansas	50% funding for ramps, bath tub lifts, etc.	grant	Easter Seal Society Don Clements 3709 SW Plaza Drive 267-4590	will mail out form to be completed by applicant	
3. Multiple Sclerosis Chapter	will fund a portion of all types of surgical equipment (50% off on Medicare; the difference not to exceed $200	grant	Multiple Sclerosis 4015 W 21st 272-5292	application/interview. Appointment approved on case by case basis	
4. Community Development	a. major rehabilitation (including making the accessible). *See Interagency Agreements for eligibility requirements	grant/loan	City of Topeka Dept. of Community Dev. Glenn Briggs/Al Bailey 820 S Quincy 234-0072	application, verification & waiting list	8-12 months
	b. emergency assistance (to include accessibility items on a case by case basis).	grant		application & contractors inspection & bid process.	1-2 weeks
	c. PMP assistance; C.D. to provide materials (up to $1000) for minor repairs (to include accessibility items).	grant		application, inspection, city commission approval.	2 weeks

Agency	Eligible items	Type: loan/grant	Contact, Address & Phone #	Process	Process Time
5. Section 8 Moderate Rehabilitation Program	Rehabilitates sub-standard rental units to Section 8 code standards and can include accessibility items.	loan: provides rental income that will repay rehabilitation costs, meet monthly operating costs and allow reasonable profit.	THA 1312 Polk 233-4176	application made by landlord/property owner	
6. HUD Section 202 Housing for elderly and disabled	Provides "start-up" financing for the development of rental housing for low and moderate income elderly and/or handicapped persons.	loan: to cover 100% of costs for developing and building housing for elderly and handicapped.	HUD Area Office, 1103 Grand Avenue 6th floor K.C., MO 64106 816-374-6038	application made by private non-profit organization.	
7. Housing Assistance Plan, City of Topeka (202)	Community need for housing and goals of activity towards meeting needs. Include housing needs of the disabled.	report to HUD of housing need, rental subsidy needs and condition of existing housing stock.	Deb Salburg CD Office 820 Quincy Suite 501 234-0072	application made to CD office, after receiving City Commission approval.	18 months (varies)
8. Muscular Dystrophy Association	Funding of equipment with Hoyen lifts, etc.	MDA will make purchase of necessary equipment.	Wilma Ussery K.C., MO 816-931-3646	attend K.U.M.C. clinic (eligibility determination.	
9. Farmers Home Administration	repair loans and/or grants may be used to remove health hazards. (Grants only to low-income elderly homeowners, 62 yrs. or older). home improvement loans may go further by bringing the home up to minimum standards and making changes for the convenience of the family, i.e., remodeling the kitchen.	loan/grant	USDA Building 926 W 6th Holton, KS 66436 913-364-3121	applications for loans are filed in the Farmers Home Administration County Office serving the area where the property is located.	

#8- 2-15-84

Mr. Chairman, Senators, Ladies and Gentlemen

I am very pleased, and grateful to you for giving me this opportunity to tell how important the SB 366 for the handicapped persons is to the citizens of Kansas

I am Bobby Gene Fisher as president of the Topeka Association of the Deaf and as a deaf citizen of Kansas.

The Topeka Association of the Deaf supports the SB 366. It is important that all citizens be given equal rights as in our bill of rights. It is also important to note that SB 366 does not ask for anything special between landlord and tenant, just an equal chance as other people have to function independently in society.

Now, I want to simply ask you to back favorably on this bill.

Thank you.

Att. 8

#9- 2-15-84

Virginia Rogers

Kansas Association for the Legalization of Midwifery

PEACE & HOME

Association, Inc.

I am here to ask your approval of Senate Bill # 634. As the Chairman of the Kansas Association for the Legalization of Midwifery (which I shall refer to as KALM), and as President of PEACE & HOME of Wichita, I represent approximately 250 families desiring to see the state of Kansas recognize the practice of midwifery and provide a means by which a person who could prove their competency would be acknowledged by license to practice midwifery.

I am aware of the Kansas Act on Credentialing (K.S.A. 65-5001 thru 5010), requiring health care personnel seeking credentialing to apply through the statewide health coordinating council, but these statutes refer to health care personnel! As consumers, we are not allowed to place an application before the SHCC committee, ergo our bill before you today.

After many meetings and months of careful thought we have put together this bill which we feel provides the structure to allow the safe practice of midwifery in Kansas. We have asked a regulatory council be established composed of medical professionals, midwives, and a consumer to allow for a balanced approach in the establishment of educational requirements and regulation of practice. We seek a means by which we will know that a midwife has met certain criteria by passing state licensing requirements.

As consumers we are concerned that our right to give birth at home safely is protected. We are not anti-medicine, we merely do not believe in approaching what is usually a normal body process from an aspect of fear of the abnormal. We know that a birth that is attended by a competent midwife is safe.

A competent midwife is capable of monitoring a birth and observing signs indicating things may not be completely normal, knowing what her limits are, and knowing if further help should be sought. A competent midwife is also capable of applying emer-

Att. 9

gency life-sustaining measures while enroute to a hospital or waiting upon an ambulance, which by the way, is staffed by para-professionals without an R.N. or M.D. degree. It is time to recognize a trained midwife as a para-professional in her own right! A good midwife does not lose face when she must call on medical help. She knows her limits and realizes she has a "par-nership" with medical personnel. It is her job to know when help must be sought. Unfortunately, many medical professionals put midwives down and make them feel defensive and a "failure" even before any problems arise. The judgement against the midwife comes before fact, or even in spite of a job well done in handling a difficult situation.

We are very concerned that our right to have our babies at home is not taken away from us. We believe we have the right to choose the environment for our births and the atmosphere that our newest, most impressionable baby will be exposed to. But our choice to choose home, can only be done with safety and therefor be a responsible choice, only if we can also choose the presence of a midwife competent enough to oversee the birth. My husband and I consider ourselves fairly well informed about birth, but we are not competent enough to judge the well-being of our own labor/birth experience as evidenced by the birth of our fourth baby, and second home birth. Our baby was slow to start breathing and was resusitated by the midwife's ability to recognize a problem and use her skills from training. Yet my husband and I neither one were aware, until we noticed the midwife begin to work that the baby even had a problem. Had we attempted this birth on our own, simply exercising our own right, we would have lost the baby because (1) we did not recognize a problem and (2) by the time we would have become concerned over no breathing there would have been quite a delay and we would have been too panicked to know what to do. Having had three previous "perfect" births, we very easily could have been tempted to go it alone, but thankfully we did not. This experience emphasizes the need to have a midwife for our freedom to choose home to be exercised safely.

There will always be those who feel home birth and midwives should be done away with. They are the ones who want to treat every case of normal childbirth from the fear syndrome of "what

if" something goes wrong. They are those who would choose to live thier lives in accordance to "what if" in total anticipation of the worst. My husband and I are well aware that "what ifs" do exist, but we are also aware that that is the very smallest chance compared to normal birth, and even so, a competent midwife is trained to act in an emergency. We can never eliminate the unknown from any aspect of our lives, but I for one do not choose to live by fear of the unknown. There are others who would not agree - let them choose the ultimate medical route of hospitalization, but as for us, we ask that you grant us the means of competent midwives, so that we have the freedom to choose home birth with safety, and seek further medical help <u>if</u> it becomes necessary.

In spite of the updating hospitals are going through and the family-centered atmosphere advertised in the birthing rooms, and in spite of the shame, guilt and fear many would try to make me feel, there are still women like myself who are happy, proud and thankful to have our babies at home and want the choice available for others who choose the same.

Birthing at home also have economic advantages. A survey of the Wichita hospitals indicates an average 2-day stay costs at least $2000.00. An average home birth in Kansas rarely exceeds $400.00. For a couple having no medical insurance this is an obvious economic advantage. Not to mention the fact that if our midwives were lisenced most insurance companies would include them in their coverage, thereby easing the burden even on an 80/20 co-payment plan for those with health insurance. It would also be an obvious financial advantage to an insurance company to pay O.B. benefits of 80% on $400.00 instead of $2,000 or more!

With clear legalities established for midwives, there would be guidlines judging one's qualifications, and the midwife would also be free to carry out basic emergency routines in a home setting within the scope of established procedure, instead of having to wait for the arrival of an EMT, who though skilled is also a non-physician. Homebirth would truly take a step forward in safety with the legalization of midwifery. If the state of Kansas denies midwives legal standing, then we couples also become denied of our freedom of choice in having a safe home birth. We <u>need</u> the option of competent care at our births at home.

Signe E. Rogers

Signe Rogers, 216 E. Third, Newton, Ks.

#10 ~~Ag~~ - 2-15-84
- Landis-Eason -

WHAT ABOUT SAFETY?

The safety of homebirth is currently an issue of debate even though 98% of the people now alive were born at home.(1) It is an important issue involving a multitude of opinions and emotions by people of all professions and lifestyles. In addition to the obvious concerns with safety, the issue raises questions regarding our basic right to freedom of choice.

The American College of Obstetricians and Gynecologists (ACOG), one of the most vocal critics of homebirth, 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 has published a study which states that out-of-hospital births pose a two-to-five times greater risk to a baby's life than hospital births. The data from this ACOG study was based solely on birth certificates obtained from health departments of only eleven states. Additionally, there was no differentiation between planned and unplanned homebirths. (2)

There have been several other studies published which support the safety of homebirth. A study was done in North Carolina during the years 1974 through 1976 that focused on the place and circumstances of delivery with emphasis given to homebirths and how they related to the neonatal mortality rate. An important factor in this study is the recognition of the different types of "out-of-hospital" births, including planned home deliveries with midwives, planned home deliveries with no attendants and unplanned home deliveries. It was found that the neonatal mortality rate of planned home deliveries was 6 per 1,000 compared to 120 per 1,000 with unplanned home deliveries, making the risk of unplanned home deliveries 20 times that of planned home deliveries. Other findings of the study were as follows: Neonatal deaths per 1,000--(a) in hospitals--12/1000; (b) in clinics or offices--16/1000; (c) planned with no attendant present--30/1000; and (d) enroute to hospital--68/1000. (3)

Attch. 10

Another interesting and in-depth study is that of Dr Lewis Mehl, published in the New England Journal of Medicine. He compared over 1,000 hospital births to the same number of planned homebirths, matching the women on 23 different criteria to control all of the variables. The study found that the hospital setting had three times greater likelihood of cesarean sections, twenty-times more use of forceps, twice as much use of oxytocin to induce or accelerate labor, greater use of analgesia or anesthesia & nine times greater incidence of episiotomy with a greater incidence of severe tears needing repair. The hospital sample also had six times more infant distress in labor, three times more postpartum hemorrhage, four times more infection in the newborn & three times more babies needing help to begin breathing than the homebirth sample. There were thirty cases of birth injury (including skull fractures, nerve injuries, etc.) compared to no such injuries at home. There were no maternal deaths in either the home or hospital setting and the infant death rate of the study was low and basically the same in both cases. (4)

It has long been known that the United States rates high in comparison to other developed countries in its infant mortality rate. Throughout the world, for decades, the developed countries with the best pregnancy outcomes have been those with the most midwives while those with the worst outcomes are those with the most doctors. "The more highly specialized the birth attendant, the worse the statistical results. Family doctors and general practitioners do better, but the best results are by the care of skilled midwives." While theoretically it might seem true that there would be greater risk in a home setting, at a distance from medical backup, we are seeing that the opposite is actually the case. (5)

The Netherlands, a country of highly diverse cultural influences, has developed a professional and medically-backed service for home deliveries that is utilized by 70% of the birthing population. Childbirth is considered a normal physiological

event, and that attitude is accepted by most Dutch hospital personnel who have been active in bringing a home-delivery like atmosphere into most hospital settings. (6) In her article, "The Cultural Warping of Childbirth", Doris Haire states that more and more Dutch obstetricians feel that, "When the labor of a normal woman is unhurried and allowed to progress normally, unexpected emergencies rarely occur." They also point out that the small risk involved in a Dutch home delivery is more than offset by the increased hazards resulting from the use of obstetrical medication and obstetrical tampering which are more likely to occur in a hospital environment, especially in countries where professionals have had little or no exposure to normal labor and birth in a home environment during their training." (7)

The training of medical students in the United States today is of crucial concern when considering the safety issue. The stress and importance of technological procedures in many medical institutions most often supports the medical view of pregnancy as a disease-oriented and unnatural occurence that requires intervention. The American Foundation for Maternal and Child Health found that large medical school affiliated institutions have a greater tendency to intervene in the normal birth process in order to provide teaching opportunities, thus causing higher infant mortality rates and neurologically damaged children. (8)

Additionally, the rate of cesarean sections in this country has increased by 156% from 1968 to 1977. The national rate had risen from 5.0% in 1968 to 12.8% in 1977, with some individual institutions reporting rates up to 25%. During this same period of time the birth rate actually declined 12%. (9)

