A US Perspective on Maternity Care

WHERE WE ARE HEADED
AND HOW OUR DIRECTION
CAN CHANGE

Session goals:

- National statistical realities of contemporary US maternity care for mother and infant
- Short and long-term outcomes of unnecessary maternity care
- Root causes of unnecessary maternity care
- National initiatives provide opportunity for change
NATIONAL STATISTICAL REALITIES OF US CONTEMPORARY MATERNITY CARE

Statistical Trends in the U.S.

- Birth rate
- Maternal Mortality
- Infant Mortality
- Prematurity/Low birth weight
- Racial disparities
USA 1996-2007

Birth Rate per 1,000 women 15-44 years

Numbers of Births: USA 2007

- Number rose 1% to 4,317,119
- Highest number of births ever registered for the U.S.
Maternal Mortality

More on Maternal Mortality
Maternal Mortality Issues

- Unchanged since 1982, despite advances in diagnosis and acute critical care
- It is likely that it is underestimated
- A significant portion of the burden of maternal mortality is borne by African-Americans
- The rate may be increasing

Maternal mortality is perhaps best viewed as the “tip of the iceberg” or the extreme end of a long spectrum following severe morbidity and life-threatening “near-misses.” In either case, the implication is that maternal mortality is a culmination of events involving action or inaction on the part of the patient, physician, and/or State healthcare agencies, which ultimately pave the way for a maternal death.”

Lang & King, 2008
Infant Mortality: 2000-2006

Figure 1. Infant mortality rate: United States, 2000–2005, and 2006 preliminary

Rate per 1,000 live births

- 2000: 6.89
- 2001: 6.94
- 2002: 6.96
- 2003: 6.94
- 2004: 6.78
- 2005: 6.36
- 2006: 6.71

SOURCE: 2000–2005 data are from the linked birth/infant death data sets; 2006 data are from the preliminary mortality file.

Infant Mortality: International

Figure 2. Infant mortality rates: Selected countries, 2004

- Japan
- Sweden
- Spain
- France
- Germany
- Australia
- England and Wales
- Canada
- United States

Rate per 1,000 live births

Infant Mortality: Disparities

Figure 3. Infant mortality rates by race and ethnicity: United States, 2000 and 2005

- American Indian or Alaska Native: 8.30 (2000), 8.06 (2005)
- Non-Hispanic white: 5.70 (2000), 5.78 (2005)

*Includes persons of Hispanic and non-Hispanic origin.

Infant Mortality & Gestational Age

Figure 5. Percentage of infant deaths by weeks of gestation: United States, 2000 and 2005

- 2000
  - Less than 32 weeks: 32.6% (37 and over: 34.4%)
  - 32-33 weeks: 3.8%
  - 34-36 weeks: 9.7%
  - 37 and over: 34.4%

- 2006
  - Less than 32 weeks: 31.4% (37 and over: 54.9%)
  - 32-33 weeks: 3.9%
  - 34-36 weeks: 9.8%
  - 37 and over: 54.9%

Preterm birth: 1996-2006, USA

![Graph showing percent of live births for preterm births from 1996 to 2006 in the USA.](image)

Preterm is less than 37 completed weeks gestation.

Late preterm births: 1996-2006 US

![Graph showing percent of live births for late preterm births from 1996 to 2006 in the USA.](image)

Late preterm is between 34 and 36 completed weeks gestation.
Twin deliveries: 1996-2006 USA


Triplet and higher order deliveries: 1996-2006 USA

Preterm by race/ethnicity: 2004-2006 Average

Low birthweight by race/ethnicity: 2004-2006 average
The Case of Cesarean Delivery

SHORT AND LONG-TERM OUTCOMES OF UNNECESSARY MATERNITY CARE

Percentage of All Births by Cesarean Delivery
Maternal Cesarean Morbidity

- Etiology:
  - Natural
  - Iatrogenic
- Temporal:
  - Short-term
  - Long-term
- Type:
  - Physical
  - Psychological
  - Developmental

Maternal Cesarean-related Morbidity

- Emergency hysterectomy
- Blood clots and CVA
- Surgical injury
- Long hospitalization and more likely re-hospitalization
- Infection
- Poor birth experience
- Less early contact with babies
- Intense and prolonged postpartum pain
- Poor overall mental health and self-esteem
- Poor overall function
- Chronic pelvic pain and bowel obstruction
Severe Ob Morbidity

Comparing 1998-1999 to 2004-2005:
- Renal failure increased by 21%
- Pulmonary embolism by 52%
- Adult respiratory distress syndrome by 26%
- Shock by 24%
- Blood transfusion by 92%
- Ventilation by 21%

Kuklina et al., 2009

Further. . .

