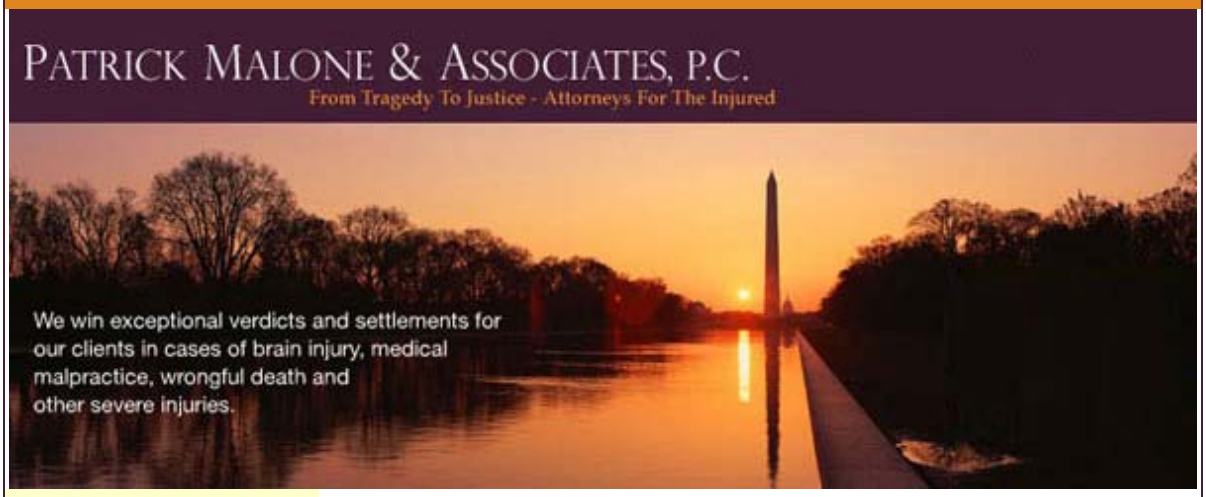
Getting the Best Medical Care: a Newsletter from Patrick Malone



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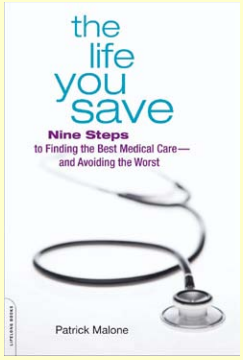
Our firm's website

Read an excerpt from Patrick Malone's book: ***The Life You Save: Nine Steps to Finding the Best Medical Care -- and Avoiding the Worst***



What's Wrong with the Pregnancy Health Care Assembly Line

Dear Patrick,

Most of the time, childbirth is a cause for joy and celebration. But sometimes, serious injury can happen to mother or baby. And the track record of U.S. hospitals is pretty bad compared to other advanced countries. The standard measure is the percent of babies who die before their first birthday -- infant mortality -- and as we've written before, the U.S. infant death rate doesn't stack up well against other countries.

There are many reasons for this, but one is the profit-oriented "labor-and-delivery machine" that has made delivering babies big business in America. That's according to Consumer Reports.

"Childbirth is the leading reason for hospital admission, and the system is set up to make the most of the opportunity," Consumer Reports says. "Keeping things chugging along are technological interventions that can be lifesaving in some situations but also interfere with healthy, natural processes and increase risk when used inappropriately."

In this issue, we'll discuss some overused medical technologies in childbirth and some ways to ensure a safe birthing experience for you and your baby.

For more information about birth injuries and their prevention, see a collection of articles on our website covering a wide range of issues.

Ten Overused Baby Delivery Technologies

Since the mid-1990s, one in three babies in the United States has been delivered via Cesarean section surgery. That's at least double what the World Health Organization deems optimal.

In an effort to reclaim the process of giving birth to a more natural and healthful, cost-effective-experience, Consumer Reports cites 10

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procedures it considers overused. The organization makes clear that sometimes complications in childbirth make inducing labor, for example, or performing a C-section, the safest option. But when they're not medically necessary, the following interventions are associated with poorer outcomes for moms and babies.

