

“WHAT CAN BE SAFER THAN HAVING A BABY IN THE USA?”

LOUIS WEINSTEIN, MD
(MAY 2010)

Political correctness won't lower maternal mortality

Wow! What a great article! In all honesty, I began reading it reluctantly, expecting to encounter a lot of out-of-touch, politically correct garbage. It drives me crazy that people use these stats on maternal mortality to disparage our care, when people who care for these patients know the role that these mitigating variables (like substance abuse and obesity) play. There is always room for improvement and self-evaluation but, as a society, we need to start being honest and responsible. We need to identify the pertinent issues and stop worrying about offending people.

I recently started a healthy lifestyle and diet program in my office, and the results have been stunning. Not only are women losing significant weight, but the number of medications that have been discontinued in the process is unbelievable. We are conducting a research trial into the effects of this program on polycystic ovary syndrome.

Too many physicians are afraid to confront a patient about the truth and consequences of her body mass index of 35. Too often, those same physicians are quick to hand out prescriptions for expensive medications, thinking they are “fixing” something, when all they are doing is wasting money and generally worsening the patient’s health.

Other countries and cultures have confronted the reality of some of these issues with “forced sterilization” and limits on family size. That sounds terrible, but at some point we have to start facing reality.

Another great example: In today’s paper, an article described



MAY 2010

people’s protests against a proposed tax on soft drinks. The people said that “groceries” should not be taxed. I think such a tax is a bad idea, but calling a totally nonnutritive, unhealthy beverage “groceries” shows how unrealistic we are about the truth.

Thanks to Dr. Weinstein for standing up and saying something that needed to be said. Anyone who is “offended” needs to get a grip and understand the role of objective evaluation and discussion. Everything needs to be on the table.

Donald J. DeBrakeleer, DO
Lansdale, Pa

Change is a long, slow process

How many pregnancies is too many, in Dr. Weinstein’s opinion? Three, four, five, six? Is Dr. Weinstein implying that women need to have a license to have sex? Silly analogy!

I agree that education and contraception are part of the answer, but Dr. Weinstein’s proposed solutions are ridiculous and expensive. Free contraception is a good idea, but who pays for those “vouchers” and the compensation for not getting pregnant?

How long do we pay women to abstain from reproducing? Do we stop payment when they get pregnant? Can we get our money back? The federal government is trillions of dollars in debt, and Dr. Weinstein wants to emulate the Department of Agriculture and pay farmers not to grow corn? We can’t expect women to inculcate values that aren’t there in the first place simply by paying them!

One change is necessary but impossible: development of a long-time perspective. That’s what’s needed for a woman to delay gratification in the near term in favor of long-term benefits, such as financial freedom and personal maturity. A good Jewish mother would do the job. Money won’t do it—only long, long dinner-table conversations about right and wrong.

Stan Franklin, MD
Lewisville, Tex

Maternal mortality is under-reported and misclassified

A case series of US maternal deaths that I have pulled together over more than a decade indicates that the recent rise in maternal mortality is caused by more than matters of lifestyle. To blame are many variables other than lack of access to prenatal care due to discrimination, transportation issues, and other common problems in the lives of low-income women.

My series of 325 deaths, most of which occurred since 2000, includes many women who had “good” insurance and plenty of prenatal visits. A rather high number of women bled to death in hospital during or following cesarean delivery, and some experienced pulmonary embolism in hospital or after release. Six deaths were related to epidural anesthesia, and quite a few involved ruptured uteri

or amniotic fluid embolism following induction. Among the deaths were numerous mothers of multiples.

What's missing from Dr. Weinstein's discussion is the 1998 revelation by the Centers for Disease Control and Prevention (CDC) that we have a large degree of misclassification and underreporting of maternal death in the United States. Since this revelation made the news in the late 1990s, the CDC has not been able to claim, with any degree of credibility, that reporting has substantially improved.

We still have several states that don't use the US Standard Death Certificate (why is it optional?) and some that fail to document the prior pregnancy status of the deceased mother. It's possible in many states to fill in the "cause of death" box with "cardiac arrest" or some other malarkey, with no repercussions for the person who certified the death or the institution where it took place. In other words, we have an honor system of reporting.

Most states have no mortality and morbidity review committees. How can the in-house reviews of for-profit hospitals' be considered adequate?

Late maternal deaths are often—perhaps usually—missed. I have reports of what seems to me an incredibly high number of deaths due to postpartum psychosis suicide; these are usually not low-income women.

