Commentary

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What can be safer than having a baby in the USA?

Many things, regrettably—even in our 21st century health care system. I have an idea for a strategy to change the situation.

A recent report[1] by the National Highway Traffic Safety Administration revealed that deaths from automobile accidents have declined strikingly since 1954, reaching the lowest level ever recorded today: 1.16 fatalities for every 100 million vehicle-miles traveled. Why this improvement? Reasons include an increase in seat belt use and a lower rate of drunk driving, both secondary effects of better law enforcement, safer roads, and people just driving less.

There are lessons to be learned from this success that can be applied to obstetrical care and, potentially, to lower the unacceptably high rate of maternal mortality in this country.

Things aren't working as we need them to

Truly, it is a reflection of a broken health care system that we, as health care providers, cannot say that we have seen a dramatic decrease in maternal mortality. In 2006, the latest year for which statistics are available, maternal mortality in the United States was at the highest level recorded since 1991: 13.3 deaths for every 100,000 live births (in California, the rate is 16.9 for every 100,000!).

Remember the Healthy People 2010 benchmark of 4.3 maternal deaths for every 100,000 live births? Clearly, we will not see that number any time in the near future; achieving it is as likely to happen as getting the national cesarean delivery rate to fall below 15% from the current level above 30%, or the return of vaginal breech deliveries!

Maternal mortality numbers are even more distressing when you appreciate that **1)** African American women have three to four times the death rate from pregnancy complications that white women do and **2)** minorities (African Americans, Latinos) are having the majority of pregnancies.

In a society supplied with well-trained obstetricians, marked improvements in the safety of anesthesia, and a plethora of maternal-fetal medicine specialists, we must do some serious introspection and ask ourselves: **Why are so many young women dying? And what can we do to prevent their deaths?**

Why the rise in maternal deaths?

Multiple reasons are cited for the rise in maternal mortality. They include:

- difficult access to care
- racial discrimination
- increase in substance abuse
- barriers to communication with non–English-speaking patients
- lack of health insurance
- inflexible appointment hours
- lack of transportation to visits
- serious comorbidities (e.g., diabetes).

Each of these has some validity. But my opinion (and many of you will disagree with me) is that our society has not addressed the real issues driving the problem—issues that are difficult to face:

First, some women have too many pregnancies.

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Dr. Weinstein reports no financial relationships relevant to this article.

Second, certain women who have serious medical conditions, including morbid obesity and substance abuse, are having pregnancies when they should not have *any at all.*

It is an interesting observation that a person needs a license to drive a car or hunt deer but only a simple act of intercourse with no contraception to become pregnant.

What I've learned from my work

I have spent more than 35 years caring for pregnant women of low socioeconomic status. I am proud to have played that role. The two constant themes in my work with these patients are that **1)** they feel a lack of control over most aspects of their life and **2)** they lack self-esteem.

Pregnancy, however, is the one thing that they can control. It is the one time when others become interested in their welfare, and their best opportunity to have a *something* (a baby) that is *all theirs*.

But their adherence to appointments and laboratory testing is often poor. And their use of contraception between pregnancies is sporadic.

The 18-year-old woman who is in her second pregnancy often has a mother who is in her early 30s and a grandmother around 50. For these women, and for their children and grandchildren, the cycle of poverty is repeated *endlessly*. No matter how much money or effort is put into providing resources to care for them, little has changed in the past 30 years, and there is, I believe, little hope for change in the future. The only solutions that I can discern that will decisively break the cycle of poverty, lower the rate of maternal mortality, and improve the well being of women and their newborns are **education** and **contraception**.

My three-pronged proposal

Several actions can improve the outcome of a pregnancy for mothers of low socioeconomic status and their babies. I understand that many people will find these actions coercive and prejudicial, which truly they are not.

• All forms of contraception should be free for women, and access to contraception should be easy. Such a policy would result in fewer unintended pregnancies and abortions and better pregnancy spacing. The expense of free and universal contraception offers a great return on investment compared to the cost of care for a premature baby who spends *any length of time* in the neonatal intensive care unit.

Young women should be compensated for using whatever contraceptive they choose by being given vouchers that can be redeemed for material goods at select venues or free minutes for their cellular phones.

• All women who qualify for Medicaid coverage of pregnancy should be aggressively encouraged to have a preconception visit at least 3 to 6 months before they plan to become pregnant to assess any risks to themselves or their fetus and have a program put in place to maximize outcomes. This encouragement can take place at any visit in which contraception is discussed.

At this visit, an attempt can be made to optimize their clinical condition by:

- counseling them about drug and alcohol use and smoking
- assessing their risk of genetic disorders
- initiating folic acid and dietary modifications
- performing appropriate screening tests (i.e., blood glucose).

Appropriate consideration should be given, and discussion held, during the visit about whether the patient should even consider becoming pregnant. She should be given a realistic assessment of the risk of pregnancy and childbirth to her and the baby—including the potential for death.

The preconception assessment should be conducted by a physician, a midwife, or a nurse practitioner who has not been involved in the care of the patient. Doing so will minimize the introduction of any bias into the conversation by a treating physician.

When it is in a woman's medical best interest *not* to conceive, she should become eligible for expedited adoption and be compensated for each reproductive year in which she does not conceive.

Last, a strong financial incentive should be offered to women who complete this preconception evaluation.

Many will say that such a program is unfair and prejudicial to women of lower socioeconomic status. But a precedent exists: Medicaid prohibits the performance of a sterilization procedure unless a signed permit has been in place 30 days or longer.

• Pregnant women who adhere to a prenatal care plan should be compensated with vouchers that can be redeemed for baby items, maternity clothes, or food for the family at select venues. They should also be compensated for keeping prenatal appointments; obtaining timely laboratory tests; attending prenatal classes; avoiding drugs, alcohol and smoking; returning for postpartum assessment; and using reliable contraception.

Education + contraception = fewer deaths?

Would such a plan work? I am convinced that it is worth trying. What do you think? Send your comments to me at obg@qhc.com!

Reference

1. Traffic safety facts. Early estimate of motor vehicle traffic fatalities in 2009. National Highway Traffic Safety Administration. http://www-nrd.nhtsa.dot.gov/Pubs/811291.PDF. March 2010.