As an attorney with a fair amount of experience in helping families who have had tragic, unnecessary birth-related injuries, I have a few thoughts to add to what the Consumer Reports reviewers found, and a couple of areas of strong disagreement, as you will see below.

For more information about each of these ten subjects, visit the Consumer Reports story posted on the website.

1. C-section with a low-risk first birth. A C-section is major surgery. That always increases the odds of complications, especially infection or pain at the site of the incision. Rare but potentially life-threatening complications include severe bleeding, blood clots and bowel obstruction. A C-section can complicate future pregnancies, increasing the risk of problems with the placenta, ectopic pregnancies (which occur outside the uterus) and rupture of the uterine scar.

Babies born by C-section can be injured during the procedure and are more likely to have breathing problems. They are less likely to breast-feed.

2. An automatic second C-section. Just because your first baby was delivered by C-section doesn't mean your second must be. Many women who have had a C-section are good candidates for a vaginal birth after cesarean (VBAC).
But the percentage of VBACs has declined sharply since the mid-1990s. Some obstetricians don't do VBACs because they lack hospital support or training or because their malpractice insurance won't provide coverage.

IMPORTANT NOTE: Our firm has represented several clients with tragic outcomes from attempted VBAC deliveries that have gone wrong. There is one key question you must ask the facility before agreeing to try a VBAC delivery. Read the full article about VBAC injuries on our web site to get this question and other important background.

3. An elective early delivery. A full-term pregnancy is 39 to 40 weeks, but between 1990 and 2007, full-term births dropped by 26 percent. Carrying an infant to term has health benefits for both moms and babies. Full-term babies have lower rates of breathing problems, are less likely to need neonatal intensive care, have fewer feeding problems and have a higher rate of survival in their first year. Some research even suggests that full-term infants benefit from cognitive and learning advantages that continue through adolescence.

Mothers who give birth even in late preterm are more likely to suffer from postpartum depression. The procedures required to intentionally deliver a baby early (induced labor or a C-section) carry a higher risk of complications than a full-term vaginal delivery.

4. Inducing labor without a medical reason. The percentage of births resulting from artificially induced labor more than doubled from 1990 to 2008. Women who go into labor naturally often can spend the early portion at home, moving around as they feel most comfortable. An

induced labor takes place in a hospital, where the woman is hooked up to at least one intravenous line and an electronic fetal monitor. Induced labor may occur before a woman's body or baby is ready. Labor may take longer and odds of needing a C-section increase significantly. Induced labor often leads to further interventions (epidurals for pain relief, the use of forceps or vacuums) that carry additional risks.

5. Ultrasounds after 24 weeks without a specific reason. Absent a specific condition a doctor must follow, such as gestational diabetes, ultrasound after 24 weeks is unnecessary. Some practitioners use it to estimate fetal size or due date, but that's not a good idea because the margin of error increases significantly as the pregnancy progresses. Ultrasound doesn't provide additional information leading to better outcomes for either mother or baby.

6. Continuous electronic fetal monitoring. (*This one on Consumer Reports' list I disagree with strongly, but I'm including it in this list for the sake of completeness.*) Continuous monitoring requires being hooked up to a monitor recording the baby's heartbeat throughout labor. It restricts the mother's movement and increases the chance of a cesarean and delivery with forceps.

Some people claim monitoring does not reduce the risk of cerebral palsy or death for the baby, but that's controversial. The fact is -- and this is Malone talking, not Consumer Reports -- that while cerebral palsy rates have been pretty steady since the advent of electronic monitoring, the rate of stillbirths has dropped dramatically, and that has saved many babies' lives.

Click here for a good discussion on the Malone web site of how fetal monitoring works and the signs that doctors and nurses use to assess how well the baby is tolerating the labor.

