Regional Oral History Office
The Bancroft Library

University of California
Berkeley, California

# NAOMI NEWHOUSE, RN
# KAISER PERMANENTE MEDICAL CARE ORAL HISTORY PROJECT II
# YEAR 3 THEME: DIVERSITY AND CULTURALLY COMPETENT CARE

Interview conducted by
Aliza Simons
In 2008

Since 1954 the Regional Oral History Office has been interviewing leading participants in or well-placed witnesses to major events in the development of Northern California, the West, and the nation. Oral History is a method of collecting historical information through tape-recorded interviews between a narrator with firsthand knowledge of historically significant events and a well-informed interviewer, with the goal of preserving substantive additions to the historical record. The tape recording is transcribed, lightly edited for continuity and clarity, and reviewed by the interviewee. The corrected manuscript is bound with photographs and illustrative materials and placed in The Bancroft Library at the University of California, Berkeley, and in other research collections for scholarly use. Because it is primary material, oral history is not intended to present the final, verified, or complete narrative of events. It is a spoken account, offered by the interviewee in response to questioning, and as such it is reflective, partisan, deeply involved, and irreplaceable.

**********



It is recommended that this oral history be cited as follows:

Naomi Newhouse, RN, “Kaiser Permanente Medical Care Oral History Project II: Year 3 Theme: Diversity And Culturally Competent Care, conducted by Aliza Simons, 2008, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 2009.

Copy No. ___

**Discursive Table of Contents— Naomi Newhouse, RN**

**Interview: August 19, 2008**

**Naomi Newhouse, RN**
**Interviewed by Aliza Simons, ROHO**
**Interview #1: 08-19-2008**

[Begin Audio File 1 newhouse_naomi_1_08-19-08.mp3]

01-00:00:00
Simons: My name is Aliza Simons. Today is the 19th of August, 2008. And I'm here in Danville, California with?

01-00:00:09
Newhouse: Naomi Newhouse.

01-00:00:14
Simons: And this is for the Kaiser Permanente Oral History Project, Year Three on diversity and culturally competent care. And this is Tape 1. I thought to get started I would ask you how you first became interested in a career in medicine.

01-00:00:33
Newhouse: I became interested in a career in medicine when I was growing up in a small community that had a very low socioeconomic status. And I saw the results of poverty on not only the social system but on the psychological and physical well-being of the community, and I wanted to do whatever I could to help. I think that in that community it was pretty clear that the women suffered the most from where I could see, my vantage point. When economic realities hit a community that doesn't have a lot of resources and a lot of options, women are often the ones that suffer. Of course, and the children when their husbands are stressed. Lots of domestic violence, lots of social inequities occur. And in my role as an advocate for women from an early age I recognized that women were most vulnerable when they were pregnant and bearing children. And so my desire to support them in that process came about when I encountered a woman in our community that had been left by her husband and she was struggling with an unwanted pregnancy and trying to feed the three children she had. And just befriending her and walking that path with her gave me an appreciation for the intensity of her struggle. And I decided that I wanted to make a difference in the world, and help women that found themselves in similar situations.

01-00:02:18
Simons: How old were you at this point?

01-00:02:20
Newhouse: I was thirteen. She was a woman in our church community. And she received some support from the church. But in that day and age a woman that's by herself already has two strikes against her. And there's suspicion about why she's by herself. And it was part of my awareness that women need to be able to take care of themselves should something go wrong in their lives. Their husbands can leave them. Their husbands can harm them. They can tear them

down or they can be a great support for them. And so because it's a gamble, a woman needs to be able to take care of themselves from the get-go.

And I learned that by watching the women around me, appreciating the women that could take care of themselves and providing leadership to other young women around them. I decided I wanted to be a woman like that. And I started on the path to become one.

01-00:03:22
Simons: So it was from this firsthand experience that you came to this realization that this is what you wanted.

01-00:03:32
Newhouse: Yes, yes. And as I grew up and saw a lot of my teenage friends become engaged in sexual activity at an early age and how that impacted their lives over time I quickly made choices for myself there as well. Like I wasn't going to become sexually active. I wasn't going to drink. I wasn't going to make myself vulnerable. Because the outcomes didn't seem to be very positive. My father being a teacher in the community and my mom being a professional woman in the community, and it being a small community, everybody knows one another. And I just didn't gossip a lot. And the young women in the community came to me to help them get their therapeutic abortion, to help them with an STD that they got, because they knew I didn't talk and that they could trust me with the information. And so then I would be the one that held their hand when they had the abortion and I would be the one that drove them in for antibiotics when they had an STD. And so I started becoming part of that service culture at an early age and found that I liked it. I liked helping others.

01-00:04:44
Simons: How early of an age?

01-00:04:44
Newhouse: Well, I was thirteen when I started thinking about who I wanted to be. And I was fifteen, sixteen, as soon as I could drive, I would take them into the local town where they would have some confidentiality to seek medical care and support them in whatever they were doing to take care of themselves. So I was young, I was sixteen, seventeen.

01-00:05:09
Simons: And just because you were I guess good at holding confidentiality people sought you out?

01-00:05:17
Newhouse: Well, being the daughter of a teacher, you're already a little bit on the outside of a teenage social circle. Some would refer to it as being a teacher's pet. Because we socialized with other teachers. So they treated me differently and they expected more from me. And just that kind of energy and expectation set me apart from the other kids. And so I was with them but I wasn't amongst—I

was amongst them but I wasn't one of them. I guess that's what you could say. I was amongst them but I wasn't one of them, because I was his daughter, right? And his protection covered me and his connections gave me a different status I guess or just a social standing. So I was set apart from the beginning. And I think that was intentional on his part because he wanted more for me than to get pregnant and marry somebody in town.

And it worked. It worked. And it was a little lonely when I was younger, but then later on actually most of my closest friends were married women that I related more to than I did the young teenagers, because they were at a level of understanding in their lives and on a path that I related to more than the younger people that I was actually going to school with.

01-00:06:41
Simons: I'm wondering if you connected your personal experiences of I guess feeling that a woman's choice is important to feminism.

01-00:06:55
Newhouse: Well, for me it was just about survival. When I was watching the women in these communities that's what they were doing. They were surviving. I saw them at the stores. I saw them at the school events. And it wasn't about evolution of your personal empowerment, it was about putting food on the table and taking care of your family. And that's always the first step in the hierarchy of human development. But clearly I wanted more than that for myself. I wanted more than that for my daughters and for my sons. And that's where it begins. It's just an appreciation for how power is distributed in a social setting, who's respected, who isn't, what does it take to earn the ability to protect yourself and others. Those were all lessons I learned very early.

01-00:07:52
Simons: What does it take to protect yourself and others?

01-00:08:00
Newhouse: The ability to see danger before it gets close. The ability to network socially without compromising oneself. Personal integrity. The ability to stand on your own when it's not comfortable to do so. The ability to lead when it's necessary and to collect the resources and influence the choices of others in the direction that you think will bring them the best outcome.

01-00:08:37
Simons: So from this background how did you eventually get into midwifery?

01-00:08:44
Newhouse: Well, there weren't any midwives in the Pacific Northwest at the time. There were nurses and there were doctors.

01-00:08:54
Simons: In Spokane.

01-00:08:54
Newhouse: Yeah, Spokane. North of Spokane in a small, small, small town. The physicians were servants of the community. They were supported by the community. We lived next door to our community physician. I heard him get up in the middle of the night and go off to the hospital to deliver a baby. Because his garage door was right next to my bedroom window. And I knew that wanting a family it didn't seem like a good match to be a physician. Because he didn't have any time for his daughters. His mother took care of his daughters. His marriage had been destroyed by his career. And so it didn't look so good from the outside. He never slept. He was always on call for the whole town. And yet he worked with a nurse that seemed to have a way of I guess you would say midwifing him through the whole process of the healing work that he was doing. She had everything arranged for him. She was able to move people in and out of his office day. And she knew how to call you at home if there was a problem. Everybody knew everybody. And she was really the glue that held him together. And of course later on they got married.

But I think that she was my first role model in how to midwife someone, because she midwifed that doctor so that he could care for the community.

01-00:10:32
Simons: So you're using here midwife as a verb.

01-00:10:37
Newhouse: Yes. Because midwifing someone is to—midwife, the Latin, is to be with woman. It's to be alongside a woman and support her in whatever path she's on. And so this nurse was midwifing this doctor. She was walking alongside him and helping to facilitate his life. And that's why I think wife is involved. Because wives culturally have had that role in their families, right? They're with their husbands. They're supporting their husbands. And for a feminist model that means that you're advocating for the woman who is in a transition, being a transition of suffering from breast cancer or transition into the next life. Death is just as much of a facilitation as birth is. And in my early career I spent a lot of time helping people make that transition. So birth was a natural fit, because it's work that I was familiar with. It's just facilitating that transition from one plane of existence to another. Anyway, so that's how I was drawn into it. Helping women around me in the community.

01-00:11:52
Simons: Then you did a pilot program at Redwood City? Or you went to UCSF?

