Overview & Suggestions for Rehabilitating 21st Century Maternity Care

Originally Prepared for Carol Sakala, Childbirth Connection --
January 2007 ~ Faith Gibson, LM, CPM

I've been waiting all my life to bring the current 19th century obstetrical curriculum into the 21st century. At the same time, I also want to bring those useful aspects of modern medicine unique to obstetrics, especially evaluation techniques/technologies and life-saving emergency interventions, into the curriculum and scope of practice for professional midwives.

For example, the recent miniaturization of electronics in the obstetrical field means that our mfry practice now owns and uses a wonderful lithium battery operated EFM compatible with monitoring mothers in deep water tubs. It is the size of an average hardcover novel (6" x 10" x 1 inch thick) and weighs about a pound. It's made in the UK and is fully functional, including the ability archive thousands of records or to fax an electronic copy of an EFM tracing to a perinatologist. We also have pulse oximetry for newborns, to help distinguish cardiac anomalies from the "just slow to pink up" garden variety, less-than-optimal Apgar score. Both of these things help us decide whether or not the situation requires transport and if so, how urgently.

Most of the time the mother or baby do not need any obvious treatment but would benefit from an evaluation via simple electronic equipment *heretofore only available in institutional settings*. The need to use this high tech equipment in my own practice is rare (1-3 times a year at most) and it most often provides information (and documentation) that allows us to stay out of the hospital or to print out and take the EFM tracing into the hospital with us, so we can establish that there was no fetal distress prior to our leaving home.

The obstetricians are usually thunderstruck when I show up with an EFM printout, thinking as they do, that midwives can't even walk and chew gun at the same time. Personally, I encourage community midwives to have access to technological tools of this sort by having geographically grouped practices that allow them to share the cost. And it helps to bridge that incredible chasm between physiological birth attendants and obstetrical providers. This is good for midwives, good for childbearing families, good for doctors and good for society.

Behavior Vs Beliefs – difference between blessing and curse

Attempts to change unhelpful or harmful behaviors within the medical profession will never achieve the stated goal of normalizing the care of healthy childbearing women unless we <u>first</u> address and change the false beliefs *about* normal birth -- the underlying motives behind the behavior, which are based on bad information from the pre-1910 era, combined with a strong dose of hubris, misogyny and the all to human desire to preserve an economically advantageous status-quo.

Attempts to change physician *behavior*, without first dealing with erroneous beliefs, means arguing about whether the appropriate C-section rate should be 17% vs. 47%, and then to be 'nice' and appear cooperative, *settling on the statistical mean of 32%* (bad idea!). It means endless debates about whether or not we should 'let' women use deepwater tubs during labor and

(gasp!) deliver in water; how long we should 'let' women push and whether inductions should be scheduled at 40 wks versus 41 weeks.

No, no, no, no!

Changing *beliefs* means that we are talking about how to rehabilitate our national maternity care policy, so as to enjoy the advantages and efficacy of other developed countries. It means a robust public discourse about how best to teach physiological management, how to help maternity care providers implement these changes and the best way to bring the rest of the medical-industrial complex up to speed (including policy changes for insurers and all levels of government).

Yes, yes, yes!

In a document sent as an attachment to this one, I have listed what I believe to be the core **characteristics of effective physiological management** and what I call the '**five elements for success' for normal spontaneous birth**. This list is based on 14 years as a hospital maternity nurse, prior to 25 years attending planed home birth *and* also continuing as a labor attendant for planned hospital births (I like to see what the other half is doing!).