7. Early epidurals. An epidural delivers anesthesia directly into the spinal canal. The mother remains awake but feels no pain below the administration point. But the longer an epidural is in place, the more medication accumulates and the less likely the mother will be able to feel to push. Epidurals can retard labor.

8. Routinely rupturing the amniotic membranes. Doctors sometimes rupture the amniotic membranes or "break the waters" to strengthen contractions and shorten labor. But the practice may increase the risk of C-sections. Artificially rupturing amniotic membranes can cause problems with the umbilical cord or the baby's heart rate.

9. Routine episiotomies. A surgical cut just before delivery to enlarge the opening of the vagina can be necessary if a delivery requires the use of forceps or a vacuum, or if the baby is descending too quickly for the tissues to stretch. Otherwise, routine episiotomies are associated with damage to the perineal area and a longer healing period.

10. Sending your newborn to the nursery. If the baby has a problem that needs special monitoring, care in a nursery or an intensive care unit is essential. Otherwise, allowing healthy infants and mothers to stay together promotes bonding and breast-feeding.

How to Improve Your Odds of a Safe, Natural Childbirth

The following guidelines, courtesy of Consumer Reports, can help you manage your pregnancy for the best possible outcome. In addition, see our article on prenatal care.

(To learn more about the legal and emotional issues if a baby has been injured in the birthing process, link here.)

- Find an obstetrician who supports vaginal birth.
- Ask about hospital C-section rates, especially if you're having your first child. The target rate is around 15 percent, according to the American College of Obstetricians and Gynecologists. If it's difficult to find a hospital with a C-section rate that low, you might be able find one that meets the more modest goal of about 24 percent, which was set by the government's Healthy People 2020 initiative.
- If you've had a C-section, ask if your obstetrician and hospital are willing to try a VBAC. Inform them that you understand that you your baby will be monitored continuously during labor, and ask what the hospital would do if an emergency C-section became necessary. Review the rates of planned early deliveries for hospitals in your state on Leapfrog, a consumer health organization.
- By delaying administration of an epidural and using labor support strategies, you might be able to get past a tough spot. If you do have an epidural, ask the anesthesiologist about a lighter block.
- Consider a midwife if your pregnancy is low-risk. Certified midwives provide a range of care during pregnancy, childbirth and the postpartum period. Certified nurse midwives (CNMs) and certified midwives (CMs) have graduate degrees, have completed an accredited education program and must pass a national certification exam. The American College of Nurse-Midwives maintains a list of caregivers. Make sure the midwife you're considering is licensed to practice in your state. CNMs are licensed in every state, but CPMs and CMs are not.
- Ask if a breech baby can be turned. Because a baby delivered buttocks- or feet-first can be in danger, many practitioners recommend a C-section when the baby is not coming out head first. But a skilled practitioner often can turn a breech baby in the last weeks of pregnancy. Because it carries some risk-membranes might rupture or in rare cases the baby can become tangled in the umbilical cord-it should be done in a hospital. With the increasing use of C-sections, some practitioners have little training or experience with the external version procedure. If yours is not, consider asking for a referral to someone who is.
- Get support during labor. Women who receive continuous support have shorter labor and are less likely to need intervention. The most effective support comes from someone who is not a member of the hospital staff and is not in your

social network-a trained birth assistant, or "doula." Ask your provider for a referral.

Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you.

New research on the importance of reading -- and understanding -- the labels on any prescription drug you take.

The difference between "board-certified" and "board-eligible" specialists in medicine is important, and too many consumers are confused. Some straight talk here.

We've learned a lot more about medical error in the last few years, and the exponentially higher levels of injury to patients that happen from preventable mistakes. But we have a ways to go in understanding the extent of the problem and figuring out answers, as patient safety advocate Helen Haskell wrote recently.

Past issues of this newsletter:

Here is a quick index of past issues of our Better Health Care newsletter, most recent first.

To your continued health!

Sincerely,

Patrick Malone
Patrick Malone & Associates