LETTERS

More on Midwives

Thank you for publishing the article by Gabay and Wolfe, "Nurse-Midwifery: The Beneficial Alternative," in the September/October 1997 issue of *Public Health Reports*. It contains a good overview of the practice of certified nurse-midwifery but completely ignores an important and fundamental aspect of midwifery—the practice of direct-entry midwifery. The authors also failed to discuss the national certification for such midwives—the Certified Professional Midwife (CPM)—or the existing infrastructure of state-licensed midwives.

While the article makes a good case for the individualized care and lower intervention rates that are achieved through the use of nurse-midwives, it should be noted that both obstetricians and certified nurse-midwives practice primarily in hospital and clinic settings. The benefits cited are realized to an even greater extent when the practice setting moves from the hospital to the home or freestanding birth center and a direct-entry midwife serves as the maternal care provider.

Why? Women with low risk pregnancies who choose this option will unequivocally tell you that birthing in familiar surroundings or their own home without the distraction of strangers creates the optimal level of comfort and relaxation for the laboring mother. Removing the distraction of a noisy hospital setting and the ever-present potential for unwanted and unnecessary interventions is perhaps the single greatest factor in speeding delivery in normal, low risk, birth situations.

The article also focuses on the state of Florida and its active support for nurse-midwifery services. Yet it omitted the story of how Florida was equally aggressive in promoting the education and practice of licensed direct-entry midwives. The CALL TO ACTION campaign and the Florida Midwifery Resource Center were created to advance the practice of midwifery in general, not just that of certified nurse-midwives. Because Florida has a large number of freestanding birth centers and a significant immigrant population accustomed to out-of-hospital care by midwives, the state needed practitioners who were trained to practice in out-of-hospital settings. Florida created its own infrastructure for direct-entry midwives to fulfill this specific need.

The success of the Florida maternal care campaign is a testament to the effective use of the full range of midwifery practitioners and the services they provide. A more inclusive article would have pointed to this success and would have described the various midwifery options, including CNM (Certified Nurse-Midwife), CM (Certified Midwife), CPM (Certified Professional Midwife), and LM (Licensed Midwife).

For information about the Midwives Alliance of North America, contact me at PO Box 188, Summertown TN 38483; tel. 931-964-2589; e-mail <cpmcnel@ usit.net>.

Carol Nelson, LM CPM
Midwifery Education and Advocacy Coordinator
Midwives Alliance of North America ■

Inappropriate Photo

I just came across *Public Health Reports*, Vol. 112, No. 5, September/October 1997. I regret to say that I do not see the point of your cover picture. It was in bad taste and did not enhance the article in any way; instead, it has taken away from the professional nature of your journal.

Harsohena K. Ahluwalia, MD
Pediatrician ■

SES Data Are Available

The article by Krieger et al. ("Can We Monitor Socioeconomic Inequalities in Health?" 112:6;481–91) is of great interest to us at the National Center for Health Statistics. We agree that accurate monitoring of social inequalities in health requires that appropriate data be routinely collected and published. Appropriate measures include educational attainment of mother and father for births and educational attainment and occupation for decedents.

The authors report that vital records information on socioeconomic status (SES) is published only by a limited number of states, thus restricting the ability to monitor trends and variations in fertility and mortality by socioeconomic status. While it is true that not all states publish these data, NCHS does publish this information. National, state, and substate (county and city) data on births by educational attainment of mother and on deaths by education and occupation of decedent are available from NCHS in tabular form and on public use data tapes and CD-ROMs that include unit record data.[1–6]

In monitoring fertility and mortality differentials by SES, it is important to keep in mind that block-level SES data, or even county- or state-level SES data, needed for linking and for computing population-based rates are not routinely available from the U.S. Bureau of the Census. Detailed information of this nature is generally available only for Census years, thus precluding states from calculating population-based rates from vital statistics data. This severely restricts the ability of states to monitor trends and differentials in fertility and mortality by socioeconomic status and to develop intervention strategies to reduce differentials.

Mary Anne Freedman, MA
Director, Division of Vital Statistics
National Center for Health Statistics

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Following Up on Screening Tests

Early detection of disease has always been an important component of public health. Screening tests are the most frequently used method for detecting disease before the appearance of symptoms. Recently, however, the cost-benefit ratio of some mass screenings has stimulated controversy. Yet little research has been done on the outcome of screening—in particular, on the follow-up behavior of people with positive screening results for whom a visit to a health care provider is recommended.

We recently conducted a study of the follow-up behavior of adults screened at health fairs in Middlesex County, New Jersey. In September, October, and November 1996, 948 people older than 18 received from a Middlesex County Health Department (MCHD) registered nurse or physician one or more of the following tests at one of 12 local health fairs: oral cancer screening, hearing test, Papanicolaou test, clinical breast examination, rectal examination, glaucoma test, blood pressure reading or blood testing (SMA-24 with cardiac risk profile).

A total of 2193 screening tests were performed. Of the 948 adults screened, 470 (49.5%) had one or more test results outside the normal range, a figure consistent with previous researchers' experience. Those with abnormal results were notified by an MCHD representative, either in person at the time of the screening or by mail after laboratory results were received. They were told their test results were outside the normal range and were urged to discuss their results with a medical professional.

MCHD makes one routine telephone call to each person with abnormal results to find out whether the person has sought medical follow-up. We wanted to explore the reasons why people do or do not act on recommendations for follow-up medical appointments. Over a four-week period in Spring 1997, we administered a 31-item Health Belief Model-based survey, developed and pretested by MCHD, as part of the routine phone call to the 470 adults with screening tests outside the normal range. Three attempts were made to reach each person by telephone.

To achieve results at the 95% confidence level, 216 completed surveys were needed. We analyzed the data once 216 adults completed the survey (46% response rate). Many of those surveyed had taken multiple screening tests. More than two-thirds (67%) of those surveyed were female. Respondents ranged in age from 19 to 85. The mean age was 63.7, with more than two-thirds of respondents older than age 60.

Of the 216 respondents, 139 (64%) reported seeing or discussing their screening test results with a medical professional. Of them, 64% reporting following up within one month, 85% within two months, and 91% within three months. Many who had not followed up yet said they were now motivated to do so by the MCHD call.

The following findings may interest the public health community:

- A perception that the consequences of the identified health problem were very serious was the strongest predictor of following up on abnormal tests results.
- Lack of insurance and lack of a family physician were major barriers to follow-up among the younger adults.
- Reminders within the first three months of a screening test increased follow-up activity.
- Participants' intentions with regard to follow-up proved to be a useful predictor of actual follow-up behavior.
- For at least half of the respondents, screening was used to monitor existing conditions rather than to identify new conditions.
- A surprising number of participants mentioned an interest in herbal and alternative therapies. MCHD staff had expected requests for more information on chronic ailments such as diabetes or arthritis and were struck by this change.

If people with limited resources are using screening opportunities to monitor their health, health fairs may be providing an important service. Yet, our findings suggest that without additional follow-up efforts, screening at health fairs may not be an efficient use of resources. Patients may need more education about the seriousness or urgency of some health issues (for example, hearing loss or cervical cancer) to motivate them to be tested. Finding out whether people have medical care and providing access to care if they don't, assessing their intention to follow up if follow-up is indicated, and provid-