Call to Improve Maternal Morbidity, Mortality Rates

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WASHINGTON — Despite claims to the contrary, there is still more work to do to reduce maternal morbidity and mortality in the United States, Cynthia Berg, M.D., said at a meeting sponsored by the Jacobs Institute of Women's Health.

Throughout the 20th century, maternal mortality in the United States gradually went from 900 deaths per 100,00 live births to about 10, noted Dr. Berg, who is a medical epidemiologist at the Centers for Disease Control and Prevention, Atlanta. "But in the past 20 years, there hasn't been a meaningful drop."

As a result of this slowing in decline, "some people believe that the United States has reached an irreducible minimum," she continued. "However, I would say there are a few pieces of evidence that would refute this claim."

For one thing, there are large racial and ethnic disparities in the risk of pregnancy-related death. For example, "the risk for black women is four times that for non-Hispanic white women, and that is one of the largest gaps in reproductive health treatment in the United States," Dr. Berg said. "Hispanics, Asian/Pacific Islanders, and Asian women also have a 50%-70% higher rate of pregnancy-related mortality than non-Hispanic white women."

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Disparities also appear if both race and birthplace are taken into account. Although Hispanic and Asian women born in the United States have mortality rates similar to native-born white women, Hispanic and Asian women born outside the United States have a much higher mortality risk, according to Dr. Berg.

Although maternal mortality is often the focus of research, maternal morbidity deserves more attention than it is getting, said Stacie Geller, Ph.D., director of the University of Illinois at Chicago National Center of Excellence in Women's Health. "Clearly, studying morbidity itself is important, but it also is another way to try to reduce maternal mortality."

One study by Dr. Berg and her associates found that 43% of women experience some form of maternal morbidity, based on data from the National Hospital Discharge Survey for women giving birth between 1993 and 1997. The most common condition was obstetric trauma such as a third- or fourth-degree laceration or hematoma (10.6%), followed by infections such as amnionitis (8.4%). Rare and serious complications like hemorrhage or pulmonary and amniotic embolisms occurred in less than 0.1% of the study group.

Dr. Geller cited three factors that placed women at higher risk of adverse outcomes during their pregnancies: lack of health insurance, particular clinical diagnoses, and preventable events.

"Most [preventable events] were due to provider issues," she said.

Dr. Geller cited a study she and her colleagues had done, which found that a woman who died from a pregnancy-related cause was two times more likely to have had a provider-related preventable event, compared with her counterpart with severe morbidity. "It's not good news, but it means we can do something about it by changing provider behavior."

Dr. Geller recommended more use of departmental and institutional review committees to study maternal morbidity and mortality cases. She also recommended that statewide maternal death review committees expand their scope to include near-miss morbidity cases.

Some audience members disagreed with Dr. Geller's approach. "If you continue to say some of these deaths are provider related versus system related, that propagates the continuation of individualized blame for adverse outcomes in the health care system," said Michele Curtis, M.D., of the department of obstetrics and gynecology at the University of Texas at Houston Health Science Center. "The aviation industry has demonstrated profoundly to us, as has the specialty of anesthesia, that we can, if we choose to use a system-based analysis and get away from the blame game, make much more progress on a population level." ■