Appendix 1. Provider Group Histories

1. The Group Health Obstetrician–Gynecology and Nurse-Midwifery Practices

(See http://www.ghc.org/provider/WomensHealth/maternityServices.jhtml)

Group Health Cooperative was founded in 1945 as a non-profit organization whose focus was on quality, medical evidence, and preventive care. The "co-op" was consumer-governed: votes cast by the general membership determined organizational goals, bylaws, and elections to the Board of Trustees. Controversy reigned. The very notions of a physician group practice and of prepaid health care were often and roundly criticized as socialized medicine and a communist plot[1]. As with all aspects of postwar America, health care was evolving beyond its wartime focus, and new ways to deliver medical care were being considered. The founders' efforts were timely, and over time, successful.

Group Health Central Hospital in Seattle opened in 1960. Its Labor and Delivery unit was staffed by physicians who held a traditional medical philosophy of obstetric care. Fathers were not allowed to be present at the delivery of their children; labor, delivery, and postpartum rooms were separate.

In the late 1960's, the feminist movement and consumers' issues about reproductive rights for women pushed Group Health to pay attention to its treatment of women. In 1973, co-op member activists formed the Group Health Women's Caucus. Their proposal to the Board of Trustees included access to natural childbirth techniques and hospital privileges for trained midwives. A Midwifery Task Force was created in 1978, but change was resisted by Group Health doctors who believed that physicians' and midwives' training and practice styles were inherently incompatible and unworkable in a combined labor and delivery unit.

Across Lake Washington in Redmond, the Group Health Eastside Hospital opened a labor and delivery unit in early 1980. The first Certified Nurse-Midwife (CNM), Katherine Camacho Carr, was hired by Group Health to develop a demonstration midwifery service. Her first 6 months were spent developing practice

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guidelines, a credentialing process, recruiting additional midwives, and negotiating family-centered changes in the policies and procedures in labor, delivery, and postpartum care.

Completed in 1984, data from the Midwifery Demonstration Project provided evidence that Group Health consumers were highly satisfied with midwifery care, patient outcomes were comparable to physician care, and midwifery care was cost effective. The Board of Trustees subsequently decided to expand the midwifery service throughout the cooperative, starting at the Eastside hospital. There, the administration and physician leaders agreed to hire three CNMs who were credentialed by the Obstetrics department, but reported to nursing administration. This coincided with a full remodel of the unit, in which Labor and Delivery and Recovery and Postpartum rooms were introduced, and women labored, birthed, and completed their postpartum recovery in the same room. The CNMs provided care to low-risk pregnant patients and established their own caseload of clients. Two staff obstetricians were assigned to the midwifery practice to be primary consultants, to review charts, and to provide input into practice guidelines. Obstetrician consultation was readily available in both the inpatient and outpatient settings.

In 1990 the Family Beginnings Unit opened on the Group Health Central Hospital campus in Seattle. It held 13 modern Labor and Delivery and Recovery and Postpartum rooms with whirlpool bath labor tubs. Three CNMs and 12 physicians staffed Family Beginnings Unit under the progressive leadership of Dr. Ruth Krauss, obstetrician–gynecologist (ob-gyn). In the mid-1990s, the Family Beginnings Unit was remodeled into our present facility containing 15 Labor and Delivery and Recovery and Postpartum rooms, two operating rooms, an antepartum testing service, and additional postpartum and antepartum rooms for high-census use.

In 1996, our overall Family Beginnings Unit provider group expanded to include more midwives—two private, independent CNMs and seven CNMs from Virginia Mason Medical Center[1] (personal communication, Krauss and Karr).

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Our model includes 24/7 in-house, on call presence by a Group Health ob-gyn to handle all consultations and emergencies (as well as to manage their own patients' care). The Group Health and Neighborcare Health CNMs have regularly scheduled meetings with one ob-gyn (who represents the whole ob-gyn group) to consult on non-emergent cases; they can also consult in person or over the telephone with the on-call ob-gyn (as do the private practice CNMs).

