

Short Hospital Stays for Mothers and Newborns

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Routine length of hospital stay for mothers and newborns began to decline substantially during the 1970s, initially in response to public pressure to de-medicalize childbirth and give women and families more control over the postpartum experience. The pace of decline in postpartum length of stay accelerated as cost containment became a driving force in health care in the United States, especially over the past 5 to 10 years. A public and professional outcry has recently been raised, as many third-party payers have limited their coverage for hospital stays to 24 hours after uncomplicated vaginal delivery and 48 hours after uncomplicated cesarean section. Official statements have been issued by the American Academy of Pediatrics (AAP),¹ the American College of Obstetricians and Gynecologists,² and the Committee on Scientific Affairs of the American Medical Association³; while the statements have differed, all have expressed concern and advised caution. Federal legislation has been considered by the United States Congress, and several state legislatures have bills under consideration or laws already enacted that mandate third-party reimbursement for specified minimum lengths of stay, generally 48 hours following vaginal and 72 hours following cesarean delivery, if requested by either physician or patient.

A review of the published literature reveals that there is little scientific evidence to support current practices.⁴ Many studies have been conducted, and a range of claims have been made based on the study results.⁵⁻²⁵ The limitations of the research published so far, however, make it impossible to obtain information needed to guide clinical or reimbursement practice affecting the majority of the maternal-newborn population, ie, those without obvious medical complications at or soon after delivery. No adequately designed studies have assessed the consequences of postpartum stays of less than 48 hours (hereafter referred to as short stays, following AAP guidelines¹) in the

absence of additional office or home visits by trained nurses or physicians. Some studies have looked at newborn morbidity associated with short stays accompanied by recommendations to return 1 to 2 days later for a pediatric office visit; however, some of these studies lacked appropriate comparison groups,^{5,10-12} had inadequate sample size, or lacked generalizability.^{5,10-12} Overall, the effects on breast-feeding, maternal well-being, and family functioning were not adequately considered.^{5,10-12} One of these studies¹¹ claimed to have found early discharge to be safe, but reanalysis of their data by this author revealed a statistically significant, almost threefold increase in infant rehospitalizations in the early discharge group.⁴ Furthermore, studies of this approach to postpartum care for low-income families found high no-show rates for the recommended early postdischarge visit.^{11,12}

Most studies of early postpartum discharge have combined short stays with a series of nurse home visits soon after discharge.¹³⁻²⁵ Although the more rigorously designed studies in this category have generally been small and have looked at carefully selected and prepared populations at low psychosocial risk, their combined results suggest that this approach may be reasonable.²²⁻²⁵ Results of such studies cannot, however, be generalized to the effects of short stays in the absence of home visiting and without stringent screening using psychosocial, educational, and medical criteria. Furthermore, no published study has had adequate statistical power to detect clinically significant effects on rehospitalization.⁴ If a study is too small to detect a difference in a given outcome, one cannot consider the failure to find an elevated risk as evidence that none exists.

Practitioners need to be aware that the safety and advisability of early postpartum discharge, particularly in the absence of repeated nurse home visits, have not been demonstrated. They should also recognize, however, that the advisability of longer hospital stays has not been adequately studied either. Given the events occurring in the first few postpartum days, current clinical practice needs to be guided by caution in the absence of firm scientific evidence demonstrating that a less cautious approach is safe. Neonatal jaundice often does not peak until the 3rd

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day of life, and bilirubin levels prior to that time are not always good predictors of the peak level. Furthermore, breast milk may not have come in fully before the 3rd postpartum day, potentially limiting the effectiveness of breast-feeding instruction. Breast-feeding difficulties can lead to neonatal dehydration and exacerbate jaundice; mastitis, which is more common with improper feeding techniques, is a potential maternal complication. Given these concerns alone, common sense would seem to dictate evaluation on the 3rd postpartum day by a professional with training in both neonatal and maternal assessment and the promotion of breast-feeding. Postpartum stays of less than 72 hours, therefore, appear to be short stays in relation to physiologic events, unless expert clinical follow-up on the 3rd day is assured.

In addition to neonatal jaundice and breast-feeding promotion, a number of other important issues arise when considering the needs of women and families during the first postpartum days. Women are generally extremely fatigued; they are often physically uncomfortable because of either perineal trauma or cesarean incisional pain. Breast engorgement, urinary problems, and constipation are common, as are concerns about vaginal bleeding and discharge. Although full-blown postpartum depression is relatively rare and tends to occur later, "blues" significant enough to warrant professional support and guidance for the woman and her family are quite common,²⁶ and can predict later depression.²⁷ Family stresses involving siblings, partners, and extended family are often considerable. Although a multiparous woman may have the advantage of prior experience with childbirth, she faces added strains related to caring for other children in addition to herself and the newborn, as well as the occurrence of new conditions not necessarily confronted with previous births.

Hospitals may not be the ideal setting for postpartum services, but this does not mean that professional services are unnecessary. The nature of the medical problems that can occur postpartum requires supervision by a highly trained primary care professional. If timely detection and intervention with less intensive services are ensured for everyone, few mothers with term babies born without complications would actually require subsequent intervention with hospital-level resources. The home setting seems generally more appropriate than the clinic as a setting for an early postpartum visit, for several reasons, including women's fatigue and discomfort and greater time constraints on education and supportive counseling in a clinical facility. Other important reasons to consider home-based early postpartum care are the opportunity to promote families' being together during this critical period and to conduct a home assessment. The assessment of psychosocial and socioeconomic vulnerabilities and po-

tential environmental hazards, with referral to appropriate supportive services, is critical.

Although home-based care for both mother and baby appears ideal, its outcomes have not yet been rigorously evaluated. There is a rich experience with universal postpartum nurse home visiting in many European countries. Because this approach in Europe has been considered to be so obviously dictated by common sense, it has not been studied in ways designed to produce hard data of the type now demanded by third-party payers in the United States. Third-party payers, however, should not be viewed as the only obstacle to a more rational and humane policy on early postpartum care. Another contributing factor is the specialty-oriented fragmentation of care among different providers without anyone taking overall responsibility for the care of both mother and baby. In addition, most physicians have viewed home-based care as the province of nurses, and may be less than enthusiastic about incorporating postpartum nurse home visiting into their routine practice if they see it as threat to their role or income.

Public debate and the corresponding legislation have focused almost exclusively on concerns about length of stay and have given inadequate attention to the broader issues about what kinds of home-, office-, and hospital-based services and what kinds of connections among these different services are needed for both mother and child in the early days following birth. Family physicians have a unique contribution to make in speaking to the issues surrounding early postpartum care because of their relationships not only with mothers and babies but with families as well. The traditional focus of family practice on providing continuous and comprehensive care and addressing the common health needs of the general population also makes the issue of health services for medically low-risk mothers and newborns one clearly within the family practice purview. Family physicians should provide leadership in the development of health services that meet the needs of mothers and newborn babies and should serve as outspoken advocates on their behalf.

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