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## PREVENTING A RETURN TO TWILIGHT AND STRAITJACKETS: Using the Patient Protection and Affordable Care Act as a Starting Point for Evidence-Based Obstetric Reform in the United States

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# PREVENTING A RETURN TO TWILIGHT AND STRAITJACKETS: Using the Patient Protection and Affordable Care Act as a Starting Point for Evidence-Based Obstetric Reform in the United States.

Alexius Cruz O'Malley\*

## ABSTRACT

*The United States has the most medicalized approach to childbirth of any nation in the world. Women in the United States have a greater lifetime risk of dying due to pregnancy-related complications than women in forty other developed nations. Babies born in the United States have a higher risk of dying within the first months of life than babies born in the forty other countries. Poor outcomes combined with costly, procedure-intensive care have been labeled the “perinatal paradox: doing more and accomplishing less.” Inspired by her own pregnancy and childbirth experience, the Author explores this “perinatal paradox” and the state of obstetric care in the United States today; the social policy implications of this most-medicalized approach; and proposes best-evidence based reform using the Patient Protection and Affordable Care Act (PPACA) as a starting point. The present Article first explores the systematic issues plaguing obstetrics and the maternal experience in the United States, historically and today. Second, it discusses several causal theories including: the practice of defensive medicine, fee-for-service medical reimbursement systems, and for-profit insurance companies and hospitals. Third, it details the legislative history of the Patient Protection and Affordable Care Act (PPACA), identify several starting points the PPACA provides for evidence-based reform, and then proposes several enhancements to move obstetric care forward. Ultimately the Article promotes the use of best-evidence based care, integrative healthcare information technology systems, greater access to midwives and birth centers, combined with the advances made by PPACA, in an effort to significantly enhance obstetric care in the United States and save the lives of women and babies across the country.*

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I. INTRODUCTION

The United States has the most medicalized approach to childbirth of any nation in the world.<sup>1</sup> Obstetric care in the United States is “intervention intensive, expects trouble, and does not promote, support, or protect physiologic birth.”<sup>2</sup> In 2009, 98.9% of U.S. births were in hospitals and 86.7% were attended by doctors of medicine, with only 7.4% of hospital births attended by midwives.<sup>3</sup> The hospital setting has proven to be very dangerous for “normal” births.<sup>4</sup> Poor outcomes combined with costly, procedure-intensive care have been labeled the “perinatal paradox: doing more and accomplishing

<sup>1</sup> Heather Joy Baker, *We Don’t Want to Scare the Ladies: An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*, 31 WOMEN’S RTS. L. REP. 538, 552 (2010) (“The United States has ‘the most intense and widespread medical management of birth’ in the world, with 99% of births taking place in a hospital. This rate is staggering when compared to other industrialized countries, such as the Netherlands, where 20%– 30% of childbirths occur at home, and Dublin, Ireland, where 80% of women are cared for solely by a midwife.”).

<sup>2</sup> Judith A. Lothian, *Safe, Healthy Birth: What Every Pregnant Woman Needs to Know*, 18 J. PERINATAL EDUC. 48, 49 (2009).

<sup>3</sup> Joyce A. Martin et al., *Births: Final Data for 2009*, 60 NATIONAL VITAL STATISTICS REPORTS 13 (2011); Baker, *supra* note 1.

<sup>4</sup> AMNESTY INTERNATIONAL, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 80 (2010) available at <http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf> (Normal births are those that are considered to be low risk based on the pregnant woman’s and fetus’ health. Approximately 83% of women have low-risk pregnancies in the United States.).

less.”<sup>5</sup> While giving birth at home<sup>6</sup> may not be the most optimal choice for high-risk patients or patients with complications,<sup>7</sup> it may be less dangerous for no- or low-risk patients.

Amnesty International published a report titled *Deadly Delivery: The Maternal Health Care Crisis in the USA*, based on research conducted during 2008 and 2009 suggesting that women in the United States have a greater lifetime risk of dying due to pregnancy-related complications than women in forty other developed nations.<sup>8</sup> Maternal deaths<sup>9</sup> are only the “tip of the iceberg” when it comes to problems plaguing the maternal experience in the United States.<sup>10</sup> “[M]any other nations are doing a better job with measures such as perinatal, neonatal, and maternal mortality, low birth weight, and cesarean rates.”<sup>11</sup> According to the World Health Organization (WHO), babies born in the United States have a higher risk of dying within the first months of life than babies born in forty other countries,<sup>12</sup> with an infant mortality of 4.3 deaths per every 1000 live births.<sup>13</sup> The benchmark of the top three countries is 2.7 per 1000,<sup>14</sup> with countries like Sweden, Singapore, and Iceland averaging 2 per 1000.<sup>15</sup>

Nonetheless, per capita health expenditures for the United States far exceed those of *all* other nations,<sup>16</sup> amounting to some \$86 billion annually in pregnancy and childbirth related costs.<sup>17</sup> Medical interventions<sup>18</sup> in general are on the rise, including labor

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<sup>5</sup> CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE pg. v (2008); *See also* AMNESTY INTERNATIONAL, *supra* note 4, at 1 (“More than two women die every day in the USA from pregnancy-related causes . . . Severe complications that result in a woman nearly dying, known as a ‘near miss,’ increased by 25% between 1998 and 2005. During 2004 and 2005, 68,433 women nearly died in childbirth in the USA. More than [one] third of all women who give birth in the USA—1.7 million [of approximately 4 million] women each year—experience some type of complication that has an adverse effect on their health.”)

<sup>6</sup> Basic information about home births is available online. *See* AMERICAN PREGNANCY ASSOCIATION, <http://www.americanpregnancy.org/labornbirth/homebirth.html> (last visited Mar. 4, 2012). Women often select the home birth option to try to avoid the medical interventions often employed by doctors in hospitals and to be free to give birth in a familiar setting, under her control.

<sup>7</sup> Harriet Hall, *The Business of Being Born*, SCIENCE-BASED MEDICINE (Mar. 25, 2008) <http://www.sciencebasedmedicine.org/index.php/the-business-of-being-born/> (“Home births scare me witless, because I’ve seen a normal delivery turn to disaster in a heartbeat. As one doctor says in the movie, a woman can hemorrhage and bleed out in a matter of minutes.”)

<sup>8</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 1.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> SAKALA & CORRY, *supra* note 5, at 3 (provides a cross-national comparisons from the World Health Organization and the Organisation for Economic Co-operation and Development).

<sup>12</sup> *U.S. Newborn Death Rate Trails Behind 40 Other Nations*, INTERNATIONAL BUSINESS NEWS, <http://www.ibtimes.com/us-newborn-death-rate-trails-behind-40-other-nations-307366>, (Aug. 31, 2011 10:27 AM).

<sup>13</sup> *Id.*; WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS 2010 REPORT 45–55 (2010) (table 1: Mortality and burden of disease); *See also* Jack A. Ginsburg, et al., *Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries*, 148 ANNALS OF INTERNAL MEDICINE 55, 75 (2008).

<sup>14</sup> *Id.*

<sup>15</sup> WORLD HEALTH ORGANIZATION, *supra* note 13, at 48–55.

<sup>16</sup> SAKALA & CORRY, *supra* note 5, at 3.

<sup>17</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 1.

induction and cesarean section. Both are at an all-time high in the United States despite serious known risks<sup>19</sup> and warnings from the World Health Organization.<sup>20</sup> One would hope that with the advent of modern medicine and lifesaving medical interventions the risks for mothers and babies would significantly decrease. However, most medical interventions, such as labor induction methods, cesarean section surgeries, and episiotomies<sup>21</sup> were intended to be used *only* for high-risk patients or for those with complications during labor or childbirth.<sup>22</sup> Yet today they are widely over utilized. While high risk patients may require more interventions, this is not the “norm.” In fact 90% of pregnant women are healthy and do not require intervention.<sup>23</sup> Yet, cesarean deliveries reached a record high of 32.9% of all hospital births in 2009.<sup>24</sup>

Obstetricians are being trained that medical interventions *are* the new “norm” and that interventions are necessary during childbirth to make the childbirth experience as “efficient” as possible,<sup>25</sup> to mitigate the doctor’s risk of liability and to increase profits.<sup>26</sup> Unfortunately, “[c]onsistent with common patterns of innovation in medicine . . . obstetric practices such as episiotomy . . . and electronic fetal monitoring . . . were adopted prior to adequate evaluation.”<sup>27</sup> According to Kathleen Rice Simpson,<sup>28</sup> an

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<sup>18</sup> A medical intervention is any measure whose purpose is to improve health or alter the course of disease. FREE DICTIONARY BY FAFLEX, <http://medical-dictionary.thefreedictionary.com/intervention> (last visited Mar. 4, 2012).

<sup>19</sup> Kathleen Rice Simpson, *Reconsideration of the Costs of Convenience Quality, Operational, and Fiscal Strategies to Minimize Elective Labor Induction*, 24 J. PRENAT. NEONAT. NURS. 43 (2010).

<sup>20</sup> See generally WORLD HEALTH ORGANIZATION, *supra* note 13, table 1: Mortality and burden of disease; AMNESTY INTERNATIONAL, *supra* note 4.

<sup>21</sup> Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX: J. L.-MED. 325, 348 (2003) (“An episiotomy is a deliberate incision made to enlarge the opening of the vagina. Physicians make a cut, usually from the bottom of the vaginal opening down towards the rectum (median episiotomy) or, less frequently, diagonally towards a point to one side of the rectum (mediolateral episiotomy). Episiotomies are intended to help preserve the pelvic floor, by preemptively making a clean incision rather than allowing the fetus’ head to tear the tissue raggedly as it comes through, and by helping to prevent overstretching of the muscles of the pelvic floor. They also are used to help prevent trauma to the fetus’ head and speed up delivery in the event of fetal distress, and to enlarge the vaginal opening for forceps use.”).

<sup>22</sup> AMNESTY INTERNATIONAL, *supra* note 4.

<sup>23</sup> *Id.*

<sup>24</sup> Joyce A. Martin et al., *supra* note 3, at 13.

<sup>25</sup> AMNESTY INTERNATIONAL, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA*, available at <http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf>; see also Elizabeth Swire Falker, *The Medical Malpractice Crisis in Obstetrics: A Gestalt Approach to Reform*, 4 CARDOZO WOMEN’S L.J. 1, 28 (1997) (“The “normal” [less technologically invasive] birth is more difficult to identify, because doctors are trained to expect a complicated birth requiring the utilization of EFM [Electronic Fetal Monitoring], IVs, and Cesarean sections.”).

<sup>26</sup> David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation Against Themselves and Their Colleagues*, 12 AMERICAN LAW & ECONOMICS REVIEW 69, 73 (2009) (“From a defensive medicine perspective, U.S. obstetricians seem to be viewing cesarean section as a safe option.”).

<sup>27</sup> SAKALA & CORRY, *supra* note 5, at 8. See also, Baker, *supra* note 1, at 578 (“Obstetrics is a practice steeped in its own tradition, often accepting common practice instead of common sense. In her book, Henci Goer notes, ‘episiotomy . . . is the quintessential example of an obstetrical procedure that persists despite a total lack of evidence for it and a considerable body of evidence against it.’”).

<sup>28</sup> Kathleen Simpson, PhD, RNC, FAAN, is a perinatal nurse specialist at St. John’s Mercy Medical Center in St. Louis, MO. In that role she is responsible for clinical practice, education, and research for the labor

expert in the area of labor inductions<sup>29</sup> and augmentations,<sup>30</sup> there is a cascade of interventions related to induction, each with their own set of complications or iatrogenic<sup>31</sup> harm.<sup>32</sup>

Obstetric care in the United States has started down a very slippery slope of medicalization and overuse of interventions, which has drastically changed the maternal experience. I, like many pregnant women, took a crash course in pregnancy and childbirth in the United States. On my own initiative, I researched the benefits and importance of proper prenatal care, nutrition, exercise and preparation for childbirth. I also realized the importance, the hard way, of choosing the right obstetrician or caregiver for my individual needs.

After doing extensive research, I was shocked by some of the issues plaguing obstetrics, prenatal care, and the childbirth experience in the United States. I was also disappointed to find that my healthcare providers were not educating me about my options; most of my information was obtained via Bradley Method<sup>33</sup> childbirth classes, and independent research.