01-00:11:59
Newhouse: Well, I went into nursing because in California to be a midwife you have to be a nurse first. And when I married my first husband his father was a physician at the Redwood City Kaiser. And his sister was a member of the Farm commune in Tennessee. They were a group of young teenagers in San Francisco that became part of a commune. Stephen Gaskin led this particular commune in the sixties. And they were flower children. They all decided to go

to Tennessee. They pooled their money. They bought this really inexpensive property in Tennessee. And they all arrived there and began to of course have babies. And then the wife of the leader took on the role of midwifing those deliveries. And then she wrote the book *Spiritual Midwifery*. And so Kristin brought this home when they finally left the farm with six children. She was one of the women in the book, the famous book *Spiritual Midwifery*, she delivered her babies with these midwives. And she was pictured in the book several times, because she delivered several kids there. And she was photogenic. Anyway, so that was my first connection with my route of advocating for women. It's like "aha"! It was an "aha"! moment for me. I knew I wanted to head for nursing or medicine, didn't want to throw my life on the rocks of medicine. But I wanted to find a way that I could be who I wanted to be and have what I wanted to have in life, and that was a loving family, and to have a work-life balance. And it seemed like a good fit, nurse midwifery.

01-00:13:58
Simons: So that book *Spiritual Midwifery* was a really big influence on you.

01-00:13:58
Newhouse: Huge. It was a complete turning point. And so it was right there. It was like "aha"! It was exactly what I wanted to do.

01-00:14:05
Simons: Were there any other texts that were particularly important for you?

01-00:14:14
Newhouse: I think *Our Bodies, Ourselves* was also very influential in empowering young women of that era.

01-00:14:22
Simons: Around what year was this?

01-00:14:29
Newhouse: Oh, gosh. Let's see. We're talking about '80, '81.

01-00:14:33
Simons: So *Our Bodies, Ourselves* and—

01-00:14:37
Newhouse: Yeah. And the *Spiritual Midwifery*. And of course my experiences at home recognizing the importance of knowing how your body works and watching my friends getting into trouble. It was motivation. It was actually another stone down the path of how I was going to proceed with my career in service to other women and families.

01-00:15:03
Simons: So you went to school. Sorry, I'm a little confused about the path of going to school and then becoming a midwife. So if you could outline your background.

01-00:15:15
Newhouse: Well, so I'm in this small-town community. And I know I don't want to be a woman in that community pretty quickly. It didn't seem like there were many options. And so there was a family in Palo Alto. Of course my first husband's family. They had a young son who came up to a summer camp that my dad was a counselor at. Because my dad was a hunter and a fisherman as well as a teacher. So he taught this young man how to fly-fish and how to hunt. And so that's how we were connected with this family in Palo Alto. And so periodically like when you know someone in a town you're traveling through, members of the family would travel through. And that's when I met my ex-husband, my first husband, when I was just a child of like ten, and he was like twenty-five, coming through town. And so that was our first contact with the family. And then he kept in touch because he thought I was special. And then when I was eighteen invited me down to go skiing. And then I was out the door as soon as I graduated from high school. I told Mom and Dad I wasn't going to Eastern Washington University, I was going to go to San Francisco State, and I was going to live with the Evans family and go to school. And that's what I did.

So I pursued my bachelor's of science in nursing from San Francisco State, finished school, married their eldest son, and started working at Stanford as an ICU and stepdown nurse right out of school from San Francisco State.

01-00:16:47
Simons: Okay, I'm seeing.

01-00:16:50
Newhouse: Yeah, yeah. And then I went into midwifery because I knew that there was a midwife starting at Redwood City. Her name was Jeanne Rous, one of the first midwives in the Kaiser system. And she's fairly famous in the midwifery culture. She's a woman that had a lot of power. A lot of personal power, very tall woman. And so I was a nurse alongside this woman at Redwood City Kaiser for about three or four years, and she mentored me. She taught me the art of midwifery. And she became a dear, dear friend and encouraged me to apply to the program at UCSF, and I got right in, I was very lucky. And then I pursued my midwifery after I had my two children.

01-00:17:32
Simons: How do you feel like Jeanne Rous was an influence? Was it the fact that she was very powerful? Did she have an influence on you that way?

01-00:17:47
Newhouse: She was—and I'm speaking here past tense because she's just recently passed away. She was a phenomenal woman. She was very unique. We shared a similar background. She was raised in the Willamette Valley in Portland. She came out of far more poverty than I did. I was in an impoverished community but my family would have been considered middle class. We ate like kings because my father hunted, fished, and mom was a tremendous cook, kept a

large garden. And I didn't suffer any of the hardships that I saw other women suffering from poverty that Jeanne did. And she bore the marks of the poverty. She bore the physical violence of a desperate father on occasion. So she had come up into advocacy for women the hard way. And she was the ultimate shaman, someone who heals through their wounds. And she became extremely sensitive, like many people do when they're under some kind of duress or stress or abuse, to predicting potential danger. And so that is how intuition is developed over time, because you learn to see deeply, look carefully for your survival. And so she became extremely intuitive. Plus you're gifted with certain abilities. She had those abilities. She could look at a woman in labor and tell you how far along she was. She could tell you what was going to happen next without even touching her. She became that good. And so I was so honored and fortunate to work alongside her and watch the subtleties of her practice, because that you can learn. If you're steeped in it for long enough you can pick that stuff up.

So I was fortunate I got to learn that. But there were also drawbacks to working with someone like Jeanne, because when you're that wounded, often you're not aware of how you impact others, and I watched her social interactions with the nurses and knew I would do things differently. How she overreacted and was oversensitive. And how she projected—hard for me to describe. But she projected a shield around her. So she was unaware. It was a shield of protection and she couldn't see through it to others' reactions and they couldn't see through it to understand her pain. And so she was misinterpreted. She felt alone.

01-00:20:25
Simons: But you were able to.

01-00:20:30
Newhouse: Yeah I was. I think I was because of what I had walked through, because of my gifts, and also because she let me in. And I understood her. I understood her better than some of the people there did. Most of the people that knew her greatly appreciated her. But being a woman that had power, she was also resented, and she was a little feared. And I had to draw boundaries with her too, because she didn't have good boundaries. Not being allowed to have them as a child. And that's another drawback to living in that kind of reality when you're young. And I had to tell her no, no, no, no, no, this is where you stop emotionally, because she would reach out in ways that many people would recognize as just making them very uncomfortable, but I called her on it, and she respected me for that and she loved me for that.

01-00:21:32
Simons: I think it's really interesting that I guess as mentors and learning from mentors you learn so much from what you perceive they do right but also what you perceive that you want to improve on.

01-00:21:49

Newhouse: I could put her in the same category with my father and with my mother in that they were all extraordinary people. And I learned from the best of what they did and I learned from the worst of what they did. And my best teachers were the ones that showed me the outcome of making bad choices or behaving in a negative way or stepping over your boundaries of power with another person. And that's been extremely helpful in my role as a healer, because you're working with an individual that brings their own culture, their own reality to you. And you have to be aware of your own biases, your own values, and you can't project those onto the person. So you have to have your own personal boundaries there in your self-awareness. But you also have to have intimate regard and respect for their reality and their value system and their ethics. And you have to ask questions so you know what they are and then you have to keep your place and not extend into their world inappropriately. You have to be able to invite them to meet you in a place where you can both work on something together. But you can't invade and you can't intrude. And that boundary needs to be kept with great care. And some of my best examples are people that have done that or not done that and what the outcome has been.

01-00:23:18

Simons: And you feel like that's something you learned from Jeanne.

01-00:23:23

Newhouse: I felt that what I learned from Jeanne was her woundedness was her most powerful means of healing others. It also made her blind. So she was not quite as self-aware as she needed to be on her impact on those around her. She was an artisan. She would be considered one of the great shamans if we would list her as a shaman or a healer in this century. And that sounds grandiose. But you'd have to work with her to understand that. She was an artist. And artists are forgiven many things. And what she needed to be forgiven is absolutely minute compared to what most artists need to be forgiven. So to her credit she overcame everything. And she became who she was. But I did watch, I did watch her consequences, and I did learn so that I wouldn't have to suffer her consequences. I'm not big on suffering. I like to avoid that if at all possible.

01-00:24:42

Simons: So from working with Jeanne then you got into UCSF.

01-00:24:43

Newhouse: Well, I got into UCSF right away, and that's not easy to do, because there's a waiting list. And several times people have to apply for two or three years. But I think it was the letter that Jeanne wrote that moved the committee and I never saw the letter. There was another midwife there that I worked with that I asked to write a letter. And at the end of school they showed me the file, and for some reason Jeanne had gotten her letter back, but this other woman's letter was still in the file. And if Jeanne hadn't written the letter she must have written I wouldn't have got in. Because that woman had it in for me and whoa, that was quite a moment, to read the letter. But I think I was one of

their very successful students. I weathered the program quite well. I had two small children in diapers. And I took out a loan and did the program and was given the thesis award at the end of the program because I'd done a fabulous job on my thesis. And one of the instructors said, well, I was already a midwife when I got there, because I'd spent all that time with Jeanne. And so I learned a great deal from that faculty, but she said the essence of what I had I had when I came in. And one of the faculty members is now one of my dearest friends and comes to my house on a regular basis and makes us amazing food. Susan Leibel, another one of my great teachers. So I did well at UCSF. And I was ready to go be on faculty at the University of Nebraska right after school was over. Because I wanted to go to a practice where I could teach physicians how to properly care for women in labor and deliver babies.

