From: Kimberly Swagler
To: Council Clerk; City Council Email
Subject: Re: Grady OB Closure
Date: Sunday, June 21, 2026 5:24:15 PM

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On Sun, Jun 21, 2026 at 17:13 Kimberly Swagler <kimberlyswagler@gmail.com> wrote:

Please read the following statement during the city council meeting tomorrow.

Good evening-

In an emergency, the residents of Delaware county and surrounding areas depend on Grady to provide safe and timely care. The CDC estimates that more than 80% of maternal deaths are preventable and includes access to care as a contributing factor (1). Furthermore, the infant mortality rate in Ohio is among the worst in the nation. Major risk factors for infant mortality include no or lacking prenatal care and the usage of Medicaid as the primary insurance source (2). Both of these risk factors point to socioeconomic challenges, including transportation. Removing obstetric care from Delaware County will further limit this access by removing the ability of patients to utilize the DATA bus or other local means of transportation to seek care.

Obstetric emergencies can't be planned for. When a patient wakes up in the middle of the night bleeding heavily, they don't have time to drive 35-40 minutes or greater to seek care. Approximately 1 in 100 pregnancies are affected by a placental abruption in which the placenta separates partially or completely from the uterine wall. The rate of stillbirth for the general population is 0.3-3%. In cases of placental abruption, that number rises to 20-40%. Beyond the risk of neonatal death or injury, women run to risk of severe hemorrhage which can lead to death or hysterectomy if not treated promptly (3).

Emergency Room nurses and physicians are incredible assets, but pregnancy/neonatal care is a specialty for a reason. For the patient actively hemorrhaging, there is no one in the ER trained or certified to interpret electronic fetal monitoring to assess fetal well being. This skill takes extensive review and education to master reliably. Subtle changes in fetal heart tracings can indicate severe fetal distress, but it takes a trained eye to recognize and respond appropriately.

ER teams are masters at running codes on adults. No OB nurse is going to jump in and claim they have the same skillset, and likewise with neonatal codes. Chest compressions are the hallmark of adult resuscitation- in fact, the American Heart Association now teaches compressions only CPR for bystanders. In neonatal resuscitation; only 0.25-1% will require compressions. The primary method of supporting a neonate is ventilation due to the underlying acidosis of the intrauterine environment. Asking an ER team to completely flip their standard process in a high intensity emergency situation is asking for errors to occur. Furthermore, ER nurses are not routinely certified in neonatal resuscitation- the OB team responds to all Code Pinks (code in an infant under 28 days old) in the hospital. Removing that support from the ER team is an immediate danger. Ask how many members of the ER team have ever ventilated a newborn? Compared to an adult, the lung volumes are much lower and less air and force is needed to successfully ventilate a neonate. However, as this is not a skill the ER utilizes, the damage caused by using too much force or volume to ventilate a neonate could lead to a pneumothorax or other respiratory collapse. Oxygen levels utilized during resuscitation of infants have to be closely monitored to prevent constriction of the blood vessels in the brain as the infant transitions to breathing and oxygenating independently. An oxygen level of 60% would alarm an ER team, but can be completely normal for a newborn still in transition (4,5).

NRP (Neonatal Resuscitation Program) requires two separate team members attend every delivery with one staff member solely present for the infant (6). In an already over extended ER, that's taking a large portion of the nursing team away from the rest of the patients, some of whom may be critically ill. Furthermore, say the infant comes out requiring resuscitation. You now have at least 1 nurse and 1 respiratory therapist with the baby. What happens if the mom now hemorrhages? A woman dies every 12 minutes from a postpartum hemorrhage (7). The medications used to treat a postpartum hemorrhage are unfamiliar to nurses outside of the OB arena and come with risks. For example, Methergine given to a woman with blood pressure concerns will cause worsening hypertension and can lead to severe range blood pressures. Hemabate given to an asthmatic will cause the airway to swell and spasm and can lead to a loss of airway requiring intubation and ventilation.

A blood pressure of 140/90 in an ER patient isn't alarming. A BP of 140/90 in a pregnant or freshly postpartum

patient can indicate impending organ damage, circulatory collapse, seizure, or stroke. As a community, are we willing to gamble with the lives of mothers and infants? Even one negative outcome is too many. The mother who is in labor at the edge of fetal viability shouldn't be driving to riverside through construction and traffic trying to get access to care before she delivers in her car without the ability to help her baby. The patient who has a seizure in the middle of the night while pregnant isn't stable to be driven around central Ohio during rush hour in an ambulance trying to get to care. This closure presents an immediate and avoidable risk to the residents of Delaware County.

Kimberly Swagler

Sources:

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6. https://www.ahajournals.org/doi/10.1161/circ.102.suppl_1.i-343

7. https://www.sciencedirect.com/science/article/abs/pii/S0140673626009025