Other statistics that promote the safety of homebirth are from The Farm in Tennessee, a spiritual community with self-trained midwives and a self-contained system of prepared homebirth. They have recently published their statistics for 722 births they managed between October of 1970 and August of 1977. These include 28 deliveries considered high-risk which delivered in a nearby hospital, leaving

94% of which were delivered at home with midwives. There were nine cesarean sections (1.2%) and two forceps births (0.3%). They never had a mother die. Their total number of perinatal deaths (babies dying between 28 weeks gestation through 28 days after birth) was fifteen, a rate of 20.8 per 1,000, which compares favorably to hospitals. They had nineteen breech (buttocks first) births, eleven were first time mothers and none required a cesarean section. They were all born without anesthesia and thirteen of the nineteen had no episiotmy. This is in contrast to common hospital procedure of automatic cesarean section for breech deliveries. (10)

In a very recent article, Doris Haire discusses the trends in maternity care. She points out that our system of providing obstetric care is not always in the best interests of normal pregnant women and their offspring, and in many cases it is not even in the best interests of high-risk mothers and their offspring. She quotes Dr. Roberto Caldeyro-Barcia, President of the International Federation of Gynecologists and Obstetricians from 1976 through 1979, "In the last 40 years many artificial practices have been introduced which have changed childbirth from a physiological event to a very complicated medical procedure in which all kinds of drugs are used and procedures carred out, sometimes unnecessarily, and many of them potentially damaging for the baby and even for the mother." She discusses those common obstetric practices that are now being proven to be detrimental to maternal and infant outcome. For example, confining the mother to bed during labor has been shown to prolong labor, increase the need for pain relieving drugs and uterine stimulants, increase the use of forceps in delivery and increase the incidence of abnormal fetal heart rates and poor Apgar scores. She discusses the questionable safety of ultrasound and obstetric drugs. She then describes the data she obtained from the North Central Bronx Hospital, a New York hospital where 30-60% of the mothers are high risk. The data indicates, ". . . that educating mother

for the childbearing experience, permitting one or two of the mother's loved ones to provide her with strong emotional support during labor and delivery, and avoiding unnecessary intervention in the birth processes can significantly improve the outcome of pregnancy, even when two-thirds of the obstetric population would be considered high risk or at risk." The maternal and infant outcome at North Central Bronx in this 1978-79 study she quotes is outstanding when compared to other studies. Taking into account the fact that 30-60% of the mothers are high risk makes the study's results truly remarkable. What is the reason for this favorable outcome? In one word--midwives. Midwives with appropriate medical consultation essentially run the obstetric service. Doris Haire concludes, "There is no doubt in my mind that ultimately the midwife will be recognized as the health professional most capable of improving the outcome of pregnancy throughout the United States." (11)

As the studies indicate, much consideration is now being given to the questions of birth--its setting, attendants and outcome. There is no one correct answer for every expectant parent. The answers are as individual as the people involved. However, it is apparent that barring high-risk situations birth should take place wherever and with whomever the expectant parents feel most comfortable. As awareness and alternatives grow in the birth movement, more and more options are available and more and more opportunities exist for exercising individual freedom of choice.

REFERENCES

(1) Childbirth at Home, Marion Sousa.

(2) "Homebirth, An Alternative on Trial", Linda Fitzgerald, New Age Magazine.

(3) "Home Delivery and Neonatal Mortaility in North Carolina", Claude Burnett, et al., Journal of American Medical Association.

(4) "Home Birth vs. Hospital Birth: Comparisons of Outcomes of Matched Populations", Lewis Mehl, et al., Journal of Reproductive Medicine.

(5) The Five Standards for Safe Childbirth, David Steward, Ph.D.

(6) "Childbirth in the Netherlands: A Contrast in Care", Doris Haire, International Childbirth Education Association News.

(7) "The Cultural Warping of Childbirth", Doris Haire, International Childbirth Education Association.

(8) "Perinatal and Maternal Morbidity Rates by Sizes of Hospitals", American Foundation for Maternal & Child Health, Inc.

(9) "An Evaluation of Cesarean Section in the United States", Helen Marieskind, Ph.D., Department of Health Education and Welfare.

(10) Spiritual Midwifery, Ina May Gaskin.

(11) "Improving the Outcome of Pregnancy Through Increased Utilization of Midwives", Doris Haire, Journal of Nurse Midwifery.

Improving The Outcome of Pregnancy Through Increased Utilization of Midwives

by Doris Haire

During my years as President of the International Childbirth Education Association, the National Women's Health Network, and the American Foundation for Maternal and Child Health, I have visited hundreds of maternity hospitals throughout the world: in Great Britain, Western Europe, Russia, Asia, Australia, New Zealand, the South Pacific, the Americas, and Africa.

During my visits I was privileged to observe obstetric techniques and procedures and to interview physicians, professional midwives and parents in the various countries. My companion on many of my visits was Dorothea Lang, C.N.M., Director of Midwifery for the New York City Department of Health and Past President of the American College of Nurse-Midwives. Miss Lang's experience as both a midwife and former head nurse of the labor and delivery unit of the New York Hospital—Cornell Medical Center, made her a particularly well qualified observer and companion. As we traveled from country to country, certain patterns of care an infant outcome soon became evident. For one, in those countries that enjoy an incidence of infant mortality significantly lower that that of the United States the major proportion of family planning services and obstetric care is provided by highly trained midwives. In these countries the medical expertise of the physician is called on only when the expectant mother is ill during pregnancy or when labor or birth is anticipated to be, or is found to be, abnormal. Under this system the high-risk mother, the one who is most likely to bear an impaired or stillborn child, has a better opportunity to obtain in-depth medical attention than is possible under our existing American system of obstetrical care, in which the obstetrician is also called on to serve as both midwife and physician.

Evidence is accumulating rapidly that our basic system of providing obstetric care is not in the best interests of normal pregnant and parturient women and their offspring, nor, in many cases, the best interests of high-risk mothers and their offspring.

Roberto Caldeyro-Barcia, President of the International Federation of Gynecologists and Obstetricians (F.I.G.O.) from 1976 to 1979, commented on the adverse effects of obstetric intervention on maternal and infant outcome by saying:

> In the last 40 years many artificial practices have been introduced which have changed childbirth from a physiological event to a very complicated medical procedure in which all kinds of drugs are used and procedures carried out, sometimes unnecessarily, and many of them potentially damaging for the baby and even for the mother.[1]

Obstetric residents and practicing physicians have been so pressed to keep up with technology that they have not developed or have lost their skills to perceive and interpret human factors and their contribution to the intricate checks and balances which comprise human parturition. Residents and practicing physicians have increasingly turned to electronic and ultrasonic devices to determine the status of the fetus. Yet the F.D.A. has recently cautioned that

Doris Haire is the President of the American Foundation for Maternal and Child Health. In addition, she is the Chair of the Committee on Health Law and Regulation of the National Women's Health Network. She also serves on the Advisory Board of the Journal of Nurse-Midwifery, *representing Consumer Affairs.*

> Increasing concern has arisen regarding the fetal safety of widely used diagnostic ultrasound in obstetrics. Animal studies have been reported to reveal delayed neuromuscular development, altered emotional behavior, EEG changes, anomalies and decreased survival. Genetic alterations have also been demonstrated in-vitro systems.[2] (For more details on diagnostic ultrasound see *Federal Register*, Tuesday February 13, 1979, part 3, pp. 9542-9545.)

Amniotomy (the artificial rupture of membranes), which is frequently carried out to insert the monitoring electrodes into the fetal scalp, is a procedure shown by Caldeyro-Barcia, Gabbe, and others to increase the risk of umbilical cord compression,[2] cord prolapse, and increased pressure on the fetal brain.[3] Amniotomy causes the baby's head, rather than the intact amniotic wedge, to serve as a battering ram to open up the birth canal.

I recently attended the Tokyo Congress of the International Federation of Gynecologists and Obstetricians. The research data presented by Doctors Caldeyro-Barcia, Flynn, and others demonstrated that American obstetric practices are frequently detrimental to maternal and infant outcome.

For example, several researchers showed that merely confining a mother to bed during labor tends to significantly[4]

1. Prolong labor by 2.5 hrs.
2. Increase the mother's need for pain relieving drugs and uterine stimulants.
3. Increase the need for forceps extraction of the infant.
4. Increase the incidence of abnormal fetal heart rates and poor Apgar scores in the neonates.

Despite evidence that ambulation during labor improves the mother's comfort and the immediate and probably the long-term outcome of the pregnancy, the vast majority of obstetric patients in the United States are routinely confined to bed.

Drugs are used frequently as a substitute for quality care. Yet neither physicians nor other hospital personnel appear to be fulfilling their legal obligation to inform their obstetric patients that

1. There is no obstetric drug that has been proven safe for unborn children.
2. The drugs offered to them during labor and delivery can depress their infant's cardiovascular, respiratory, and thermoregulatory mechanisms.
3. No one knows whether the brain circuitry of the infant may be permanently affected by the drugs offered to them during labor and delivery.

Perhaps some mothers would not care about this, but their indifference does not remove the health professional's legal obligation to inform the patient of the risks involved in the treatment and of alternative treatments that do not involve those risks.

The improvement in the outcome of pregnancy resulting from the greater use of well-trained midwives was made evident in 1971 by Levy, who reported that during a 2-year medically directed nurse-midwifery program in California, the number of prenatal visits doubled and the incidence of infant deaths decreased significantly.[5]

Across the continent, the success of the California nurse-midwifery program in improving infant outcome has been essentially duplicated by the Frontier Nursing Service in remote Leslie County, KY, one of the poorest counties in Appalachia; in Su Clinica Familia, located in the Mexican border town of Raymondville, Texas; and at the North Central Bronx Hospital in New York.

North Central Bronx Hospital

I recently obtained data from the obstetric service at North Central Bronx Hospital in New York that demonstrates clearly that educating mothers for the childbearing experience, permitting one or two of the mother's loved ones to provide her with strong emotional support during labor and delivery, and avoiding unnecessary intervention in the birth processes can significantly improve the outcome of pregnancy, even when two-thirds of the obstetric population would be considered high risk or at risk.

It is appropriate to this discussion to describe the obstetric service of the North Central Bronx Hospital because it is a city hospital, serving one of the more sociologically depressed areas of New York. The mothers cared for at North Central Bronx Hospital are primarily black and Hispanic, with a smattering of whites. Thirty percent of the mothers are clearly medically high risk. An additional equal perecentage of mothers would probably be considered at risk in most institutions.

The maternal and infant outcome at North Central Hospital in 1978 and 1979 is outstanding by any criteria.* Given the 30% incidence of high-risk mothers it is truly remarkable. This good outcome is the result of the skilled and tender care of certified nurse-midwives who, with appropriate medical consultation, essentially run the obstetric service. The care of high-risk mothers and at-risk mothers is essentially the same as for low-risk mothers unless there is a medical indication for intervention. If a mother or infant requires medical attention, it is provided by a board-certified obstetrician rather than by a resident. If a premature, low birth weight or sick infant is anticipated, the chief pediatric residents are in attendance at delivery. The intensive care nursery is under the direct supervision of a board-certified neonatologist 24 hours a day.

The midwives practice nonintervention obstetrics in keeping with the latest scientific research. The results of their efforts refute the premise that it is the mother alone, not the management of her pregnancy, labor, and delivery, that determines the infant outcome of her pregnancy.

A review of the records of approximately 2608 births carried out from January 1 to December 31, 1979 at North Central Bronx Hospital reveals the following enviable statistics:

Every mother admitted to the obstetric service, whether low-risk or high risk, and regardless of age, was cared for by midwives. With the exception of severly Rh-sensitized expectant mothers, obstetric patients were not transferred to another hospital.

Eighty-eight percent of the deliveries were normal, spontaneous vaginal deliveries (without fundal pressure).

Eighty-three percent of the total population of mothers were successfully delivered by midwives.

Ninety-three percent of the infants over 1000 g. born in the obstetric service had Apgar scores of 7 or above at 1 min. of life; at 5 mins. the rate was 98.3%.

Analgesia and anesthetic drugs were used in fewer than 30% of all labors.

Unless there is a specific medical contraindication, mothers are encouraged to walk around during labor to shorten labor (by 2.5 hr. on average) and reduce the discomfort of contractions.

The incidence of instrumental delivery was 2.34% (low forceps 1.57%; mid forceps 0.5%; vacuum extractor 0.15%).

The neonatal mortality rate among infants 1000 g. or over was 4.2/1000; at 750 g. or over it was 7.6/1000.

The perinatal mortality rate among infants 750 g. or over was 14.5/1000. (The overall rate for New York City was 15.9; for all other municipal hospitals in the city the rate was 20.6. Statistics are not available for more than 1000 g.).

The overall cesarean section rate was 9% (7% primary and 2% repeat).

All mothers who had experienced a previous Cesarean section were allowed to experience spontaneous labor. Of these, 37% gave birth vaginally.

There were no elective inductions of labor.