I was looking for having the maximum impact on women that I could. And watching that midwives were so restricted in the state of California and realizing I could only deliver so many babies, I thought, if I can get into a medical school training program and impact the way physicians are training women, that I would have exponential impact on how women are treated.

01-00:27:03
Simons: So in what ways did you feel at that time that midwives were—

01-00:27:10
Newhouse: Well, we were restricted in the state of California quite heavily. Because the California Medical Association has such a strong lobby and has restricted us legislatively. So we can't admit to the hospital, we can't discharge without the physician signing it. At that time we couldn't write our own prescriptions and we needed them to cosign our delivery notes. And that was also motivation for me to get into leadership as soon as possible and change legislation as soon as possible, which we've successfully done in the last ten years.

01-00:27:46
Simons: In what way?

01-00:28:25
Newhouse: Well, instead of going to Nebraska, when I was interning at Hayward, I was doing my last six weeks of training. At UCSF you have to actually go into practice in a particular hospital. So I was working with my third mentor, Susan Snydal, delivering babies at Hayward, and I was divorced at that point, and Dr. Newhouse met me at Hayward Kaiser. We met over a C-section. It was very romantic. I was assisting him with that. And he was going really fast and trying to show off. Anyway—

01-00:28:26
Simons: Trying to show off over a C-section?

01-00:28:29
Newhouse: Yes, trying, it was great. Yeah, the nurse that was helping us do the surgery, all the nurses knew we were dating before we knew we were dating. It was

very funny. Anyway, so I pushed the instruments back at him and told him to slow down and behave himself, and after that he asked me out for coffee and the rest is history. So he convinced me not to go to Nebraska and to instead work there at Kaiser Hayward. And so I did, and began working as a staff midwife at Hayward with the support of Larry Wellman, the chief, and Susan Snydal, the midwife lead there at the time. And within a year I was in leadership at the regional level. I became the chief of the midwives for northern California. And then we started to work on legislation that changed our practice.

So with the help of the California Nurse Midwife Association, and with the critical support of Delores Jones, who was the nursing executive for Kaiser at that time, we approached the Government Relations Committee at Kaiser and with their support were able to move two very important pieces of legislation, the first being for professional exemption, which keeps midwives out of overtime so that we will be viable in the system, and then for prescriptive authority. I'll never forget. The afternoon I was with my new midwife boss, Susan Snydal. We were doing postpartum rounds and I was writing a prescription for a woman that was going home for Vicodin, because she had a lot of pain when she was breastfeeding. And Susan said, "You can't write that prescription, the doctor has to write that." I said, "Well, why not? I should be able to write this prescription." She said, "When you go and change the law you can write the prescription." And she looked at me and I looked at her and I said, "Don't challenge me." And she still remembers that to this day. When we got the law signed into practice, she was just like, "I'll never forget that day I told you you couldn't do that prescription and you said, 'Watch me.'" So anyway, with the help of Delores Jones and the California Nurse Midwife Association, we crafted legislation and lobbied it and got it passed. So now midwives can write prescriptions both in the office and the hospital without needing any kind of cosignature at all. Just on our own DEA authority. So that was a very huge step in the right direction. Pretty cool.

01-00:30:50
Simons: So what other kinds of legislation did you work on at that point?

01-00:30:55
Newhouse: Well, there was professional exemption. We've worked on several different bills that chip away at what California Medical Association has done to restrict our practice. And we've worked sometimes in collaboration with the nurse practitioner lobby and sometimes without collaboration. But professional exemption and small changes like yes we can do physical exams for people that need physical exams, eye exams, little pieces of legislation that give us more authority to practice.

My most recent role as a board member of the California Nurse Midwife Association in the last year was around EMTALA. So CMS is a body that oversees Medicare, and they decided that only certain people could do a

medical screening exam. So when a woman came into labor she would need a provider on that list that was authorized to evaluate her and then send her home. And for some reason CMS didn't list midwives on that list, even though we were the perfect person to evaluate someone in labor and send them home. Working with the California Nurse Midwife Association, with the American College of Nurse Midwives, we were able to encourage CMS to reevaluate it, made the case for it, so they changed the list, and added us to the list of those who could do a medical screening exam. So that had national impact, which is great. So those are little battles we're constantly involved in fighting.

01-00:32:40
Simons: Why do you feel like the California Medical Association enacted those restrictions on midwives?

01-00:32:43
Newhouse: Oh, they want the market. If they can control whether I can admit or discharge to the hospital, if they can keep me in a supervisory relationship with them, then they can control whether I practice or not. It's a subtle form of restraint of trade, because they don't want the competition.

01-00:33:04
Simons: And do you feel like that's a monetary thing?

01-00:33:06
Newhouse: Oh yeah, oh yeah, yeah, it's totally monetary. And it's also about control over women too. So they are protecting their lifestyle, they're also protecting their right to practice medicine in the way they feel like practicing it whether it's evidence-based or not. And that's exactly what I'm here for. This really resonates with me as being something that needs to be corrected, because evidence-based practice, cost-effective care, is just assumed in quality. And so when you're practicing evidence-based care and best outcomes happen for Mom, then the organization that's supporting that woman wins and the woman wins. That's why I threw my bets in with Kaiser from the beginning, because they were fiscally incentivized to promote the well-being of a woman and her family. They were not perversely incentivized to create pathology so they could make money on it. And outside of our system that's reality.

01-00:34:08
Simons: In what ways does that happen outside of the Kaiser Permanente system? And in what ways inside the Kaiser Permanente system is that prevented?

01-00:34:15
Newhouse: Well, an example would be a new particular focus of mine, and that's cesarean delivery upon maternal request. And I spoke at the national OB/GYN conference on that recently. When a woman just decides she'd rather have a C-section than go through labor, and she's young, she has no medical reason for it, you put a scar on the uterus, and the next pregnancy she has is actually high-risk, because there's a scar on the uterus that can open up during labor.

Or, more importantly, the scar creates abnormal placentation for the next placenta that comes down and tries to embed in the uterus. And so what the placenta does is it becomes more aggressive than it needs to without a scar, and it actually becomes part of the muscle of the uterus. Now this woman's life is in danger. As well as the baby she's carrying. So the more C-sections a woman has the more risk of abnormal placentation, the more risk of OB disasters, train wrecks, women coming in at twenty-eight weeks hemorrhaging. Will the baby make it? Maybe. Will she make it? Maybe.

Now she's got two kids at home and she's in trouble.

01-00:35:30
Simons: What I understand about this is that currently it's something like one out of four women get a C-section.

01-00:35:37
Newhouse: Yes. And for a medical reason a C-section is wonderful. If a woman has a medical reason. If a system has a medical reason to do a caesarean it is a lifesaver. It's not the devil. It's not evil. It's a lifesaver when it's used correctly. When it's not used correctly it's malpractice.

01-00:36:01
Simons: And what I've heard is—correct me if I'm wrong here. What I understand is happening is that especially in private practice women come in, they give them epidurals that they don't actually need, and then that leads to complications, which then leads to C-sections, which then causes what you were just talking about. But also somehow makes doctors in private practice more money.

01-00:36:29
Newhouse: Well, it's the height of arrogance to pretend that in the last 100 years we could have improved on a birthing process that's taken millennia to refine. And the perfect example is bottle-feeding and breastfeeding. Remember when bottle-feeding was all the rage? Then oh no, we discovered that breastfeeding a baby means they have half the cancer risk, half the hospitalizations. They don't have asthma, they don't have obesity, they don't have diabetes. And Mom has a better outcome with breast cancer down the line. So obviously the bottle-feeding idea was a bad idea. But it had to impact an entire generation or two before we figured that out.

And so that's what I see here, is that when we presume that we can improve on something or we stand on the premise that we're doing something because we're supporting her choice to have a birth the way she wants to, I'm very supportive of any woman's right to make any choice she wants to, but you better inform her what she's buying. Because what she's buying is pathology. She scars her uterus, it's going to weave pathology into her childbearing future forever. And that will be something she needs to hear loud and clear.

And the physician needs to make clear that's what's happening. There are many physicians that refuse to do it. They refuse to do an elective caesarean upon maternal request because they don't want to be involved in it. And it's often the women that really demand it that will sue you later when there's a problem. And so what you really need—and that's what I propose to the system—is a thorough consent form that's just like we have for plastic surgery. Any plastic surgeon knows this. It's the crazy lady they can't convince it's a bad idea to do a surgery that comes back and nails them later. So it's a forty-page consent.

And with each paragraph the woman signs I understand. With each paragraph the woman signs I understand. So that's the kind of protection our system needs when the social push is the normalization of surgical procedure and women are asking for it.