When I decided to pursue natural, intervention-free childbirth I was met with significant resistance from my obstetricians. When I asked about the plateau that most

and delivery, antepartum and obstetric triage units of a perinatal service averaging over 8000 births per year. Dr. Simpson is the author of AWHONN's (Association of Women's Health, Obstetric and Neonatal Nurses) Practice Monograph on Cervical Ripening and Labor Induction and Augmentation. She has conducted research regarding safe care when using the high alert medications oxytocin and magnesium sulfate and is the author of several articles on this topic. *Kathleen Simpson – Biography*, AWHONN (Mar. 4, 2012) <http://awhonn.confex.com/awhonn/2008/webprogram/Person949.html>.

<sup>29</sup> "Labor induction — also known as inducing labor — is a procedure used to stimulate uterine contractions during pregnancy before labor begins on its own. Successful labor induction leads to a vaginal birth. A health care provider might recommend labor induction for various reasons, primarily when there's concern for a mother's health or a baby's health. Labor induction carries various risks, including infection and the need for a C-section. Sometimes the benefits of labor induction outweigh the risks, however." There are various methods of induction including stripping or sweeping the amniotic membranes, ripening the cervix, breaking the bag of waters, or administering intravenous medication including Pitocin.

*Definition of Labor Induction*, MAYO CLINIC, <http://www.mayoclinic.com/health/labor-induction/MY00642> (last visited Jan. 21, 2012).

<sup>30</sup> Labor augmentations or stimulation is similar to induction, however, it merely "speeds up" the process once a woman is in labor.

<sup>31</sup> Iatrogenic: induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures.

<sup>32</sup> Kathleen Rice Simpson, *Reconsideration of the Costs of Convenience Quality, Operational, and Fiscal Strategies to Minimize Elective Labor Induction*, 24 J. PRENAT. NEONAT. NURS. 43, 43 (2010) (related interventions include: intravenous line, continuous electronic fetal monitoring, confinement to bed, amniotomy, pharmacologic labor stimulating agents, parental pain medications, and regional anesthesia). See also Barbara L. Wilson, et al., *The Relationship Between Cesarean Section and Labor Induction*, 42 J. NURSING SCHOLARSHIP 130 (2010); *Rates for Total Cesarean Section, Primary Cesarean Section, and Vaginal Birth After Cesarean (VBAC), United States, 1989-2009*, CHILDBIRTHCONNECTIONS (2011), available at <http://www.childbirthconnection.org/pdfs/cesarean-section-trends.pdf>; Kathleen Rice Simpson, *Clinicians' Guide to the Use of Oxytocin for Labor Induction and Augmentation*, J. MIDWIFERY & WOMEN'S HEALTH 214, 214 (Apr. 28, 2011).

<sup>33</sup> ROBERT A. BRADLEY ET AL., HUSBAND-COACHED CHILDBIRTH: THE BRADLEY METHOD OF NATURAL CHILDBIRTH, (5 ed. 2008) (Bradley Method is a husband-coached method of childbirth which focuses on healthy babies, mothers and families, stressing the importance of preparation for childbirth); See also *The Bradley Method of Husband-Coached Natural Childbirth*, BRADLEY BIRTH (Mar. 4, 2012), <http://www.bradleybirth.com/>.

women experience during labor in which dilation may not progress for several hours, despite contractions, I was met with a strange, disapproving look and a quick “well, no. That is just way too long. We can’t let you do that.” When asked whether I could labor as long as I would like without intervention, as long as the baby and I were healthy, they said “no.” When asked why, one of the doctors simply did not have an answer. She said “well, we just can’t let you labor for too long, the risks are too high.” When I shared my wishes not to receive an epidural, she replied “No problem, we can give you pain medication intravenously.” When I said I did not want any pain medication, I was again confronted with the disapproving glare and a curt “we’ll see how you feel in the throes of labor.” Then finally, when asked whether I was taking any birthing classes, I informed the doctor that I was taking Bradley Method classes. One doctor responded, “we are not a Bradley-friendly practice.”

I left the visit angry and confused. My doctors’ advice and reaction ran counter to everything I read during my independent research. As a result, during week thirty-seven of my pregnancy, I made the crucial decision to seek a new obstetrician who would support my decision to pursue natural, intervention-free childbirth.

During our initial visit with the new obstetrician, my husband and I asked him why there was so much resistance against natural, intervention-free childbirth from other physicians. He believed his colleagues were afraid of legal liability. He told us that he was once at a seminar about medical malpractice and was advised by an “expert” that if he ever made a mistake, he should bury it. He was also told that the life of a child was worth less than a lifetime of paying for a mistake in malpractice insurance premiums.

But our new obstetrician’s priorities were different. He preferred to empower women to control their birth experiences and to give babies the best start possible. He only required me to do two things: wear a port for an IV in case of emergency and to wear an external fetal heart monitor. “Otherwise,” he said, “I don’t care if you give birth while standing on your head.”

His approach was so dramatically different from the practice we transitioned from. Our previous obstetric office required that I play musical chairs among ten physicians who booked appointments seven minutes apart, avoided answering questions, and pushed two page pamphlets and prenatal vitamin samples as a way of educating me about proper prenatal care and childbirth. Our new obstetrician took as much time as needed to understand my needs and goals for my pregnancy and childbirth experience, answer questions to quell my fears, and give a thorough explanation of what to expect in the coming weeks.

I have come to understand that women handle the anxieties associated with pregnancy and childbirth differently. Some are more fearful the more they learn about the process and what is happening within their bodies. Others, like me, take comfort in knowing all of the details. Regardless, all women should have the opportunity to choose the healthcare provider that suits her needs and all healthcare providers should be held accountable for educating their patients about a woman’s options, proper prenatal care and obtain informed consent when appropriate.

Many academic papers have been written and several think tanks have come together over the past several years to discuss the state of obstetric and maternal healthcare in the United States. Important conclusions were drawn and alliances built to

try to improve healthcare for future pregnant women and babies.<sup>34</sup> As a result of much of this work, several pieces of legislation<sup>35</sup> have been proposed, signaling small steps toward the end goal to provide more adequate evidence-based maternity care. “The opportunity to improve health care using existing scientific knowledge is immense. Much is known that is not being used in routine care, leading to a large gap between knowledge and practice.”<sup>36</sup>

In this paper, first I explore the systematic<sup>37</sup> issues plaguing obstetrics<sup>38</sup> and the maternal experience in the United States, historically and today. Second, I discuss several causal theories including: the practice of defensive medicine,<sup>39</sup> fee-for-service<sup>40</sup> medical reimbursement systems, and for-profit insurance companies and hospitals.<sup>41</sup> Third, I

<sup>34</sup> See SHERMAN FOLLAND, ALLEN C. GOODMAN & MIRON STANO, *THE ECONOMICS OF HEALTH AND HEALTH CARE* (1997) (discussing the responsibility of government to act in the face of uncertainty; governmental resources, knowledge, expertise, and will to act; and a rationale why public citizen participation is critical to health care).

<sup>35</sup> Newly introduced bills include: the PPACA, Patient Protection and Affordable Care Act, 42 U.S.C.A. § 18001 (2010); Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010); and Maximizing Optimal Maternity Services for the 21st Century, H.R. 5087, 11th Cong. (2010) (This bill was introduced July 21, 2010 with sponsors added in December 2010, but never became law. It largely referenced WHO findings).

<sup>36</sup> See Charles M. Kilo, *Improving Care Through Collaboration*, 103 PEDIATRICS 384, 384 (1999) (describing a collaborative improvement model bringing health care professionals together to focus on and accelerate the improvement of gaps between knowledge and practice in healthcare).

<sup>37</sup> Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 N. ENGL. J. MED 2205, 2205 (2006) (“[One] statistic from the landmark 1999 Institute of Medicine (IOM) report [states] that as many as 98,000 deaths in the United States each year result from medical errors. But the IOM also found that more than 90% of these deaths are the result of failed systems and procedures, not the negligence of physicians.”).

<sup>38</sup> The American Congress of Obstetricians and Gynecologists (ACOG), a private, voluntary, nonprofit membership organization with over 55,000 members, is the leading group of professionals providing healthcare for women. ACOG defines an obstetrician as a physician who practices obstetrics, which is defined as “the branch of medicine that deals with the care of women during pregnancy, childbirth, and the recuperative period following delivery.” American Heritage Medical Dictionary, <http://medical-dictionary.thefreedictionary.com/obstetrics> (last visited Mar. 4, 2012); Roger A. Rosenblatt et al., *Why do Physicians Stop Practicing Obstetrics? The Impact of Malpractice Claims*, 76 OBSTETRICS & GYNECOLOGY 245, 245 (1990) (“ACOG reports that most obstetricians are also practicing gynecologists, and many family physicians are licensed to provide obstetric care as well.”); Sarah Domin, *Where Have All the Baby-Doctors Gone? Women’s Access to Healthcare in Jeopardy: Obstetrics and the Medical Malpractice Insurance Crisis*, 53 CATH. U. L. REV. 499, 499 (2004) (“Therefore, unless otherwise specified, the term “obstetrician” and those statistics concerning the practice of obstetrics refer to those doctors that provide obstetric care, whether they are obstetricians, ob-gyns, or family physicians.”).

<sup>39</sup> Kenneth Deville, *Act First and Look Up the Law Afterward?: Medical Malpractice and the Ethics of Defensive Medicine*, 19 THEORETICAL MEDICINE AND BIOETHICS, 569, 570 (1998) (“The American Medical Association (AMA) has defined defensive medicine as the “performance of diagnostic tests and treatments which, but for the threat of a malpractice action would not have been done.”).

<sup>40</sup> Fee-for-service is when “medical providers are paid for each service they perform rather than for providing quality care.” PUBLIC CITIZEN, *Setting the Record Straight on Medical Liability Limits: Tort “Reform” Hurts Patients, Costs Billions, and Shields Those Who Cause Harm*, PUBLIC CITIZEN, (2010) [http://www.citizen.org/documents/Medical\\_Malpractice\\_Fact\\_Sheet.pdf](http://www.citizen.org/documents/Medical_Malpractice_Fact_Sheet.pdf).

<sup>41</sup> See generally Steffie Woolhandler & David Himmelstein, *The High Costs of For-Profit Care*, 170 CANADIAN MED. ASSOC. J. 1841 (2004) (discussing the changes in hospitals and insurance companies after the shift from non-profit to for-profit models); *Did Blue Cross’ Mission Stray When Plans Became For-Profit?*, NPR.ORG (March 18, 2010), available at



detail the legislative history of the Patient Protection and Affordable Care Act (PPACA),<sup>42</sup> identify several starting points the PPACA provides for evidence-based reform,<sup>43</sup> and propose several enhancements to move obstetric care forward.

## II. A BRIEF HISTORY OF OBSTETRIC CARE

Until the 1930s, women were giving birth at home without medical intervention.<sup>44</sup> With the advent of pain medication and medical devices to “help” the labor process, women began having babies in hospitals.<sup>45</sup> In the 1930s, doctors were giving women x-rays to measure their pelvis until they realized the use of x-rays caused cancer in babies.<sup>46</sup> In the 1940s, most women were given the amnesiac “twilight sleep” for pain relief and were fully sedated and lacked memory of their baby’s birth.<sup>47</sup> To protect women from the violent thrashing induced by powerful drugs, they were often restrained—sometimes for days—in their own excrement, in large cribs, wearing football helmets and strapped down to the beds using lambs’ wool so the restraints would not leave marks.<sup>48</sup> In the 1950s and 1960s, doctors prescribed thalidomide<sup>49</sup> for morning sickness, which caused more than 10,000 babies to be born with “sealed limbs,” or born without arms or legs. The drug was banned in 1962.<sup>50</sup>

More recently, doctors in the 1990s began administering Cytotec to induce labor in women. Despite serious risks, including abortion, premature birth, birth defects, uterine rupture, and even death of the mother or baby, doctors are still using Cytotec to induce labor today. Cytotec was approved by the FDA only as an ulcer medication and is often

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<http://www.npr.org/templates/story/story.php?storyId=124807720> (discussing the historical reasons behind Blue Cross’ shift to a for-profit company).

<sup>42</sup> Patient Protection and Affordable Care Act, 42 U.S.C.A. § 18001 (2010); *See also National Economic and Social Rights Initiative*, WOMEN AND THE HUMAN RIGHT TO HEALTH CARE: A PERSPECTIVE ON THE FEDERAL HEALTH REFORM LAW (June 2010), *available at*

[http://www.dghonline.org/files/page\\_attachments/Women\\_health\\_reform\\_factsheet\\_0-1.pdf](http://www.dghonline.org/files/page_attachments/Women_health_reform_factsheet_0-1.pdf) (the Patient Protection and Affordable Care Act was “[s]igned into law by President Obama on March 23, 2010, this act together with the Health Care and Education Reconciliation Act (P.L. 111-152), expands Medicaid and tightens some insurance industry regulations, while leaving the current market-based system largely intact.”).