Uterine stimulants such as oxytocin were employed in only 3% of mothers' labors and only when there was a medical indication.

Vaginal examinations are kept to a minimum (three to five times) during labor to avoid causing the mother unnecessary discomfort, to avoid the inadvertent rupture of the mother's membranes, and to avoid an increased likelihood of maternal infection.

Great care is taken by the midwives to avoid the inadvertent or intentional rupture of the mother's membranes during internal examinations of the mother during labor.

Fewer than 50% of mothers (including the 30% who were high risk) were monitored electronically. Many of the mothers who are monitored are monitored only intermittently to minimize the fetus's exposure to the potential risks of ultrasound.

To avoid maternal exhaustion during labor, mothers who are not high risk are allowed to eat and drink during labor. This practice has not resulted in a single case of aspiration of vomitus in the 2 years since the institution of the practice.

The mother's pelvis and perineum are not "prepped" (shaved and washed with antiseptic solution). Enemas are not given.

Throughout their labor and delivery mothers are accompanied by one or two companions of their choosing.

Sixty-four percent of the mothers gave birth in their labor rooms. Twenty-one percent gave birth in labor beds that had been moved to the delivery room because of indication that the mother may need an assisted delivery or that the assistance of a pediatrician may be required. In only 15% of births were mothers moved to the delivery table for delivery.

Eighty-five percent of mothers gave birth in the semisitting position without stirrups.

Almost half (45%) of the mothers gave birth over an intact perineum. Episiotomy was performed in only 26% of births. Twenty-six percent of the mothers experienced first or second degree tears. Most first degree tears did not require sutures and all healed without complication. Three percent of the mothers experienced third degree lacerations, and 1% experienced fourth degree lacerations. These lacerations were extensions of the episiotomies and occurred after the application of forceps by the obstetrician.

Premature and low-birth-weight infants are delivered over an intact perineum unless there is insufficient stretch to the mother's perineum.

The midwives at North Central Bronx Hospital have demonstrated that even high-risk mothers and their offspring benefit from a policy of nonintervention unless there is a clear medical indication for such intervention.

I appreciate the skills of the neonatologist in saving very premature,ill, and defective infants. However, there is no doubt in my mind that ultimately the midwife will be recognized as the health professional most capable of improving the outcome of pregnancy throughout the United States. It is obvious from the good infant outcome of infants delivered at the North Cental Bronx Hospital and other midwifery services in the United States that we could reduce the numbers of newborn infants requiring intensive care by increasing the number of midwives and expanding the services offered by them nationwide.

References

1. Caldeyro-Barcia R: Obstetric intervention: Its effect on the fetus and newborn. II. Presentation to the American Foundation for Maternal and Child Health Conference, New York, 1975.

2. Gabbe S. et. al.: Umbilical cord compression associated with amniotomy: Laboratory observation. Am. J. Obstet. Gynecol. 126:353-355, 1976.

3. Caldeyro-Barcia, R. e.t al.: Adverse perinatal effects of early amniotomy during labor. In Gluck, L. (ed.): Modern Perinatal Medicine. Chicago, Year Book 1974.

4. Flynn, A.M. et. al.: Ambulation in labor. Br. Med. J. 1978, 2:591-593.

5. Levy B., Wilkinson F. Marine, W.: Reducing neonatal mortality rate with nurse-midwives. Am. J. Obstet. Gynecol. 109:50-58, 1971.

[Ed. Note: Ms. Haire reports that analysis of data from 1980 confirms the excellent results achieved in the original study.]

This article was adapted from the author's testimony presented at a Public Hearing sponsored by the Mayor's Blue Ribbon Commission on Infant Mortality, Washington, D.C., February 14, 1980.

Other Publications in the Health Monograph Series

- THE CARE OF THE DRUG DEPENDENT WOMAN AND HER INFANT by Enrique M. Ostrea, Jr., M.D. with Cleofe J. Chavez, M.D. and Joan C. Stryker, M. D.

PLANNED HOME CHILDBIRTHS:

PARENTAL PERSPECTIVES

By

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tacts with these 163 women, 74 qualified as having had a planned home birth and were interviewed while 76 indicated that their out-of-hospital birth had been involuntary. The other 13 women were eligible for interviewing but refused.

Interviewing

One female interviewer conducted the entire field work, thus assuring maximum uniformity and consistency of interviewing. In addition to instruction in interviewing techniques, her training included review of the 1975 home birth study and basic instruction to understand the process of pregnancy, labor, delivery and the various complications that may arise in connection with birth. The interviewer also participated in the final stage of developing the questionnaire and, thereby, became well acquainted with the goals and purposes of the study. Interviews were conducted between June and September 1977.

Although 13 respondents refused to participate in the study, the interviewer was generally well received by the participants, in many instances with the warmest hospitality. For many women the interview seemed to be a welcome opportunity to speak with another adult during the day or to have a chance to discuss personal problems. Many people were excited and anxious to tell about their birth experience. On the other hand, several did not seem to care one way or another if they were interviewed. They answered all the questions but gave the impression of being uncomfortable and looking forward to the end of the interview. Some respondents were suspicious that "the state" was interested in them and their home birth. One woman, for example, asked if her child's behavior and development would be followed through school. A major difficulty with the interviewing was locating the respondents' residences which were located throughout the state.

The Questionnaire

The initial version of the questionnaire was based on the exploratory study of 1975 home births. It was revised to accommodate more open-ended questions in the hope of eliciting detailed information on the reasons women chose a home delivery. It was pretested in the Lansing, Michigan area and finalized in April 1977 (see Appendix D).

HOME BIRTH PARENTS

Since the decision to have a home birth stands in stark contrast with the societal norm that women who are about to give birth belong in a hospital, it seems plausible to expect that this decision is made by a group of people who have rejected existing social norms more generally. Kendall (1972) has argued that home birth parents are part of the commune culture, whereas Hazell (1974, p. 8) concluded that the majority of the women who deliver at home are "quite average people," and that only ten percent of them are members of the "hip" culture. Our study reveals that the home birth parents come from a variety of socio-economic, educational and religious backgrounds, but almost all are white Americans.

INCOME AND HOSPITAL INSURANCE

The average income of the home birth parents was $16,770 as compared to a $15,258 average family income for the state of Michigan.* Almost 20% of the families in the sample

* Michigan average income was obtained from U.S. Department of Commerce, Bureau of Census, "Household Money Income in 1975, by Housing Tenure and Residence for the United States, Regions, Divisions and States" (Spring 1976 Survey of Income and Education), Current Population Report, Series P-60, Consumer Income No. 108, November 1977, prepared by K. Apple.

earned less than $8,000 (Table 1). Two-thirds of the respondents had hospital insurance. As Table 2 indicates, low income is associated with lack of hospital insurance, but the relationship is not strong.

TABLE 1
Family Income Distribution of Home Birth Parents

Income Bracket Dollars Per Year	Number of Respondents	Percentage
1,000 – 3,999	3	4.0
4.000 – 7,999	11	14.9
8.000 – 9,999	8	10.8
10,000 – 12,999	13	17.6
13.000 – 19,999	20	27.0
20.000 – 29,999	10	13.5
30,000 – 49,999	2	2.7
50,000 and over	5	6.8
Not ascertained	2	2.7
Total	74	100.0

TABLE 2
Parents' Income by Hospital Insurance

Income	Parents have hospital insurance: Yes		No		Total
	Number	Percent	Number	Percent	Percent
Less than $8,000	5	35.7	9	64.3	100
$8.000 – $12,999	12	57.1	9	42.9	100
More than $13,000	31	83.8	6	16.2	100
Not ascertained 2					

RACE

Respondents were essentially homogeneous in their racial background. One oriental and four black women were among those interviewed. Hazell (1974, p. 9) viewed the absence of black women in the home birth movement in California in light of their broader aspirations.

> Black people are beginning to be found in childbirth classes, but they are upwardly mobile and tend to opt for the "best" physician and hospital available. This tends to mean that they have the modal American birth, leaving responsibility for management to doctors, nurses and other hospital personnel.

One would expect this statement to be true for black women with higher incomes. Black families with low incomes, however, may well choose a home delivery for economic reasons. This study cannot provide evidence for this point since there were only four black women in the sample, none of whom had an income below $8,000 per year.

In interpreting the racial and other social characteristics of the women in the sample, it should be remembered that the sampling conditions may have introduced a bias whereby people from minority, ethnic or lower socio-economic groups were underrepresented. For example, out-of-hospital births to unwed women could not be included in our sample for legal reasons, but the racial and educational distributions of this group are known. Of the 123 such births in Michigan, 65 were to black women and 58 were to white women. This stands in marked contrast to the racial distribution of the study population. Also, the unwed mothers were generally less educated than the planned home birth mothers. Fifty-two percent of the unwed women had not completed high school, compared to 10% of the study population. Of course, it is not known how many of the out-of-hospital births to the unwed mothers were planned; but even assuming that only a small percentage were planned home births, the social characteristics of the study population would have been significantly different had they been included.

RESIDENCE

The majority of the women in the sample (42) had spent most of their lives in an urban area and 52 had lived primarily

in Michigan. Nineteen women previously lived in other parts of the United States and three in foreign countries. At the time of the interview, respondents were distributed over 26 counties in Michigan, with the heaviest concentration in Oakland, Wayne, Ingham and Kent counties.

RELIGION

Almost one fourth (16) of the respondents said they had no religion. Over half identified with either Catholic or Protestant religions, or they simply indicated that they were nondenominational or Christian. The remainder were members of religious groups such as Jehovah's Witness, Christian Science, Divine Light Mission and Church of God. It is noteworthy that some of these religions reject certain forms of modern medical and health care.

EDUCATION

The home birth parents had generally achieved a fairly high level of education. The majority of the husbands had attended at least one to two years of college, and 46% of their wives also were college educated. The second largest group consisted of those who had completed high school. A small group, 10% of the mothers and 5% of the fathers, had not completed high school.

TABLE 3
Education of Home Birth Parents

Educational Level	Mother		Father	
	Number	Percent	Number	Percent
Some high school	8	10.8	4	5.4
High school completed	32	43.2	29	39.2
College and beyond	34	46.0	41	55.4
Total	74	100.0	74	100.0

AGE

Almost 79% of the respondents were in their twenties, 28% were between 30 and 34 years old, and the balance was either

18 or 19 (4.1%) or between 35 and 39 years old (4.1%). Thus, the overwhelming majority of mothers was in what is normally considered the optimal child bearing age of 20-34 years.

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FACTORS INFLUENCING THE DECISION TO DELIVER AT HOME

PREVIOUS HOSPITAL DELIVERY

Most of the women (44) in the sample had delivered a child in a hospital prior to their home delivery in 1976. Because previous research had established negative reactions to the hospital as a major element in the attitudinal profile of couples who opt for a home birth (Hazell, 1974), it seemed important to ask the respondents of this study how they felt about their previous hospital deliveries. The women had much to say in response to this open-ended question. Their answers can be grouped into three broad categories: positive, tolerable and negative hospital experiences. The majority of women (26) fell in the latter category, while 10 women reported a tolerable and 7 a positive experience (1 not ascertained).

Why do so many women react negatively to their hospital experience? A loss of control, which has several facets, was the most frequently mentioned reason. To many, a loss of control meant not being able to participate in decisions concerning the conduct of their care. Some said it meant a loss of dignity and a failure to be recognized as an individual with unique needs and desires. Additionally, for some women loss of control meant an inability to actively participate in their own

delivery. More specific reference to loss of control included responses that they were given medication when they did not feel it was necessary; that they were "put down," as the respondents phrased it, for wanting to nurse; or that they were left unattended in labor. As can be seen from Table 4, resentment of the institutional atmosphere of the hospital is mentioned more frequently than resentment of physicians.

TABLE 4

Reason for Negative Feelings About Hospital Deliveries† (Multiple Responses)

	Respondents Citing Reasons	
	Number	Percent
Loss of control due to hospital procedures	28	63.6
Separation from baby	24	54.5
Impersonal, non-supportive relationship with staff	20	45.5
Dehumanized, assembly-line hospital atmosphere	14	31.8
Separation from husband	8	18.2
Resentment of doctors	8	18.2
Hospitals are for the sick	8	18.2
Total number of respondents who had previous hospital delivery	44	

† Q: How did you feel about your hospital delivery?

Quotations from two women may give some of the flavor and detail of the concerns which were expressed:

> I felt like I was a sick patient and treated as such. I didn't like the idea of taking the baby away at birth. Babies need the closeness of their mother. The people in the hospital were kind, but they were anti-nursing,* so I didn't receive encouragement when I needed it. The main thing that bothered me in the hospital was that their routines did not allow me to be in the positions during labor that I found comfortable. Instead of being able to lay on my side, I had to lie on my back. They believed in Lamaze so they let my husband into the labor and delivery rooms. But I was very lonely and forced to lie on my back for 22 hours. My pregnancy and labor were normal so there was no reason for the restrictions.
>
> They were giving the baby supplementary formulas and sugar water when I was trying to breast feed. Hospital personnel and doctors alike need to school themselves on nursing . . . and be able to help and advise the nursing mother. They kept me for two extra days. They did not respect my wishes as the mother of the child. They had rigid standard procedures. My bed was next to the nursery and instead of sleeping I lay awake listening to the baby cry. Instead of nursing on demand they brought the baby on their schedule.