01-00:38:33
Simons: You just mentioned that it's arrogant to think that we can improve upon a birthing method that has taken millennia to perfect.

01-00:38:42
Newhouse: Right. Yes. I digressed from your point. I think that it's important to remember that when a woman is essentially healthy and we don't interrupt her laboring and birth process, the outcomes are best, they're optimal. She delivers more quickly with less complications and she recovers far faster than a woman who comes into the hospital, we induce her labor, and then her labor is dysfunctional because her body wasn't quite ready, and then she needs an epidural because she's so uncomfortable and it's taking so long. And then the epidural diminishes the effectiveness of the contractions and so then you use Pitocin to pick up the rate of the labor and then oh no the baby doesn't like that so you got to put an internal monitor on the baby. And well, we don't know exactly what the uterus is doing, so we put an internal monitor on the uterus. And pretty soon those act as wicks for infection, and oh, no, she's infected.

Well, an infected uterus doesn't contract well. So where she ends up finally, is she gets stuck and needs a C-section. That's how we create pathology when we interrupt the birth process.

01-00:39:51
Simons: Right. And I guess I'm wondering more I guess looking historically why do you think it's now that people have decided oh we can improve upon this birthing method that has taken millennia to perfect. Is it that this is a generational thing or a technological thing or what do you think?

01-00:40:17
Newhouse: Well, to secure a monopoly on the market, I think that the medical establishment has done a really good job of convincing women they aren't

normal and healthy and that they need their assistance. They've created a need for themselves very effectively in the last seventy years.

We will rescue you. You couldn't possibly do this on your own at home. Your body can't have a baby. You have to have our assistance. We're necessary. And so they instill fear in a culture. And women are afraid. They don't trust their own bodies. They don't trust the process. The rescue by a male is part of our culture in America. It's part of our culture all over the place. Add to that the economic disempowerment of women. Add to that the fact that women are under new social expectations to deliver at a certain time for arbitrary reasons like their husband needs to be at a convention so they have to deliver at this particular time or this is the only time my mom can be here to help so I need to deliver at a certain time. The normalization of surgical procedure in the last fifteen years with Nip/Tuck on and Hollywood and plastic surgery that you can drive in and drive out with has also contributed to this order up a surgical intervention like it's a casual request.

01-00:41:46
Simons: So you feel like it's the establishment of medical authority.

01-00:41:54
Newhouse: That's part of it. I can't blame all of that on the poor physicians. I love my doctors. I married one of them. I wouldn't work without a doctor, because I can always be guaranteed the baby and the mom are going to be fine. It's part of it. It's part of the acculturation of several generations that women need assistance from a medical establishment to birth. That has been an intentional market monopoly on the part of medicine. You can even read their notes in their conventions with [Dr. Joseph B.] DeLee in the early 1900s. He made it very clear that if you do a forceps and an episiotomy and deliver that baby fast and convince the woman that that's the best thing and that's what she needs, the physicians will be able to monopolize birth. He comes right out and says it.

And so for me the elective caesarean is just the episiotomy and the forceps about four inches higher. It's just in a different location. But it's the same philosophy. A midwife can't do a C-section. So it cuts us out of the market. Pardon the pun. So I think it's intentional on some level because most physicians know that when women are essentially normal they don't need physicians. And it's frightening to know that they're not needed. And being a midwife in a group of physicians, especially when you're cutting a new trail, is a little dicey, because your existence is living proof that women do well when they're supported. Not without a lot of medical intervention. And it's a real walk on a fine line to be in that kind of a system and be friendly with the people you might need help with while you're living proof of the fact that they're not that necessary most of the time.

01-00:43:44
Simons: I think for me what's really powerful and interesting about what you're saying is that it seems to tie into these narratives of women needing men, men coming to rescue women, because in so many cases, especially—in the past twenty, twenty-five years it's changed with a lot of women OB/GYNs. But a lot of—there's this kind of narrative of male OB/GYNs coming in rescuing a woman that you seem to be touching upon.

01-00:44:14
Newhouse: Yes. And I think that it's an even harder road for female obstetricians. I will tell you that my most difficult relationships have not been with the male obstetricians, they've been with the female obstetricians. And I trained alongside them up at UCSF and I watched that whole process. And in their training of the patriarchy of medicine, they were expected to sacrifice their intuitive heart on the altar of the patriarchy of medicine. Do not trust your feelings. Do not trust your intuition. Do not listen to the patient. You know what's best for the patient. You tell her what's best for her and you perform a procedure on her and you leave the room. I watched that process. So these women that went into medicine were expected—it was beaten out of them if they didn't give it up right away. It was a brutal process to watch.

And so when they see me out here in practice they see how they've betrayed themselves, because I didn't do that. I would not do that. And now I still have that intuitive sense, that commitment to listening to the woman, the teamwork with another woman and her family and actually facilitating her birth versus doing it for her and how much better that is for everyone. And how nourishing it is for me, because I benefit from honoring that relationship. It's juice. And those women don't get any of that, and they're mad at me, they resent me. And so it's a whole other level of look what I gave up, and I gave it up and somebody else didn't, and then they're missing their heart, they're missing that heart in their chest that's gone now. Some of them find their way back to it. They start to pick it up a little bit when they work with us. And some of them find a way to keep it throughout school, or they put it to sleep and wake it up again. Some programs aren't that aggressive in that fashion. The medical schools out of Michigan, very, very enlightened. But the UC programs and some of the other really high-profile medical programs are very patriarchal, very, very down on any kind of qualitative impact that research or medicine has. And they're very, very big on quantitative and patriarchal practices in medicine.

01-00:46:38
Simons: And you feel like that's linked to medicine as a whole?

01-00:46:42
Newhouse: It's linked to allopathy. It's linked to again the patriarchal medical model. And that is to take the authority away from a woman and her family to make decisions so that they can be made for you and the doctor knows best. And you will let me do this to you and then I'll bill for it and we'll all be very

happy. There's a little bit of truth to that. And the more the culture becomes aware and educated—the Internet has really blown that old myth completely out of the water, because people get their own information now. Whether it's accurate or not, they have demanded a player's role at the table in their health care. They've demanded it. And that's been a real shift for medicine, and they've had to go to more of a service-oriented paradigm in medicine. And a lot of the physicians resent it and resist it because it's not a model they're familiar with. It's certainly not a model where they're in control. And they didn't go into this to be retail. They didn't go into this with a service orientation. They came into this for whatever reason they came into it, but it wasn't customer oriented. And that's where the mettle is tested for me with a physician. And this is why my husband's work resonates so well within my soul because his orientation is service, not only to the patients but to the physicians. To keep the physicians in a place where they feel supported and they have a role, they have an ability to meet the service demands that the system is asking of them, at the same time meet their own needs and survive in the system.

So it's a paradigm shift that's happening slowly. Some places it's happening more abruptly. But the paradigm is far less top-down doctor-down-to-patient and more a collaborative-with-the-patient model, which is another reason I work for this organization, because they support that, because they know that if a patient is participating in their health care then they have better outcomes and it's cost-effective. So it's a win-win.

01-00:49:04
Simons: I'm wondering if you could back-step a little bit and talk about some of the points that you've touched on about how important it is for women to make their own choices and your role in that as a facilitator, as a midwife, somebody who is with women.

01-00:49:18
Newhouse: Well, again women are the experts on what's happening in their lives. So when I have a patient in my office and they have a problem, any solution I might offer or interject, its relevance depends on where she's at and what's really happening in her world. If she's being abused at home, if she doesn't have support to do what she needs to do to get better, then all of the recommendations I have are worthless, absolutely worthless.

So the first question you have to ask a woman with terrible migraines is what's going on in your life that you've got all these bad headaches, what's going on, what's going on. Is it work? How's your relationship with your family? Do you feel supported? Often you get to the root of what you're working with first. And that takes time. Okay? That takes a relationship. That takes trust that you win with a woman by showing them your heart. And in this system you don't have the benefit of living in community with most of these people. So they don't get to watch you and know you over time and

therefore trust you. You have to perfect the fine art of instant intimacy with that person. You have to be able to walk in that room, show them your heart somehow quickly so that they trust you.

01-00:50:44
Simons: How do you do that?

01-00:50:44
Newhouse: It's an art. It is an art. And very few people get it. It's an art form. And my husband watched my MPS scores and said, "What are you doing? You always get great scores. What's going on?" And I'm like it was part of what I learned growing up. It's just really being in a small community everybody knows you, but just being a genuine human being and being transparent so they see your heart, they see who you are. You're there to help them. Hi. My name is. You hold their hand and shake it. You look them in the eye. And then you sit down and listen. You sit down below them, below their eye level. And you sit there and listen. And you ask them questions. And not in a way that makes them feel like they're being interrogated. But it's the occasional touch on their shoulder or touch on their knee in a safe place. It's your open heart willing to listen. And it has to be fast. When you meet a patient in labor you've got to establish that connection quickly. And you know what? She wants to trust you. Because she needs to trust you. And so that's a sacred gift she's giving you. You can never mistreat it and never misuse it. So you move in quickly. You win her trust. You affirm that she can trust you with a glance and a pat on the shoulder and a nod and you get right into her eyes and you look at her and she sees you. She sees you and then she trusts you and then she relaxes and she gives you her baby.