Although outside the scope of this article, in order to see the "big picture" at Family Beginnings, it is worth noting that the Group Health ob-gyns also function as consultants to two other types of maternity care provider. Family practice physicians from both Group Health and local community clinics collaborate with the ob-gyn in their clients' maternity care, as do Licensed Midwives who are contracted with Group Health to offer home birth to low-risk women who carry group health insurance. The family physicians from the community clinics serve a primarily low-income and indigent population. (Please see section 4 of this Appendix for information about the Licensed Midwives' Provider Group History, and Appendix 2 for information on the Legal Framework in Washington State for Licensed Midwifery.)

2. The Neighborcare Health Nurse-Midwifery Practice

(See: http://www.neighborcare.org/programs/midwifery)

Faced with declining numbers of deliveries, possible closure of their obstetric unit, and growing consumer demand for in-hospital midwifery care, the Board of Directors at Virginia Mason Hospital decided in 1979 to begin a midwifery program. They recruited Carol Verga, CNM, who designed and implemented a private practice model for the Midwifery Department within the hospital's Obstetrics section. This model gave the midwifery group institutional status, protection to practice independently, and an opportunity to consult appropriately.

The Virginia Mason Midwifery Service grew quickly, and in 1980 extended their services using a shared-care model with local community clinic family practice physicians. The community clinic clients received obstetric care in their home clinics from both the clinic family physicians and the Virginia Mason midwives, and were birthed by their shared call team at Virginia Mason Hospital. This community clinics consortium later evolved into the Puget Sound Neighborhood Health Centers (PSNHC).

In 1996, Virginia Mason joined with Group Health in an alliance of clinics, hospitals, and health plans. This included moving all Virginia Mason births to Family Beginnings. The Virginia Mason ob-gyns and CNMs continued to work within their own collaborative practice model, representing approximately 25% of the births at Family Beginnings Unit.

For financial reasons, Virginia Mason Medical Center discontinued all obstetric services in late 2001. PSNHC hired the Virginia Mason midwives and negotiated a contract with Group Health, which featured a new obstetric collaboration model for the PSNHC midwives. In 2007, PSNHC changed its name to Neighborcare Health. The names changed but the midwifery group remained sound.

In 2010, the Neighborcare Health midwives delivered 337 babies. Seventy percent of the women were under a public insurance plan (typically Medicaid), 21% were privately insured, and 9% were self-pay. Financial status is one way to quantify health risk, and this predominantly low income, multilingual, multiethnic population is relatively high risk. Since access to care is a significant issue for these community clinic clients, the Neighborcare midwives tend to keep and co-manage most of their higher-risk patients with the Group Health ob-gyns, although they do transfer out cases like multiple gestation and insulin-dependent diabetics. In 2010, their practice's overall cesarean delivery rate was 17.8%; the primary cesarean rate was 10.5%; the vaginal birth after cesarean delivery (VBAC) rate was 28.6%; and the VBAC success rate was 76.9%.

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3. Private Practice CNMs

Group Health grants hospital privileges to appropriately credentialed private practice CNMs. Currently, two CNMs with their own private practices deliver at Family Beginnings and collaborate with the Group Health ob-gyns as needed.

Sally Avenson, CNM

Ms. Avenson started attending out-of-hospital births in 1980 under the mentorship of Washington State's first two Licensed Midwives, Elaine Schurmann from Chile, and Kirsten Bjerregaard from Denmark. At that time, obstetric residents at the University of Washington Hospital were requesting exposure to midwifery models of care. In response, the obstetric leaders invited the three midwives to deliver their clients at the University Hospital, where Avenson has maintained collaborative care relationships ever since.

Sally has been in continuous solo private practice in Seattle since 1981. Averaging 100 births per year for over 3 decades, she has managed births in clients' homes, free- standing birth centers, and several Seattle-area hospitals.