* Anti-nursing here means against breast feeding.

What emerges from these answers is the fundamental conflict between the way the respondents view their role in the labor and delivery process and the view of the patient that is implicit in the organization of hospitals. These women feel strongly that they understand the birthing process and that they are often a better judge of how to proceed than the physician or the staff. In holding this view, they are not arguing that they are the experts and the hospital staff and physicians are not. However, they do view themselves in conflict with the procedures which they believe exist for the convenience of the staff or are anchored more in hospital tradition than in expert knowledge. Above all, the women want to be active participants in what they consider a very crucial experience in their lives, whereas the hospital staff insists upon passive submission. Most of the women walked away from a hospital delivery with a deep sense of deprivation, as if they had been robbed of something that they had reason to expect should be their own.

THE DECISION TO DELIVER AT HOME

How do women who have chosen to depart from the generally accepted norm of delivering in the hospital explain their decision?

Many of the themes that emerged in the women's replies were similar to those mentioned in connection with the discussion of previous hospital deliveries. Dissatisfaction with hospital procedures was most frequently listed. For example, respondents were critical of hospital nursery practices that separate the mother from her newborn. The argument that a hospital is an inappropriate place to deliver a baby because pregnancy is not a disease, and a distrust of doctors were also mentioned here. But the decision to have a home birth was not entirely based on a negative reaction toward hospitals. The women who planned home births did so with much appreciation for the emotional support of relatives and friends which exists in the home. Furthermore, they wanted to assume an active role in the birthing process. The importance of exercising control and an emphasis upon *natural* delivery figured prominently in the responses. For many women the home was viewed as the most natural place to deliver a child.

> I felt the hospitals were unwilling to make changes that would permit the pregnant woman to have an active part in the labor and delivery. I felt that childbirth should be a natural process — not surgery.

> Because of the previous hospital experience, I really wanted to be able to control the delivery in a normal relaxed atmosphere. I wasn't relaxed in the hospital.

> I wanted to have my friends and family with me during the birth. I just feel more comfortable at home. . . . I believe in doing things the natural way. It was easier to deliver at home.

When asked why they decided to deliver their baby at home, 21 women mentioned economic factors. For example:

> I've never considered any other way. I had seen a home delivery with a midwife and a doctor and I thought I would be more relaxed here. I didn't really have the money and I didn't want to pay $2,000 unnecessarily. I'm healthy . . . and didn't anticipate any complications. After I did some reading I found many more reasons. I wanted to keep the baby with me and breast feed; I didn't want to be hassled by the nurses about it. When I thought of the birth I envisioned the family being with me and a few friends — not making a big deal about it. I wanted my husband to be involved — as did he — and I didn't foresee the hospital agreeing to this.

> My decision was a result of all the things I went through in the hospital. Also the financial part. With my last child the bill was $1,500. I looked for quite a while to find a doctor who would deliver at home. I called all over . . . and they all acted like I was crazy. I had talked to somebody in the congregation who knew someone who had a doctor who did home deliveries. Finally I found a doctor when I was seven and a half months pregnant. Having a baby at home is natural. The other children accepted him. . . .

It is apparent from these answers that financial concerns were among many issues in the home birth decision. Their importance, as compared with the other factors, is difficult to establish. It should also be pointed out that a direct question about the importance of financial factors was not asked. Instead, there was an open-ended question about the general reasons for the home birth decision. This was done in order

TABLE 5

Parents' Income by Importance of Economic Reasons for Home Birth Decision

Income	Financial Factors Given for Home Birth Decision: Yes — Number	Yes — Percent	No — Number	No — Percent	Total Percent
Less than $8,000	3	21.4	11	78.6	100
$8,000 – $12,999	6	28.6	15	71.4	100
More than $13,000	12	32.4	25	67.6	100
Not ascertained	2				

to avoid suggesting answers. It may well be that some women chose not to mention economic issues even though they played a role in their decision. People may have been hesitant to mention financial reasons to a stranger. More important, women may have forgotten that economic reasons were an important component in this decision which they themselves have increasingly come to view in terms of either their criticism of the hospital or in terms of the importance of assuming active responsibility for the delivery.

In reflecting about the importance of economic factors in the decision to deliver at home, it is worthwhile to again refer to the incomes of the respondents. With more than half of the families earning over $13,000 per year, it is difficult to

TABLE 6

Reasons for Home Delivery† (Multiple Responses)

Reasons	Number	Percent
Dissatisfaction with hospital procedures and routines, and loss of control in hospital	49	66.2
Emphasis on comforts and emotional security in home	40	54.1
Desire to be close to and/or involve family and friends in birth process	39	52.7
Wanted natural birth, no drugs, no intervention	34	45.9
Control in the birth process (either loss of control in the hospital and/or positive control at home)	33	44.6
Desire to care for infant	28	37.8
Economic factors (e.g., no insurance)	21	28.4
Hospital is for sick people and or concern over infection	19	25.7
Resentment towards or distrust of doctors	16	21.6
Total number of respondents 74		

† Q: Why did you decide to deliver at home?

explain the planned home birth phenomenon entirely in terms of poverty. Moreover, there is no statistically significant relationship between income and the reporting of financial reasons in the decision to deliver at home. That is to say, women in the higher income brackets are just as likely as those with lower incomes to mention economic factors. Therefore, it can be concluded that although the cost factor is certainly an element in the decision, it does not appear to be central to the decision to avoid a hospital.

THE DECISION-MAKING PROCESS

When did women decide to have a home birth and who participated in or tried to affect the decision? Thirty-seven women made the decision to deliver at home during the pregnancy which lead to the 1976 home birth; 33 decided at an earlier date, either before their first pregnancy (12), during a previous pregnancy (12), between the last and recent pregnancy (6) or during previous labor and delivery (3).

Given the emphasis which women placed on the role of family and friends, it is interesting to know who participated in the decision. In the majority of cases (65) the father was involved, but the woman generally suggested the idea first (44 instances). In 43 cases, others encouraged the home delivery — friends primarily (34), but also relatives (15), a physician or other health professional (6).

Although encouragement from others was forthcoming, efforts to discourage the woman from delivering at home were even more frequent. Sixty women, or 81%, said efforts had been made to discourage them from having a home birth. A variety of specific concerns were expressed in the attempt to discourage women — fear of complications during birth, concerns over the safety of the mother or the child — indicating that some of the relatives, friends or health professionals with whom the respondent was in contact considered the risks of a home birth to be extensive.

Most of the women (59) knew someone who had had a home delivery and 15 had attended a home delivery other than their own. As can be seen from the following quote, knowing someone who had delivered at home can be an important element in the decision making process.

> One reason for our home birth was that we didn't have insurance and hospitals are expensive. After we talked to a woman who had two babies at home . . . she recommended a couple of books and reading the books we decided to have the baby at home. My mother had 14 children at home and no complications. Knowing that helped me to decide.

The experience of an older relative who delivered at a time when home births were still common and the experience of contemporaries who chose a home birth more recently seem important in influencing women in their decision. This finding stands in contrast to Hazell's (1974) observation in one California study in which members only occasionally knew others who had a home birth.

TABLE 7

Who Discouraged Home Delivery† (Multiple Responses)

Who Discouraged Home Delivery	Respondents Who Cited Sources of Discouragement	
	Number	Percent
One or more members of mother's family	26	43.3
Friends	23	38.3
Physician	21	35.0
One or more members of father's family	18	30.0
Everyone	12	20.0
Nurses or other hospital personnel	6	10.0
Total number of respondents who received discouragement	60	

† Q: Did anyone discourage you from having a home delivery?

RISKS

How do women who have delivered at home view the question of risks? As can be seen from Table 8, the attitudes of the women in the sample can be distributed along a continuum. At one end of this continuum are those women who state definitely that there are risks in home deliveries (16); at the other extreme are those who state that there are fewer risks in delivering at home than in the hospital (18). In between these extremes are those respondents who are of the opinion that there are risks if (a) the woman has not received prenatal care or (b) during prenatal care, the pregnancy is diagnosed as problematic. Others state that the decision to deliver at home has to be based on individual circumstances or that there are no special risks unique to a home birth. On the whole, most women do not feel that there are major risks attached to delivering at home, especially if proper steps have been taken to ascertain potential problems through prenatal care. These answers are not surprising. If women perceived major risks, one would not expect them to make a decision in favor of a home confinement. Moreover, by definition, only those who successfully completed a home birth were surveyed. Women who planned a home delivery but had to go to a hospital because of major complications during labor or delivery are not included in the sample. One would expect women who had complications to be less sanguine about the risks involved in a home birth. Perception of risks was not related to level of education.

TABLE 8

Perception of Risk

Perception of Risk	Number of Respondents	Percent
There are risks in home deliveries	16	21.6
Yes, there are risks if pregnancy is diagnosed as problematic or if no prenatal care	15	20.3
Decision has to be based on individual circumstances	8	10.8
No special risks unique to home deliveries	17	23.0
Fewer risks at home than in the hospital	18	24.3
Total	74	100.0

Home Delivery and Neonatal Mortality in North Carolina

Claude A. Burnett III, MD, MPH; James A. Jones, MPH; Judith Rooks, CNM, MS, MPH; Chong Hwa Chen, MS; Carl W. Tyler, Jr, MD; C. Arden Miller, MD

• **Neonatal mortality is examined by place and circumstances of delivery in North Carolina during 1974 through 1976 with attention given to home delivery. Planned home deliveries by lay-midwives resulted in three neonatal deaths per 1,000 live births; planned home deliveries without a lay-midwife, 30 neonatal deaths per 1,000 live births; and unplanned home deliveries, 120 neonatal deaths per 1,000 live births. The women whose babies were delivered by lay-midwives were screened in county health departments and found to be medically at low risk of complication, despite having demographic characteristics associated with high-risk of neonatal mortality. Conversely, the women delivered at home without known prenatal screening or a trained attendant had low-risk demographic characteristics but experienced a high rate of neonatal mortality. Planning, prenatal screening, and attendant-training were important in differentiating the risk of neonatal mortality in this uncontrolled, observational study.**

(*JAMA* 1980;244:2741-2745)

SUMMARY reports of state vital statistics have traditionally classified births as occurring in-hospital and out-of-hospital. Fetal and infant mortality has also been reported using this differentiation. Being the best that is generally available, such information has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery. However, with increasing interest in home delivery, the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them. This article provides an analysis of neonatal mortality in North Carolina during 1974 through 1976, with attention given to the places and circumstances that characterized out-of-hospital deliveries.

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

Most of the medical profession advocates hospital delivery and views home delivery as a regressive step that would reverse the historical improvement in the safety of childbirth. Most women choose to deliver in a hospital where physicians are able to intervene effectively in emergencies, many of which cannot be anticipated with even the best prenatal care. However, an increasing number of women prefer delivery at home in order to be among familiar people and surroundings, to avoid the perceived risks of highly technical medical care, and to reduce cost.