<sup>43</sup> SAKALA & CORRY, *supra* note 5, at 7 (arguing evidence-based maternity care uses best available evidence to identify and provide optimal maternity care, defined as effective care with the least harm); *see also id.* at v. for a more comprehensive list of barriers to evidence-based maternity care.

<sup>44</sup> THE BUSINESS OF BEING BORN, *available at*

<http://www.youtube.com/watch?v=tzxs5qPsqX4&feature=related>.

<sup>45</sup> Judith Rooks, *Pregnancy & Birth: The History of Childbearing Choices in the United States*, OUR BODIES OUR SELVES, *available at*

<http://www.ourbodiesourselves.org/book/companion.asp?id=21&compID=75>

<sup>46</sup> *The Business of Being Born*, YOUTUBE (2008),

<http://www.youtube.com/watch?v=tzxs5qPsqX4&feature=related>.

<sup>47</sup> Katy Dawley, *Origins of Nurse-Midwifery in the United States and its Expansion in the 1940s*, 48 J. MIDWIFERY & WOMEN’S HEALTH 86, 86 (Apr. 2003).

<sup>48</sup> ROBERT A. BRADLEY ET AL., HUSBAND-COACHED CHILDBIRTH: THE BRADLEY METHOD OF NATURAL CHILDBIRTH (5th Ed. 2008); *supra* note 47, at 91; *supra* note 46.

<sup>49</sup> THE BUSINESS OF BEING BORN, *supra* note 46.

<sup>50</sup> Carl Zimmer, *Answers Begin to Emerge on How Thalidomide Caused Defects*, N.Y. TIMES, Mar. 15, 2010, <http://www.nytimes.com/2010/03/16/science/16limb.html?pagewanted=all>.

used as an intentional abortion drug.<sup>51</sup> Cytotec is just one example of a gap in the FDA's drug approval system, which has dangerous consequences for pregnant women and unborn babies. First, the "FDA approves most drugs without any evidence of safety or efficacy when used during pregnancy."<sup>52</sup> Second, while the United States has a system in place to insure that all drugs are evaluated by the FDA before allowed on the market and certain drugs are dispensed only through physician prescription, there is a hole in this system. Once a drug has been approved by the FDA for one use and put on the market, there is nothing to prevent a physician from using that drug for whatever use at any dose.<sup>53</sup>

Doctors continue to use Cytotec and other induction drugs—claiming they are safe—at an increasing rate, yet these drugs still are not FDA-approved for this use.<sup>54</sup> In fact, the FDA released a warning to healthcare providers and the public in 2009 about Misoprostol (marketed as Cytotec) and the significant, serious risks of use during labor and delivery.<sup>55</sup> Risks include: torn uterus, severe bleeding, having the uterus removed (hysterectomy), and even death of the mother or baby.<sup>56</sup> The FDA also warns that these side effects are more likely to occur in women who have had previous uterine surgery, previous Cesarean delivery, or several previous births.<sup>57</sup> The FDA is still evaluating Cytotec.<sup>58</sup>

The United States has a poor track record in obstetric care of implementing medical procedures later proven to be unnecessary or harmful. Even today, where evidence of harm exists and procedures are proven unnecessary, some medical procedures remain in widespread use.

### III. OBSTETRIC CARE TODAY: PREGNANCY AND MODERN DAY MEDICAL INTERVENTIONS

Today many women envision an ideal childbirth occurring in a sterile environment in which they are surrounded by machinery and hospital staff, lying on a hospital bed with an intravenous line of medication numbing the pain, and are required to push only minimally before a baby appears. The medicalization of childbirth over the past several

<sup>51</sup> Alisa B. Goldberg & Deborah A. Wing, *Induction of Labor: The Misoprostol [Cytotec] Controversy*, 48 J. MIDWIFERY & WOMEN'S HEALTH 244, 244 (2003). Cytotec is approved by the FDA only as an oral medication used to prevent stomach ulcers. Marsden Wagner, *Misoprostol (Cytotec) for Labor Induction: A Cautionary Tale*, 49 MIDWIFERY TODAY 31, 31–33 (1999); *Misoprostol (Marketed as Cytotec) Information*, U.S. FOOD AND DRUG ADMIN. (Feb. 26, 2013), <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111315.htm> [hereinafter *Misoprostol Information*].

<sup>52</sup> Kate Greenwood, *The Mysteries of Pregnancy: The Role of Law in Solving the Problem of Unknown but Knowable Maternal–Fetal Medication Risk*, 79 U. CIN. L. REV. 267, 277 (2011).

<sup>53</sup> Wagner, *supra* note 51, at 32.

<sup>54</sup> Goldberg, *supra* note 51, at 244 (claiming that Misoprostol or Cytotec is safe but still not FDA-approved for this use).

<sup>55</sup> *Misoprostol Information*, *supra* note 51.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Misoprostol Information*, *supra* note 51.

decades has drastically changed the knowledge and comfort women have throughout pregnancy and childbirth.<sup>59</sup>

Today our culture often breeds fear around childbirth through graphic educational videos shown to young girls to prevent sexual activity,<sup>60</sup> the media,<sup>61</sup> and horror stories from friends and family—all depicting childbirth as a negative experience fraught with unbearable pain.<sup>62</sup> For example, the “reality” television series, “A Baby Story,” reinforces women’s fears about pain in childbirth and mirrors the medicalized model.<sup>63</sup> Because there are many uncontrollable unknowns about labor (e.g., when it will begin, duration, level of pain), for some women it is more appealing to be able to schedule an induction, ask for an epidural, or schedule a cesarean section surgery.<sup>64</sup>

However, for the 4 million women giving birth in the United States each year,<sup>65</sup> pregnancy and childbirth are empowering rites of passage and a physiologically natural journey that results in the joy of delivering a new life into the world. No doubt, there is pain. There are also situations in which there *should* be medical interventions, but for the vast majority, childbirth with the least amount of intervention is best for both mother and baby:

With appropriate support and protection from external interference, childbearing women and their fetuses/newborns experience innate, mutually regulating, hormonally driven processes that have developed during human evolution. These processes facilitate the period from the onset of labor through birth of the baby . . . as well as the establishment and continuation of breastfeeding and the development of mother-baby attachment. . . . When facilitated, these . . . functions overwhelmingly succeed in conferring a cascade of physical, psychological, and social benefits for the mother-baby dyad[,] . . . [and] [w]hen caregivers recognize and give priority to these capacities, mothers and babies experience these

<sup>59</sup> See Sarah Jane Brubaker & Heather E. Dillaway, *Medicalization, Natural Childbirth and Birthing Experiences*, 3 SOC. COMPASS 31, 31–48 (2009) (calling for a “renewed examination of the medicalization of childbirth from a critical perspective”).

<sup>60</sup> See Kristina Hofberg & I.F. Brockington, *Tokophobia: An Unreasoning Dread of Childbirth: A Series of 26 Cases*, 176 BRITISH J. PSYCHIATRY 83, 83 (2000) (dread or phobic avoidance of pregnancy and childbirth may date from adolescence . . .).

<sup>61</sup> See Sarah Clement, *Television Gives a Distorted Picture of Birth as Well as Death*, 317 BRITISH MED. J. 284, 284 (1998); Tiffany L. Holdsworth-Taylor, *Portrayals of Childbirth in the Media: Is It Causing Women to Fear?*, 18 INTERNATIONAL DOULA MAGAZINE 1, available at <http://www.naturalmothering.ca/index.php/pregnancy-a-labour/126-portrayals-of-childbirth-in-the-media-is-it-causing-women-to-fear.html> (“In sum, the media has seldom depicted childbirth accurately. Danger means high ratings, so normalcy has no value . . . the demands of commercial television and film have lead [sic] to the propagation of many myths and misconceptions about labour [sic] and birth . . . Women and girls raised on this sort of thing without a source of more accurate knowledge learn to equate labour pain with danger. Pain is portrayed as if it could be fatal.”).

<sup>62</sup> Katharine M. Hikel, *The Real Risks for Cesareans: An Expert Interview with Pamela K. Spry, B.S.N., M.S., C.N.M., Ph.D., Medscape Ob/Gyn & Women’s Health*, MEDSCAPE.COM (July 22, 2009), <http://www.medscape.com/viewarticle/706095>.

<sup>63</sup> Alicia VandeVusse & Leona VandeVusse, *Reality Television as a Source of Information About Birth: The Messages and Their Implications*, 53 J. MIDWIFERY & WOMEN’S HEALTH 482, 482 (2008).

<sup>64</sup> Hikel, *supra* note 62.

<sup>65</sup> Joyce A. Martin et al., *supra* note 3, at 6.

benefits and avoid risk of known [and unknown] harms of avoidable, medically unnecessary interventions. By mobilizing these capacities, caregivers also humanize childbirth, show respect to women and fetuses/newborns as agents of these processes, enable all involved parties to experience the remarkable competence of birthing women and newborns, strengthen mother-baby bonds, and foster a uniquely fulfilling and empowering experience . . .<sup>66</sup>

Unfortunately, many studies show that instead of allowing the natural, physiological progression of labor and delivery to occur, medical interventions, whether necessary or unnecessary, are used with extraordinary frequency.<sup>67</sup>

In a survey of over 1500 women who gave birth in 2005, 94% of those surveyed had electronic fetal monitoring,<sup>68</sup> which can often lead to false signals of distress that then lead to unnecessary cesarean sections.<sup>69</sup> Over 50% had experienced attempted labor inductions via drugs or other techniques.<sup>70</sup> The use of synthetic oxytocin (57%) or rupture of membranes (65%) to induce or augment labor had been used,<sup>71</sup> which can lead to adverse effects on the mother and baby, including uterine rupture, fetal distress and, unnecessary cesarean section surgeries.<sup>72</sup>

Approximately 76% of women surveyed had been given epidural or spinal analgesia (pain medication).<sup>73</sup> These pain medications result in zero mobility from the waist down 100% of the time<sup>74</sup> and confine women to the hospital bed instead of employing various birthing positions to help progress labor.<sup>75</sup> Pain medication, specifically epidurals, has been shown to actually slow the progression of labor—requiring additional pain medication or other interventions.<sup>76</sup>

One quarter of the women surveyed had still been given an episiotomy,<sup>77</sup> a procedure no longer recommended by the American Medical Association (AMA) or American College of Obstetricians and Gynecologists (ACOG).<sup>78</sup> Of the over 1500 women surveyed, 68% gave birth vaginally and 32% experienced a cesarean.<sup>79</sup> And while there are countless known benefits to breastfeeding, several hospital practices interfere

<sup>66</sup> SAKALA & CORRY, *supra* note 5, at 25–26.

<sup>67</sup> *Id.* at 25–28 (reflecting the results of a 2005 “Listening to Mothers II” survey in which over 1500 women help clarify the extent to which they experienced obstetric interventions during childbirth, information that is not always consistently or accurately documented in medical records).

<sup>68</sup> *Id.* at 25–28.

<sup>69</sup> Domin, *supra* note 38, at 507 (“[T]he use of an external fetal monitor (EFM) during labor and delivery may lead to a false positive of fetal distress, which in turn, convinces the physician to perform a cesarean section, a very invasive surgery, when not actually necessary. In 1978, doctors performed an estimated 96,500 cesarean sections for this reason.”).

<sup>70</sup> SAKALA & CORRY, *supra* note 5, at 25–28.

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> Penny Simkin, *Moving Beyond the Debate: A Holistic Approach to Understanding and Treating Effects of Neuraxial Analgesia*, 39 BIRTH 327, 329 (2012).

<sup>77</sup> SAKALA & CORRY, *supra* note 5, at 25–28.