Her path to attending clients at Group Health came by way of Virginia Mason Hospital, where she delivered babies from 1986 to 1996. (She fondly recalls her first weeks at Virginia Mason as "having birthed and gone to midwife heaven.") Because some Virginia Mason obstetricians were not comfortable accepting out-of-hospital labor transfers, during this period her out-of-hospital transfers went to Seattle's tertiary level obstetric units, where the obstetric residents assumed management of her patients' care.

When Virginia Mason closed its obstetric unit in 1996, Ms. Avenson "coat-tailed" with the Virginia Mason midwives and obstetricians in their move to the Family Beginnings Unit. There she found the relationships between doctors, midwives, and nurses to be collegial, respectful, flexible and client-centered. Sally recalls, "At first I actually thought a couple of the MDs were midwives." She and her clients benefited

from the efforts of the director of Puget Sound Neighborhood Health Centers when he convinced the major private insurance companies to cover Group Health and "his" midwives, including Sally.

Avenson's clients are mostly Caucasian and college-educated. Eighty per cent are privately insured; 20% are on a DSHS publicly funded insurance plan. In collaboration with local hospitals' obstetricians, she cares for many women with significant risk factors, including twins, prior cesareans, and transfers into hospital care from local Licensed Midwives (typically for failure to progress in labor). In fact, in 2010, 14% of Sally's deliveries were with women who had risked out of their Licensed Midwives ' practices. Avenson's overall vaginal delivery rate for 2010 was 68.2%; cesarean rate was 31.8%; primary cesarean rate was 27.3%; VBAC rate was 66.7% and VBAC success rate was 80% (personal communication, Avenson).

Midwife Seattle

(See: www.midwifeseattle.com)

Previously a partner with the Virginia Mason midwifery group, Cindie Brown, CNM, opened her solo private practice in 2000. Her births occurred at Swedish Ballard Medical Center until 2005, at which time Ms. Brown obtained delivery privileges at Group Health and also began attending out-of–hospital births. To allow expanded out-of-hospital birth coverage, she hired two Licensed Midwives in 2009. Their group practice was then named "Midwife Seattle."

Midwife Seattle is currently the only group practice in the region in which CNMs and Licensed Midwives share patient care, as well as the only group that offers birth attendance in three settings: home, freestanding birth center, and hospital. Their client population is largely college-educated and Caucasian. The majority carry private insurance, and approximately 20% of the patients are either uninsured or on state assistance. The practice is limited in the number of clients it can manage and so accepts clients seeking trial of labor after cesarean delivery (TOLAC), but rarely those seeking or requiring elective repeat cesarean. Midwife Seattle

anticipates extension of their services to local immigrant populations and public health departments in the near future.

Because Ms. Brown has privileges at Group Health and a collaborative relationship with their ob-gyns, the practice is able to provide continuity of care for their clients who plan out-of-hospital birth but then transfer into the hospital for risk management, labor augmentation, or pain management. As of this writing, Midwife Seattle has attended 232 deliveries since it's formation in 2009. Ninety-five of these delivered at Group Health, 25 of which were clients who had planned out-of-hospital births but required transfer into a hospital. Overall statistics for the practice's nearly 2 years of service include: total transfer rate of 19%; vaginal birth rate of 86.6%; NSVD rate of 84%; cesarean rate of 13.4%; primary cesarean rate of 10.9%; VBAC rate of 70.4%; and successful VBAC rate of 72.4%. (personal communication, Brown).

Both independent CNM practices face a number of logistical and business challenges working within the Family Beginnings collaborative practice model. One is in maintaining insurance coverage for patients' care at Group Health whenever the relationship between Group Health and an insurance company is altered, or a consultation fee is not covered. For a small business this can have a huge effect, including losing clients who cannot afford self-pay or large co-payments. Both CNMs have maintained simultaneous privileges at different hospitals and collaborative relationships with multiple physicians. These arrangements allow for flexibility in response to issues of client preference, insurance coverage, point of service, birth site, and transfer of care. Unfortunately the independent CNMs are sometimes simply unable to bring a client to Family Beginnings as planned when RN staffing or patient volumes are problematic.