It's the same way in the office. But it has to be something that you're aware of. You have to be self-aware. You have to love yourself. You have to love the work. You have to take care of yourself. You can't walk in there upset about something else and be effective that way. You can look at that. Somebody's MPS scores. When they go down for the month of November, my husband's first question now is I wonder what's going on in that doctor's life. You see? He's doing the same kind of work. And sure enough, their mom died that month. That physician's mother died in November. That's why their scores tanked. Because their heart was broken. And when they walked into that room upset they couldn't minister to the person they were taking care of in the same fashion, because their heart was broken. And that has relevance for us in our jobs. And so we need to recognize it and do what we need to do to take care of ourselves so that we can be available to our patients.

01-00:53:12
Simons: You said that very few people possess this ability. And I'm wondering whether you feel like it's something that can be taught, this kind of sensitivity, this kind of awareness, I guess cultural competency, right?

01-00:53:23
Newhouse: Right.

01-00:53:23
Simons: Is this something that you need a certain background for? Is it something that you can develop? Is it something that you can read about in booklets and pamphlets for instance that Kaiser Permanente publishes?

01-00:53:41
Newhouse: Well, I liken it to picking up another language. Right? If you want to learn a new language and you don't know the language you've got to want to learn it very badly, right? The motivation to want to learn something that's completely foreign to you has to be deep inside your soul. Right? You have to really want something to pick it up. And if you really want to pick it up then you'll find someone that knows what they're doing and you'll mentor alongside them and you'll pick it up. Because we're all designed to pick it up. We're all connected intuitively in ways that we haven't even begun to understand. And if you tune into that you can find it. But that's work. Tuning in takes a long time and a lot of work. And it takes a heart for it. You've got to want it. You've got to want it real bad. And that's what I mean.

Most people are in the profession for many different reasons. If you go into it for service and you go into it to improve the lives of those around you and to connect with others, then you want to develop that and you want to be better at it. Because that's where really the true healing occurs. It doesn't come when I give her a pill. It doesn't come when I quickly relieve something with a surgical procedure. There are deeper reasons people have disease in their lives. And to get to those root causes is the real work of a healer. And then also recognizing that the true responsibility for doing that healing work doesn't lie with the healer, but it lies with the woman or the man that's seeking the healing. They have to make the changes in their lifestyles. They have to leave the abusive husband and go to school. They have to change their reality to do the healing work. The credit goes to them. You're a mirror. You're holding a space for them so that they can see what they need to do next. And so they get the credit because it's their work to do.

So it can be taught if it's wanted. It has to be sought after. And it's incredibly rewarding when you start down the path, because as soon as you start down the path the first thing you realize is how little you know. And the farther you get the more you realize how little you know. And so your respect for what you don't know grows and that makes you even better, because your eyes get opened wider and wider to what's impacting other people, because you're looking for more answers. I know this is so corny and it's so trite, but it's a journey. And it doesn't stop. And every day when something wonderful happens and you get feedback from a patient and you get feedback from a family it surprises you and it's so wonderful because you didn't expect it. So that's the reward for it down the line.

01-00:56:55
Simons: I'm wondering what are some of the ways that you personally have had to hold a mirror up to yourself and do self-awareness and self-reflection in order to provide that kind of awareness and make that kind of space.

01-00:57:14
Newhouse: Well, I have done that kind of personal work. And it's not easy to do, and it's actually painful work to do.

01-00:57:19
Simons: Do you feel like that's necessary?

01-00:57:23
Newhouse: Oh yeah. Oh yeah. You've got a splinter and you've got to dig into it to take it out. What's hard about any kind of self-awareness and any kind of work that you need to do to dig something out and look at it is that life is hard enough, right? Life hurts enough. And it's hard enough. And now you're asking somebody. You might want to go in and talk to somebody, work with a healer, work with a shaman, work with a therapist, and really dig in and see where that issue is and what's driving it. Oh yeah, well, that sounds like a lot of fun. I've already seen like thirty patients today and I'm going to see thirty patients tomorrow and be on call on the weekend. Like when am I going to have the time or the energy to suffer. Because you have to feel those feelings that are driving whatever the issue is again to work through it. And everybody innately knows that and so they're averse to it.

So if they're doing just fine and everything seems to be fine, the motivation for the work isn't there. But just watching again Jeanne and her process and her expertise and her splendor I guess is what I would describe was motivation for me, because even though she wasn't as self-aware as she could have been, being partially self-aware and doing the role, doing the work was incredibly exciting to watch. And so when I was starting to do the work and I'd get a block, I'd feel a block, like I was angry or something had really upset me, or I would get a sense that it's time for a change, that to me was the message that I needed to look deeper to see what was the next step, what did I need to do next, what was the next level. And that required personal work. Yes, I did that. I continue to do that.

And then I stretch and I reach for the next goal. And I reach for a new skill set. I reach for a new opportunity to grow and challenge myself. And that means I'm growing and alive and I'll probably keep doing that for quite some time. I hope I will.

01-00:59:51
Simons: Thinking about a little bit earlier when you were talking about culture and how each woman is a small culture within herself, and I'm wondering if you have experienced any challenges or what kind of thinking you've done about backgrounds regarding cultural backgrounds, national origin, ethnicity, race,

religion, and how you have taken those into account in providing that kind of awareness and that kind of space.

01-01:00:26
Newhouse: Well, working in Hayward and Fremont really gives an individual quite the opportunity to experience many different cultures, because it's quite a melting pot. And one of the largest cultures is the Afghan population. And I like this example because it's a real example.

01-01:00:44
Simons: I know you—

01-01:00:46
Newhouse: I wrote about that.

01-01:00:48
Simons: Okay, I read that, yeah, in the *Permanente Journal* in 2005.

01-01:00:53
Newhouse: Yeah. Oh my goodness. Yes, yes. So that's an example of meeting somebody where they are and working with them and having sensitivity to what drives their value system. Do you want me to tell the story?

01-01:01:08
Simons: Do you want to tell that story? Yeah.

01-01:01:10
Newhouse: Okay. So let's see. If I remember it correctly I had a patient I had never met before in labor and delivery, and I spent the whole day with her in labor. She had her entire family there. They often all come in. And they're welcome in my births and labors to be present, the family, if that's what the woman wants. So there were many, many people. They were praying and there was lots of touch and lots of support from the other older women to the woman in labor. It was actually quite beautiful to watch.

And so it came time to deliver the baby. And so we went to the delivery room. Again, I invited the family members to come if they wanted to because it was a very uncomplicated birth, there was no reason for pediatricians to be present, there was plenty of room. So I delivered the baby, and I was fixing a little tear she had. And then I felt somebody in the back pocket of my scrubs, like a nurse was going after my pager or something. And I turned around and found it was the father of the baby stuffing something into my pocket. So over the course of the day I'd really built a wonderful working relationship with the women and the family and they came to trust me and I could see affection in their eyes. And so when I took the gloves off and examined what he put in my pocket, it was several 100-dollar bills. I can't even remember how many now. But it was startling. And they were all looking at me with great expectancy on their face to see me receive the gift with gratitude. I could tell that's what they wanted me to do.

Well, I can't—nobody can accept money like that. It's inappropriate in our system and in our culture to accept money like that. But in their culture that's what happens. And realizing that, I was in a bit of a dilemma. Because I couldn't reject the money without offending them and I couldn't accept the money either. So knowing they were very religious people, throughout the day learning that about them, and said, "I just can't accept the money," and I opened my hands up and I gave the money back to the father. And he wouldn't accept it, so I put it on the table. But they were so offended, just as I anticipated, that they actually turned their bodies away from me and gave me their backs, they were so upset.

They were completely offended. And so I lifted my hands in the air and just proclaimed, "I'm sorry, but it's against my religion. I can't accept money. It's against my religion." And they went oh, okay. It was fine. Because I was recognizing their value system and I was resonating with my value system. And they were accepting me for my value system. So we were able to meet at that bridge. And then I was back in their good graces and we finished up with the delivery and got her to breastfeed and everything was fine. I was sweating it there for a while, because I was really stuck. I didn't want all that hard work that I had done that day to build a relationship with this family to be completely destroyed.

And then later on, a couple months later, I got the sister of the mother I'd delivered in my prenatal panel. And so pretty soon I became the local Afghan community midwife. And all the patients started coming. Not all the patients, but many, came into my practice to be delivered. And when someone got married we were invited to a special dinner and the place of honor in the community center in the Afghan community. And there we were getting treated with all sorts of love and respect. And holding a couple of the babies I'd delivered on my lap, I was just in heaven. I was in absolute heaven. Because that's a hard thing to do, to interface like that in a different culture and to be that embraced.

01-01:05:05
Simons: I just feel like that's not something you can be taught in medical school. Like that's not cultural competency 101, saying that it's against my religion to accept 200 dollars from you.