<sup>78</sup> *See id.*

<sup>79</sup> *Id.*

with breastfeeding — even for women who intended to exclusively breastfeed. In fact, 39% of newborns were taken from the mothers during the first hour after birth<sup>80</sup> (the most critical physiological time to establish latching and bonding).<sup>81</sup> And 66% of mothers were given formula samples.<sup>82</sup> The hospital also gave babies formula or water supplement (38%) or a pacifier (44%) which can disrupt the establishment of breastfeeding.<sup>83</sup>

These and other common interventions disrupt and preclude the physiologic capacities of the childbirth process and incur a cascade of secondary interventions used to monitor, prevent, and treat the side effects of the initial interventions . . . As one intervention justifies or increases the likelihood of using others, the cumulative effect is to create a distorted understanding of childbirth as a time when things are likely to go wrong and intensive medical management is required . . .<sup>84</sup>

Nurses administer induction and pain medication intravenously, often without women's consent and under the guise of making women more comfortable. However, induction drugs come with their own set of risks and pain medication often slows the natural labor progression.<sup>85</sup> If labor then fails to progress quickly enough or complications occur, doctors often perform a cesarean section. "The cesarean section rate in the U.S. rose 50% between 1996 and 2006 while epidurals, a rarely used anesthetic before the 1990s, have become a dominant form of obstetrical anesthesia."<sup>86</sup> These common practices are leading to a distorted view of what pregnancy and childbirth should be and are putting women and babies at significant risk.<sup>87</sup>

*A. A Human Right to Healthcare: Proper Prenatal Care, Bodily Autonomy, and Informed Consent*

Inducing labor before a woman's body is physiologically and biologically ready can result in premature babies, extended and more painful labor, medication-related side effects, unnecessary cesarean surgeries, and even the death of mother and baby.<sup>88</sup> Many

<sup>80</sup> SAKALA & CORRY, *supra* note 5, at 25–28; see also Sari Goldstein Ferber & Imad R. Makhoul, *The Effect of Skin-to-Skin Contact (Kangaroo Care) Shortly After Birth on the Neurobehavioral Responses of the Term Newborn: A Randomized, Controlled Trial*, 113 PEDIATRICS 858 (2004). Hospitals often have different procedures dictating when and how routine care is provided, some hospitals for example, will check APGAR scores while the baby is on the mother's chest during the first one to five minutes after birth. For an explanation of newborn screening procedures and why, see *Baby's First Test*, HEALTH RESOURCE AND SERVICE ADMINISTRATION, <http://www.babysfirsttest.org/screening-procedures#WhyAre> (last visited Mar. 3, 2012).

<sup>81</sup> SAKALA & CORRY, *supra* note 5, at 25–28.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> SAKALA & CORRY, *supra* note 5, at 28.

<sup>85</sup> Eugene Declercq, Mary Barger & Judith Weiss, *Contemporary Childbirth in the United States: Interventions and Disparities*, in REDUCING RACIAL/ETHNIC DISPARITIES IN REPRODUCTIVE AND PERINATAL OUTCOMES 401, 405 (Arden Handler et al. eds., 2011), available at [http://link.springer.com/content/pdf/10.1007%2F978-1-4419-1499-6\\_16](http://link.springer.com/content/pdf/10.1007%2F978-1-4419-1499-6_16).

<sup>86</sup> See *id.* at 402.

<sup>87</sup> See *id.* at 401.

<sup>88</sup> Simpson, *supra* note 19, at 43–44; see also, AMNESTY INTERNATIONAL, *supra* note 4, at 79 ("Inducing labor significantly increases the likelihood of a c-section for first-time mothers when the cervix is not ready

women are not properly informed or educated about the risks involved with inductions and cesarean sections.<sup>89</sup> These practices have become so common that many women are asking for elective, planned inductions or cesareans without realizing the risks involved.<sup>90</sup>

For instance, a woman is four times more likely to die having a cesarean section than a vaginal birth.<sup>91</sup> Yet cesarean section surgery became the most common operating room procedure in the country in 2008, performed on 1.4 million women.<sup>92</sup> While rates vary across states,<sup>93</sup> “the 2009 cesarean rate of 32.9% marked the 13th consecutive year of increase and a record-level national rate.”<sup>94</sup> In 1978, it was estimated that 96,500 unnecessary cesarean sections were performed for fear of litigation, and this number has risen over the past three decades.<sup>95</sup> One of several important objectives of Healthy People 2020, an initiative three decades in the making by the U.S. Department of Health and Human Services to improve the nation’s health, is to reduce cesarean births among low-risk women giving birth for the first time. In 2007, the number of caesarean births among this population reached an all-time high of 26.5% and continues to rise.<sup>96</sup>

These statistics show a marked increase in the use of interventions over the past several decades with no indication of a leveling out or decrease on the horizon. Many pregnant women lack adequate knowledge and power to control their pregnancy and

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for labor and has been associated with a higher risk of hemorrhage. A national survey found that 25% of women who had either a primary or repeat c-section reported feeling pressurized by a health provider to have a c-section; 11% reported pressure to induce labor. According to the survey, only 16% of white women had any choice in the decision about episiotomy (a surgical incision through the perineum); for African-American women the figure was only 4%.”).

<sup>89</sup> Vani R. Bettgowda, et al., *The Relationship Between Cesarean Delivery and Gestational Age Among US Singleton Births*, 39 CLINICS IN PERINATOLOGY 309, 309–23 (2008), available at <http://www.mdconsult.com.turing.library.northwestern.edu/das/article/body/285879022-2/jorg=journal&source=&sp=20648270&sid=0/N/642457/1.html?issn=0095-5108>.

<sup>90</sup> *Id.* at 311 (“[The] sharp increase in primary cesarean section rates, which may further increase subsequent cesarean delivery rates considering that women who have a primary cesarean section are increasingly likely to be delivered by repeat cesarean section. Cesarean section rates also vary by maternal race/ethnicity, with the highest cesarean section rates for women who were non-Hispanic black (32.6%), followed by non-Hispanic white (30.4%) and Hispanic (29.0%) women. Between 1996 and 2005, these rates have increased substantially for all maternal racial/ethnic groups, with an increase of 50% for non-Hispanic black women, 46% for non-Hispanic white women, and 45% for Hispanic women. The increasing rates of cesarean delivery provide a picture of changing maternal risks and obstetric practice patterns in the United States.”).

<sup>91</sup> JENNIFER BLOCK, *PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE*, Introduction p. xix (2007).

<sup>92</sup> *United States Maternity Care Facts and Figures*, CHILDBIRTH CONNECTION, available at <http://transform.childbirthconnection.org/resources/datacenter/factsandfigures/> (Dec. 2012).

<sup>93</sup> *Id.* (“The cesarean rate varied across states in 2009, from a low of 22.8% in New Mexico to a high of 39.6% in Louisiana, and was 48.0% in Puerto Rico.”).

<sup>94</sup> *Id.*; see also, “The national cesarean rate has increased annually from the mid-1990s and has reached a record level each successive year of the present century.” SAKALA & CORRY, *supra* note 5, at 2 (in relative short periods of time—less than ten years—the national cesarean rate rose by 50%, medically induced labors rose by 135%, from 9.5 to 22.3%, and the most common gestational age of infants dropped from forty to thirty-nine weeks.).

<sup>95</sup> Domin, *supra* note 38, at 507.

<sup>96</sup> *Healthy People 2020 Summary of Objectives: Maternal, Infant, and Child Health*, U.S. DEPT. OF HEALTH & HUMAN SERVICES, <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26> (last visited Oct. 30, 2012).

childbirth experience.<sup>97</sup> As a result, mothers and babies are paying a high price for efficiency and “innovation”—sometimes even with their lives.<sup>98</sup>

Physicians should respect women’s autonomy to make decisions about interventions and educate women during prenatal visits. Instead, women’s autonomy is being stripped away and a growing “us vs. them” sentiment is emerging between women and their obstetricians.<sup>99</sup> Many women are asked to make important consent decisions while in the throes of labor<sup>100</sup> and most feel they lack the power to refuse a course of treatment.<sup>101</sup>

Multiple factors contribute to a failure to support physiologically natural childbirth with as little medical intervention necessary for a healthy mother and baby. A lack of access to proper prenatal care,<sup>102</sup> physicians’ failure to educate pregnant women about their options, violations of autonomy, and women’s right to informed consent are all contributing factors. Amnesty International reports that barriers to proper prenatal care and the lack of informed consent are serious human rights violations and significant factors contributing to the dramatically high rate at which medical interventions are being performed on women.<sup>103</sup>

As pressures mount to maximize the efficiency of obstetric practices, the “health care provider has evolved into the reluctant business person” which “often translates into hectic doctor-patient office visits that reflect a sense of ‘prenatal surveillance’ more than prenatal care and education.”<sup>104</sup> As with many businesses trying to streamline their processes, pregnant women are pushed along the assembly line: enter doctor’s office, wait to be seen, urinate into a cup, get weighed and have blood pressure taken, wait to be seen, brief physical examination, and out the door. While physicians often schedule patient visits in fifteen-minute allotments, the average time a patient spends face-to-face with the doctor is eight to ten minutes.<sup>105</sup> The average time a patient spends waiting is

<sup>97</sup> Baker, *supra* note 1, at 543, 559; *see also* Jane Staton Savage, *The Lived Experience of Knowing in Childbirth*, 15 J. PERINAT. EDUC. 10, 10–24 (2006).

<sup>98</sup> Baker, *supra* note 1, at 570–71 (“Despite society’s casual attitude toward the procedure, cesarean section delivery is surgery and carries with it all the risks and complications of major medical intervention. For the mother, the risks include anesthesia reactions, infection, hemorrhage, bladder and uterine lacerations, internal scarring, painful sexual intercourse, and accidental death, just to list a few.”).

<sup>99</sup> Lateefah Torrence, *The Birth Plan Debate: When Did it Become Us vs. Them?*, NATIONAL PUBLIC RADIO (July 14, 2011, 2:29 PM), <http://www.npr.org/blogs/babyproject/2011/07/15/137827510/the-birth-plan-debate-when-did-it-become-us-vs-them>.

<sup>100</sup> SAKALA & CORRY, *supra* note 5, at 8 (“[It is a] challenge for women [to make] informed decisions about many crucial care matters while in labor and [the circumstances place] constraints on their choice at that time.”).

<sup>101</sup> *Understanding and Navigating the Maternity Care System; Informed Decision Making*, CHILDBIRTH CONNECTION, <http://www.childbirthconnection.org/printerfriendly.asp?ck=10081> (last visited Jan. 17, 2013).

<sup>102</sup> SAKALA & CORRY, *supra* note 5, at 25–28.

<sup>103</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 79–80.

<sup>104</sup> Christine Robillard Isaacs, *Group Prenatal Care: A New Model for Obstetric Practice*, 30 POSTGRADUATE OBSTETRICS & GYNECOLOGY 1, 1 (2010). *See also* Michael C. Lu, *Healthcare Reform and Women’s Health: A Life-Course Perspective*, 22 CURRENT OPINION IN OBSTETRICS AND GYNECOLOGY 487, 491 (2010) (discussing the need to restructure physician reimbursement plans so as to correct the perverse incentive for providers to rush through visits).

<sup>105</sup> Isha Patel, et al., *Patient Satisfaction with Obstetricians and Gynecologists Compared with Other Specialties: Analysis of U.S. Self-Reported Survey Data*, 2 PATIENT RELATED OUTCOME MEASURES 23 (2011).

twenty-five to thirty minutes.<sup>106</sup> Some studies show that patients speak for an average of twenty-three seconds before their physician interrupts them.<sup>107</sup> Short, impersonal visits result in patient dissatisfaction and physician burnout.<sup>108</sup>

Rarely, if ever, are important topics discussed, such as fetal development, maternal nutrition, risks of smoking and alcohol use, labor and delivery expectations, and breastfeeding and maternal depression.<sup>109</sup> Instead, these topics are “often outsourced to separate classes or independent learning performed by the patient of her own ambition.”<sup>110</sup> On the other hand, physicians take the Hippocratic Oath<sup>111</sup> and are required to adhere to a code of ethics. “The Code reminds members of their ethical obligations, provides standards, . . . and clarif[ies] the nature of the fiduciary relationship.”<sup>112</sup> “Ethics codes remind the professional that [their] knowledge is to be used to further the public’s and the patient’s interests, rather than the professional’s self-interest.”<sup>113</sup> Therefore, informed consent and safe, evidence-based care should take precedence over efficiency or profitability.<sup>114</sup>

While obstetricians and hospital staff have become proficient at making the birth experience at the hospital as profitable as possible, the experience for mothers during childbirth is dehumanizing. For example, if a woman presents with signs of labor but the labor does not progress fast enough, nurses push Pitocin to increase contractions. The contractions increase in intensity and pain, the woman asks for relief, so nurses push pain medication. Then the labor progression slows as a result, more Pitocin is administered and the cycle continues until finally labor has progressed to the point of pushing, or in 32.9% of situations such as these, the woman undergoes an invasive cesarean section surgery to remove the baby.<sup>115</sup> Each time there is an intervention, hospital profits increase as the risk to mothers and babies also increases.<sup>116</sup>

<sup>106</sup> *Id.*

<sup>107</sup> *The Doctor Will See You – If You’re Quick*, NEWSWEEK (Apr. 16, 2012 12:00 AM), <http://www.thedailybeast.com/newsweek/2012/04/15/why-your-doctor-has-no-time-to-see-you.html>; Sarah Varney, *What’s Up, Doc? When Your Doctor Rushes Like The Road Runner*, NPR.ORG, (May 24, 2012 4:01 PM), <http://www.npr.org/blogs/health/2012/05/24/153583423/whats-up-doc-when-your-doctor-rushes-like-the-road-runner>.