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

MATERIALS AND METHODS

This study used neonatal death rates as a measure of the risk associated with the place and circumstances of birth. Vital records of live births and neonatal deaths registered in North Carolina for 1974 through 1976 constituted the initial source

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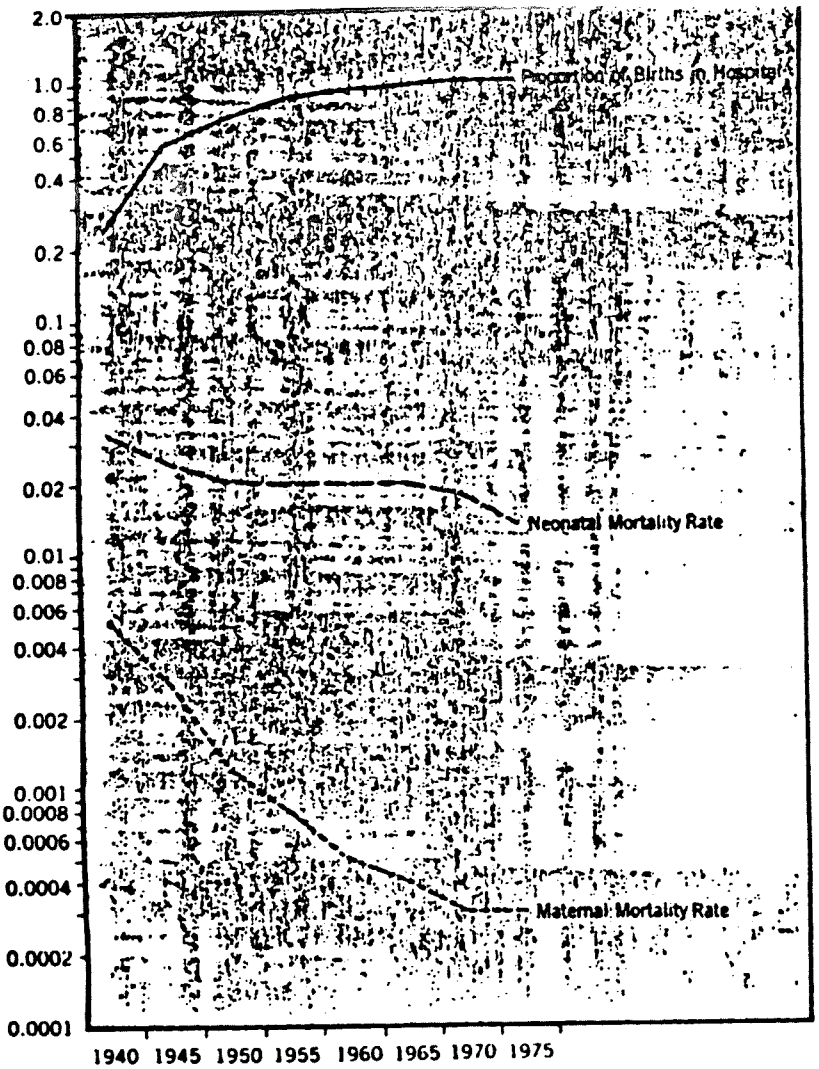

Proportion of births in hospital, neonatal mortality rate, and maternal mortality rate, North Carolina, 1940 to 1975.

of information. Birth records were coded as occurring in a hospital, in a clinic or office, enroute to a hospital, or at home. Infant death records are routinely linked with their corresponding birth records in North Carolina, making it possible to determine mortality by birth characteristics.

To estimate the risk of neonatal mortality associated with the circumstances of home delivery, the 1,296 home deliveries occurring in North Carolina during 1974 through 1976 were classified by both their planning status and the attendant present. If a home delivery was chosen and a healthy infant anticipated, it was classified as planned.

Emphasis was placed on determining the planning status of those home deliveries that resulted in neonatal death. Misclassification of a small number of these deaths would have had a notable effect on reported neonatal mortality rates. Therefore, these deaths were individually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery.

Two simplifying assumptions were made in classifying all home deliveries by planning status. We assumed that all home deliveries attended by a lay-midwife were planned. This assumption was justified for two reasons. First, for a lay-midwife to receive a permit to attend a home delivery, a pregnant woman had to be approved by a health department as being at low risk of complications. This was considered evidence of careful planning. Second, a lay-midwife would probably not attend an unplanned home delivery and report it on the birth certificate because of the risk of permit revocation.

Our second assumption was that home deliveries of infants weighing 2,000 g or less at birth and not attended by a lay-midwife were precipitate and unplanned. have been planned but were classified unplanned. However, no such assumption was made in the classification of neonatal deaths that followed home delivery. Therefore, any classification error introduced by the second assumption would have increased the apparent neonatal mortality rate of home deliveries classified as planned and not attended by a lay-midwife, and decreased the apparent neonatal mortality rate of home deliveries classified as unplanned.

In June 1978, birth certificate copies of the remaining unclassified home deliveries were sent to the health department of the county of residence of the mother. A brief questionnaire accompanied each certificate requesting that health department staff determine the reason for home delivery and identify the attendant present. Four reasons for home delivery were provided: precipitate, intended, failure to plan for health care, and unknown. Field work by county health department staff was necessary when no detailed record described the circumstances of the birth.

RESULTS

Births Associated With Home Delivery.—Table 1 shows a classification of all 1,296 home deliveries for 1974 through 1976. Seventy-two percent of home deliveries were classified as planned. Of these, 768 were attended by lay-midwives and were assumed to be planned; 166 were classified by questionnaire as "intended" and were therefore considered planned. Of the 166 home deliveries classified as "intended," 57% occurred by preference, 26% were for economic reasons, 8% were for religious reasons, and 9% were for other or unknown reasons.

Nineteen percent of home deliveries were classified as unplanned. The 51 infants born at home, attended by other than a lay-midwife, and weighing 2,000 g or less were assumed to be precipitate, unplanned home deliveries. An additional 199 were classified by questionnaire as either "precipitate" or "failure to plan for health care" and were also considered unplanned.

Neonatal Deaths Associated With Home Delivery.—The planning status of the home deliveries that resulted in neonatal death is shown in Table 2. Of the 36 neonatal deaths associated with home delivery during the three years, six (17%) followed planned home delivery, and 30 (83%) followed unplanned home delivery.

Table 1.—Planning Status of All Home Deliveries*

	No.	%
Planned	934	72
Lay-midwife (assumed planned)	768	
Classified by questionnaire	166	
Unplanned	250	19
Birth weight ≤2,000 g (assumed unplanned)	51	
Classified by questionnaire	199	
Unknown	112	9
Total	1,296	100

*North Carolina, 1974 through 1976

Six neonatal deaths occurred following planned home delivery. In three instances, a trained attendant was not present; in three others, delivered by lay-midwives, death was attributed to congenital anomalies.

Two of the 30 unplanned home deliveries resulting in death were classified as "unplanned—no alternative." Allegedly, one mother, who delivered a 2,800-g infant at eight months, went to a hospital but was turned away for lack of funds. The other, who delivered a 1,400-g infant at seven months, reportedly had been told not to go to the hospital without payment in hand. We concluded that these home deliveries were not intended.

Five of the 30 unplanned home deliveries resulting in death were classified as "unplanned—suspected homicide or neglect." Three involved unwed teenaged mothers charged with homicide. Of the two remaining deaths, one infant was found drowned in a canal and the other was grossly neglected. These home deliveries were judged to be either precipitate or intended without preparation for a healthy infant.

Neonatal Mortality Rates Associated With Home Delivery.—Home deliveries, without regard to their planning status, were associated with a neonatal mortality rate of 30 per 1,000 live births. However, when subdivided by their planning status (Table 2), a different picture emerged. The neonatal mortality of planned home deliveries was 6/1,000, while that of unplanned home deliveries was 120/1,000. The relative risk of unplanned home deliveries was 20 times that of planned home deliveries.

The planning status of 112 home deliveries remained unknown following the questionnaire survey. If these had been planned, the neonatal mortality rate of planned home deliveries would still have been 6/1,000. If all of these home deliveries had been unplanned, the neonatal mortality rate of unplanned home deliveries would have been 83 rather than 120 per 1,000.

Table 2.—Neonatal Mortality by Planning Status of Home Deliveries*

	Deaths, No. (%)	Births	Rate†
Planned	6 (17)	934	6
Infant normal	3 (8)		
Congenital anomaly	3 (8)		
Unplanned	30 (83)	250	120
Precipitate	23 (64)		
No alternative	2 (6)		
Suspected homicide or neglect	5 (14)		
Total	36 (100)	1,184	30

*North Carolina, 1974 through 1976.
†Neonatal deaths per 1,000 live births.

Table 3.—Neonatal Mortality by Place and Circumstances of Delivery*

	Deaths	Births	Rate†
Home—planned, attendant physician	0	55‡	0
Home—planned, attendant lay-midwife	3	768	4
Hospital	2,805	242,245	12
Clinic or office	15	949	16
Home—planned, attendant not physician or lay-midwife	3	100‡	30
Enroute	12	177	68
Home—unplanned	30	250‡	120
Total	2,868	244,544	12

*North Carolina, 1974 through 1976.
†Neonatal deaths per 1,000 live births.
‡Excludes 112 home deliveries with unknown planning status and 11 planned home deliveries with unknown attendant.

The effect of possible classification error introduced by the assumption that the home deliveries of 51 infants weighing 2,000 g or less and not attended by a lay-midwife were precipitate and unplanned can be similarly examined. If all 51 home deliveries had been planned, the neonatal mortality rate of planned home deliveries would still have been 6/1,000; the neonatal mortality rate of unplanned home deliveries would have been 151/1,000.

Table 3 shows all neonatal deaths for the three-year period by place and circumstances of delivery, in rank order from the lowest to the highest neonatal mortality rate. The 112 home deliveries with unknown planning status and 11 planned home deliveries with an unknown attendant are not included in the births column or in the denominators of the neonatal mortality rates. The rates ranged from zero neonatal deaths for planned home deliveries attended by a physician, to 120 neonatal deaths per 1,000 unplanned home deliveries. Planned home deliveries, prenatally screened as low risk and attended by lay-midwives, were associated with a neonatal mortality rate of 4/1,000 live births. However, all three deaths following delivery by lay-midwives were associated with congenital anomalies and may not have been preventable.

Hospital deliveries, including high-risk pregnancies and low-birth-weight infants, were associated with a neonatal mortality rate of 12/1,000 live births. After excluding infants weighing 2,000 g or less at birth, the neonatal mortality rate for hospital deliveries was 7/1,000, while that for lay-midwife home deliveries remained 4/1,000. This difference was not statistically significant.

Three groups of home deliveries can be distinguished from Table 3: (1) unplanned; (2) planned without known medical screening and without a trained attendant; and (3) planned, selected based on medical screening, and with at least a minimally experienced attendant (grouping home deliveries by physicians and lay-midwives together). Group 1 had 1 times (95% confidence limits 1.1 to 11.1) the

Table 4.—Percent Distribution of Births by Selected Maternal Characteristics*

	Home Lay-Midwife, %	All Deliveries, %	Neonatal Mortality Rate† All Deliveries
Age, yr			
<20	40	24	14
20-24	34	35	11
25+	26	41	10
Race			
White	4	69	10
Nonwhite	96	31	15
Marital status			
Married	56	84	10
Unmarried	44	16	16
Education, yr			
<12	69	36	14
12	29	42	10
>12	2	22	9
Prenatal visits			
0-2	5	3	65
3-7	68	19	28
8+	27	78	5
Birth weight, g			
≤2,000	0	3	288
2,001-2,500	6	5	24
2,501-3,000	20	18	5
>3,000	74	74	2
N	467	159,333	...

*Home deliveries by lay-midwives vs all deliveries, and neonatal mortality rate for all deliveries North Carolina, 1975 through 1976.
†Neonatal deaths per 1,000 live births.

neonatal mortality rate of group 2. Group 2 had 8 times (95% confidence limits, 2.2 to 31.3) the neonatal mortality rate of group 3.

Lay-Midwife Deliveries.—Table 4 compares the maternal characteristics of the 467 women delivered by lay-midwives with all 159,333 deliveries occurring in North Carolina during 1975 and 1976. The table also shows the neonatal mortality rate for all deliveries relative to maternal characteristics. The distributions for the demographic variables of age, race, marital status, and education reveal a preponderance of mothers in high-risk categories among lay-midwife home deliveries compared with all deliveries. The women attended by lay-midwives were more likely to be young, black, unmarried, and less educated than the average woman who delivered in the state. Despite their high-risk demographic profile, these women had a relatively low-risk medical profile. None of their infants weighed 2,000 g or less, and their neonatal mortality rate was one third that for all deliveries.

Planned Home Deliveries Without a Trained Attendant.—Contrasted with women delivered by lay-midwives, women who delivered without a trained attendant had a low-risk demographic profile: 5% were younger than 20 years, 78% were white, 90% were married, and 48% were educated beyond high school. While they were at high risk with respect to prenatal care (38% with two or less prenatal visits), their deliveries were at low risk with respect to infant birth weight (only 2% of the infants weighing 2,000 g or less). Even with these favorable characteristics, their neonatal mortality rate was eight times that of lay-midwife home deliveries.

COMMENT

This study showed that the outcome of delivery varied importantly by both the place and circumstances of delivery. In-hospital vs out-of-hospital classification does not adequately group births by risk of neonatal mortality. Even more specific designation of the place of birth does not suffice to describe risk. Deliveries occurring at home ranged from lowest to highest risk of neonatal mortality depending on planning and the attendant present.

Medically selected women delivered at home by lay-midwives were at high demographic but low medical risk. The screening process carried out through physician-supervised prenatal care at local health departme was apparently effective.

In contrast, planned home deliveries without known medical screening and without a trained attendant resulted in high neonatal mortality despite their low-risk demographic profile. Having less prenatal care and not having a trained attendant at delivery appears to have lessened the demographic advantage for this group and predisposed their infants to higher mortality.

Unplanned home deliveries were associated with neonatal mortality even higher than deliveries en route to the hospital, although the difference was not statistically significant. After analyzing 100 consecutive cases of unattended home deliveries in England, Fraser[1] concluded that "while precipitate labour is an important factor, inadequate preparation and instruction of the patient are the commonest causes" of unattended home delivery.