4. Licensed Midwives

The Seattle Home Maternity Service

(See: www.seattlehomematernity.com)

In 1978, Marge Mansfield and Suzy Myers co-founded the Seattle Midwifery School (SMS). It was a 3-year training program for "direct-entry" midwives, meaning that a registered nursing degree was not a prerequisite to entering the training program. SMS has since evolved into the Department of Midwifery at Bastyr University, a 3-year program granting a master's degree in midwifery (see www.seattlemidwifery.org). Marge and Suzy were among the first direct-entry midwives educated in the United States to be licensed in Washington State. They established the Seattle Home Maternity Service (SHMS) in 1981.

With the exception of a brief 2-year period (when Providence Hospital in Seattle granted privileges to a few Licensed Midwives under a pilot project), their births have always occurred at home or at the Seattle Home Maternity Service's out-of-hospital birth center. The center opened in 1983 and is the oldest freestanding licensed birth center in Washington State.

The SHMS practice has enrolled an average of 120 births per year for nearly 30 years. Approximately 90% of their clients are Caucasian, 50% are primiparas, and 50% are multiparas.

Malpractice insurance became available to Washington's midwives with the establishment of the Joint Underwriting Authority in 1996. Passage of "every category of provider" law in the same year meant that Licensed Midwives could obtain contracts with health plans operating in Washington (see Appendix 2). SHMS midwives took advantage of both laws and became "contracted providers" with Group Health and other major insurance carriers. Since that time, Group Health has continued to re-credential these well-respected Licensed Midwives. As one of the Group Health ob-gyns commented, "It works well. This system gives patients the choice to have the care that they want."

SHMS midwives enjoy a comfortable relationship with the obstetricians at Group Health, where they encounter respectful and helpful consultation whenever requested. They transfer out-of-hospital clients to Family Beginnings should maternity care complications occur. For example, if a woman in labor needs to transfer to the hospital for the completion of her delivery (typically for pitocin augmentation or pain

management), the Licensed Midwife contacts the obstetrician on call, who accepts the client for care. After admission to hospital, the Group Health ob-gyn and CNM on call determine who will be the primary provider for the woman depending on her risk status. Typically, the CNM assumes the role of primary provider in collaboration with the ob-gyn, thus offering the client the comfort of a "midwife-to-midwife" transfer of care. The Licensed Midwife provides medical records and clinical input to the Group Health providers, and is welcomed to give ongoing "doula" support to the client throughout her labor and birth. The Licensed Midwife reassumes the patient's care after hospital discharge, including a home visit shortly after hospital discharge.

From the time of admission through hospital discharge, the SHMS clients are officially Group Health patients, so their outcome statistics are included in the overall Family Beginnings data. The Licensed Midwives also keep their own practice stats separate from those of Family Beginnings Unit. The vast majority of SHMS clients are privately insured (87%); 13% are either self-pay or under a state-funded program such as Medicaid. In 2009-2010, the practice enrolled 260 women for care and had a total of 193 births, of which 148 delivered out-of-hospital and 45 transferred into hospital (a 23.3% transfer rate). They had 176 vaginal births (91.2%) and 17 cesareans (8.8%), all of which were primary cesarean deliveries. Among their 45 transfers into hospital, the vaginal delivery rate was 62.2% and the cesarean rate was 37.8%.

Approximately 13% of SHMS clients are covered by a Group Health insurance plan. In Ms. Mansfield's words, "Whenever possible, the practice utilizes Group Health for in-hospital patient care, as it is well-known in the out-of-hospital community as the most desirable facility in the city" (personal communication, Mansfield).