<sup>108</sup> Virginia Adams O’Connell, et al., *Physician Burnout: The Effect of Time Allotted for a Patient Visit on Physician Burnout Among OB/GYN Physicians*, MED. PRAC. MGMT. 1, 2 (2009).

<sup>109</sup> Technical Assistance Paper, U.S. Department of Health and Human Services, *Giving Children the Earliest Head Start: Developing an Individualized Approach to High-Quality Services for Pregnant Women* (August 2000), <http://www.ehsnrc.org/pdf/files/tano3.pdf>.

<sup>110</sup> Isaacs, *supra* note 105, at 1

<sup>111</sup> Clifford Perlis, et al., *Role of Professional Organizations in Setting and Enforcing Ethical Norms*, 30 CLINICS IN DERMATOLOGY 156, 157 (2012).

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> Kathleen Rice Simpson & Kathleen E. Thorman, *Obstetric “Conveniences” Elective Induction of Labor, Cesarean Birth on Demand, and Other Potentially Unnecessary Interventions*, 19 J. PERINATAL & NEONATAL NURSING 2, 134– 44 (2005). Countless publications analyze and discuss efficiency in healthcare and health policy, *see, e.g.*, ROWENA JACOBS, ET AL., MEASURING EFFICIENCY IN HEALTH CARE (2006); Alan M. Garber & Jonathan Skinner, *Is American Health Care Uniquely Inefficient?*, (NATIONAL BUREAU OF ECONOMIC RESEARCH, Working Paper No.14257, 2008).

<sup>115</sup> Joyce A. Martin et al., *supra* note 3, at 13.

<sup>116</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 79; SAKALA & CORRY, *supra* note 5, at 35; Judith A. Lothian, *Safe, Healthy Birth: What Every Pregnant Woman Needs to Know*, 18 J. PERINATAL EDUC. 48, 48 (2009).



#### IV. SYSTEMATIC PROBLEMS AND PERVERSE INCENTIVES DETERIORATE THE OBSTETRIC PROFESSION: DEFENSIVE MEDICINE, MALPRACTICE INSURANCE, FEE-FOR-SERVICE INCENTIVES, FOR-PROFIT HOSPITALS, AND INSURANCE COMPANIES

There are fundamental, widespread, and systematic issues infesting the healthcare system, causing medical errors and tainting the maternal experience in the United States.<sup>117</sup> Certainly, obstetricians are not solely to blame for the problems with obstetric patient care.<sup>118</sup> Obstetricians are not resistant to improving or advancing their practices, but many just simply do not have the time to focus on research and continued education because they must find ways to pay for rising costs of practice.<sup>119</sup>

Some believe the vicious cycle that obstetricians have become a party to—which violates not only medical ethics but also women’s rights—stems from increased medical malpractice insurance premiums. Others believe that the “fee-for-service” reimbursement programs provide greater incentive for doctors to over utilize services and perform unnecessary procedures because they are paid for each individual service performed.<sup>120</sup> Another theory is that the transition from nonprofit insurance companies and hospitals into for-profit institutions has resulted in an increased need for efficiency and revenue generating for investors.<sup>121</sup> Many studies have focused on the belief that our overly litigious society has created a practice called “defensive medicine.” Others believe that the entire tort and medical malpractice legal system is in need of reform. Each of these theories will be addressed in turn below. While the myriad of issues are intertwined, the hope is that many of them could be resolved or significantly improved through healthcare reform.

##### A. Malpractice Insurance Costs

Many obstetricians cite the exorbitant cost of purchasing malpractice insurance as a reason for leaving the profession.<sup>122</sup> Ironically, this decrease in the availability of

<sup>117</sup> Clinton & Obama, *supra* note 37, at 2205 (“[One] statistic from the landmark 1999 Institute of Medicine (IOM) report [states] that as many as 98,000 deaths in the United States each year result from medical errors. But the IOM also found that more than 90% of these deaths are the result of failed systems and procedures, not the negligence of physicians.”).

<sup>118</sup> See generally SAKALA & CORRY, *supra* note 5.

<sup>119</sup> See Domin, *supra* note 38.

<sup>120</sup> See SAKALA & CORRY, *supra* note 5, at 35.

<sup>121</sup> See David M. Cutler & Jill Horwitz, *Converting Hospitals from Not-for-Profit to For-Profit Status*, in THE CHANGING HOSPITAL INDUSTRY: COMPARING FOR-PROFIT AND NOT-FOR-PROFIT INSTITUTIONS 64 (David M. Cutler ed., 2000) chapter available at, <http://www.nber.org/chapters/c6759>; *Understanding Medical Malpractice Insurance: A Primer*, 12 available at [http://www.rwjf.org/pr/synthesis/reports\\_and\\_briefs/pdf/no8\\_primer.pdf](http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no8_primer.pdf). (discussing the skyrocketing insurance premiums between 1999–2002 and the increase since, even after the transition to for-profit steadied)

<sup>122</sup> Domin, *supra* note 38, at n.22 (“The unavailability of obstetric services also results from the increasing cost and number of medical malpractice suits affecting obstetricians, which also lead to increases in insurance premiums . . . A study examining the reasons why physicians stop practicing obstetrics concluded that the personal involvement of obstetricians with medical malpractice claims has a direct relationship with the decision to discontinue obstetric practice . . . [T]he experience of defending one

obstetric care also increases malpractice insurance premiums.<sup>123</sup> While unnecessary medical procedures violate medical ethics and basic human rights to bodily autonomy, some say that obstetricians make these decisions because the cost of being in business is exorbitant.<sup>124</sup> Medical malpractice premiums force doctors to turn away patients or refuse to perform certain high risk procedures in order to stay in business. “One in 10 obstetricians have [sic] stopped delivering babies, unable to pay malpractice premiums on the order of \$1,000 per baby, according to the American College of Obstetricians and Gynecologists (ACOG).”<sup>125</sup> “Some hospitals . . . have stopped delivering babies altogether; and the number of unnecessary caesarian sections have increased to the detriment of the health of mothers, according to the ACOG.”<sup>126</sup>

“[The medical malpractice insurance] system focuses on the misdeeds of individual healthcare providers, but medical errors are often due to breakdowns in whole systems of care.”<sup>127</sup> Yet the premiums place a disproportionate amount of the burden on the shoulders of individual obstetricians and, as a result, patient safety is compromised.<sup>128</sup>

Liability and malpractice premium increases have recently become “meteoric.”<sup>129</sup> “For instance, in 1960, overall medical malpractice insurance costs were \$60 million, but by 1991 they had risen over a hundred-fold to \$5.6 billion.”<sup>130</sup> “More recently, annual professional liability insurance premiums have reached \$10 billion nationwide.”<sup>131</sup> “On the individual level, these costs are evidenced in the doubling and even tripling of premiums, with some as high as \$200,000 per year for obstetricians in [some geographic areas].”<sup>132</sup>

The “ACOG outlines the following problems as part of the larger maternal healthcare access crisis: fewer obstetric providers, a rural crisis, community clinic cutbacks, less prenatal care, [and] less preventative healthcare.”<sup>133</sup> The high malpractice premiums may certainly be contributing to the decline in obstetric providers, the rural crisis, and community clinic cutbacks. This results in less or poor prenatal and preventative healthcare overall.

### B. *Fee-for-Service System and Hospitals as Businesses*

Whether hospitals are not-for-profit or for-profit, there is no significant evidence that the quality of care is any better or worse depending upon the status. But both non-

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malpractice claim does not lead the average obstetrician to give up obstetrics; rather, it is a combination of factors . . . [including] the cost of purchasing malpractice insurance, the pervasive fear of being sued, and a general rise in the level of tension in the obstetric suite.”)

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> Philip K. Howard, *Why Medical Malpractice is Off Limits*, WALL STREET JOURNAL (Oct. 15, 2009), <http://online.wsj.com/article/SB10001424052970204488304574432853190155972.html>

<sup>126</sup> *Id.*

<sup>127</sup> *Understanding Medical Malpractice Insurance*, *supra* note 121, at 7.

<sup>128</sup> *Id.* at 6–7.

<sup>129</sup> Domin, *supra* note 38, at n.13 (the resulting behavior might be “different if these insurance hikes were affordable,” however, ACOG has labeled them as “meteoric,” which is no exaggeration).

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> Domin, *supra* note 38, at 537; see also, *Understanding Medical Malpractice Insurance*, *supra* note 121.

profits and for-profits must cut rising healthcare costs.<sup>134</sup> Instead of focusing on teaching medical students to support<sup>135</sup> the natural, physiological process of pregnancy and childbirth, medical students are taught to be efficient and profitable through higher patient turnover and a higher number of services.

*Citizens United* reports that the “the more likely cause of skyrocketing health costs is the fee-for-service system in which medical providers are paid for each service they perform rather than for providing quality care.”<sup>136</sup> Not only are providers paid for each service, but certain services such as inductions, epidurals, and cesarean sections result in higher pay-outs than others.<sup>137</sup> “[I]ncentives arising from service bundling and global fee payment systems [] encourage use of interventions and measures to hasten and control childbirth even though such care generally is not optimal for mothers and babies.”<sup>138</sup>

In addition, Medicare revenues at hospitals have increased and doctors and hospitals are likely exploiting Medicare loopholes.<sup>139</sup> For example, a service which may have previously been billed under one visit is now billed separately, most likely to maintain costs yet maximize revenues, or increase the amount of reimbursement to the doctor or hospital.<sup>140</sup>

Fee-for-service systems provide a perverse incentive for obstetricians to throw out under-utilized, evidence-based care in order to obtain the highest payment for services and squeeze as many paid procedures into schedules as possible. As a result, doctors induce labor or plan cesarean sections in an effort to not only increase payments for labor and delivery services, but also expedite the process and increase patient turnover.

Both inductions and cesarean sections cost patients and insurance companies more money than vaginal deliveries. The average complicated cesarean costs \$16,000 versus just \$7,000 for an uncomplicated vaginal birth in a hospital or a mere \$1,600 for a vaginal birth in a birthing center<sup>141</sup> outside a hospital (often attended by a midwife).<sup>142</sup> Inductions lead to an increased likelihood of cesarean section and cesareans require women to undergo more cesareans in future pregnancies and require more extensive postnatal care. For-profit entities are choosing the more invasive, unnecessary treatments in order to pay malpractice premiums and to maintain profits to satisfy investors.<sup>143</sup>

<sup>134</sup> Cutler & Horwitz, *supra* note 121.

<sup>135</sup> See Falker, *supra* note 25, at 14 and n.177.

<sup>136</sup> *Setting the Record Straight on Medical Liability Limits: Tort “Reform” Hurts Patients, Costs Billions, and Shields Those Who Cause Harm*, PUBLIC CITIZEN (2010) available at [http://www.citizen.org/documents/Medical\\_Malpractice\\_Fact\\_Sheet.pdf](http://www.citizen.org/documents/Medical_Malpractice_Fact_Sheet.pdf)

<sup>137</sup> See SAKALA & CORRY, *supra* note 5, at 35.

<sup>138</sup> *Id.* at 8.

<sup>139</sup> David M. Cutler & Jill Horwitz, *Converting Hospitals from Not-for-Profit to For-Profit Status*, in *THE CHANGING HOSPITAL INDUSTRY: COMPARING FOR-PROFIT AND NOT-FOR-PROFIT INSTITUTIONS* 64 (David M. Cutler ed., 2000) chapter available at, <http://www.nber.org/chapters/c6759>.

<sup>140</sup> *Id.* at 67–68 (suspecting that the rise in Medicare reimbursements is due to exploiting Medicare “loopholes” that allows hospitals to admit a patient for once service (e.g., hospitalization) and then move the patient for another service arising out of the same treatment needs (e.g., rehabilitation), effectively collecting two payments for the same service.