Adequate prenatal care and provision of care appropriate to medical risk has been repeatedly associated with lower neonatal mortality. Montgomery[2] and later Levy et al[3] showed that a nurse-midwife program, which emphasized prenatal care for a medically underserved population, was associated with a notable decline in neonatal mortality followed by a sharp rise after discontinuation of the program. Zackler et al[4] have reported that a maternal and infant care project, which provided prenatal care to girls who conceived when they were younger than 15 years, was associated with lower neonatal mortality compared with a population that did not receive project services. In large-scale studies of vital statistics data, Kessner et al[5] in New York and Dott and Fort[6] in Louisiana found that adequate prenatal care was associated with less risk of low birth weight and neonatal mortality.

Several limitations of this study suggest cautious interpretation of its findings. Inferences regarding the safety of home births should await prospective controlled studies. Potential deficiencies of this study include the following: home delivery practices in North Carolina were not necessarily representative of practices in other states; there was a small number of neonatal deaths in the study; th

possible errors in classifying the place and circumstances of birth; underreporting of home births and neonatal deaths may have occurred.

Two factors restricted the scope of this study. First, home deliveries and hospital deliveries attended by nurse-midwives were not represented, but are an increasing proportion of deliveries in other states.[7] Second, lay-midwives practicing in North Carolina during the study were initially certified in 1964 or before and had at least ten years' experience with home deliveries.

Despite including all births in a three-year period, the number of home deliveries in this study remained small. There were so few neonatal deaths that the neonatal mortality rates of subgroups of home deliveries could be substantially altered by the addition or reclassification of several neonatal deaths. The findings need testing where home delivery is more common.

Retrospective classification of birth regarding intent to deliver in the place and circumstances in which delivery actually occurred is difficult at best. Intended home deliveries followed by neonatal death may have been misclassified as precipitate and unplanned. Women who chose home delivery but developed a problem during labor may have gone to the hospital to deliver. Hospitals are appropriately the intended place for most high-risk deliveries. This fact confounds comparison of the neonatal mortality of hospital and home deliveries.

Some home births may not have been reported to state registrars, especially if the infant died. Possibly such underreporting was more frequent in planned home deliveries when a preventable death caused guilt feelings. However, because lay-midwives need a permit for each home delivery and have a reputation to maintain, such underreporting is probably less likely than for home deliveries that did not come to the attention of the health department before delivery.

In conclusion, there has been a dramatic shift from home to hospital delivery in the last 40 years in North Carolina. The potential risk of delivery at home may be unacceptable to most women. However, some women still prefer or economically need an alternative to a high cost physician-hospital delivery. Indeed, cost and preference accounted for more than three fourths of the reasons for the dangerous planned home deliveries not attended by a physician or lay-midwife.

Poor women in some rural areas are still experiencing high levels of preventable neonatal mortality because of lack of medical attention. To extend adequate prenatal and delivery services to these women, economically realistic alternatives should be developed before existing traditional services are phased out. For prenatally screened low-risk women, delivery by a trained nurse-midwife under physician supervision, perhaps in a birthing center with hospital backup, may have a cost advantage over physician-hospital delivery without unacceptable risk of maternal or neonatal mortality. Whatever program a community develops, monitoring the quality of prenatal care, adequately identifying high-risk pregnancies, and training competent birth attendants all require the knowledge, expertise, and support of the medical community.

References

1. Fraser A: Unexpected home confinement. *Br Med J* 1969;3:646-649.
2. Montgomery T: A case for nurse-midwives. *Am J Obstet Gynecol* 1969;105:309-313.
3. Levy B, Wilkinson F, Marine W: Reducing neonatal mortality rate with nurse-midwives. *Am J Obstet Gynecol* 1971;109:509.
4. Zackler J, Andelman S, Bauer F: The young adolescent as an obstetric risk. *Am J Obstet Gynecol* 1969;103:305-312.
5. Kessner D, Singer J, Kalk C, et al: Infant death: An analysis by maternal risk and health care. *Inst Med Natl Acad Sci* 1973;50:13-18.
6. Dott A, Fort A: The effect of availability and utilization of prenatal care and hospital services on infant mortality rates. *Am J Obstet Gynecol* 1975;123:854-860.
7. Rooks J: *Nurse-Midwifery in the United States: 1976-1977*. Washington, DC, American College of Nurse-Midwives, 1978, pp 29, 40-41.

KEVIN KRAJICK

HOME VS. HOSPITAL

WHERE ARE BABY, MOTHER (AND DOCTOR) SAFER?

EDFOTO-Ed Tilly

In November, 1981, Dr. George Wootan stood before a medical board that would decide whether or not to take away his practice. Outside the hearing offices of the New York State Department of Health stood 100 of his former patients—mostly mothers with small children and babies—protesting the health commissioner's decision to suspend Wootan's license. They held signs like "The Commissioner's Position Is an Outrage to Free and Thinking People" and "Freedom of Choice—Support Dr. Wootan."

The extraordinary support for Wootan, which also has included fund-raising concerts and lectures and close to $10,000 in donations to his legal defense, is a testimony not only to the esteem his patients have for him, but to the high emotions that surround the kind of medicine he practices.

Wootan is one of a handful of doc-

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While home birth in itself is not illegal, many of the doctors around the country who practice home births are facing loss of hospital privileges, suspension of licenses, and revocation of malpractice insurance.

tors who deliver babies in their patients' homes. Many other doctors feel the practice is unsafe and archaic. But there is a substantial constituency of parents and other health professionals who believe that home births are at least as safe as hospital births, and possibly safer. They believe that physicians like Wootan are being persecuted by medical authorities on trumped-up charges because they practice a brand of medicine that the medical establishment does not like nor understand.

While home birth in itself is not illegal, and it is not mentioned in the charges against Wootan, all the charges against him involve things he allegedly did wrong at home births. Many of the other doctors around the country who practice home births also are facing loss of hospital privileges, suspension of licenses, and revocation of malpractice insurance.

Wootan has become a central figure in the increasingly polarized debate over home birth. He is "a great man and a hero" in the eyes of Dr. Herbert Ratner, a founding member of the Chicago-based, 35-member American College of Home Obstetrics, because he is "fighting the medical establishment so he can offer people a choice about their medical care."

But in the words of Dr. George Ryan, immediate past president of the American College of Obstetricians and Gynecologists (ACOG), doctors like Wootan offer nothing but "the potential for disaster." The 23,000 member ACOG, which represents most of the country's obstetrician-gynecologists, firmly opposes home births, as does the AMA and most other major physicians' organizations.

Despite what home birth advocates describe as a growing movement away from hospital births, there is little evidence that the vast majority of Americans want their children to be born anywhere but in the hospital. As late as 1939, half of all births in the United States took place at home, but by 1975 the figure had dropped to about one percent, and it remains there. Research by the National Center for Health Statistics indicates that home birth is increasing in 20 states (Idaho leads the way, with 2.3 percent), but decreasing or remaining stable in others.

There are fewer than 100 doctors who attend or supervise home births, by most estimates. Almost all of them, including Dr. Wootan, are general practitioners, not obstetricians. Doctors attend about half of the 35,000 registered, planned out-of-hospital births each year. The rest are attended by midwives or nurse-midwives, who under most state laws have to be supervised by a doctor.

Both advocates and opponents of home birth cite safety as the major reason for their stands. "Innumerable deaths are caused by hospitals," asserted David Stewart, a medical statistician and leader of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), a leading home birth organization. "Doctors in hospitals cause the majority of the crises they see. They start out with a perfectly normal situation and turn it into an abnormal one by intervening too much," claimed Stewart.

Home birth advocates' major arguments against hospital births are as follows:

- The presence of sophisticated emergency technology in the hospital presents a threat, not a help, to the nine out of 10 mothers who need no intervention. Women whose labors last slightly longer than "normal" (a term that varies drastically in definition, depending on who is talking) or have even the slightest problem are often subject to drastic and unnecessary obstetrical procedures, such as labor-inducing drugs, analgesics, anesthetics, artificial rupture of amniotic membranes, use of forceps, insertion of monitoring electrodes, X-rays, ultrasound waves, and Caesarean deliveries. All of these interventions, while lifesavers in a few cases, are usually unnecessary and, put together, increase the risks of birth, home birth advocates charge.
- Hospitals present a greater risk of infection because of the high concentration and myriad assortment of foreign bacteria present, antisepsis notwithstanding. At home, bacteria are also present, but mother and fetus are more likely to have developed immunity to them.
- The hospital produces anxiety in the mother because it is a strange place with unaccustomed sights and smells, and because family members are often excluded from the birth. Often, this anxiety causes normal labor to stop as soon as a woman arrives at the hospital. Then, doctors take artificial steps that would not have been necessary had the birth taken place in the home.

Home birth advocates also rely on their feelings to argue their side.

Diane Balog, a resident of East Greenbush, New York, delivered two children in hospitals before she decided to have her third at her own house. She claims that at the hospital she was given drugs without her consent.

"I was completely at their mercy," she said. "If I had had anything but an absolutely normal delivery, they would have cut me open." She also objected to the "assembly-line atmosphere" of the hospital. "I was just another one of the cattle. They didn't even bother to learn my name."

Like Balog, though, most parents who elect home birth see the impersonality of the hospital as a secondary reason. Said Joann Rogoff, whose first son Dr. Wootan delivered in her bedroom two years ago, "Sure, we liked being home and having people around who we loved. But our bottom-line concern was safety."

Advocates of home birth cite studies to back up their assertions of safety. Hospital births versus home births have been studied in Sweden, Denmark, Holland, England and the U.S. with no discernible differences in outcome. In Holland, where close to half of all births take place at home, infant mortality rates are much lower than in the United States. A study done in 1975 of 1,046 California mothers showed no difference in infant

mortality at home or in the hospital.

On the other hand, proponents of hospital births cite statistics that they say prove exactly the opposite. A German study done in the 1960s showed double the infant mortality rate for home births as for hospital births. A 1975 study done by ACOG suggested that the home birth infant mortality rate in Michigan was four times that of the hospital rate, in Hawaii it was three times higher, and in Oregon it was twice as high. ACOG members also cite dropping U.S. infant and maternal mortality rates as evidence that hospitals are safe.

Studies that support either point of view are open to serious question, according to many medical scientists. Most studies extend only over short periods of time and have small sample groups and inadequate controls. Mortality rates could easily be affected by factors other than the place of birth. Perhaps the most obviously flawed research is the ACOG study, which includes unplanned and unattended out-of-hospital births, which nearly everyone agrees are far more dangerous than planned professionally attended home births.

"We're never going to have a completely controlled and reliable study. It can't be done, and it won't be done," said Dr. Harold Kaminetzky, a past president of ACOG. "We have to base our opinions on the best available evidence and on common sense, and they indicate that the safety of the home is far less than in the hospital." Kaminetzky said that the ideas that hospitals carry increased risks of infection and of unnecessary obstetric intervention are false.

According to most doctors, about two-thirds of the mothers who stand a substantial risk of serious complications during labor can be identified well in advance and advised to have the baby in the hospital. But some problems just happen without warning while the baby is being born and have to be dealt with in minutes. The most frequent and serious of these are a twisted umbilical cord, which sometimes requires an immediate Caesarean, and rupture of the uterus, which can bleed a mother to death in minutes.

"At a time of unparalleled advances in perinatal medicine, the home offers nothing safer, and the hospital offers all kinds of lifesaving techniques," said ACOG's Ryan. "Why throw away all that safety? Sure you may be able to transfer to the hospital in time, but in a few cases there is no time."

Only three to five percent who begin labor at home wind up having to go to the hospital because of complications, according to home birth practitioners. ACOG claims the number is closer to 20 percent.

Doctors who attend home births say the risks of complication are their first consideration.

"Almost any complication can be handled on the spot," asserted Dr. Gregory White, a Chicago general practitioner who has delivered more than 1,000 babies in his patients' homes during the past 28 years, plus another 3,000 in hospitals. "What many obstetricians would identify as an emergency can usually be handled with very little intervention. There is almost never a good reason to send someone to the hospital, unless, of course, they want to go."

Most home birth practitioners carry an assortment of emergency equipment such as suction units for clearing an infant's respiratory tract and portable oxygen tanks. In recognition that some emergencies can be handled only at a hospital, many home birth doctors limit their practices to patients who are within 15 or 20 minutes' drive of a hospital.

"What it boils down to, I think, is that you cannot choose a risk-free delivery," said Wootan. "There is absolutely no question in my mind but that there are some babies who will die because they were born at home. There is also no question in my mind but that some babies will die because they were born in the hospital. I happen to believe that a lot more of them will die in the hospital, for different reasons than they'll die at home. You have to take your choice of risks."

In many localities, however, prospective parents are prevented *de facto* from making the choice for home birth, at least if they want a doctor or a certified midwife to attend. That is because there are many areas where no doctor will take responsibility for such a birth. Some couples decide to go ahead with a home birth anyway, attended by an unlicensed midwife or completely unattended, an outcome that many home birth proponents see as a dangerous side effect of the lack of cooperative professionals.

The greatest deterrent to doctors considering attending home births is that many of those currently doing it have found themselves facing charges of incompetence by local hospitals and state medical licensing authorities, sometimes seemingly unrelated to the home birth practices. The threat of higher malpractice insurance premiums or no malpractice insurance at all is another specter that hangs over home birth practitioners.