- Adjustment for maternal age had no effect on the increased risk for these complications
- After adjustment for mode of delivery, only the risk of pulmonary embolism and blood transfusion remained significant
Cesarean Morbidity for Newborns

- Respiratory problems: TTN and RDS
- Surgical injuries
- Failure to establish breastfeeding
- Asthma in childhood and adulthood

Maternal Future Reproductive Morbidity

- Involuntary infertility
- Reduced fertility due to decreased desire to have more children
- Cesarean scar ectopic pregnancy
- Placenta previa and accreta
- Placental abruption
- Uterine rupture

- Hemorrhage
- Low birthweight
- Preterm birth
- Stillbirth
- Maternal death
ROOT CAUSES OF UNNECESSARY CARE

Conundrum Of Etiology of Cesarean in Nulliparous Women

- Sociopolitical Environment
- Social & Physical Environment
- Assessment & Clinical Decision-Making Of HC Providers
- Intrapartum Care & Interventions
- Woman's Physical & Psychological Characteristics
- Fetal Factors

Cesarean for Dystocia in Nulliparous Women

Lowe, N. K. 2007
What does it mean to be safe for mothers and babies?

Intervention & Safety

“High rates of cesarean delivery reflect procedure use in mothers and infants who obtain little benefit from the procedures. . . Higher procedure rates might even be associated with iatrogenic harm, stemming from surgical complications, *interruption of physiologic processes*, or *long term consequences* that are not offset by therapeutic benefit”

Baicher, Buckles, & Chandra, 2006
Another View of Birth Safety

- NSVD optimal without maternal or fetal injury
- Intervention as medically indicated
- Operative vaginal vs abdominal delivery
- Influence of belief and values
- Playing the numbers

NATIONAL INITIATIVES THAT PROVIDE OPPORTUNITY FOR CHANGE
The National Priorities Partnership

- AARP
- AFL-CIO
- Agency for Healthcare Research & Quality
- Alliance for Pediatric Quality
- America’s Health Insurance Plans
- American Board of Medical Specialties
- American Nurses Association
- AQA Alliance
- Centers for Disease Control
- Centers for Medicare & Medicaid Services
- Consumers Union
- Hospital Quality Alliance
- Institute for Healthcare Improvement
- Institute of Medicine
- The Joint Commission
- LeapFrog Group
- National Association of Community Health Centers
- National Business Group on Health
- National Committee for Quality Assurance
- National Governors Association
- National Institutes of Health
- National Partnership for Women & Families
- National Quality Forum
- Pacific Business Group on Health
- Physician Consortium for Performance Improvement
- Quality Alliance Steering Committee
- U.S. Chambers of Commerce

Released in November 2008
The Reality. . .

The promise of our healthcare system is to provide all Americans with access to healthcare that is safe, effective, and affordable. But our system today is not delivering on that promise.

National Priorities & Goals, 2008

Six Priority Areas

1. Engage patients & families in managing their health and making decisions about their care.
2. Improve the health of the population
3. Improve the safety and reliability of America’s healthcare system
4. Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care
Six Priority Areas (continued)

5. Guarantee appropriate and compassionate care for patients with life-limiting illness

6. Eliminate overuse while ensuring the delivery of appropriate care
   • Unwarranted maternity care interventions, targeting:
     • Cesarean Section

We must fundamentally change the ways we deliver care.