<sup>141</sup> SAKALA & CORRY, *supra* note 5, at 2.

<sup>142</sup> *Id.* at 30.

<sup>143</sup> See Woolhandler & Himmelstein, *supra* note 41, at 1–2.

### C. *For-Profit Insurance and Hospitals*

It was inevitable that someone would realize obstetric healthcare was big business.<sup>144</sup> In fact, the top five annual hospital charges in 2008 include two pregnancy-related conditions: the mother's pregnancy and delivery (\$22 billion to Medicaid and \$30 billion to private insurers) and newborn infants (\$19 billion to Medicaid and \$21 billion to private insurers).<sup>145</sup> Some suggest that when nonprofit insurance companies and hospitals transitioned to for-profit entities, the industry's focus changed from patient satisfaction to shareholder satisfaction.<sup>146</sup>

Today, those who argue against "universal healthcare" fail to realize that the government is already shouldering a form of healthcare coverage that only covers a small percentage of the population but costs more than Canada's universal healthcare system.<sup>147</sup> "In 2008, two government payers, Medicare and Medicaid, bore responsibility for 60% of the national hospital bill."<sup>148</sup> And there seems to be some discrepancy between what the government pays and what private insurers pay for the same services: "[a]lthough the cost of prenatal care for Medicaid and privately insured women was similar, the hospital component of care for privately insured women was about \$2,000 more than the hospital component for women with Medicaid coverage."<sup>149</sup>

According to the Universal Declaration of Human Rights, all people have a right to the health care they need.<sup>150</sup> Yet women are more likely than men to forgo needed health care due to cost-related access barriers.<sup>151</sup> The report by Amnesty International discusses the high number of women who are uninsured or underinsured and must go to great lengths to obtain healthcare when they are pregnant or giving birth.<sup>152</sup>

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals cannot turn away a woman in labor, regardless of her ability to pay. However EMTALA does not protect a woman from being billed for care after delivery, which may send her into debt or bankruptcy, especially following a c-section or a complication requiring additional medical intervention. While some hospitals sometimes write off these bills as charitable care if a woman cannot pay, this is not always the

<sup>144</sup> Healthcare in general is big business, not just obstetric healthcare. The nation's hospitals billed nearly \$1.2 trillion in total charges in 2008 for 39.9 million hospital stays. For more details, *see generally* Lauren M. Wier & Roxanne M. Andrews, *The National Hospital Bill: The Most Expensive Conditions by Payer, 2008*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (March 2011), *available at* <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb107.pdf>.

<sup>145</sup> *Id.* at 3.

<sup>146</sup> Cutler & Horwitz, *supra* note 121.

<sup>147</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 28 ("The most recent in-depth study found that approximately 31% of U.S. health care costs, more than US\$1,000 per person, was spent on administrative services in 1999, more than three times the amount spent in Canada (US\$307) which has a national single payer system.")

<sup>148</sup> Wier & Andrews, *supra* note 144, at 2.

<sup>149</sup> SAKALA & CORRY, *supra* note 5, at 3.

<sup>150</sup> NATIONAL ECONOMIC AND SOCIAL RIGHTS INITIATIVE, WOMEN AND THE HUMAN RIGHT TO HEALTH CARE: A PERSPECTIVE ON THE FEDERAL HEALTH REFORM LAW 1 (June 2010) [hereinafter NESRI Report], *available at* [http://www.dghonline.org/files/page\\_attachments/Women\\_health\\_reform\\_factsheet\\_0-1.pdf](http://www.dghonline.org/files/page_attachments/Women_health_reform_factsheet_0-1.pdf).

<sup>151</sup> *Id.*

<sup>152</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 38–39.

case. EMTALA also fails to guarantee prenatal and postpartum care as well as any treatment beyond “stabilizing” any health emergencies during pregnancy or birth.<sup>153</sup>

Hospitals are also able to charge patients differently for the same services, depending upon insurance coverage status.

“In most states, insurers are currently allowed to consider gender when setting premium rates in the individual health insurance market, where people buy coverage directly from insurance companies. As a result of ‘gender rating,’ women are often charged more than men for the exact same coverage.”<sup>154</sup> Fortunately, PPACA prohibits most uses of gender rating by insurers and “pregnant women can no longer be charged higher premiums.”<sup>155</sup>

In addition, co-payments for particular preventative services will be eliminated,<sup>156</sup> thereby facilitating better health prior to conception and better overall women’s health. On the other hand, there are major barriers that PPACA does not resolve. For example, “prohibition of gender rating will not apply to firms with over 100 employees, which may keep coverage more expensive in firms that employ a mostly female workforce.”<sup>157</sup> And the “[s]hortage of health professionals, including family doctors, midwives, and pharmacies in many rural areas” will continue to exist.<sup>158</sup> The PPACA promises to start leveling the playing field for women and provide greater access to healthcare, but certain barriers will remain.

#### D. *Defensive Medicine*

“Defensive medicine,<sup>159</sup> a strategy of using tests and procedures primarily to thwart potential litigation rather than to advance the well-being of patients, is widely deplored as a growing blight on medical practice that raises health care costs, compromises the physician’s professional integrity, and drives a wedge through the doctor–patient relationship.”<sup>160</sup> Instead of encouraging natural childbirth, many doctors practice defensive medicine and unnecessarily intervene in order to avoid liability.<sup>161</sup>

Many clinicians are reluctant to admit making decisions based on the fear of litigation and conflicting studies on the practice exist.<sup>162</sup> However, a 2009 ACOG survey

<sup>153</sup> *Id.* at 39.

<sup>154</sup> NATIONAL WOMEN’S LAW CENTER, HEALTH CARE: MAKING THE GRADE ON WOMEN’S HEALTH, available at <http://hrc.nwlc.org/policy-indicators/gender-rating-individual-health-insurance-market>.

<sup>155</sup> NESRI Report, *supra* note 150, at 3.

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

<sup>159</sup> Deville, *supra* note 39, at 570 (“The American Medical Association (AMA) has defined defensive medicine as the “performance of diagnostic tests and treatments which, but for the threat of a malpractice action would not have been done.”).

<sup>160</sup> Abigail Zuger, *Dissatisfaction with Medical Practice*, 350 N. ENGL. J. MED. 69, 72 (Jan. 2004).

<sup>161</sup> See Anna Mavroforou, Evgenios Koumantakis & Emmanuel Michalodimitrakis, *Physicians’ Liability in Obstetric and Gynecology Practice*, 24 MED. LAW 1 (March 2005) (discussing common causes of medical litigation in obstetrics).

<sup>162</sup> See Sen. Orrin G. Hatch, Commentary, *It Is Time to Address the Costs of Defensive Medicine*, 170 ARCH. INTERN. MED. 1083, 1083 (2010); Ken L. Bassetta, Nitya Iyer & Arminee Kazanjian, *Defensive Medicine During Hospital Obstetrical Care: A By-Product of the Technological Age*, 51 SOC. SCI. & MED.

found that almost 60% of obstetricians reported making changes to their practice because of the affordability or availability of liability insurance.<sup>163</sup> Of those, 21% reported reducing the number of high-risk patients, 10% reported reducing the number of births that they attend, and 6.5% had stopped practicing obstetrics altogether.<sup>164</sup> While personal admissions are hard to come by, studies that examine *actual* physician behavior confirm that these decisions are being made at an alarming rate.<sup>165</sup>

Others, including Harvard University health economist Amitabh Chandra, are not convinced that defensive medicine is driving up healthcare costs.<sup>166</sup> While Chandra believes medical malpractice weighs heavily on the minds of practitioners, it may not be the answer to “meteoric” healthcare costs.<sup>167</sup> He theorizes that it balances itself out because while some doctors give more care to avoid liability, others give less care to avoid liability.<sup>168</sup> Nonetheless, while defensive medicine may not explain the rise in healthcare costs, it is clear that the motivation behind these decisions alters patient care.

Some statistics show that there are some positive aspects to the fear of malpractice liability such as an “increased use of . . . written informed consent, more frequent consultations with other physicians, increased attempts to provide written or tape-recorded information to patients, and more frequent explanations of the potential risks of a recommended procedure.”<sup>169</sup> Though these effects are positive, the motivation behind them wreaks havoc on the profession and the negative aspects of defensive medicine create significant risks to the health of mothers and babies.<sup>170</sup>

In addition, the fear of lawsuits has “caused academic medical centers to change the ways in which medical students are taught and evaluated.”<sup>171</sup> For example, some medical schools in the United States teach students to avoid vaginal breech deliveries because “if the baby turns out badly, you are at risk and you will be sued.”<sup>172</sup> Students are told that

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523, 524 (2000); Katherine Baicker & Amitabh Chandra, *Defensive Medicine and Disappearing Doctors?* HEALTH & MED. REG., 24, 24 (2005); Dranove et al., *supra* note 26, at 75.

<sup>163</sup> AMNESTY INTERNATIONAL, *supra* note 4, at 63; *See also* David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in Volatile Malpractice Environment*, 293 JAMA 2609, 2616 (2005) (survey of 824 high-risk physicians, including obstetricians/gynecologist, revealed that 93% practiced defensive medicine).

<sup>164</sup> Amnesty International, *supra* note 4, at 63.

<sup>165</sup> *See generally* Tanya Albert Henry, *Defensive Medicine to Avoid Liability Lawsuits is Widespread*, AMERICAN MEDICAL ASSOCIATION NEWS (posted July 12, 2010) available at <http://www.ama-assn.org/amednews/2010/07/12/prsb0712.htm> (“The vast majority of doctors practice defensive medicine to protect themselves from medical liability lawsuits . . . About nine in ten physicians said doctors order more tests and procedures than patients need so they can protect themselves against lawsuits . . .”); *See* Praveen Dhankhar & M. Mahmud Khan, *Threat of Malpractice Lawsuit, Physician Behavior and Health Outcomes: A Re-Evaluation of Practice of “Defensive Medicine” in Obstetric Care*, MED.-LEGAL STUDIES EJOURNAL, available at <http://ssrn.com/abstract=1443555>; Studdert et al., *supra* note 163, at 2616.

<sup>166</sup> *Here & Now: Health Economist: Problem with Care it is ‘Insulates me from Prices,’* 90.9 WBUR (Jan. 2, 2013) (downloaded using 90.0 WBUR) available at <http://hereandnow.wbur.org/2013/01/02/excess-medical-spending>. Chandra further sites excessive costs caused by both, over-use of medical procedures that do not provide therapeutic value as well as treatment that patients do not want.

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> Falker, *supra* note 25, at 5.

<sup>170</sup> *See generally id.* at 12.

<sup>171</sup> *Id.* at 14.

<sup>172</sup> *See* Falker, *supra* note 25, at n.177

they have a stronger legal position if they perform a cesarean section because of the perception that “you’ve done everything that can be done.”<sup>173</sup>

Virtually the entire focus of medical training is on the detection and treatment of complications of pregnancy and labor and related interventions. The result of this preoccupation is a continual narrowing of the concept of ‘normality’ as obstetricians seek ways to employ their skill at treating and correcting the abnormal. Technology is heavily emphasized; thus, routine use of technology increases, and manual skills are lost through disuse.<sup>174</sup>

However real these fears of litigation are, the perception alone has had a widespread effect on the profession. It appears that medical malpractice litigation has been decreasing for years and is at the lowest level on record, yet healthcare costs continue to rise and doctors are making healthcare decisions based on these fears.<sup>175</sup>

#### *E. Tort Reform Debunked*

Despite the decrease in the quantity of litigated suits, many tout the need for medical liability limits and tort reform to control costs (i.e., jury awards), deter defensive medicine practices,<sup>176</sup> and attract physicians.<sup>177</sup> Several studies found no evidence that tort reform has had any of these effects.<sup>178</sup> “There is no real evidence that the medical liability system deters negligent care. The tort system tends to be defended primarily on the basis of its deterrent effect, but the available evidence suggests that deterrence of

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<sup>173</sup> *Id.* at 12.

<sup>174</sup> *Id.* (discussing the influence of medical textbooks, residency, and day-to-day practice and its impact on obstetricians’ perception of normal birth). Anecdotally, the author’s doctors and nurses throughout the first thirty-seven weeks of her pregnancy did not teach her anything about proper nutrition, exercise, and natural methods of preparing her body for childbirth. The doctor and nurses at the hospital also did not have experience with women who prefer to deliver drug-free, vaginally, and using various birthing positions. In fact, all the nurses in the ward came to witness her labor and delivery because it was not commonplace. *Id.*

<sup>175</sup> Studdert et al., *supra* note 163, at 2616; PUBLIC CITIZEN, *supra* note 40.