01-01:05:23
Newhouse: It was spontaneous. And it came again from my heart's desire to please them and to honor the work that we'd done together. I didn't want all the work we'd done together to end in that kind of acrimony. It was heart work. It was work that I'd done from my heart. And they knew it. And I didn't want to hurt their feelings. I had a relationship with them in eight hours, and that's the key, is relationship, you show them your heart and why you're doing the work, and they want to trust you because they need to in the moment. They're not in their country. They're out of water, so to speak. And you are the only

connection they have with a system that supports them but is yet alien to them. You better open your heart because that's all they've got. You're all they've got. And so it's your job, it's your call to do that.

Anyway so when I was in the fellowship with California Health Care Foundation, they were talking about these kinds of things can be taught. And I agree with you. It can be taught but the student has to be willing and ready and seeking it. It can't be taught like you call somebody to a class and open up the textbook to page forty-eight. No, no, no, no. Their heart has to be ready. They have to be seeking a teacher. They have to be seeking a path, because it's a healer's path. And just like somebody who is very interested in business or real estate, they seek that. They're going after that information. They want to learn. It's not any better or any worse than that. It's heart work, and I keep saying the word heart. But it's why we're all connected on the planet. It's the great equalizer, the heart, and I'm talking about the human spirit. We're all the same really. Our hearts are all connected. And so when you know your own heart really, really, really well, you have the door into someone else, if they'll let you in, if they'll trust you. And so that is the work that's done. I don't know how to teach that. I can emulate it and I can model it. And when people see it and see the results they're either jealous and they resent you for it or they want it and they'll come up to you and say, "Teach me. What are you doing? What are you doing? Talk to me. Talk out loud. What are you thinking?" That's when you know you've got somebody who really wants to know. And that's when you give the information, when you share.

01-01:08:13
Simons: What I wonder about is Kaiser Permanente as an organization and how Kaiser Permanente fosters or doesn't foster that kind of understanding. So the way Kaiser Permanente puts out handbooks and does these national diversity conferences every year and I wonder if—I don't know. Because what you just said leads me to believe that that's just not enough from the organization. And I'm wondering what kind of experiences you've had at Kaiser Permanente fostering that or not.

01-01:08:55
Newhouse: Well, Kaiser Permanente let us in the door, okay? They let us in the door. And they support me. They support the midwife program. They support David's work. And they're beginning to understand it more and more. They are. They're getting there. They really are getting there. I don't think they really have it yet. They don't really understand what they have yet. They don't understand the role of it yet.

01-01:09:25
Simons: When you say they, you're referring to?

01-01:09:25
Newhouse: I'm talking about the corporate entity. I think that any corporate entity has to have a certain amount of separation from the people they are supporting. I

think that that's part of being a corporation. On the other hand, to have a level of intimacy with the actual work that we're doing would only benefit them. And it's my hope that over time they align themselves with the ethics and the models that they have in their own system. And they give a certain amount of attention to it, like with the Thrive campaign. They see on a level that this approach to being this kind of service-oriented, it's beyond service-oriented, it's actually culturally competent care, meaning culturally competent care of the individual you are sitting next to right now and reaching them where they are and the culture they bring and their life experiences. They see the value of it. But I don't know if they spend a lot of time thinking about why it works so well. I don't know if they spend a lot of time asking why this is such a market draw or why this would be a long-term benefit to really focus on. They work with a lot of numbers. The work with the near future. They work with all sorts of very complicated stressful issues to keep the organization alive, and I'm grateful for their business savvy. I'm grateful for their ability to be competitive in a market. Because when they survive I can do my work. And that's my hope, is that they will continue to grow in their awareness around true marketability and truly reaching people at the essence of where they live so they'll support these types of service lines that will promote the long-term viability of the organization, because that for me is the answer.

I don't think in two-year budgets and five-year budgets. I think in twenty-year budgets. I think in ramifications for impacting a health care model nationally. That's what I think we have the potential to do. We have the potential as an organization to be the model of health care, to be it, to form it, to lead it, to support it and to grow it. And they're on the right track.

01-01:12:23
Simons: Why do you feel like Kaiser Permanente has that potential? Why Kaiser Permanente?

01-01:12:27
Newhouse: Because it's aligned with evidence-based practice. Because it's aligned with wellness. Because it's aligned with health promotion. Because it doesn't make its money on pathology. Because it doesn't make its money on a dysfunctional system. Their ability to survive depends on their ability to promote cost-effective care. And quality is assumed in cost-effective care. If you don't have quality, your care will be astronomical because you'll have complications. You'll have bad outcomes. And that costs money. So that's why they're the best game in town. That's why they're our best hope for health care. Because in their pursuit of cost-effective care quality is assumed and quality results in best outcomes and optimal outcomes for families, optimal outcomes for actual business systems. So it's an alignment with growth and progress. That's why I think it's going to succeed as the model.

01-01:13:39
Simons: And as compared to what is—

01-01:13:39

Newhouse: As compared to a system that's perversely incentivized to create pathology where cost-effective care isn't even considered, where marketing to the most expensive treatment profiles, the most expensive drug therapies, the most expensive electronic systems as far as the fanciest procedures, all the things that private practice pursues to pad their wallets. Actually the ramifications, the product of that, is more pathology. The product of doing plastic surgery on a woman five times is that she's going to need reconstructive surgery the rest of her life. So the products create more pathology, more cost. So that's why that system is doomed to failure. And they are in the death throes right now. The private systems are in a death Kussmaul breathing mode. And they're getting desperate. And the more desperate they get the more ridiculous their procedures and their pursuits will become. And then they're going to be done.

01-01:14:54

Simons: Just to shift gears really briefly I want to touch on something that you mentioned before. And what I'm wondering is in terms of providing—back to culturally competent care. One thing that's come up again and again is that it's about truly listening, it's about being open. These are things you can't necessarily teach someone. You can't make a doctor or clinician, you can't make that person care in that way. And so there are a lot of culturally competent care booklets that teach like these tips and tricks. For instance Afghan populations have certain religious practices. As a doctor you should shake somebody's hand such-and-such way. And a lot of clinicians that I've talked to have said that that is just a way of sidestepping around the actual issue, which is about being open and asking questions. And that is one criticism of culturally competent care. And I was wondering if you could briefly comment on that.

01-01:15:54

Newhouse: Well, it's the first step. And the organization has done a good job in giving us the tools. Now if I didn't know certain aspects of the Afghan culture I wouldn't have been as good at maneuvering in that particular situation I was in, right? I knew about how the family structures worked. I knew that the fathers weren't very involved and I knew that the women were really driving that particular moment in that event. And so I trained my focus on them. I didn't even look at the men. I trained my focus on the women because I learned in a little booklet that this is what's true for their culture, okay? And so that helps. But they see right through you if you're not genuine. So you can have all those tools, right? You can have all those tools that our organization faithfully gives us. But if they don't see you opening your heart to them you're all done. Your effectiveness is over and they can't trust you. So it's half the answer. It's not the whole answer. So the rest of it comes from the provider. The rest of it comes from the healer that's willing to meet those people face to face, heart to heart, and really work with them. They know a genuine person when they see one. We all do. And we feel it. And so if that part isn't there, game over, tools didn't help you. It's just the start. But the

tools are important. The information and the education is important. The rest of it has to be the work you do in building a relationship with that clientele.

01-01:17:32
Simons: You keep on using this term of heart. And like opening your heart. And opening your heart to a patient. And I'm wondering if you could I guess explain that a little bit more.

01-01:17:50
Newhouse: Well, I don't mean open yourself so they can cross your boundaries in any inappropriate way whatsoever. What I am describing is that they see you. Opening yourself to the point where they can look in and see who you are and see what you want to do for them and see what your intentions and your motives are. I'm speaking about transparency. I'm speaking about a desire on your part to be of service to them. And that's your primary motivation. They have to sense that. They have to sense that you want to help them and that's what you're there to do and that's your most important focus at the moment. That's what I mean by that.

01-01:18:43
Simons: What I think that you've touched upon a lot in our conversation, which I'm curious to ask you more about, is you use the term shaman and these ideas of opening your heart and really connecting with somebody. It seems like this is spiritual work in a way.

01-01:19:09
Newhouse: Well, any work that we do with any other human being is spiritual work, whether we recognize it or not. This is a recognition that I am paying attention to what I'm doing. We all are creating something. We're born to be creators on this planet. We create constantly. If we are awake and we create with awareness we create beauty. If we're asleep—and we're still creating, we're just making a mess. Okay? We're just making junk and chaos and disruption and dysfunction. So of course it's spiritual work. My relationship talking to you is a spiritual act. We are connecting, we're talking, this is spiritual work, because our bodies are bodies and our minds are minds and our spirits are spirit and what we manifest in our daily lives is a reflection of who we are inside, not of how much money we make, what our roles are, what our status is, but a genuine human spirit relationships with other genuine human spirits. Everything we do is spiritual interaction, whether it's paying the bills, washing the car. We're actively engaged in life. And what I'm speaking to is the difference between being aware of what you're doing and creating something that will help someone else or yourself versus not being aware about what you're doing and then they can't trust you to make a connection and create something good with you. It's like opening yourself up is an invitation. So you look at them, you let them see you, and you're inviting them to work with you. That's all you can do. They may not meet you there. And then you still have to take care of them. That's fine. I can do that. But boy, what a difference when I can win their trust and they agree to meet me at

the middle and then we work together. Unbelievable difference. Real physical problems are prevented when you can do that with someone.