There are wealthy countries where such irregularity and laxity in reporting of such an important metric would not be tolerated. Why does the United States accept such shoddy accounting? Don't we value our mothers?

My project, "The Safe Motherhood Quilt Project," has taught me that US women are dying for a vari-

ety of reasons that don't fit the usual perceptions. I know because families of deceased women often provide me with the "inside story" from their perspective.

Ina May Gaskin, PhD (Hon), CPM, MA
Curator, The Safe Motherhood
Quilt Project
Summertown, Tenn
www.rememberthemothers.org

A national initiative is the key to success

Congratulations to the good Dr. Weinstein for beginning a dialogue that is long overdue in this country. I have been in practice many years. For the past 3 years, I have been on the ObGyn faculty at a family medicine residency, helping them care for a large "safety net" population.

Although I share many of Dr. Weinstein's views, I think any approach other than a national initiative, endorsed by the President and a majority in Congress, will fall short. For example, I think the First Lady would be the perfect champion of this vision for a better tomorrow. There are huge cultural and religious challenges to overcome in addition to the "endless cycle" Dr. Weinstein mentions.

As a practical matter, free access to contraception is essentially available through local health departments, but it must be complemented by well-trained providers to effect proper usage and long-term management. Integral to this effort is programmed education within indigent, at-risk communities regarding the clear benefits of limiting family size and proper birth spacing if multiple pregnancies are planned.

Among my greatest frustrations are the impediments—both governmental and local institutional—to postpartum tubal ligation. For example, the onerous Medicaid Sterilization Consent form must be signed

at least 30 days in advance and must be present on the labor and delivery unit at the time of the procedure. Another absurdity is the fact that women covered by "emergency Medicaid" who desire sterilization can have postpartum tubal ligation covered only if they happen to have a cesarean delivery!

On the local front, many hospitals—and I am not referring to the Catholic institutions—are reluctant to make this service remotely a priority. As a result, women who clearly should not be having children and who desire to end the cycle of dysfunction themselves often leave the hospital after delivering another child on the margins, only to repeat the process.

I cannot help but notice the proverbial 900-lb gorilla in the room: abortion. Ideally, abortion should be covered as part of the full scope of reproductive health care, but dogmatic religious paternalism in this country has curtailed the availability of safe, compassionate, and timely provision of this service to women in need. ACOG should be the obvious champion here, but it appears that political correctness and religious "sensitivities" trump ethics and the rights of women.

Kenneth W. Elkington, MD
North Colorado Family Medicine
Greeley, Colo

Contraception should be free and easy to get

I'm a certified nurse midwife with 30 years of experience, most of it involving indigent patients, many of them in relatively rural areas. I strongly agree with Dr. Weinstein's comments and suggestions. There is something wrong and sad about a country that does not provide free and easily accessible contraception and education to all girls and women of repro-

ductive age. We should not have 14-year-olds seeking fertility treatment because they are not pregnant yet and all their friends are!

Teresa Warner, CNM
Lynchburg, Va

We need to prevent pregnancy, not just “treat” it

Although many people acknowledge the detrimental effects of drugs and alcohol in pregnancy, the role of obesity gets much less attention. Yet, obesity is extremely common in obstetric practices today. Thanks to Dr. Weinstein for expressing what, I am sure, many practicing obstetricians have thought but have been unwilling to verbalize for fear of generating accusations of racism.

I remain uncertain as to how to attack the problem of teen pregnancy in the African-American culture because the phenomenon is so well accepted, and no amount of education has seemed to change that. I hope that, with health reform, we can begin to emphasize the importance of preventing pregnancy rather than merely treating it. The greater acceptance of the IUD by many low-income patients has helped to reduce the rate of unwanted pregnancy.

Leslee Jaeger, MD
Osseo, Minn

Stop rewarding bad behavior

Fantastic commentary! I couldn't agree more. It's nice to know that somebody in our field is courageous enough to speak these social truths. I especially liked the idea of ending the cycle by compensating women who adhere to a contraception plan—brilliant! Instead, here in America we continue to reward negative behavior, and the cycle just continues.

In my young career, I certainly haven't seen what Dr. Weinstein has

seen, yet I still agree wholeheartedly, despite being very liberal socially.

Any way I can help?

Tyler Hancock, MD
Department of
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High rate of cesarean delivery is to blame for maternal deaths

Thanks for the commentary on maternal mortality. During my 38 years of practice, from 1958 until 1996, I experienced only one maternal death, which occurred during the last 6 months I practiced. A woman undergoing a routine, repeat cesarean delivery went into disseminated intravascular coagulation 30 minutes postoperatively and died 1 week later. I was sued, of course, but won the case 5 years later.