1. Crowley W. Group Health Timeline: a chronological overview of 60 years of Group Health History, 1947-2007. Seattle (WA): Group Health; 2007.

Appendix 2. Legal Framework

Washington State Laws and Regulations Governing Midwifery Practice

1. Certified Nurse-Midwives (CNMs) and Advanced Registered Nurse Practitioners (ARNPs)

CNMs are licensed as Advance Practice Nurse Practitioners under Washington Actuarial Code 246-840-300. This states that an ARNP is a registered nurse prepared in a formal educational program to assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns and problems; is prepared and qualified to assume primary responsibility and accountability for the care of patients; incorporates the use of independent judgment as well as collaborative interaction with other health care professionals when indicated in the assessment and management of wellness and health conditions as appropriate to the ARNP's area of practice and certification; and functions within his or her scope of practice according to the Nursing Quality Assurance Commission's approved certification program and standards of care developed by professional organizations. American College of Nurse-Midwives' (ACNM's) Standards for the Practice of Nurse-Midwifery have been adopted for Washington's CNMs.

The nature of "collaborative interaction" is not further defined, does not specify any particular category of "other health professionals," and is a matter for the ARNP's judgment within the context of national scope of practice statements (see http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-300).

2. Mandated inclusion in health plans

The "Every category of health care provider" law of 1996 mandated that health carriers shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by Basic Health Plan services (see http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-205).

3. Licensed Midwives (LMs)

Recognized by statute in 1917, LMs were the first midwives licensed to practice in Washington State and are regulated by the Midwifery Advisory Committee of the Washington State Department of Health. Licensed Midwives are authorized under the law to provide complete care for women during the maternity cycle, from initial visit through 6-8 weeks postpartum. Their duty is to consult a physician "when deviations from normal occur." They legally obtain and administer medications considered necessary for low-risk labor and delivery, including oxytocin, methergine, and misoprostol (postpartum use only), lidocaine for suturing, and antibiotics for GBS prophylaxis. They have prescriptive authority for certain emergency medications, including magnesium sulfate, terbutaline, and epinephrine, as well as vitamin K and eye prophylaxis for newborns. They are also authorized to initiate intravenous therapy for hydration and volume replacement (see http://apps.leg.wa.gov/rcw/default.aspx?cite=18.50).

4. Joint Underwriting Authority (JUA)

In the mid-1990's, the Midwives Association of Washington State (http://washingtonmidwives.org/) negotiated with the state government for the formation of The Washington State Midwifery & Birthing Center Joint Underwriting Association to provide malpractice insurance for Licensed Midwives, CNMs, and

licensed birth centers. A Joint-Underwriting Association (JUA) is a government-organized non-profit insurer of last resort. It offers insurance when it becomes effectively unavailable on the open market. Currently, the only JUA in operation in Washington State is the one for midwives (see http://washingtonjua.com/).

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Appendix 3. American College of Obstetricians and Gynecologists and ACNM Documents on Collaborative Practice Relations

(See the ACNM Library at http://www.midwife.org/ACNM-Library)

1. **Joint Statement of Practice Relations between Obstetrician–Gynecologists and Certified Nurse-Midwives/Certified Midwives (2011)**

(See http://www.midwife.org/index.asp?bid=59&cat=3&button=Search&rec=224)

This recently-updated statement says, "The American College of Obstetricians and Gynecologists (the College) and the American College of Nurse-Midwives (ACNM) affirm our shared goal of safe women's health care in the United States through the promotion of evidence-based models provided by obstetrician–gynecologists (ob-gyns), certified nurse-midwives (CNMs), and certified midwives (CMs). The College and ACNM believe health care is most effective when it occurs in a system that facilitates communication across care settings and among providers. Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability. Recognizing the high level of responsibility that ob-gyns and CNMs/CMs assume when providing care to women, the College and ACNM affirm their commitment to promote the highest standards for education, national professional certification, and recertification of their respective members and to support evidence-based practice. Accredited education and professional certification preceding licensure are essential to ensure skilled providers at all levels of care across the United States."

