Joint Efforts Will Help Maternity Outcomes

BY MICHELE G. SULLIVAN

FROM A TELECONFERENCE ON PATIENT SAFETY

If it takes an entire village to raise a child, it's going to take an entire country to raise maternal/fetal outcomes.

Everyone involved in maternity care – from payers and hospital administrators to laboring women and their nurses – needs to team up to improve the health of moms and newborns, even if that means admitting that mistakes can be made.

"Even the best people in obstetrical units can't do anything without leadership being willing to put moms' and babies' safety as the highest priority," Maureen P. Corry said during a teleconference on patient safety. "Everyone needs to be respected, encouraged to speak up, and listened to. Right now, there is a hierarchy [in health care facilities] that makes people fear retaliation if they speak up – and this is an incredible barrier to improving care."

Ms. Corry, executive director of Childbirth Connections, was one of several experts who spoke at the Partnership for Patients webinar, sponsored by the Department of Health and Human Services. Tasked with improving patient safety across the country, the initiative brings together all manner of health care stakeholders in webcast brainstorming sessions, with the aim of providing "take-home" strategies for systems improvement.

Wednesday's session focused on decreasing obstetrical adverse events. Although much of the data needed to succeed in this effort have long been available, many hospitals have yet to incorporate them into a cohesive obstetrical safety policy, the speakers said.

As cesarean section rates continue to rise (more than one-third of births in 2009), outcomes have continued to deteriorate, said Dr. Peter Cherouny, chair of the perinatal collaborative at the Institute for Healthcare Improvement. "No matter how much money we continue to throw at this, it's not a problem that has gone away. Maternal mortality in the United States has continued to increase at a rate of 2% per year for the last 20 years."

Most mothers are healthy and leave the hospital with healthy babies, he said. But mistakes that put mothers and babies at risk continue to occur. The best way to view this is that all mistakes can be prevented.

"Communication errors are the sentinel event in the vast majority of perinatal adverse events," he said. "That means up to 90% of birth trauma should be considered preventable."

But people on the front line often ignore this possibility, partly because they resist the idea of being fallible and partly because they fear retaliation from someone higher in the administrative hierarchy.

This means that mothers can be intimidated by health care professionals, nurses can feel intimidated by physicians, physicians can fear administrators, and administrators fear those that make the hospital world go around – namely payers.

Instead of continuing this culture, Dr. Cherouny said, real change can only occur when everyone in the chain drops their shield against retaliation and adopts instead a stance of individual empowerment.

Mothers can be at the root of this cultural shift, Ms. Corry said, when they learn the risks and benefits of possible interventions and insist on having input into their own care.

Childbirth Connection recently published the results of its Listening to Mothers II survey. "We found that 97% of mothers wanted to know every or most of the possible complications of induction and cesarean, but that most of them couldn't correctly identify the adverse effects of either one," Ms. Corry said.

The survey also showed that 45% of mothers with a prior cesarean section were interested in the option of a vaginal birth after cesarean, but were denied that option due to caregiver or facility unwillingness to perform it.

"Seventeen percent of the mothers reported that they also felt pressure from a health care professional to have an induction [before the onset of natural labor], and 25% felt pressure to have a cesarean section."

Since risk increases with every unnecessary intervention, everyone would benefit by a more restrained approach to labor and delivery. Early induction of labor and elective cesareans are two good places to begin a shift toward safer childbirth.

Administrators sometimes fear that it may simply be too expensive to make institutional changes, the presenters agreed. But this is a short-sighted view, said Dr. Alan Fleischman, medical director of the March of Dimes.

"There are many published studies that reinforce the idea that this cultural change actually improves financial outcomes. Lawsuits decrease. Length of stay decreases. Overall costs decrease. And positive outcomes increase all the way around. These are good arguments that we can use to get these changes in motion."