I believe that the criminally high rate of cesarean delivery—31% in the United States—is a major contributor to maternal mortality. Today's obstetricians are subjecting women to too many unnecessary operations.

If the cesarean delivery rate continues to climb, we might as well consider our specialty subsidiary to surgery. Obstetrics is obviously not being emphasized in residency training programs. When I entered practice, the cesarean delivery rate was 5% to 7%!

Is anybody studying the increase in maternal mortality in light of the rising cesarean delivery rate?

I think physicians who perform elective cesareans should be charged with criminal assault!

John W. Luce, MD
New Buffalo, Mich

Education is the key to reducing maternal mortality

I applaud Dr. Weinstein for stating so succinctly what many of us here

in the sunny South have been saying for many years. We must have a reproducible method of screening those young women who, for a multiplicity of reasons, should not become pregnant—or, who, if they do become pregnant, should not be cared for by the community generalist practitioner, a midwife, or the overburdened ObGyn who is trying to run an office, see patients, and master the newest gadget or robot in the OR. Education is the key—not only for the laity, but also for health care providers!

P. D. Bullard, MD
West Columbia, SC

To lower maternal mortality, focus efforts on the poor

I just read Dr. Weinstein's commentary on maternal mortality in the United States and wholeheartedly agree! I appreciate the fact that he chose not to poetically or politically expound on “system failures” or similar vague ideas. His proposals are realistic and hit the nail on the head.

The reason that the United States appears to be lagging in some international comparisons is that our poor lack sufficient knowledge and resources to take care of themselves. They are the ones who need help—not the well-off suburbanite. The well-off can count on receiving outstanding care in this country, much better than the care available in other parts of the world, including most parts of Europe.

I would add “education in contraception” to Dr. Weinstein's first prong of suggestions. Not only should we hand out contraception for free, but we should offer classes and information—at no charge—to educate patients about the use and advantages of contraception.

I agree that financial incentives should be offered for compliance with good policies and lifestyles, but

I would suggest that they be reserved for patients on Medicaid.

Matthias Muenzer, MD
Medford, Mass

We need to study other medical delivery systems

I read Dr. Weinstein's commentary on maternal mortality with interest. I agree that our nation's rank of 33rd in the world, just slightly better than Cuba, is a disgrace. Many of the causes of maternal mortality are sociological, as Dr. Weinstein points out, arising from poverty, drug abuse, violence, obesity, and limited access to care. The escalating cesarean delivery rate and the resultant increase in the incidence of abnormal placentation and ruptured uteri are also contributors.

Some regions that have the lowest birth rates also have the lowest rates of maternal mortality—namely, Hong Kong and Macau. It would be interesting to study their medical delivery systems to see how they keep maternal mortality low.

Allen E. Ott, MD
Southampton, NY

Two measures would lower mortality

I would add two suggestions to those offered by Dr. Weinstein:

- Abolish the Medicaid requirement that a patient has to be 21 years old to undergo sterilization. There is absolutely no

reason for a 19- or 20-year-old who has three or four children to have to wait until she is 21. She has already failed responsibility.

- Reimburse clinicians for office-based Essure sterilization at a rate that encourages them to avoid costly hospital sterilization procedures.

C. Lampley, MD
Shelby, NC

Counsel women before they get pregnant

Dr. Weinstein is 100% right! I completely agree with his proposals. Anyone who has ever covered the labor and delivery unit of a hospital that provides care for minorities has had to deal with extremely high-risk patients. The first thing that comes to my mind when I see such a patient: "I don't understand how she got pregnant in the first place!" (Most of the pregnancies are unintended.)

If we would spend our money on preconception counseling, we could keep most of these women out of our labor and delivery units and reduce the complication rate.

Jose Carugno, MD
Bronx, NY

Show me the data

Dr. Weinstein said that multiple reasons exist for the rise in maternal mortality, and mentioned, among

them, "racial discrimination." What is the evidence that racial discrimination has contributed to the rise in maternal mortality?

Steve Eddy, MD
Chandler, Ariz

>> Dr. Weinstein responds:

Fruitful discussion was the goal

I truly appreciate the time and effort of the readers who responded to my editorial on maternal mortality. Having been elected to the School Board while living in Ohio and advocating an increase in school taxes, political correctness has never been a goal of mine. My purpose was to start an honest and fruitful discussion of what is occurring in obstetric care in the United States and to offer novel approaches that have the potential to improve the health care of all women and their children.