01-01:21:23
Simons: And there are lots of statistics that show that if a patient trusts their clinician that the rate of compliance just like goes way, way, way, way up.

01-01:21:38
Newhouse: That's right, because you honored them and invited them to work with you. They know you care about them. Not in an inappropriate way at all. But you care about them. And I think this is what medicine is so afraid of. Is that the medicine, the allopathic patriarchal medical model is afraid of being accused of doing something wrong, being inappropriate. Opening up is very scary to a male physician who's an OB/GYN because they're afraid of getting accused of harassment. That's their fear. And so a lot of fear keeps us shut up behind walls and then nobody is inviting anybody to connect and then there's problems and there's no communication, there's no working together to solve a problem.

So it's a scary concept to many, many people in the practice of medicine to actually ask them to let someone see that you care to help them. It's scary because they're afraid that that's going to invite somebody who doesn't have good boundaries, that's going to invite problems for you as a provider, and frankly I'm so exhausted as a provider, it's asking for a whole new skill set again, it's like learning another language. If English is your first language, when you're under stress you're going to go back to English even if you've decided to learn Spanish, right? So what you're asking someone to do is pick up this whole new skill set, use it automatically, be comfortable with using it automatically, and that just doesn't often happen that way.

01-01:23:29
Simons: I guess what I'm wondering is what do you feel like—and you've touched on this—but what do you feel like is special about the way that midwives are able to provide care during deliveries as opposed to other clinicians. Is there a way that midwives are able to be more sensitive?

01-01:23:53
Newhouse: Well, the first thing we offer most of the cultures around is a woman to care for them. And that honors many religions. So their religious beliefs, they don't like men taking care of their women when they're in labor. Another man should never see their wife naked. So that's a real draw just because we're female. That's how this has been. It's just one small piece of it. But it does make a difference.

Midwives are nurses first. So we're trained in a more holistic approach to patient care. We're trained educators. We're trained to predict problems before they occur and see problems down the road before they get there. So that's why midwives have good outcomes. We can see that this woman who's

getting really stressed out by her job might end up with something like migraines or high blood pressure. And so we're working with her in the beginning to help her mediate that reality so that it doesn't later on become a problem.

Or someone who's developing obesity or somebody who's prediabetic. Catching them before they get sick and making the intervention with that patient before they develop something that needs more serious intervention. Before the pathology becomes so marked that they need some kind of intervention like labor induction, et cetera. So our model is preventative. Our model is to educate and support women. Our model is to be advocates for women and the role they want to play in their labor. Some women simply want to be, well, put to sleep so to speak. They just don't want to feel their labor. They want an epidural immediately and that's what they want. And it's our job to advocate for that within the safety of evidence-based medicine.

So that's the reason that midwives are so well suited to the system, because we look for problems to prevent them in the first place so you don't have a problem to fix, and we're educators and women's advocates so that we support them in the type of birth choice they want to have. They relax. And when people are relaxed and they feel supported you know the outcomes are improved. There's nothing worse than a woman who's scared to death and tense in labor. She stops having her labor. So if she can trust you and she's not afraid, then better things happen. I hope that answered most of the general gist of it. But the critical piece is we have more willingness, again, to open ourselves up so the patients can see us. And we invite them in to work with us. I think that's much more a midwifery skill set than it is a physician skill set. Some nurses are very good at it. And a nurse taught me. And I honor our nurses. But it's something you're more likely to find in a midwife.

01-01:26:56
Simons: I'm also curious to ask you about in terms of midwives being validated in the medical system how some ways that midwives in general are seen as not as—so before I came here I was talking to my mom on the phone. And I was delivered by a midwife.

01-01:27:29
Newhouse: Oh. Wow.

01-01:27:29
Simons: And she was telling me about how at the time it wasn't that controversial, but her mom, my grandmother, really had a problem with it and saw it as an irresponsible alternative, is what my mom said to me. And I'm wondering if you could speak to some of the challenges that midwives face, maybe being seen or historically being seen by the medical establishment as an irresponsible alternative.

01-01:28:03
Newhouse: Well, they created that perception on purpose. And they created that perception on purpose to obtain a monopoly on the market. So that woman, your grandmother, was living in a time when the American Medical Association had had great success in convincing people that the safest place to deliver was in the hospital under scopolamine medication when you were unconscious and unaware of everything that was happening to you. They convinced women and an entire culture they had a better product.

And of course they didn't have a better product, because they were trying to improve on a system that worked well for millions of years without them. They were interfering with the best product. And they bore the results of that over time. And they are still bearing the results of that over time. So she was a victim of that propaganda. And so she really believed that it wasn't the responsible choice to make. Actually your mother was heroic in bucking that perception, betraying her mom's advice and believing in herself and believing in her body.

01-01:29:25
Simons: When do you feel like the American Medical Association started spreading that propaganda?

01-01:29:28
Newhouse: Well, again, I quoted DeLee's lecture. I think it was 1910 or something, or nineteen aught aught something, where he was talking about okay, we have all these family practice physicians, we have all these midwives, we have other providers that are walking into our market. At that time a lot of babies were born at home. At that time a lot of family practice physicians were managing normal birth.

And the OB/GYN community, anxious to create a specialty that could monopolize the market, went in this direction, to medicalize normal birth, to create a necessity for their specific skill sets so they could monopolize the market. It was very intentional.

And we're all reaping the benefit of that now with a C-section rate of 34 percent, which is absolutely criminal, because it's not appropriate. The World Health Organization has really made it clear that in healthy populations section rates shouldn't be any more than 15 percent for complications, 10 percent for normals.

So there's money to be made, and that's what's happening here. In a hospital system, maternity care is 11 percent of their bottom line. And that's a big part of your bottom line, and they'll do what they need to do to protect it. And if that means they have to spend a lot of money to keep legislative practice very restrictive for midwives, that's what they will do, because it pays off in the end for them.

And again it's not incentivized for what's best for the women. And that is for me why I'm involved in midwifery. Because it's not incentivized in the right way. It's incentivized for what's best for their lifestyle, what's best to propagate and validate their practice styles that are not based on evidence in a great many areas. And it's not good for the general public as a whole.

01-01:31:34
Simons: I'm curious to know what you think it will take in the future to go against that. Will it take women like my mom who were freethinking and decided, you know what, I'm going to have a midwife? Will it take the Internet as you said before? Will it take radical restructuring and new legislation?

01-01:31:59
Newhouse: I think it'll take a combination of all those things. I think that it's an ebb and flow. Several years ago the section rate went up and the consumer groups just reacted in a frenzy about how horrible that was and the pushback actually changed practice.

I haven't seen that kind of indignant roar from consumers given the recent rise in section rates. And I do believe that that's because surgical procedures have become normalized in our culture, and because very powerful people are making a lot of money on the way things are working.

I think that it's going to be a combination of tragic train wreck outcomes that are on the way—those placenta accretas that grow all the way through the uterus into the bladder and women have a very small chance of surviving the surgery, let alone delivering a healthy baby, their life is endangered. And that's going to be a health care fiscal hit that most systems can't survive.

When you have a woman with a bleeding previa, she can spend weeks in a labor and delivery unit, taking up a hospital bed, with a full OR team at the ready to rescue her life. That is expensive. And I think that is what's going to push it over the edge.

So the cost of the bad outcomes based on the surgical interventions that were done without evidence-based practice for perverse fiscal incentives are going to drive bad outcomes. And it will be part of the death throes of private practice. And I hope to see Kaiser Permanente rising out of that like a zenith with evidence-based practice and optimal patient outcomes as not only the survivor but the leader in how medical care should be established. That's what my hope is.

[End Audio File 1]

[Begin Audio File 2 newhouse_naomi_2_08-19-08.mp3]

02-00:00:00

Simons: This is the Kaiser Permanente Oral History Project, Year Three on diversity and culturally competent care. This is tape two of my interview with Naomi Newhouse in Danville, California, and today is the 19th of August, 2008. And I have a couple more questions I want to ask. And you mentioned that you'd like to address the collaborative team.

02-00:00:32

Newhouse: Yeah. When midwives were introduced into the northern California system about twenty years ago we were immediately involved with working with the entire health care team with nurse practitioners, with the nurses on the unit and with the physicians and the other specialists that have a role in delivery of maternity services. And over time we've had to walk a really fine line with the nurse practitioners, because they're represented by CNA, which is a union, and we're not. And we've kept ourselves out of CNA and will continue to do so because we prefer to work on a more professional level directly with the regional administrative team for all of our administrative needs versus being in an adversarial relationship with them under a union relationship.