The Partnership for Patients webinar was sponsored by the Department of Health and Human Services. ■

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Abortion Rate Holds Steady

The number and rate of abortions performed in the United States remained about the same from 2007 to 2008, according to the latest abortion surveillance data collected by the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention. The data, published in Morbidity and Mortality Weekly Report, showed that in 2008 more than 825,500 abortions were reported to CDC. This resulted in an abortion rate of 16 abortions per 1,000 women aged 15-44 years, the same as in 2007. This rate is consistent with the recent leveling off of the abortion rate after years of steady declines, the CDC researchers wrote. However, the abortion ratio, which calculates the number of abortions compared to live births, increased slightly between 2007 and 2008. The 2008 abortion ratio was 234 abortions per 1,000 live births, a 1% increase over 2007. The CDC figures also showed a 17% increase in the number of nonsurgical abortions performed between 2007 and 2008. In 2008, of the abortions performed at 8 weeks gestation or earlier, 22% were nonsurgical.

Psoriasis TX During Pregnancy

Topical treatments such as petroleum jelly should be the first-line treatment of psoriasis in pregnant women, according to recommendations from the National Psoriasis Foundation's (NPF's) medical board. The expert panel recommended that physicians turn to moisturizers and emollients as the first treatments since they have no adverse effects. After that, they suggested the use of low- to moderate-dose topical steroids. If necessary, high-potency topical steroids may be used, but only in the second and third trimesters, the board wrote. As a second-line treatment, physicians may recommend light therapy using narrowband ultraviolet light B (UVB). Broadband UVB can also be used if narrowband is not available. The NPF medical board said TNF inhibitors, as well as the immunosuppressant drug cyclosporine, can be used in the second and third trimesters, but with caution.

Infertility Tax Credit Proposed

Federal legislation would create a tax credit to help infertile couples pay for treatment, including in vitro fertilization. H.R. 3522, the Family Act of 2011, is modeled after a tax credit currently available to offset adoption expenses, and could be used for out-of-pocket expenses associated with infertility treatment as well as for treatments to preserve fertility for cancer patients. "Without this credit, access to all the advances of modern medicine and the ability to bear children, despite physical impediments, become, for average Americans, a luxury defined by the size of their wallets or the digits in their zip code," the bill's sponsor, Rep. John Lewis (D-Ga.), said in a statement. "That's not right, not fair, or just." Similar legislation (S. 965) was introduced in the Senate last May. Under both bills, the proposed tax credit would cover 50% of all applicable medical expenses, but total payments through the credit would be capped at $13,360 for a lifetime. The credit would be available to married couples filing jointly with adjusted gross incomes of less than $222,520 .

AMA Criticizes Pregnancy Centers

The American Medical Association House of Delegates at its interim meeting adopted a resolution calling on pregnancy counseling centers to be truthful regarding the services they offer. The resolution was sponsored by the California delegation, which said that many "crisis pregnancy centers" operate "with the intent of discouraging women with unwanted pregnancies from seeking abortion." The centers are often deceptive and have no qualified clinical staff; women who visit them may experience delays in getting true medical services, said the delegation. The House said that any center should be clear on it website or in its advertising as to which services it does or does not provide. Delegates also said that any organization that was providing medical services should abide by licensing requirements and have appropriate qualified licensed personnel.

Keep Circumcision Legal

Reacting to ballot initiatives in California, that state's delegation to the AMA House asked that body approve a resolution opposing any attempts to make circumcision illegal. The resolution said that the medical indications "are compelling enough" and that most laws exclude the prohibition of specific procedures that physicians are qualified to perform, based on their clinical judgment. The AMA House passed the resolution without much debate.

AMA: Let's Talk About Guns

The AMA board approved a California-delegation resolution asking the full AMA to oppose restrictions on physicians discussing firearm safety with their patients, such as in a new Florida law. There, violators could face suspension or revocation of their license or fines of up to $10,000, according to the resolution. In September, a federal judge upheld a motion from physicians to enjoin the law, but the state said it would appeal. There is concern that these types of laws could proliferate, especially because they appear to have the backing of the National Rifle Association.

–Mary Ellen Schneider