2. **Collaborative Management in Midwifery Practice for Medical, Gynecological and Obstetric Conditions (1997)**

(See http://www.midwife.org/index.asp?bid=59&cat=3&button=Search&rec=58)

This document defines consultation, collaboration, and referral. Because the terms are confusing due to the use of "collaboration" in both the overall title and in one form of collaborative practice, we recommend substituting the term "co-management" for "collaboration" as one of the three types of collaborative interaction. The intent of this document and our revision is the same.

3. **Collaborative Agreement between Physicians and Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) (2006)**

(See http://www.midwife.org/index.asp?bid=59&cat=3&button=Search&rec=57)

This ACNM position statement strongly supports the principle of collaboration in the delivery of healthcare services, and opposes requirements for signed collaborative agreements between physicians and CNMs as a condition for licensure, reimbursement, clinical privileging and hospital credentialing, and prescriptive authority.

4. **Principles for Credentialing and Privileging Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) (2006)**

(See http://www.midwife.org/index.asp?bid=59&cat=3&button=Search&rec=82)

This ACNM position states that CNM scope of practice should be defined by national standards; that state laws should be reflected in the bylaws and guidelines of hospitals and other healthcare organizations; that a

CNM's clinical practice guidelines should be the mechanism to determine collaborative relationships; and that bylaws and guidelines of hospitals and other healthcare organizations should be written to assure that the midwife is accountable for the care she or he provides and should avoid requirements that create vicarious liability for other health care professionals.

5. **Independent Practice for CNMs and Diminished Vicarious Liability for Ob-Gyns**

For a discussion of how independent legal status for CNMs markedly limits vicarious liability for collaborating ob-gyns, the reader is referred to the 2010 landmark case of Gilbert v. Milodovnic and Washington Hospital Center. ACNM joined the American Association of Birth Centers in an amicus brief in defense of the physician. The final ruling acknowledged autonomous, independent nurse-midwifery practice and found the consulting ob-gyn not liable (see http://www.birthcenters.org/news/breaking-news/?id=100, the Winter 2011 edition of ACNM's newsletter, *Quickening*, and http://www.midwife.org/quickening/docs/QNWI11/index.html; p.8).

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Appendix 4. Scope of Practice Issues

1. The Institute of Medicine (IOM) of the National Academies

(See http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx)

Limitations on nurse practitioners' work is addressed in this IOM landmark document, "The Future of Nursing: Leading Change, Advancing Health". It asserts "…while some states have regulations that allow nurse practitioners to see patients and prescribe medications without a physician's supervision, a majority of states do not. Consequently, the tasks nurse practitioners are allowed to perform are determined not by their education and training but by the unique state laws under which they work." The authors recommend improvements in the current regulatory, business, and organizational conditions that restrain nurse practitioners' scope of practice and call on government, businesses, health care organizations, professional associations, and the insurance industry to contribute to these changes.

The report's "Recommendation 1" is to "Remove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training." In order to achieve this goal, the authors call on state legislatures to "Reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18)." Further, they call on the Federal Trade Commission and the Antitrust Division of the Department of Justice to "Review existing and proposed state regulations concerning advanced practice registered nurses to identify those that have anticompetitive effects without contributing to the health and safety of the public. States with unduly restrictive regulations should be urged to amend them to allow advanced practice registered nurses to provide care to patients in all circumstances in which they are qualified to do so" (see http://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf).

2. The New England Journal of Medicine

The 12/15/10 edition of the *New England Journal of Medicine* carries a "Perspectives" article that discusses the value of minimal restrictions on nurse practitioners' work. The authors of "Broadening the Scope of Nursing Practice" argue that expanding the role of nurse practitioners so that they are permitted to practice to the full extent of their knowledge and competence is one key to providing health care for all Americans while controlling costs

(see http://www.nejm.org/doi/full/10.1056/NEJMp1012121?query=TOC).