<sup>176</sup> Ronen Avraham et al., *The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums*, (National Bureau of Economic Research Working Paper No. 15371, 2009) available at <http://www.nber.org/papers/w15371>. Even studies that uncover positive effects seem to be minimal and limited to particular constituents. This study found that “caps on non-economic damages, collateral source reform, and joint and several liability reform reduced [employer-sponsored] premiums by 1 to 2% each. These reductions are concentrated in PPPOs rather than HMOs, suggesting that HMOs can reduce ‘defensive’ healthcare costs even absent tort reform.”

<sup>177</sup> David A. Hyman et al., *Does Tort Reform Affect Physician Supply? Evidence from Texas*, (Illinois Law, Behavior and Social Science Research Paper No. LBSS12-12, 2012) available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2047433](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2047433) (“Before Texas adopted tort reform in 2003, proponents [of tort reform] claimed that physicians were deserting Texas in droves. After tort reform was enacted, proponents claimed there had been a dramatic increase in physicians moving to Texas due to improved liability climate.” This study found no evidence to support either claim).

<sup>178</sup> This report discusses two states, Colorado and Texas, which implemented tort reform programs. It shows that despite the legal change, these states still have some of the highest health care costs in the country and Texas ordered excessive medical testing at a rate 50% faster than the national average. PUBLIC CITIZEN, *supra* note 40.

medical error is limited at best.”<sup>179</sup> In fact, Public Citizen released a report discouraging liability limits because they are bad policy.<sup>180</sup> While it is difficult to fully assess the effects of tort reform, due to a lack of systematic empirical data, the majority of the studies on the limited data that does exist do not show strong, positive results.<sup>181</sup>

## V. PROPOSED ENHANCEMENTS AND THE PROMISE OF PPACA

### A. *PPACA Legislative History*

President Obama signed the Patient Protection Affordable Care Act (PPACA) into law on March 23, 2010. The PPACA purports to make significant changes across the entire health care system, with many provisions that will improve access to affordable health coverage for women, thereby improving women’s health.<sup>182</sup> The law went into effect in 2010, but many of the changes go into effect over the course of the next several years.

PPACA has been met with significant resistance from employers, insurance companies, and others. In 2012, opponents of the PPACA challenged the constitutionality of the legislation’s individual mandate but the Supreme Court upheld the law. The legislation has changed the landscape of the healthcare industry in the United States.

### B. *Starting Points for Reform*

The PPACA provides several starting points for overall healthcare reform, but falls short of addressing the many complex issues plaguing obstetric care. While the PPACA offers a promise to provide insurance coverage to all women, 23 million people will continue to be uninsured and several regulation loopholes will remain.<sup>183</sup> Many lessons can be learned from other countries regarding universal health care insurance coverage, which provides greater access to care and controls health care costs.<sup>184</sup>

My proposed approach to reform will interweave with the new legislation set forth by PPACA, discuss how PPACA helps or hinders that progress, and identify areas for additional provisions or revision, many of which have been proven effective in other countries. This approach provides feasible and effective enhancements to the obstetric healthcare system that will fix or mitigate these issues and shift the focus to best evidence-based, quality care.

<sup>179</sup> *Understanding Medical Malpractice Insurance*, *supra* note 121.

<sup>180</sup> PUBLIC CITIZEN, *supra* note 40.

<sup>181</sup> Theodore Eisenberg, *The Empirical Effects of Tort Reform*, RES. HANDBOOK ON THE ECON. OF TORTS (forthcoming) available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2032740](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740).

<sup>182</sup> Kay A. Johnson, *Women’s Health and Health Reform: Implications of the Patient Protection and Affordable Care Act*, 22 CURR. OPIN. OBSTET. GYNECOL. 492, 493 (2010).

<sup>183</sup> *Women and the Human Right to Health Care: A Perspective on the Federal Health Reform Law*, NAT’L ECON. & SOC. RIGHTS INITIATIVE (June 2010), available at [http://www.dghonline.org/files/page\\_attachments/Women\\_health\\_reform\\_factsheet\\_0-1.pdf](http://www.dghonline.org/files/page_attachments/Women_health_reform_factsheet_0-1.pdf).

<sup>184</sup> Ginsburg et al., *supra* note 13, at 10 (“Overall, when the United States health care system is compared to other countries we find that the U.S. has the highest health care costs, yet we have the lowest life expectancy and rank lower than health systems of other countries in several key areas. People in these countries, whose physician workforces have a larger proportion of primary care physicians than the United States, see less need for a complete rebuilding of their health care systems, find their regular physicians’ advice to be helpful, and feel that they receive coordinated care.”).



First, it is critical that obstetric care and financial incentives be based upon best-evidence based, quality care and not upon the quantity of services or interventions provided. Second, integrative healthcare information technology systems can better educate doctors on the most up-to-date, appropriate course of care, as well as provide complete patient health history. Third, there should be greater access to midwives for the 90% of pregnant women who are healthy and at low risk. Fourth, in order to increase access to and quality of prenatal care and childbirth options, an emphasis should be placed on group prenatal care and the use of birthing centers. In addition to the advances made by PPACA, these measures would significantly enhance obstetric care in the United States, shift the focus to best evidence-based, quality care, and ultimately help save the lives of women and babies across the country.

### C. *Evidence-based Care and Financial Incentives Based on Quality of Care*

“Eighteen percent of the country’s economy is spent on health care and costs continue to rise.”<sup>185</sup> An estimated \$750 billion is excessive, wasted spending.<sup>186</sup> Unfortunately, perverse “financial incentives for high-tech interventions [will] remain in place [after PPACA], which have led to the medicalized model of birth that incentivizes c-sections and restricts use of midwives.”<sup>187</sup>

Incentives for doctors should be based upon the quality of care provided to patients, not fees for services. Using evidence-based maternity care, which relies on the best available research on specific practices, will benefit mothers and babies.<sup>188</sup> While this “evidence-based” practice was pioneered in the obstetric field, somehow “there remains a widespread and continuing underuse of beneficial practices,<sup>189</sup> overuse of harmful or ineffective practices,<sup>190</sup> and uncertainty about effects of inadequately assessed practices.”<sup>191</sup> Evidence-based care touts the use of the least invasive care paths.<sup>192</sup> Evidence-based maternity care supports a physiological approach to childbirth that excludes medical interventions unless the physician can prove that the intervention is absolutely necessary for that particular patient’s situation.<sup>193</sup> If the physician cannot prove that the intervention will do more harm than good, it should not be administered.

In addition, a position paper authored by members of the American College of Physicians analyzed the lessons learned from other countries and provided several

<sup>185</sup> WBUR, *supra* note 157, Chandra further sites excessive costs caused by both, over-use of medical procedures that do not provide therapeutic value as well as treatment that patients do not want.

<sup>186</sup> *Id.*

<sup>187</sup> NESRI, *supra* note 150, at 2.

<sup>188</sup> SAKALA & CORRY, *supra* note 5, at v. (“These gaps between actual practice and lessons from the best evidence reveal tremendous opportunities to improve the structure, process, and outcomes of maternity care for women and babies and to obtain greater value for investments.”).

<sup>189</sup> *Id.* at 5 (“The many beneficial, underused practices around the time of birth include continuous labor support, numerous measures that increase comfort and facilitate labor progress, nonsupine positions for giving birth, delayed cord clamping, and early mother-baby skin-to-skin contact. Best available evidence also supports providing access to vaginal birth after cesarean (VBAC) for most women with a previous cesarean.”).

<sup>190</sup> *Id.* at 4.

<sup>191</sup> *Id.* at v.

<sup>192</sup> *Id.* at 21.

<sup>193</sup> *Id.* at 25; SAKALA & CORRY, *supra* note 5, at 25.

comprehensive policy recommendations.<sup>194</sup> One recommendation is to redirect federal health care policy toward supporting patient-centered health care that builds upon the relationship between patients and their physicians.<sup>195</sup> Another recommendation is to support initiatives that provide financial incentives to physicians for the voluntary achievement of evidence-based performance standards.<sup>196</sup> Another recommendation encourages quality improvements and reductions to avoidable medical errors through incentives for systems performance that encourage comprehensive and continuous care coordination and prudent stewardship of health care resources.<sup>197</sup> All of these recommendations align with several studies that support evidence-based maternity care and the eradication of financial incentives paid for unnecessary interventions such as inductions and cesarean sections.

*D. Health Information Systems and Lifelong Healthcare Access to Improve Physician Education and Patient Care*

Integration of care over women's lifetime and continuous insurance coverage is a foundational component for proper maternal care. "While Medicaid covered approximately 40% of women's childbirth-related hospital stays and newborn care across the nation, many uninsured young women have been ineligible for Medicaid or other insurance coverage until they become pregnant—which limits childbearing women's access to health services to preemptively plan a successful pregnancy and is a barrier to proper prenatal care."<sup>198</sup>

A pregnant woman who lacks healthcare coverage at any stage of her life can result in a failure to identify potential complications during pregnancy.<sup>199</sup> Many conditions, such as diabetes or infectious diseases, can be managed with proper medical care.<sup>200</sup> However, without proper care or coverage, women and their babies may have serious adverse effects ranging from birth defects to transmitted infection.<sup>201</sup> It also increases costs to care for conditions that have gone untreated. It is critical that healthcare providers have a thorough health history of their patients in order to make decisions about proper care during pregnancy.

Obviously, insurance coverage throughout life is critical for women's access to healthcare. Under PPACA, it will become illegal for insurance companies to deny women insurance coverage due to "preexisting conditions" or other discrimination in 2014.<sup>202</sup> Until the new laws are in effect, insurance companies can continue to deny women

<sup>194</sup> Ginsburg, *supra* note 13, at 66.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.*

<sup>197</sup> *Id.*

<sup>198</sup> Carol Sakala, *U.S. Health Care Reform Legislation Offers Major New Gains to Childbearing Women and Newborns*, 37 BIRTH: ISSUES IN PRENATAL CARE 337, 337 (2010).

<sup>199</sup> Michael C. Lu, *Healthcare Reform and Women's Health: A Life-Course Perspective*, 22 CURRENT OPINION IN OBSTETRICS AND GYNECOLOGY 487, 487–91 (2010).

<sup>200</sup> See PRENATAL CARE AND TESTS, <http://womenshealth.gov/pregnancy/you-are-pregnant/prenatal-care-tests.cfm> (last updated Sept. 27, 2010); *Late or No Prenatal Care*, CHILD TRENDS (2012), [www.childtrendsdatabank.org/?q=node/243](http://www.childtrendsdatabank.org/?q=node/243).

<sup>201</sup> *Id.*

<sup>202</sup> *Id.* at 338.

eligibility just because they are currently pregnant or deem women who have had a previous cesarean section or episiotomies as ineligible due to “preexisting conditions.”<sup>203</sup>

Fortunately, PPACA offers continuous insurance coverage for 19 million U.S. women who currently lack health insurance and for many more with only sporadic coverage.<sup>204</sup>

In addition, a robust, integrated healthcare information system that includes evidence-based guidelines and protocols for doctors, as well as patient history, could dramatically improve the quality of patient care in the United States. Medical errors are often due to breakdowns in systems of care, not individual decisions.<sup>205</sup> In the United States “[t]here are no comprehensive, nationally implemented, evidence-based guidelines and protocols for promoting safe and quality maternal care and for preventing, identifying and managing obstetric emergencies.”<sup>206</sup> Today, for example, if a woman presents at a physician’s office for the first time or the emergency room, she is not likely holding a file containing her entire health history. As a result, physicians may not be aware of prior medical issues that could have a significant effect on the present situation. If such an electronic system were implemented and accessible to healthcare professionals, the risk of error would decrease and preventable complications could be treated.<sup>207</sup> “According to some estimates, improving the quality of maternal care could prevent 30 to 40% of near misses and serious complications, and 40 to 50% of [maternal and infant] deaths.”<sup>208</sup>

Information systems could provide detailed information about the woman’s health history that will be integral to doctors making decisions about a course of action. A detailed health history allows the physician to provide a more holistic, comprehensive approach to women’s healthcare which will “optimize pregnancy outcomes and developmental programming such as nutrition, stress, mental health and environmental toxicology.”<sup>209</sup>

Ideally, all women will obtain access to healthcare and insurance coverage. That access will be integrated throughout the course of their lives in order to optimize pregnancy outcomes and overall good health. More integrative information systems could close the significant gap between best-evidence based knowledge and implementation.