But before getting into those particulars, I'd like to suggest that the best place to start is by making a very **simple vocabulary distinction** between:

1) **Maternity Care** -- i.e., healthy women, normal pregnancy, spontaneous onset of labor at term, mother not planning to use labor stimulants, Rx pain meds or anesthesia; normal childbirth services provided by professional birth attendants, both midwives and physicians, in the setting of the mother's choice – hospital or independent birth center or parents' home

And/or

2) Obstetrical care -- hospital setting for high-risk women and/or low and moderate risk mothers who prefer medicalized care – continuous EFM, augmentation or induction, anesthesia, scheduled C-section, etc; a patient population that has made an informed consent choice to accept the added risks associated with the obstetrical package* when used on healthy women

Listening to Mother surveys are the best source of reliable data on what exactly that obstetrical 'package' actually is, as applied to healthy women with normal pregnancies -- that is, the average of seven significant medical-surgical interventions per hospitalization

Mothers have become the also-ran in this equation. Remember when hospital facilities for childbirth were called the 'Maternity floor' or maternity department and were organized around the needs of the MOTHER? Now they are 'OB units' or perinatal departments and are organized around the needs and preferences of doctors – obstetricians, perinatologist, etc, which includes medico-legal issues, convenience, their office hours, physician 'preferences' for elective inductions, routine stimulation of labor and medically unnecessary cesareans.

This reflects the obstetrical belief that first surfaced in the foreword of the 1970 edition of Williams Obstetrics, which enthusiastically describes how the new technology of ultrasound and

continuous electron fetal monitoring (EFM) meant that finally ***the fetus*** could (and should!) become the **"primary patient**" of the modern obstetrician. No, no, no!

The Four Cornerstones of 21st Century Maternity Care:

1. **Principles of Physiological Management** as foremost Standard of Care for HW-NP
2. **Non-Surgical Billing Code** for physiological management for HW-NP
3. **Reconfigured professional liability** for normal maternity care services
4. National Franchise for **profitable, independent Birth Centers/Maternity Homes**

Number One: Principles of Physiological Management as the Standard of Care

The main and the plain reading of the scientific literature brings one to the logical conclusion that **physiological management is the safest and most cost-effective form of care for a healthy population**. This leads us to the natural and compelling conclusion that our current obstetrically-based maternity care system for healthy women must be rehabilitated.

Physiologic care includes 'patience with nature' and a commitment not to disturb the natural process. This must be acknowledged as a biologically successful strategy, as the human species has survived and thrived for untold millennia before the adoption of the obstetrical package by early 20th century American obstetricians.

No medical devise, drug, surgical instrument or operative procedure developed over the millennia of western culture has been able to make birth safer in healthy women with normal pregnancies than spontaneous labor and normal birth. Routine obstetrical interventions applied to healthy women with normal labors and normal birth conducted as a surgical procedure are always more risky and frequently result in a cascade of interrelated interventions and complications which are avoided when the physiological principles with appropriate social and psychological support are used instead.

Physicians and midwives all over the world are taught to utilize physiological principles for normal pregnancy, labor and birth. The science supporting this is not controversial. Reliable evidence is neither lacking nor incomplete, nor is this data the subject of methodological disputes among experts in the worldwide public health field. **Mastery in normal childbirth services means bringing about a good outcome *without introducing any unnecessary harm***. Our present system of obstetrics for normal childbirth does not do this very well, as evidenced by our 30% Cesarean section rate and our 90% intervention rate in otherwise normal vaginal births in healthy women.

Ultimately, the United States can only meet the needs of our healthy childbearing population while remaining competitive in the global economy by adopting the social (rather than medical) model of pregnancy and childbirth care. This must become the basis for our national maternity care policy, one that emphasizes normal childbirth services for healthy women, ones that are scientifically-based, compassionate and fiscally sound. This rehabilitated policy for the 21st century would integrate the classic principles of physiological management with the best advances in obstetrical medicine to **create a single, evidence-based standard for all healthy women, used by all maternity care providers and in all birth settings**.

This protective and non-interventive approach for normal childbirth services includes continuity of care, an absence of arbitrary time limits, one-on-one social and emotional support through active labor, non-drug methods of pain relief and the right use of gravity. Obstetrical intervention is reserved for complications or if the mother requests medical assistance.