As a result of the pressures, many doctors who practice home birth prefer to keep a low profile. Several doctors called by *TNP* declined to be interviewed, saying that the publicity would only bring them trouble.

One who consented to an interview was Dr. Wootan. "I don't want everybody to have their babies at home," said the soft-spoken Wootan, who at 45 has 10 children of his own ranging in age from one-and-a-half to 23. "I just want people to have a choice."

Wootan, an Oklahoma native, graduated from medical school in 1963. He said he practiced conventional hospital deliveries for 15 years "without a second thought." He moved to Kingston, a city of 25,000 that is 100 miles north of New York City, in 1966.

He started becoming disillusioned with hospital births in 1977 when he was not allowed to dim the lights or practice other "natural" childbirth techniques while helping his wife deliver their ninth child at Kingston's Benedictine Hospital. "We did not have a good experience. I thought if I, as a doctor, can't get the kind of experience I want for my wife, what chance did anyone else have?"

Soon after he made his dissatisfaction known, several patients requested that he deliver their babies at home. "I went to some conferences about home birth and did a lot of reading, and I thought it sounded nice. But I still wasn't exactly ready to jump on the bandwagon," said Wootan. Nevertheless, he consented to attend several home births. With experience, he became convinced that home births were actually safer than hospital deliveries. "At first, I thought it would just be the same thing in a different place," he said. "But I found that it was a whole dif-

ferent way of dealing with birth. You can't mess around with the mother and take the risks that you might take in the hospital."

Since the only other doctor in the county who delivered babies at home had just left the state (he claims he was harassed by local medical authorities), people began coming to Wootan from miles around. He became a local curiosity, appearing on radio talk shows and in the papers.

By 1979, Wootan had what local doctors describe as the largest practice in the county. He employed two physician's assistants, an associate doctor, and other personnel. Despite his popularity as a home birth practitioner, Wootan says that home maternity comprised only 20 percent of his practice. The rest of his patients were mostly nonmaternity cases who came from as far away as Connecticut and New Jersey to see him.

Wootan's troubles began with the local hospitals soon after he began doing home births and engaging in other "alternative" medical procedures. In 1979, he did his first LeBoyer birth at Kingston Hospital, in which light and noise are minimized, and babies are immediately immersed in warm baths. The next morning he found a letter in his mailbox from the hospital's chief executive. It announced that he had been suspended from practicing at the hospital because of the "radical new obstetric procedure" he had used. When Wootan pointed out that other institutions in the area had been using the technique for some time, hospital officials acquiesced and returned his privileges.

Pressure from other doctors about his unusual practices began to radicalize Wootan. "It opened my eyes to the biases against anything but established medicine," he said. "They got mad when I didn't yell at my patients for going to a chiropractor when they got a backache. . . . I believe there are many healing arts."

In 1980, the Benedictine Hospital, which had certified Wootan for 13 years, revoked his obstetric privileges, and soon after, all of his privileges. The charges against him were that he allowed a physician's assistant to sign a patient's chart, he failed to put silver nitrate drops in newborns' eyes, he attended hospital meetings irregularly because of his frequent attendance of home births, and he immediately discharged mothers and infants who had been delivered at the hospital. No injuries to patients were cited.

At the instigation of local doctors and several parents who had complications during Wootan's home deliveries, the state Board of Health began investigating Wootan. On the afternoon of Nov. 20, 1981, a state trooper showed up at Wootan's door with a paper signed by the state commissioner of health. It said that Wootan's license was immediately suspended because he represented "an imminent danger to the health of the people of New York State." Wootan closed his office and went to visit some relatives while he figured out what to do.

The state alleged that Wootan failed to administer silver nitrate to newborns and that he referred one expectant mother to an unlicensed midwife while he was out of town. It accused him of failing to diagnose and treat such conditions as postpartum hemorrhage, pelvic disproportion, prolonged labor, and amniotic rupture, conditions that led to the death of two infants and the birth of one who was brain-damaged. Since those charges were filed, the parents of one dead infant have filed a malpractice suit against Wootan. In that case, the woman labored for 24 hours at home, during which time the amniotic sac ruptured. She finally went to a hospital, but by that time the fetus was dead. Medical investigators say Wootan failed to diagnose the woman as having too small a pelvis for the birth to take place normally.

Both Wootan and the state have commented very little on the specific cases involved. In the only case he would discuss he said, "Who wouldn't recognize postpartum hemorrhage? She was a Jehovah's Witness and wouldn't go to the hospital because of her religious beliefs. I couldn't force her; she's an adult."

Wootan and his supporters in the community say the hospitals and the state are charging him with incompetence because they want him out of the home birth business. Wootan says he has cost local hospitals and obstetricians $250,000 in lost fees since he began practicing home births: a delivery at the Benedictine costs about $2,500, as opposed to Wootan's most recent fee of $1,000. A more potent factor, he said, may be that "the medical establishment is afraid of home birth because they don't understand it. Most obstetricians would be completely at a loss if they had to deliver a baby at home."

William Fagel, a spokesman for the state commissioner of health, Dr. David Axelrod, said that "the commissioner has nothing against home births, but they have to be performed with the proper safeguards, which is the issue here." In the past few years, five other doctors in New York State who have practiced home births have faced charges of incompetence and have either gotten out of the home birth business or "gone underground," said Wootan. "If they're practicing home birth, you won't be able to find out about it," he said.

Wootan filed suit against the Department of Health. A month after his suspension, the state Supreme Court ruled that the suspension was "so unreasonable as to be arbitrary" and ordered that the state return Wootan's practice. The state immediately appealed, which meant that Wootan was automatically resuspended. In April of this year the five-member Appellate Division of the New York Supreme Court unanimously ruled in Wootan's favor, annulling the suspension. Wootan was able to practice for two weeks, during which time he delivered three children. The Department of Health issued yet another suspension, this one covering only the obstetric part of his practice. A full appeal to the state Board of Regents, which issues medical licenses, could take another year and cost $25,000 in legal fees, says Wootan. He is also suing the Benedictine Hospital for the return of his privileges there.

Wootan has filed for bankruptcy and vacated an office building he had purchased in Kingston. He made some money for a while giving lectures and teaching childbirth classes. He has the nonobstetric part of his practice back, now, but it is not enough to meet the accumulated bills, he says. At least he has kept his malpractice insurance, though his premium has been doubled since he came under fire, to $7,000.

A Friends of Wootan organization

nas raised money by holding benefits and bake sales, selling "Home Birth Is Best" T-shirts, and collecting donations. Supporters have written dozens of letters to legislators, and billboards supporting Wootan have popped up around Kingston.

Local doctors have kept their customary silence about one of their colleagues under fire. Wootan claims that most are hostile but that a few have called secretly to offer their sympathy. Wootan said he plans to "fight it out to the end. I don't see any point in running away from all of this."

While home birth does not seem about to become accepted medical practice, many of its advocates point out that the movement has had its effect on hospital deliveries. In response to criticisms and competition from alternative medical practitioners, a growing number of institutions are providing "birthing centers" that are furnished to look more like homes. An increasing number of hospitals are allowing doctors and midwives to practice various natural childbirth methods in these centers and in regular delivery rooms.

There is also a growing number of "free-standing" birthing centers, not connected to hospitals. These are usually small, comfortably furnished facilities with some emergency equipment. They are staffed mostly by midwives and a few doctors; many of them encourage natural childbirth. In 1973, there were three such facilities. Now, there are 130 of them in 27 states, according to a survey by the New York City-based Maternity Center Association.

Obstetricians, still the choice of most parents, tend to believe that nonphysicians are incapable of distinguishing among the risks and benefits of the different birth settings, an attitude that galls advocates of alternative birth practices. "More than anything, the home birth movement is a consumer movement," said Joan Bowen, president of the International Childbirth Education Association, which accepts home birth as an alternative, but does not advocate it over other kinds of birth. "The home birth movement is trying to force doctors to recognize that patients are intelligent human beings who can make a choice about medical care." ●

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I am Peggy Hardon, the mother of four children, three of which were born naturally in the hospital, one which was born at home. I want to state from the beginning, that for me, Homebirth is wonderful and undescribably beautiful! However, whether or not we agree with and support home birthing is not really the issue today. Like it or not, home births are here in Kansas and their numbers are growing each year. Because it is certainly every parents right to choose their own baby's birthplace, the issue is to make these homebirths as safe as possible for these mothers and babies by providing them well trained competent birth attendants.

It is important to note that home births did not come to be because of midwives. The opposite is true: midwives exist because they meet a vital need in this state.

I am a Registered Nurse with some obstetrical experience. For the past four years I have been a childbirth educator, and I am married to a doctor, so you can see that I have a deep love, respect and admiration for the medical profession! However, I know that every day we Doctors and nurses work with and we are greatly helped by other health care personel. Doctors and Nurses must realize that in our complex society traditional doctor-nurse-hospital medicine is not always wanted. Doctors and nurses must be careful not to become too defensive of what they perceive as being their "turf". These midwives are not trying to become doctors, nor are they attempting to "take over" the job of the Certified Nurse Midwife. The M.D.'s and C.N.M.'s of Kansas are playing an irreplaceable role in obstetrics, but they are obviously not meeting all the needs of all our pregnant women. It is the rare doctor or nurse who will have anything to do with the home birth couple and their baby.

Most midwives did not plan throughout their youth to vecome mid wives, what they did, was to perceive a need, and answer it by giving of themselves to help. despite sometimes overwhelming opposition. On their own they have studied and learned in order to beable to give even more help to those who come to them. This is why these midwives exist today in the state of Kansas.

We can only applaud these women, who in their service to the people of Kansas, are now willing to have the restrictions of licensure, provided by this bill # 634, placed on their profession, so that the mothers and babies who desire a home birth can have quality care.

Birth is different from any other area of medicine in that only a small portion of it is in any way medical. The emotional, social and spiritual aspects are by far stronger elements, areas most doctors are unable to relate to as effectively as these midwives. They are dedicated to families. They have themselves experienced pregnancy, birth and parenting, thereby sharing in common goals and direction.

Attempting to describe the mother-midwife relationship is like trying to describe other intangibles such as "love", or "respect", "empathy" or "beauty".

Some women can achieve a similar relationship with the more traditional health care providers (doctors and nurses), but many women want a birth advocate not tied to the traditional medical field.

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Public Health and Welfare Committee - Senate 1984 session

#12- 2-15

Senate Bill # 635

Testimony presented by Peggy Hilpman, Wednesday February 15, 1984.

I am not here as a representative of any organization. I have very personal interest in this bill. I am a mother of three, two of my children were born at home. Their births were attended by midwives. I currently am enrolled in a three year academic midwifery program and upon successful completion of this course. I would like to apprentice and eventually practice Non-nurse midwifery in Kansas.

The portion of this bill that I want to briefly address is Section 2 clause (d) the last line - "Licensed Midwifery is not to be construed as the practice of Medicine."

I can not and will not attempt to define the current practice of Medicine in this state, for you. I do feel, however, that care should be taken by all that Medicine and Midwifery are not confused and somehow defined as being one and the same. I am going to attempt to give you a short overview of what the practice of Non-nurse midwifery involves.

A midwife is knowledgable in the NORMAL physiologic changes of pregnancy, labor and delivery. S/he watches that each segment completes itself within a satisfactory mannor. Her role is to assist the woman in achiving optimal outcome. She does not intervene in the physiologic processes but rather enhances that process by non-invasive measures. Her primary goal is keeping the woman in optimum health during pregnancy through diet, exercise, education, monitoring fetal growth, monitoring appropriate lab values etc.. . Assuring that her pregnancy k eps within the norm. In the event of any deviation from the norm, prompt referal to the appropriate Medical agency would be made.

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During labor and delivery she continually monitors the health of the mother and child. This assures that this event completes itself within safe limits. Assisting when ne ded but keeping the policy of non-intervention.

During the postpartal period the Midwife assists the mother, child, family in adjusting to eachother and in establishing/ re-establishing the family. She may offer advise regarding breastfeeding, normal growth and development, nutrition, or psychological changes that occur among family members. When needed she will refer the family to appropriate medical facilities or other community agencies.

The profession of midwifery represents all that is best in female tradition. It combines skill and intelligence with dedicated work and nuturant supportive behavior.

There is no reason why this bill should become the next battleground between the Kansas Medical Society and Consumers. It would be a tragic and wasteful mistake to curb the opportunities available to midwives through legal restrictions, professional rivalries, and archaic attitudes toward the place of the midwife in todays society and health care system.

A 13 - 2-15-84

S.B. 634

Testimony in favor of

By: Ken Kasten

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I am a concerned parent in favor of passing S.B. 634 to license midwives in Kansas. I am here today to give a personal viewpoint on attended homebirth.

My wife and I have two children and we have another one on the way. Although we had planned to have all our children at home, an extended labor forced us to have our first child in the hospital. Our second child was born at home. We will have our third child at home.