National Priorities & Goals, 2008
National Quality Forum’s
NATIONAL VOLUNTARY
CONSENSUS STANDARDS
FOR PERINATAL CARE 2008

National Quality Forum

The mission of the NQF is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.
NQF Voluntary Perinatal Standards

- The measures are patient focused
- Address care provided by individual clinicians (doctors, nurses, and midwives)
- In hospitals and in freestanding birth centers
- Measure care at critical points for the mother and baby

NQF Voluntary Perinatal Standards

1. Elective delivery prior to 39 completed weeks gestation
2. Incidence of episiotomy
3. Cesarean rate for low-risk first birth women
4. Prophylactic antibiotic in Cesarean
5. Appropriate DVT prophylaxis for women undergoing Cesarean
6. Birth trauma rate measures (harmonized)
NQF Voluntary Perinatal Standards

7. Hepatitis B vaccine administration to all newborns prior to discharge
8. Appropriate use of antenatal steroids
9. Infants under 1500 g delivered at appropriate site
10. Nosocomial blood stream infections in neonates
11. Birth dose of hepatitis B vaccine and hepatitis immune globulin for newborns of mothers with chronic hepatitis B

12. Exclusive breastfeeding at hospital discharge
13. First temperature within one hour of admission to NICU AND
14. First NICU temperature <36°C (paired measures)
15. Retinopathy of prematurity screening
16. Timely surfactant administration to premature neonates
17. Neonatal immunization
Normal Birth

Normal probably cannot be precisely described or defined because it is an individually unique phenomenon

Normalization of uniqueness vs.

Technomedical pathologization of uniqueness
IOM Priority Areas for Comparative Effectiveness Research

- Compare the effectiveness of clinical interventions to reduce incidences of infant mortality, pre-term births, and low birthweight rates, especially among African American women
- Compare the effectiveness and outcomes of care with obstetric ultrasound studies and care without the use of ultrasound in normal pregnancies

IOM Priority Areas for Comparative Effectiveness Research

- Compare the effectiveness of birthing care in freestanding birth centers and usual care of childbearing women at low and moderate risk
- Compare the effectiveness of different strategies for promoting breastfeeding among low-income African American women
Nurses Alliance for Quality Care

- Inaugural event February 17, 2010
- Funded by a 2-year grant from the Robert Wood Johnson foundation
- PURPOSE: to advance the highest quality, safety, and value of consumer-centered health care for all individuals – patients, their families, and their communities.

NAQC will work to ensure that

1. Patients receive the right care at the right time by the right professional
2. Nurses actively advocate and are accountable for consumer-centered, high quality health care
3. Policymakers recognize the contributions of nurses in advancing consumer-centered, high quality health care.
WHAT IS “ABNORMALITY” IN CHILDBIRTH?

Increasingly it is defined as a deviation from “average”, rather than a pathological entity.

Beech & Phipps, 2004

Conclusions
Honesty about US maternity care

- EVIDENCE-BASED MATERNITY CARE – we simply are not providing it
- FAMILY-CENTERED CARE – we have equated FCC with making birth a spectator sport and not creating a safe environment for normal labor and birth and the postnatal adaptation of mother and infant
- HUMANISTIC CARE – we have succeeded in dehumanizing birth in favor of industrial childbirth

The paradox is this:

‘Women wish to be treated as individuals and assert for themselves a wish to exert control, yet in the commodification and industrialization of childbirth, they are much more likely to be treated as units of production. . . If we normalize this industrialized approach to childbirth, we likely will be stuck in it for a very long time indeed – and we can’t look to the medical profession to correct it.”

Plante (2009).
Honesty about US maternity care

- OUTCOMES – our present approach to maternity care, i.e. obstetrical care, is not improving traditional outcomes by any measure
- OTHER PHYSICAL OUTCOMES – short-term surgical morbidity, neonatal transitional morbidity, future pregnancy morbidity, maternal/child long-term health

Honesty about US maternity care

- LIFE COURSE OUTCOMES – women are systematically denied the potential for self-growth that childbirth presents; they have accepted the idea that it is to be avoided
- COST – we can simply not afford to continue the high rate of intervention for normal mothers and babies
Honesty about US maternity care

- We have succeeded in normalizing *deviance*
- Changing the course of maternity care in the United States will not be easy or without tremendous effort

**Melissa’s birth story**
April 22, 2007
My daughter, son-in-law & grandson
Kelly, Melissa, and Matthew Zart

A New Plan
Zart Baby #2
born November 22, 2009
Abigail Grace
We consider we are not moving out of our proper sphere as females when we assume a public stand in favor of our oppressed sisters.

Preamble to the Constitution of the Canton, OH Ladies Anti-Slavery Society, 1836

A paraphrase... We consider we are not moving out of our proper sphere as nurses or midwives or physicians when we assume a public stand in favor of our oppressed sisters, childbearing women.