Many first-world countries and virtually all of the third world already use this physiologic care as their standard. The United Kingdom's National Health Service (NHS) recently concluded that highly medicalized care for normal birth increased the rate and expense of obstetrical interventions and Cesarean sections *without improving maternal-infant outcomes*. Medicalized maternity care is, on average, two to ten times more expensive. It often results in costly downstream complications, such as the damage to pelvic structures following episiotomy and instrumental delivery and placental abnormalities, emergency hysterectomy, or stillbirth in a pregnancy after a prior Cesarean.

When any society spends a high percentage of its national health care budget on excessive use obstetrical procedures, it reduces their ability to meet the general needs of its population while still remaining competitive in a global economy. In response to these economic issues, the NHS changed its maternity care policy and is reconfiguring its childbirth services. The UK has adopted physiological management as the official form of maternity care for healthy childbearing women. As of 2009 the NHS will offer healthy childbearing women three choices for labor and birth (1) birth at home with a midwife (2) birth in a local midwife-led unit, based in a hospital or community clinic promoting natural births (3) birth at a hospital, supervised by an obstetrician, for mothers who may want epidural pain relief or may need specialist care to deliver safely.

This is "right use" of obstetrical medicine. In our expanding global economy, there is no doubt that other EU countries will soon follow the led of the UK. Can the US afford to maintain its wrong use of obstetrical medicine in an increasingly competitive world?

Physiological Care and Medical Education

Were physiological management of normal pregnancy and birth to become the foremost standard of care, medical educators would logically be required to both learn and teach the principles of physiological management to medical students, interns and residents, and practicing physicians would also be required to learn and utilize these same skills.

Since physicians would rarely choose to provide the requisite, full-time presence of the primary caregiver during active labor associated with physiological management, hospital labor & delivery units should be primarily staffed by professional midwives. Hospital midwives would attend all healthy women with spontaneous vaginal births unless the mother requests her physician deliver her and that physician is available and amenable.

There should be incentives for current L&D nurses who wish to retrain for hospital-based midwifery practice to do so at minimal expense to themselves.

The obstetrical package in relationship to healthy women:

Physicians utilizing the obstetrical package as the basis for care provided to healthy women with normal pregnancies would be obliged to provide fully informed consent -- true informational transparency* -- including the documented consequences of medicalizing labor and conducting spontaneous vaginal birth as a surgical procedure. [*In my opinion, the MCA/CC web site is the gold standard for this informational transparency]

Number Two: a non-surgical billing code for physiologically-based care

Maternity care for a healthy population must have **a non-surgical billing code for physiologically-based childbirth services** that compensates the primary birth attendant for one-on-one care provided during the *labor* as well as the birth *and* during the immediate PP/PN. Not only is this the most efficacious and socially appropriate form of care from the standpoint of the mother and baby, but it is also 'preventative' and 'preservative'. It prevents the unnecessary use of interventions and lowers the complications rate (especially, instrumental and operative deliveries) and it preserves the maternal pelvic floor *and* the fetal brain.

That translates into millions of health care dollars saved every year on the direct cost of maternity care and additional saving by virtue of the reduction in subsequent delayed and downstream complications. This is of great benefit to the uninsured, third party payers, the employers who foot the bill and the government-funded Medicaid programs. I believe that we in the physiological birth community have been remiss by not engaging economists in the forefront of these cost-benefit issues, especially the increased maternal and perinatal mortality and the delayed and downstream complications associated with the elective use of induction, epidural, instrumental delivery and C-section.

Defining and billing NSVD as a *surgical procedure* makes the mother's normal labor nothing more than the 'pre-op' period of time, with labor to be managed by the relatively cheap, low-status skill set of nurses (the system's opinion, not mine!), ditto for postpartum and newborn care, which is nothing more than 'post-op' care, also to be managed by nurses. This puts childbirth – redefined as it was in 1910 as the surgical procedure of 'delivery' – into the category of an operation, a slight of hand used to justify a high professional fee for very little time and not that much skill, since the mother and human biology are the source of a normal spontaneous birth, not the medical/surgical activities of the doctor.