3. National Overview and *The Pearson Report*

CNMs are legally authorized to practice in all 50 states and the District of Columbia. They are regulated on the state level, and their professional practice and interactions with other providers vary from state to state.

The Pearson Report provides an in-depth data collation and analysis of nurse practitioners and access to their care nationally and for all states. Dr. Pearson has for 23 years tracked specifics such as nurse practitioner legislation, licensing, scope of practice, prescribing details, reimbursement, claims and ratings. The report grades the states (A+ to F) regarding access to care by nurse practitioners, and summarizes information on prescriptive authority and physician involvement in nurse practitioner care.

As of 2011, nurse practitioners are able to practice completely autonomously or with relatively minor restrictions in 21 jurisdictions (including Washington, Oregon, New Hampshire, Arizona, District of Columbia, Montana and Rhode Island). In contrast, nurse practitioners in 14 states (including Alabama, Arkansas, Florida, Massachusetts and Texas) are forced to practice within very restrictive legislative rules and barriers. These barriers include written protocols for physician supervision and oversight of patient care as well as for prescriptions. (See http://www.pearsonreport.com. Subscription is required.)

Appendix 5. Notable Quotes from Providers

We surveyed the providers at Family Beginnings to get a sense of how our model works for them in everyday practice. Here is a selection of their responses.

- One CNM reported, "I feel safe with our doctors. I can tell them honestly when I reach the limits of my skills and knowledge and I can trust them to communicate in respectful ways with me and my patients".
- And from an ob-gyn's perspective, "If things aren't going well [the nurse-midwives] identify it, take initial steps, and consult in a timely manner…the patients are well prepped and already know what we have to offer. I don't feel like I am walking into a hostile situation".
- One CNM wrote a comment about TOLAC, VBAC, and community standards: "I am proud of our steady support of VBAC at Family Beginnings. I hope folks understand the difference between "VBAC rate" (VBAC as a percentage of all prior [cesarean deliveries]) and "successful VBAC rate" (VBAC as a percentage of all TOLACs), which many people and places cite, either out of ignorance or because the numbers look better. The VBAC rate is more useful and honest; it encapsulates the reality that many women who have had a prior cesarean are not allowed to attempt a TOLAC. This limitation of options is applied to far more women than those with risk factors that make TOLAC an unsafe option. We have always focused on medical evidence and offered TOLAC to appropriately selected women. That brings up the medical-legal conundrum of medical evidence [compared with] "community standards" not based on evidence—a good topic for another paper!"
- When asked to comment on challenges in providing care, one CNM wrote, "Immigrants and refugees from all over the world come to Seattle and to our practice. Offering culturally sensitive and safe care to clients who inherently mistrust hospitals and western medicine requires patience, flexibility, and understanding. At no time is this more stressful for providers than when, for reasons we may not understand, patients

adamantly refuse potentially life-saving interventions. In these cases clear communication among providers and patients could not be more difficult, or more important. We rely heavily on our cadre of local medical interpreters and doulas, as well as our multilingual staff, to provide an essential bridge between cultures."

- Reflecting on the nature of independent practice, one CNM explained, "It is very clear to me that I am an independent practitioner and that the patients I am caring for are *my* patients. This makes me really own their plans and take responsibility for the management decisions I make."
- Regarding financial incentive as a potential influence on patient care decisions, a CNM who has worked in multiple settings commented, "There is no competition here between midwives and doctors. The obstetricians want to see the midwives succeed. Since we are salaried, and all in-house, there is no motivation to 'clear the board.' This gives space and time for birth to happen." Another CNM chimed in, "I love it when the obstetricians 'out-midwife the midwives' by taking an especially patient approach to labor and birth".
- Regarding replication of our model, one CNM straightforwardly advised, "Don't be afraid. Don't stay stuck in old patterns that are not evidence-based. Don't feel like you have to re-invent the wheel."

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