So that has been a very delicate line to walk as we've grown our services to not harm the nurse practitioners. Because we can do everything they can do and more. So to honor the fact that they were here first and to keep a place for them we've elected to not provide GYN care over the lifespan, which we are completely licensed, certified, and prepared to do.

In exchange they support our ability to take care of patients that are pregnant in the office and then we care for patients in labor delivery and deliver the babies in the hospital. So just the finesse that it takes to walk that line in the system and still survive it and to grow has been the primary goal of the regional midwife chiefs group that I've chaired for about eleven years now and have had the pleasure of working with over time. So that's a very important part of our work.

02-00:02:27

Simons: What other kinds of issues do you address as the chair?

02-00:02:32

Newhouse: I address individual departments or facilities that are attempting to restrict our practice based on their lack of awareness of who we are and how we function and what our authority gives us the right to do. I'm constantly fighting the same battles over and over again around no, we don't need the physicians to proctor our births, we can proctor our own births. No, we don't need the physician to be present at the delivery. No, no. Just educating the—sometimes it's nursing management. Sometimes it's an administration team in a particular facility that's not very familiar with midwives. And I'm experiencing that now in a big way in the Central Valley, because it's a new system in that they've never had KFH hospitals. They've been privately contracting out to private hospitals. And now they have KFH for the first time.

02-00:03:30
Simons: KFH?

02-00:03:30
Newhouse: Kaiser Foundation Hospitals. This is their first experience in the Central Valley with the TPMG. It's their first experience with Kaiser Foundation Hospital. So they're on a whole new playing field with that. And there's a great deal of fear and suspicion about any particular practice that's not familiar to them. And so it's been a Herculean effort—as I expected it would be—to introduce the concept of midwifery there. Even though it's already rolled out in ten facilities twenty-four-seven and has been working for twenty years with regional policy embedded and vetted by KFH attorneys, it's still a process to bring them along with educating them who we are, what we do, what's it okay to do, what's it not okay to do, especially in the shadow and fear of the regulators visiting and finding some discrepancy and then getting fined. That's just their worst nightmare. So introducing something new to a system that's already introducing several new things, like a new hospital system to be accountable to, and introducing a new service line they're not familiar with, the anxiety levels are off the scale. So I do a lot of educating and reassuring, a lot of protecting turf, citing statute, gathering my colleagues at region to help support me when I say no, we don't need this, we need this.

It's being a change agent that makes you a target. And it's never comfortable to do that kind of work. I wouldn't call that fun. I think that what's fun is to see it progress. I think what's fun is to actually see the end product of a brand-new service of midwives coming into a med group that really appreciates them—because they do really appreciate us in the Central Valley—and then they get to reap the rewards of patient service and great outcomes, physician satisfaction, and cost-effective care. And so it's getting there that's hard. But it's working because I have the support of the admin team. And they're very motivated to make it work.

02-00:05:49
Simons: In terms of being a change agent, I'm interested to ask you about what kinds of things in terms of legislation, what other kinds of things you're currently working on. And then I guess looking towards the future what kind of things you hope will happen.

02-00:06:07
Newhouse: When we moved the legislation for prescriptive authority, right? We went to the Government Relations Committee at Kaiser. They approved it. They gave me $70,000 to use their lobby team in Sacramento and actively lobby the legislation. So we got that bill passed, right? Wonderful. Oh, I thought that was the hard part.

That's not the hard part. Then I take that legislation home and try to implement it in the very system that wanted it, that paid for it, because there are several entities within that system that were resistant to our advancement.

That's the real work that needs to be done. And so when somebody tells me they need a legislative change to improve practice, I'm thinking about the whole five-year plan of getting the bill moved, getting it done, getting it won, and then implementing it into a system that asked for it. It's gut-busting work. And that's what the change agent—that's where the work comes in, is that you have to stand there and defend the advancement to folks who are either resentful, jealous or just not willing to see you grow, for completely inappropriate reasons, but they're relevant, because they're human beings and they have an opinion, and they happen to have power within whatever committee they're in at that organizational level.

That's the hard work. That's the hard part. And to stand there and take the bullets there. Very few people have been willing to do that. And it takes a toll. So opening up this program in the Central Valley I felt uniquely equipped. At least I was aware of what I was walking into. And when I look at future legislation that's what I look at, and the real bill that needs to happen would be to change the language of the statute from the physician is in a supervisory relationship with me to a collaborative relationship with me, because that would open the door to winning licensed independent practitioner status, which would open the door to being listed as a medical staff member, which would open the door—see, these aren't guarantees. You can win that legislation and they don't have to follow through with granting you anything at the facility level. So there's no promises and no guarantees, there's just hard work to be done. But the gains that you can make are worth the effort, because the more people that are exposed to this type of care, the better.

02-00:08:37
Simons: I guess the last thing I really want to ask you about is—oh, actually, before I ask you about that, what kind of population do you see midwives being, if it's like a population? Is it mostly women? Any sort of ethnic background? Religious background?

02-00:08:56
Newhouse: You mean as providers? What would their demographic look like?

02-00:08:58
Simons: Yes, exactly.

02-00:09:02
Newhouse: Well, currently the demographic of midwives looks like white upper-class nurses that can spend the extra money, take time off from work, have enough support to get a graduate degree. Unfortunately the other side of the coin when you ask a human being to tool up and become a professional, to go to school, go to graduate school and put the kind of resources forward that that requires, they have to come from a good educational background to begin with, they have to do well in very advanced coursework to even qualify to get into a graduate program, because there are very few of them. So the people that end up making it through the system are generally white upper-middle-class

women. And that doesn't necessarily fit the demographics of the patients we serve. And there have been several attempts to bring women from other cultures up through the ranks, and many have made it, but some wash out because the academics are so hard and they're just not ready for it. They are just as smart, just as capable. It's very unfortunate, but that's the reality for medicine as well.

02-00:10:20
Simons: Have there been any frictions there between the demographic of midwives, white middle-, upper-middle-class women, and then women, particularly women of color, who the midwives are treating?

02-00:10:40
Newhouse: No, again, we're not all white. I don't want to give the perception that we're all white, because we're not. I'm just saying that the majority of us are. I'd say 80 percent of the providers come from an upper-class, middle-upper-class background. But there's just like with medicine, the patients understand that this is who's available to them to take care of them. And of course they would prefer somebody from their culture, of course they would. And when we can provide that it's golden. Not only someone who speaks Spanish but who's actually Latina. It's just wonderful. But just like everyone, they have to be fit for our system too. They have to keep our professional standards. They have to work well within our system. So it has to be a match. This is true for physicians as well.

I think that there are realities with physicians now. You've probably heard that male physicians that are OB/GYNs feel a little bit like a dinosaur, because the younger women really want to see women. And the older women are fine, because culturally that was part of their expectation, right? The male patriarchal model, we'll take care of you. So they're very comfortable with an OB/GYN taking care of them. But for women under thirty, they're looking for another woman. So that can be also something that's an issue along racial lines. We can work with our providers on their biases, but our clients have biases too, and we can't necessarily shift that. It's not our place to do that. But being market-sensitive, we have to respond to that. So we have to try to provide them with as many female providers as we can.

02-00:12:17
Simons: And then also as many providers from the same racial or ethnic background?

02-00:12:21
Newhouse: Absolutely, absolutely, because that's what they are asking for. That's what they feel more comfortable with. So we as a med group are under the charge of providing culturally sensitive care in that regard. And that's a challenge for all the reasons I cited before. Getting into educational programs, not having the benefit of good schools in the primary level can impact dramatically a person's ability to achieve that goal. So we support all our colleagues in their efforts to grow and to develop.

02-00:12:54
Simons: But you don't necessarily feel that a provider and a patient need to be of the same background in order for the most culturally competent care to be delivered.

02-00:13:04
Newhouse: Like again what I said around culturally competent care, you can't put it in a box. Just because you have a Latina midwife provider and a Latina patient doesn't mean they're going to get along very well. Okay? If she's not doing the work I talked about doing earlier. So I have not myself experienced any difficulties with that personally, being able to meet a patient and care for them and not being from their particular culture or their ethnic background. It's not been a problem for me, because they're looking into my eyes for who I am, and if I'm giving that back to them, if I'm sharing with them my desire to meet them and care for them, then that is what they're looking for. That's what they really want. They want to trust you. They want to believe you're going to care about them and you're going to take good care of them. That's what they want. So you don't generally find somebody who's coming in in an adversarial fashion.

02-00:14:08
Simons: Well, listen. That about wraps up my questions for you. At this point in the interview we like to invite people to add anything they feel hasn't been addressed or make a final statement or anything like that.

02-00:14:22
Newhouse: Well, I want to thank you for the opportunity to share some of these thoughts with you because it is my hope that in the future we will pay more attention and reawaken the intuitive and nurturing side of our healing souls and we will expect that of our care providers and actually support it and honor it. Because ultimately that is the answer for real healing to occur. So I'm hopeful that that will happen in the future more than I see today. So that's my hope. And thank you for taking the time to come and do this with me. I appreciate it.

02-00:15:03
Simons: Thank you.

[End of Interview]