As a surgical procedure, the mother is no longer the agent of her birth; instead it is the doctor who performs a delivery, making the doctor, instead of the mother, the most important person in the room. This is indecent; it is a slight of hand that uses the manipulation of vocabulary to extract an unearned financial reward and systematically violates the principles of normal biology in order to achieve this goal. It is unconscionably expensive; it harms people. This is all wrong from every angle and needs to be addressed – **the surgical-only CPT code must be amended to include a category to bill for the appropriately non-surgical care of the 70% of healthy childbearing women**.

This long overdue correction is most important in the practical realm, because as long as the 'delivery' is walled off as a surgical procedure, it triggers a cascade of expensive negative consequences. One consequence is an inappropriate legal standard based on the idea of control –

the physician as the 'captain of the ship', responsible for the actions of every employee and for a predetermined outcome. The shadow side of this is 'malpractice' litigation for the so-called 'failure' to exercise total (read "god-like") control. This is one of the factors fueling the current push for scheduling CS as the new standard of care.

Another consequence is that the surgical category of the CPT code restricts who is permitted to by state law to attend births and who is legally authorized to be compensated for childbirth services already provided. For example, if a labor patient delivers precipitous before her doctor or nurse-midwife arrives and therefore the birth is 'attended' by the L&D nurse, neither the doctor or the hospital can be compensated, since only a doctor can legally 'perform' a surgical procedures (i.e., nurses can't bill under a surgical CPT code) and of course, the doctor or physician-extender nurse midwife must, at the very least, be present in order to bill for the 'surgical procedure' of NSVD. The result is that L&D nurses must actively repulse the spontaneity of normal birth, lest they get fired for too many of those "fetal-ejection reflex" normal births, which currently mean that their employers looses a lot of money.

Three: professional liability situation has to be reconfigured

Third, the **professional liability situation has to be reconfigured** for that same 70% of the healthy childbearing population of women with normal pregnancies. This is intimately connected to the CPT code discussion above, because the surgical designation creates a pernicious form of malpractice litigation that ultimately results in an industrial complex monopoly, under a ***'pay to play'*** system, in which only the biggest fish can afford the overhead.

The actual origin of the obstetrical liability problem was the obstetrical profession's historical promise to childbearing families, starting in 1910, that if they picked physician birth attendants, instead of midwives, they would be guaranteed a good outcome. Obstetricians genuinely believed that if they used the contemporary version of the obstetrical package (i.e., the pre-emptive strike!), all unforeseeable complications associated with childbirth would be eliminated. Of course, this was a dangerous fantasy with build-in failure. When doctors could not deliver on this impossible promise, it set up the circumstance that eventually resulted in an explosion of malpractice litigation.

This really took off during the late 1960s, when plaintiff attorneys for the first time overcame the brick wall that had traditionally prevented patients from being able to legally establish negligence, without which they could not win a malpractice lawsuit. For the first 60 years of the last century, testimony to establish the "community standard of care" or more to the point, to establish that a defendant physician had violated that tightly defined and defended 'community' standard (ie. negligence or incompetent) required the expert witness to be a physician from the same geographical "community".

Functionally speaking, this meant doctors which belonged to the same county medical society, same country club or were on the same hospital staff, etc. Of course, doctors uniformly refused to criticize a colleague with who they worked, in part out of loyalty to the defendant and also out of fear of retribution from the defendant doctor or other physicians for this professional "disloyalty", since breaking ranks was/is the unforgivable sin within the medical profession.

But this ended abruptly in the 1960s when a US Supreme Court decision redefined "community standard". Under the new rule, it was no longer a geographical place but the entire profession of medicine as practiced in the United States. For the first time, a lawyer suing a doctor in New York could import expert witnesses from California and easily prevail in court, since the expert was getting paid big bucks to favor the defendant's claim. And viola, the malpractice crisis was born. It burst into roaring flames by 1976 and ever since obstetrics has been totally organized around reducing the risk to itself of malpractice litigation.