#### E. *Increase Access to Midwives and Birthing Centers*

Midwives provide care that is well suited to the needs of 90% of childbearing women. “Midwives prioritize good information, involve women in decision making,

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<sup>203</sup> *Id.*

<sup>204</sup> Erin Saleeby & Claire D. Brindis, *Women, Reproductive Health, and Health Reform*, 306 J. AMERICAN MED. ASSOC. 1256, 1256 (2011); Sakala, *supra* note 189, at 337 (“The PPACA has the potential to increase access to essential health services for up to 8.2 million women and offer subsidies for purchasing health insurance for an additional 7 million women.”).

<sup>205</sup> *Understanding Medical Malpractice Insurance*, *supra* note 121, at 12.

<sup>206</sup> Amnesty International, *supra* note 4, at 70.

<sup>207</sup> *Id.*

<sup>208</sup> *Id.*

<sup>209</sup> Michael C. Lu, *Healthcare Reform and Women’s Health: A Life-Course Perspective*, 22 CURRENT OPINION IN OBSTETRICS AND GYNECOLOGY 487, 488–89 (2010).

offer flexible and responsive care, support physiologic processes and avoid unnecessary interventions.”<sup>210</sup>

Despite their widespread use in other countries and historically in the United States, midwives are no longer as prevalent and are met with a stigma. In fact, midwifery became so taboo that midwifery certifications and services became illegal in certain states.<sup>211</sup> Where midwifery is allowed, midwives can offer all of the same services<sup>212</sup> as a physician during prenatal care and natural, no- or low-risk, childbirth and postnatal care, yet midwives were often not reimbursed for their services by insurance companies. This has resulted in a significant decrease in midwifery services in the United States. Thanks to the initiatives of several coalitions across the country working to legalize midwife certifications and increase awareness,<sup>213</sup> the PPACA changes this reimbursement practice. In section 3114 of PPACA, the Medicare fee schedule reimburses certified nurse-midwives at a rate of 100% of the physician rate, replacing a prior 65% rate of reimbursement.<sup>214</sup> “This 100% reimbursement may be expected to increase access to nurse-midwifery care, enable the growth of independent nurse-midwifery practice, and make nurse-midwives more visible in group practices and health plans, because the previous reduced rate . . . provided incentives to bill . . . through physician colleagues.”<sup>215</sup>

In addition to proper reimbursement for services, as provided by the PPACA, this paper proposes a referral program for midwives and obstetricians. An integrated healthcare information system will allow doctors to refer and share information about patients more easily. Primary care physicians could serve, as some already do, as a central repository for patient care throughout the patient’s life. Primary care physicians could perform a baseline assessment, based on agreed-upon standard protocols, to screen pregnant women and provide a recommendation as to whether the patient should begin their care with a midwife or obstetrician.<sup>216</sup>

If women show signs of being high risk, they should be referred to obstetricians who can steward them through their pregnancy with all the appropriate medical tools available. However, if women fall into the 90% of women who are healthy and at little or no risk for complications, they can keep their health care costs to a minimum and receive comparable, patient-focused care with midwives.<sup>217</sup>

<sup>210</sup> SAKALA & CORRY, *supra* note 5, at 30.

<sup>211</sup> Harlow, *Midwifery: State Regulation*, 59 A.L.R. 929 (1988).

<sup>212</sup> *Ten Steps of the Mother-Friendly Childbirth Initiative for Mother-Friendly Hospitals, Birth Centers and Home Birth Services*, BIRTH NETWORK NAT’L, <http://birthnetwork.org/resources/Documents/MFCI.pdf>.

<sup>213</sup> *See generally History*, THE BIG PUSH FOR MIDWIVES 2012 (Mar. 5, 2012),

<http://pushformidwives.org/about/history/> (launching a campaign involving midwifery issues).

<sup>214</sup> Sakala, *supra* note 198.

<sup>215</sup> *Id.*

<sup>216</sup> *See* Declan Devane, et al., *Midwife-led Versus Other Models of Care for Childbearing Women*, 3 COCHRANE LIBRARY 1 (2009), <http://apps.who.int/whl/reviews/CD004667.pdf> (“Most women should be offered midwife-led models of care and women should be encouraged to ask for this option although caution should be exercised in applying this advice to women with substantial medical or obstetric complications.”).

<sup>217</sup> SAKALA & CORRY, *supra* note 5 (“Many historic and contemporary reports and studies confirm that the physiologic approach to childbirth, which has most consistently been provided by midwives . . . has succeeded remarkably well in achieving positive outcomes for mothers and babies in diverse contexts . . . In all contexts, [only] a portion of childbearing women and newborns require and gain benefit from specialized skills and knowledge and obstetric interventions that effectively address specific problems.”).

A referral process should also be in place, wherein all midwives have a group of obstetricians and hospitals they work with to enable referrals for patients should the need arise. The process of matching patients with the appropriate caregiver would allow obstetricians to employ their medical training and procedures with a higher percentage of their patients, including such high-paying procedures as cesarean sections and other induction methods. Both obstetricians and midwives can then focus on providing the best possible care for their constituencies, while being reimbursed appropriately by insurance companies. Midwifery services may also serve as a basic, low-cost resource for pregnant women who currently have no or limited access to healthcare.<sup>218</sup> This will decrease the infant and maternal mortality rates that result from lack of access to prenatal care.<sup>219</sup>

The use of midwives for the majority of births may also result in a significant decrease in medical malpractice liability lawsuits, and therefore malpractice insurance rates will decrease and the cost to obstetricians will become more manageable.<sup>220</sup> Much of the litigation brought by patient plaintiffs are against their obstetricians—midwives are rarely implicated in lawsuits brought by their patients.<sup>221</sup> Instead, many obstetricians or hospitals bring suits against midwives because of the archaic and sporadic regulations in place for midwifery licensure and certification.

Generally, midwives have stronger, more satisfactory relationships with their patients than do obstetricians<sup>222</sup> which may help to decrease the number of medical malpractice lawsuits against obstetricians.<sup>223</sup>

Research clearly demonstrates that a troubled doctor-patient relationship and inability to communicate effectively are pivotal factors in malpractice litigation . . . The absence of a connection between the quality of care and the number of lawsuits led the researchers to conclude that obstetricians' behavior is a dominant factor in malpractice lawsuits. Consistently, a recent study published in the *Journal of the American Medical Association* . . . revealed that the degree of dissatisfaction a patient experienced with her physician was highly correlated with malpractice litigation.<sup>224</sup>

This is not to say that all obstetricians lack a connection with their patients. There are, however, significant pressures on obstetricians to keep the length of visits short and to order medical interventions to speed up the labor and delivery process—pressures that do not necessarily exist for midwives. Through more appropriate matching of patients to caregivers, the obstetric experience should improve for both patients and care providers.

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<sup>218</sup> Declan Devane, *supra* note 216, at 4.

<sup>219</sup> *Id.*

<sup>220</sup> Falker, *supra* note 25, at 29.

<sup>221</sup> *Id.*

<sup>222</sup> *Id.*

<sup>223</sup> *Id.*

<sup>224</sup> *Id.* at 9.

*F. Group Prenatal Care and Access to Birth Centers to Increase Patient Awareness and Quality of Prenatal Care*

Group prenatal care and the use of birthing centers will decrease the astronomical costs of health care and provide women with higher quality education, treatment, and autonomy to control their individual birth experiences. In 2007, the proportion of women who received prenatal care beginning in the first trimester was only 70.8%.<sup>225</sup> Of this 70.8%, the adequacy of prenatal care was questionable. For instance, only 30.1% of females took multivitamins or folic acid every day in the month prior to pregnancy.<sup>226</sup>

Prenatal care and preventative care services for childbearing women include “folic acid supplementation, breastfeeding counseling before and after birth, tobacco use counseling, and screening for several conditions for newborns . . . .”<sup>227</sup> Now, through PPACA, “[a]ll *new* health plans are required to offer, at no extra cost to the patient, all services and screenings recommended by the U.S. Preventative Services Task Force.”<sup>228</sup> These services and screenings are critical to the optimization of pregnancy outcomes and proper prenatal care; patient education about nutrition and birth place options should be automatically provided to all women.

In addition to prenatal care, birthing centers also provide benefits to expectant mothers. Yet while other countries embrace the quality and value offered to women by birthing centers, birthing centers all over the United States are closing or have been threatened with closure largely due to loss of insurance reimbursement.<sup>229</sup> In an effort to reverse this trend, a PPACA provision now requires coverage of care in freestanding birth centers that meet state regulatory requirements and requires reimbursement of birth attendants—often midwives—who are recognized by states for care within their scope of practice.<sup>230</sup>

Unfortunately, access to birthing centers and midwifery is extremely limited. “In 2009, 98.9% of all U.S. births were delivered in hospitals and the remaining 1.1% were delivered out of hospital. Among out-of-hospital births, 67.2% were in a residence (home) and 27.6% were in a free standing birthing center.”<sup>231</sup> Yet vaginal births in a birth center cost a mere \$1,600 versus \$7,000 for an uncomplicated vaginal birth in a hospital.<sup>232</sup> The cost of healthcare for Medicare/Medicaid, insurance companies, and women out-of-pocket would significantly decrease if access to birth centers increased.

Most births should be attended by certified midwives in birthing centers, instead of by obstetricians in hospitals. In doing so, the number of cesarean sections may decrease to a more acceptable level between 10–15%, as recommended by the WHO.<sup>233</sup> Many obstetricians have become surgeons as opposed to stewards of physiologically, natural childbirth. The unrealistic fear of litigation and the practice of defensive medicine will

<sup>225</sup> *Healthy People*, *supra* note 96.

<sup>226</sup> *Id.*

<sup>227</sup> Sakala, *supra* note 198, at 338 (The plans will also be required to offer additional preventative care and screenings to women [and] infants . . . that the federal Health Resources and Services Administration will identify (Section 2713 of PPACA)).

<sup>228</sup> *Id.*

<sup>229</sup> *Id.* (discussing state Medicaid programs denying birth center claims).

<sup>230</sup> *Id.*

<sup>231</sup> Martin et al., *supra* note 3, at 9.

<sup>232</sup> SAKALA & CORRY, *supra* note 5, at 12.

<sup>233</sup> *Id.* at 42.

subside with the more widespread use of midwifery and birthing center services, which would not only reduce costs but also reduce malpractice premiums and most importantly produce better, safer patient outcomes.<sup>234</sup>

## VI. CONCLUSION

The PPACA is just the beginning for obstetric reform; constituents should work together with a focus on best-evidence based care. At the Home Birth Consensus Summit, a number of representatives discussed maternity care and birth place options in the United States and developed several principles in order to commit to a shared responsibility and move toward reform.<sup>235</sup> These principle statements, which should be kept in mind when proposing legislative reform for obstetric care, include: uphold the autonomy of all childbearing women; collaborate within an integrated, equitable maternity care system; develop high quality services offered by all health professionals who are educated about one another's disciplines; and improve the current medical liability system which is currently failing to justly serve society, families, and healthcare providers.

Greater access to healthcare and life-long insurance coverage will greatly improve the maternal experience in the United States; the PPACA promises to provide coverage to millions of women. More robust, comprehensive information systems will link best-evidence based care with patient health history to facilitate the best possible decision making for physicians. By shifting the focus from financial incentives based on quantity of care to evidence-based quality of care, the negative effects of defensive medicine, fee-for-service reimbursement systems, and for-profit insurance companies and hospitals will diminish. Greater access to midwives and birthing centers will facilitate the education and empowerment of pregnant women and lead to more satisfactory birth experiences.

For the sake of women and babies in the United States and the future of our society, the maternal experience could significantly improve through obstetric healthcare reform. Financial motivations should not take precedence over quality healthcare. Quality healthcare is a basic human right that all women in the United States should have access to and such care should be supported through fundamentally sound, evidence-based standards of care.

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<sup>234</sup> *Id.* at 13 (“The National Birth Center Study of nearly twelve thousand women found excellent outcomes and very high levels of satisfaction with birth center care . . . this comparison suggests that the level of resource use in hospitals for uncomplicated vaginal births could be much lower.”).

<sup>235</sup> *Outcomes*, HOME BIRTH CONSENSUS SUMMIT (Mar. 12, 2013), <http://www.homebirthsummit.org/summit-outcomes.html> (listing representatives, endorsers and complete common ground statements are available on the website and action plans for implementation will be available in the future).