

DO ALL HOSPITALS NEED CESAREAN DELIVERY CAPABILITY?

TO THE EDITOR:

Leeman and Leeman, in their recent research article,¹ question whether rural hospitals providing maternal health services must be required to have cesarean delivery capability. Although the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) guidelines² requiring surgical access within 30 minutes are not based on objective evidence, we believe these guidelines should not be disregarded. We think these guidelines represent an effort to err on the side of safety for our patients; the authors say as much in their conclusion. No antepartum screening methodology is sensitive enough to predict all complications in all patients. The fact that the study by Leeman and Leeman demonstrated a lower cesarean section rate than the national average is not surprising, since their practice comprised low-risk patients.

Surgical care should be provided in house if possible. If this is not possible, we have to agree that the ACOG-AAP guidelines make sense and the lack of objective data should not keep us from our goal of providing the best care for all of our patients.

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TO THE EDITOR:

Leeman and Leeman recently described their successful maternity care experience in a rural hospital without cesarean delivery capability.¹ In the article they recommended the use of medical induction of labor to reduce the need for maternal transfer.

In other recent literature the use of medical induction has been shown to be associated with a significant increase in the rate of cesarean deliveries.³ Much of the increase in induction rates and therefore cesarean deliveries is due to elective inductions, those infants called "large for gestational age," or rupture of membranes of < 12 hours' duration, incorrectly called premature rupture of membranes.

The Leemans' article nicely highlights the importance of appropriate selection of candidates for medical induction and the risks of convenience or elective induction of labor. It may also reinforce the

observation that what is available is used, not always to the benefit of patients or society.

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DR LEEMAN AND R LEEMAN, CNM, RESPOND: Drs Besachio and Shenberger suggest that to provide the best care we must support the ACOG-AAP recommendations that require in-house surgical care at all hospitals and the ability to initiate a cesarean section within 30 minutes, despite the lack of evidence supporting these recommendations. In our article we stated that the "maintenance of rural surgical and anesthesia capabilities is desirable" and that "the possibility always exists for (adverse) outcomes that can be prevented by doing a rapid emergent cesarean delivery."¹ Unfortunately, rural hospitals and communities may be unable to maintain on-site cesarean delivery and anesthesia capabilities and have the choice of closing their maternity care units or continuing without on-site operative facilities. The loss of local access to maternity care in rural areas has been demonstrated to lead to adverse perinatal outcomes.⁴⁻⁶ Our study demonstrated that it is reasonable for a rural hospital without operative facilities to offer obstetric care as part of an integrated perinatal system with other institutions that have surgical facilities. We emphasized that women need to understand the risk inherent in delivering at such a facility.

Besachio and Shenberger mistakenly attribute the 7.3% cesarean rate to "a low-risk population." The 7.3% cesarean delivery rate is from the entire population of pregnant women in the Zuni-Ramah region, not just women delivering at the hospital without operative facilities. The Zuni-Ramah population is actually a high-risk group, with 9.3% of pregnancies complicated by diabetes and 14.5% complicated by pregnancy-induced hypertension.

To address Dr Yawn's letter: We share Dr Yawn's concern regarding the rising rate of labor induction nationwide and the potential effect on the cesarean delivery rate. In our article we suggested that it may be possible to decrease the transfer rate from hospitals without operative facilities, such as Zuni-Ramah, by selectively offering labor induction at the local facility, rather than transferring all women needing induction. We were not advocating an increase in the overall induction rate for the Zuni-Ramah population. Dr Yawn's letter and analysis of labor induction attributes much of the nationwide rise in inductions to elective inductions and inductions for macrosomia.

Of the 1132 pregnancies among women in the Zuni-Ramah region, there were no elective social inductions and only 1 induction for macrosomia in a non-diabetic patient.

We agree with Dr Yawn that the need for transfer for induction may have decreased the occurrence of unneeded inductions and that the local availability of labor induction could potentially increase the rate of unneeded inductions and cesarean deliveries. We are currently analyzing the factors responsible for the low cesarean rate in the Zuni-Ramah population for an article in preparation.

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THE ART of Medicine ■

Someday in another place

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Midway through my third year of medical school, I arrived at the medical center early, eager to see my assigned patients and write my notes before rounds. I scanned my list, seeing a familiar name. I decided to see this patient first, as we had discussed his case in teaching rounds the previous day.

I entered Mack Stevens's* room briskly and saw that he was already awake, looking much more alert than he had a few days before, upon admission. Mack was 26 years old and had chronic myelogenous leukemia. He had a history of transverse myelitis that had progressed to paralysis and herpes encephalopathy; he was currently taking several antibiotics for pneumonia and a urinary tract infection. He had a tracheostomy tube to assist respiration, a peg tube for feeding, a urostomy, and a colostomy.

As I approached, Mack turned his head slightly toward me with a light of recognition in his eyes. I began by asking him if he was in any pain, whether he had had fever or chills overnight, and other stock questions when I noticed that he was trying to say something to me. I tried in vain to understand him, leaning down close and watching his lips. I repeated my questions and asked him to blink if he understood me, which he did. Then he began to cry.

This young man, one year older than I, with terminal cancer, began to cry, although he was unable to form tears. He uttered a silent, open-mouthed cry that tore my heart out. I wondered why anyone got cancer and thought about how awful a disease it

was as I held his hand and talked soothingly, swallowing a hardened lump in my throat. Time ticked away in slow, lolling seconds as I felt helpless before him.

A nurse came in and injected some pain meds through his IV in accordance with his medication schedule. After a few minutes, he looked a little better. He had stopped crying and was looking at me again.

"I want you to know, Mack, that we are here for you," I said. "Dr Trake, the tall fellow who was in here yesterday, will visit again today. The other doctors [by this I meant the infectious disease team] have you on new antibiotics to get the infection in your lungs under control. We'll beat this one, buddy."

He looked up at me, blinking, unable to smile, or having no reason to smile, eyes looking up as he went through another silent day. The terrible irony was that he would probably die soon of some other complication of the CML even if we did get control of this pneumonia.

I walked out into the hall. Nurses milled about and med students zipped past with notes in their hands, on a mission, but it was all slow motion to me. Looking out the window, I saw that it was snowing, and I held my breath so I wouldn't cry. Large, soft flakes were falling, the kind that make you think of Christmas and loved ones, and I hoped that someday in another place I might meet Mack Stevens and talk to him as a friend.

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