However, it is possible to correct the obstetrical liability aspect of this problem by making a legal or contractual distinction between maternity care and obstetrical services. The way to do that is to define healthy women as maternity patient. HWNP would be offered the opportunity to "opt out" of an obstetrically-managed intrapartum (the obstetrical package) and to "op in", via signed informed consent, for intrapartum management under the principles of normal physiology. This is a category distinguished by its role of supporting a normal biological process (rather than 'performing' a medical/surgical procedure). Thus the potential professional liability for supportive services to healthy women during spontaneous biological processes would be restricted to direct negligence or incompetence.

The current obstetrical liability inverts this common sense idea. It holds the obstetrician responsible for not *controlling biology* and not preventing all the natural variations and mal-occurrences of normal birth, which can and do sometime include morbidity and mortality. An example of the difference between normal biology and surgery is simple and graphic – as an nurse and also as a midwife have seen a lot of babies take themselves out before the doctor or other birth attendant arrived, but I have absolutely NEVER seem an appendix, uterus, tonsils or any other body organ or appendage take itself out before the surgeon arrived! In a logical system, the liability of those two remarkably different processes has got to be different. In fact, US Supreme Court Justice Bryon functionally defined discrimination in 1973 by noting that it was 'capricious and arbitrary' to treat two things that were different as if they were the same ***or*** to treat the same entity in two opposing ways.

Lest this conversation get too esoteric, let me give you a modern day example. I use a Tom-Tom GPS system downloaded to my Palm-based cell phone to find my way around in the world. In general, it is very useful. However, it obviously can be misused and can fail with catastrophic consequences. For example outdated information on street construction might mean I was going the wrong way on a one-way street, hit a school bus full of small children, which caught fire and burned 34 kids alive.

A different kind of a failure might put me and my loved one in the awful position of the family of 4 (including two very young children) from northern California that got lost on their way home and were stranded in the snow for 9 days. In desperation, the father left on foot to find help and died of hypothermia before his wife and two children were finally rescued. It turns out they did not have GPS. But let's say they did and the surviving wife claimed that they used its information to take a logging road marked as private property, which led to the tragedy, thus Tom-Tom should be held responsible for the wrongful death of her husband. Considering how many GPS devices are being used and that they sell for only a few hundred dollars, this could be a litigious nightmare. Surely any attorney worth his salt could and armed with such stories have

dissuaded the Tom-Tom developers from ever marketing such a system, based on unlimited liability of staggering proportions very near the equal of any ascribed to normal childbirth.

However, Tom-Tom dealt brilliantly with its liability by requiring me and all its other users to acknowledge the exact nature of our 'contract', in particular, by defining what Tom-Tom is NOT responsible for and what I AM responsible for, EVERY SINGE TIME I turn it. When I want to use it, the very first screen every time is a legal paragraph that states I, and not Tom-Tom, is responsible for how I use the software and hardware, for obeying all traffic rules, for checking out the terrain to be sure that information provided is still valid and that I agree not to use it while driving the car, lest that contribute to auto accidents. Before I can continue on to the main menu to employ any of its marvelous features, I must tap the "I Agree" icon on its touch screen, acknowledging yet again that I understand that I am responsible for acting responsibly.

This demonstrates that if one has a good enough reason, a truly compelling incentive, it is possible to deal successfully with liability. In regard to physiological management we have millions of "good reasons" every year for putting the potential liability associated with normal birth in its 'normal' or appropriate and ***affordable*** place. In addition to the humanitarian reasons, there is the moral authority of science and sheer number of childbearing women who are healthy and enjoying normal pregnancies, which means that physiological management will always be the scientifically-mandated leader of the pack.

Four: Nationally-franchised, affordable but profitable OOH Birth Centers/Maternity Homes

Presently, what we have as an infra-structure for childbirth is the exact opposite – it is a system that doesn't have any acute care hospital beds dedicated to physiological childbirth. The modern hospital, especially the intensive care and surgical units (modern L&D is actually intrapartum intensive care) is the most expensive real estate in an already high-overhead system. While PHB (planned home birth) is a lovely thing, we must have a large scale, **reliable OOH location and institutional structure** as the majority method for providing true maternity care. This is the system used in Western Europe and Japan, which provides both safe and cost-effective care and far better maternal-infant outcomes for far less money.