We realize that complications can and do happen. Most of them can be anticipated through good pre-natal care. We were grateful for the availability of good hospital care when we needed it. There will always be those who will choose to have a hospital birth, or have contradictions for home birth. What we are asking for is the equal opportunity to choose an attended home birth.

Fortunately, the State of Kansas does not actually outlaw midwifery or home birth. However, several problems are involved in arranging a home birth. First, the midwife cannot legally charge for her services. How many of us would spend years studying and training for our profession, and then donate our time for no compensation? I personally know three midwives who essentially did just that. I have estimated approximately 35 hours were spent by the midwife during our last pregnancy and birth (this does not include post-partum care for mother and baby). This was time taken from family and personal life with no remuneration. No person can do that for very long. In contrast, the well-paid obstetrician spends about three hours with a woman during her pregnancy and birth.

The second point deals with physician back-up in case of complications. In order to cover all possibilities, our midwife works with our obstetrician. My wife makes regularly scheduled visits to the obstetrician just as though we were planning a hospital birth. In this way our obstetrician is familiar with the pregnancy in case my wife needs to go to the hospital due to complications. Most obstetricians are unwilling to provide that back-up care due to the hazy legal status of midwifery and pressure against such "unorthodox" dealings by their peers. The licensing of midwives would make it a little easier to find willing back-up physicians.

A third point involves insurance coverage. The insurance companies to whom I have spoken indicate that they would happily pay for the services of a midwife if she were licensed by the state. They have also indicated an experience of lower birth costs when the deliveries were attended by a midwife.

I would now like to clarify a few points. This bill was written by a group of parents that want to ensure the future availability of competent midwives for their home births. Since we are not midwives, we cannot go through the regular credentialling process for health care professionals.

This bill does not spell out the training that a licensed midwife should have. To do so would have made the bill overly cumbersome. It would be the duty of the regulatory council set up under this act to delineate the required training.

We are not speaking of general alternatives to a routine hospital birth such as birthing rooms, birth clinics, or home-like birth. We are explicitly talking about births attended in the home. In order to ensure a safe home delivery, there should be a competent birth attendant. Certified nurse-midwifes cannot legally attend home births. Doctors will not. Those who have tried have been persecuted and prosecuted by their peers. The only available home birth attendants are midwives.

Home birth is not a fad. It is not "innovative" birthing. Rather, it is a natural conclusion at home to a pregnancy which began in that home. Pregnancy and childbirth are not diseases, but natural bodily functions. They do not, under most circumstances, require hospitalization, drugs, and medical procedures.

We do not pretend to believe that licensing of midwifes will stamp out incompetency. It is not possible to do that, with all of the laws and examinations in effect to make sure that our physicians are capable, there are still incompetent doctors practicing. When training requirements and licensing exams are passed by any professional, it only indicates a level of proficiency. There is no way to guarantee competency in any field.

We need the midwives. They are the only professionals around who can fulfill our need. We want to be as certain as is humanly possible that the midwives we hire are well-trained.

We also want to make sure our birthing situation is not dictated to us by hospital or physician. Midwives are an endangered species. We want to see to it that the American Medical Association cannot put them out of business as they have tried to do across the country.

The midwives of today are not like the granny midwives who practiced years ago. They are armed with a wealth of knowledge and training which was unavailable to midwives of the past.

The midwives we have had have been totally dedicated to making each birth a special moment. They have spent many hours getting to know us and our every desire. Unlike a "normal" hospital birth, a home birth is a quiet, unhurried, very personal event, with only those people in attendance chosen by the parents.

We ask you to carefully consider this bill, put forth by a group of consumers to try and ensure the availability of skilled, caring professionals for our home births. Should any group of professionals have sole determination of our lives, or does the individual have the right to make his own decision? We hope that after considering the facts you will favorably pass this bill out of committee. Thank you very much.

#14-2-15-84

My name is Kris A. Berger. I am coordinator of a cesarean support group PEACE & CARE - CPM, a member of PEACE & HOME Association, Inc., (Parents and Professionals Enhancing Alternatives for Childbirth Experiences and Home Oriented Maternity Experiences), The Cesarean Prevention Movement, C/SEC, Inc., the International Childbirth Education Association, NAPSAC (The National Association of Parents and Professionals for Safe Alternatives in Childbirth) and La Leche League. I have had much experience working with parents and professionals in the childbirth field.

I would like to start by saying that I cannot understand why our government has allowed the killing of unborn children or abortion as it is called, to be legalized, but the right to give birth at home, with qualified birth attendants, because it is the safest environment for that event to take place, has not yet been legalized. I have heard it said that abortion was legalized because women were going to do it anyway, but under unsafe conditions. I have also heard it said that women had a right to make a choice about what they do with their own bodies. However, it seems that women have a right to kill their unborn children but they do not have the right to give birth to them in the environment they have chosen as the safest with qualified birth attendants. It is a fact that women will continue to give birth to their children at home. Some will be forced to have only the father in attendance, some will have friends or maybe not so qualified or experienced birth attendants and some will be lucky enough to find qualified midwives. It will go on because we parents who choose home birth know it is the safest and best alternative for us and in this free country we have a right to make this choice. Some homebirth parents may not choose to have a licensed midwife in attendance, that is their choice to make, but for those of us who do want qualified, trained and experienced midwives attending us at home, we need Senate Bill #634 passed so we will have the opportunity to hire these midwives. There are only a few nurse-midwives to my knowledge in the state of Kansas and doctors and nurse-midwives ~~do not~~ attend home births in Kansas.

only 2

no

Doctors and nurse-midwives are not trained in home obstetrics which is much different than hospital obstetrics. That is the reason many doctors, I feel, are against home birth because they have no experience with it and do not understand it. They have been trained to use medical and technological intervention in dealing with childbirth and are not familiar with natural ways. Midwives emphasize a high level of quality nutrition and other health practices which most doctors do not. Doctors have gone through 8-11 years of intense medical training and they look at birth as a medical event. Many of them truly care about their patients and have seen complications which have convinced them that all babies should be born in the hospital. Yet so many of these complications, could have been avoided through better prenatal care emphasizing nutrition, no smoking or drinking of alcohol, no medications and no unnecessary intervention during labor.

Another reason, that doctors are against home birth is because it means less money for them. Obstetrics is not much of a money maker left to itself. The only way hospitals can make money in this area is to use their technological machinery: electronic fetal monitors, epidurals, sonograms, c-sections, etc. Most birthing women don't need these things because birth is a natural event not a sickness.

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Hospitals have never been proven to be the safest place for most mothers to give birth and doctors have never been proven to be the safest birth attendants for most mothers. There has never been a study done which shows doctors are now or ever have been superior to midwives, according to David Stewart, author of the book, Five Standards for Safe Childbearing, every published study shows the opposite.

There is the radical view that every woman should give birth in the hospital and then there is the moderate view that some women belong in the hospital to birth their babies and some do not. There is nobody saying everybody should be born at home. However, there are thousands of doctors and others saying that everybody should be born in the hospital. That is an extremely radical view. They are the radicals and we who support home birth and the legalization of midwifery are the moderates. In the extreme view, there isn't even one published study anywhere, there isn't one research paper in any journal of medicine, no state report, nowhere can you find any evidence that every woman should give birth in the hospital. That viewpoint is without a shred of scientific basis and there is lots of scientific data according to David Stewart to support the moderate view.

I would like to state 3 basic reasons why hospitals are uniquely dangerous: 1) Infection, 2) Abuse of Technology, and 3) The Presence of Technology.

1. Infection is a very serious problem in hospitals. Hospitals have a higher infection rate because where else in your community is the largest concentration of sick people - the hospital, because that is really what it is for. Because there is such a concentration of pathogens in the hospital, they combat this 24 hours a day with every kind of a powerful antibiotic and antiseptic they can, which creates new strains of resistant bacteria, fungi, and viruses that no longer respond to those kind of treatments. So in the hospital, you are taking the risk of infection from germs you would never find at home and to which you are not immune. You avoid this risk by having a home birth. When you are at home you are living with pathogenically compatible germs.

   Women have died after cesareans, because they got a resistant strain of germs and there was nothing the hospital could do, the antibiotics were powerless, the antibiotics had created them, so naturally they wouldn't work. Babies who get infections in the neo-natal intensive care units have died. Even healthy babies who have been exposed to the hospital have died from infection. The Center for Disease Control in Atlanta, published a report a year ago which says there are 80,000 deaths a year in American hospitals due to hospital acquired infections.

2. Hospitals are uniquely dangerous because of the abuse of technology. When a woman goes into the hospital to have her baby the first thing they want to do is start an IV with glucose, maybe put in a little medication, an analgesic, give an enema, hook up a fetal monitor, break the bag of waters and get all the electronic devices working. 20% or more women are ending up with cesareans which is the extremist form of technology. This is just abuse. Less than 5% of women, should be subjected to any of that if they are properly cared for and are given good nutritional advice says David Stewart.

Dr. Lewis Mehl did a study and gave a paper on it at the American public health association several years back. He came up with the 4 major reasons, variables of technology, which correlated most closely with negative outcomes of babies. These 4 major causes of problems to babies were: 1) oxytocin (used to induce or speed up labor), 2) analgesia, 3) amniotomy (breaking the bag of waters), and 4) forceps. There are many hospitals where every woman who comes in gets her water broken and they put an internal fetal monitor in. The water has to be broken for this so they can also be a source of infections. Most women get oxytocin and analgesia and end up with forceps.

3. The 3rd thing which is uniquely dangerous in hospitals, is the presence of technology. Even if the hospitals could solve the infection problem and even if doctors started using technology discriminately, the presence of technology is something hospitals can't very well eliminate. This has been documented by medical doctors and the problem is called maternal anxiety. Women who were in labor at home often stopped labor on arrival at the hospital. It stopped because they went to a strange place, with strange odors, strange people, strange noises. The women are whisked off and get separated from their husbands who are signing papers. People in white coats, strangers, medical students, all kinds of activity surrounds the laboring woman. If this was done to animals during labor their labor would stop and usually the babies would be born dead.

   The very presence of the hospital environment has a mental effect on the woman which causes her hormones to change. The hormones which caused labor to start in the first place cease flowing, her blood pressure changes, and labor stops. This has all been documented in the medical literature, however, to solve this problem, these medical articles recommend that every woman be given routine analgesia and tranquilizers to calm her down when she comes to the hospital. As I mentioned previously, Dr. Mehl showed that analgesia was one of the top 4 major causes of problems to babies. An alternative to this would be for those women not to go to the hospital. Family-centered maternity care in hospitals certainly helps in this area but does not totally alleviate the problem.

Even though hospitals contain many risks, there are a few women who are at a high risk themselves, who need them. We are glad these hospitals are there for them to use. We are glad hospitals are there for us to use when something does happen at home where we need to transport to the hospital.

I myself, planned on having my first child at home in June of 1980. I had prenatal care from a doctor who knew of my plans for a home birth. During labor my midwives detected the baby was breech and we contacted my doctor and went straight to the hospital. At the hospital I was treated rudely, threatened and harrassed. My husband and I were separated from our midwives (one of our midwives was an OB nurse herself), My doctor didn't show up for three hours. They took X-rays which showed that the baby was frank breech which is the best position to deliver a breech baby vaginally. My doctor told me I had plenty of room but that I had a crooked tail bone which might get in the way and the baby's head might get caught.

I agreed to a cesarean because of this. A student nurse anesthetist, I later found out, administered the epidural which didn't take, I felt like he wasn't sure of what he was doing. So in the end I was rendered unconscious for my baby's birth. My postpartum stay was also a very negative experience with nurses too busy help a cesarean mom get around. A cesarean section is major surgery. One of the nurses told me "You are going to have start doing things for yourself!" in an unkind tone of voice. She also badgered me to let her give me an enema during visiting hours when I had visitors in my room. My doctor had told me I didn't have to have one.

Since that birth I changed doctors and hospitals and last JUly gave birth naturally. It was a wonderful experience and my two midwives and my hsuband were allowed to be with me for the birth. However, there was still some unnecessary intervention that is just inherent in a hospital birth. Last summer I also finally got to see my X-rays from my first birth. They showed no crooked tail bone. I had been lied to so they could do the c-section they wanted to do. I hardly call this informed consent and then people wonder why parents choose home birth.

It is obvious that for women who are low-risk candidates for home birth, the hospital is an unsafe alternative. Home birth itself is really not the issue here because it is not illegal in Kansas to have your baby at home. To have a qualified birth attendant to make home birth a safe alternative is what has not been legalized. Senate Bill #634 will enable midwives to be trained and licensed to attend home births. The specifics of the training are not written in the bill because that will be decided by the advisory committee. We do want these midwives to have intense training and pass certain qualifications and keep up their continuing education. These midwives will be qualified!

Parents are going to give birth at home. Please allow us the opportunity to choose qualified birth attendants. Thank you.

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