If physiologic care are can reduce the intervention rate 2 to 10-fold, a free-standing BC (most likely associated with a particular hospital) could charge a fraction of what hospital birth costs and still make an excellent profit. This would provide people with a less expensive option, an opportunity that would meld with the new health savings account plans associated with high deductible or catastrophic health insurances. They provide a predetermined 'budget' that can be tapped into for elective health care, which returns the *economic incentives to the family* to choose cost effective care.

Another wrinkle on the health insurance horizon is the likelihood, within the next decade, of requiring enrollees to use the least expensive option for elective procedures, even if that includes travel to other countries. Obviously, families are not going to fly to Thailand or New Deli for childbirth, but if efficacious options such as a maternity home down the block from an acute care hospital were available, maternity homes would become immensely popular and therefore, very profitable.

Synoptic Wrap-up of all three documents:

A newly formulated national maternity care policy for a healthy childbearing population would integrate physiological principles with the best advances in obstetrical medicine to create a single, evidence-based standard for all healthy women.

That newly configured standard must be based on criteria arrived at through an interdisciplinary process that includes the tradition and discipline of midwifery as an independent profession and also integrates the input of childbearing women and their families into the process. It is especially important to include feedback from those families who had complications following cesarean surgery or who found it virtually impossible to arrange for a subsequent normal labor and birth after a cesarean (VBAC).

Relative to the obstetrical profession, such a transformation in our national maternity care policy would require that:

· Third party payers fairly reimburse all practitioners for the professional's time spent facilitating normal childbirth, which helps avoid the need for medical and surgical interventions and the complexities and complications that medical and surgical interventions often generate.

· Tort law (medical malpractice) reform must be enacted so that doctors are not inappropriately judged by outdated medical criteria that are not evidence-based or do not use the physiological process as the base line.

A blue-ribbon panel consisting of scientists from all the pertinent disciplines – public health, epidemiology, sociology, anthropology, psychology, biology, child development, law, economics, midwifery, perinatology and obstetrics should be organized. Such a highly respected forum should study these issues and provide unbiased and fact-based news for the press and broadcast media to report and provide the energy for a spirited public discourse on this topic. This public exploration must include listening to childbearing women and their families as a class of experts in the maternity care experience.

Such a panel would produce interdisciplinary recommendations for a reformed national maternity care policy. This would include methods to reintegrate physiological management principles and practice into this reconfigured system of maternity care.

Ultimately such an exploration and resulting recommendations would need to be accompanied by legal and legislative changes affecting doctors, hospitals, midwives and the health insurance industry. Such a system would then be respected and used equally by all maternity care providers with the backing of hospitals, health insurance and medical malpractice carriers, and state and federal reimbursement systems (Medicaid / Medi-Cal) etc.

Conclusion parts 1-4:

All that stands in the way of efficacious (safe, satisfactory *and* cost-effective) maternity care for healthy women in the US is (a) adoption of physiological practices as the standard of care (b) a new non-surgical billing code (c) an adjusted professional liability that reconciles (a) & (b) and (d) development of a national system of Maternity Homes (a name that fits the idea of mother-centered, family friendly holistic care though the childbearing experience, better than 'birth center', which is place and event-specific).

Were that the case, family practice physicians, professional midwives and even obstetricians tired of the high wire game and malpractice insurance nightmare would all be interested in staffing these family-friendly maternity homes.

With the elements of success all accounted for, including other changes in third party reimbursement, venture capitalists (including hospital systems and doctors looking for an investment opportunities) would be lining up to finance a hot new franchise for a national system of maternity homes.

What's not to like?

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Continue on to Topic #2:

How a normal biological process became a surgical procedure owned by ACOG and a billing code owned by the AMA