Early Discharge

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Early Discharge

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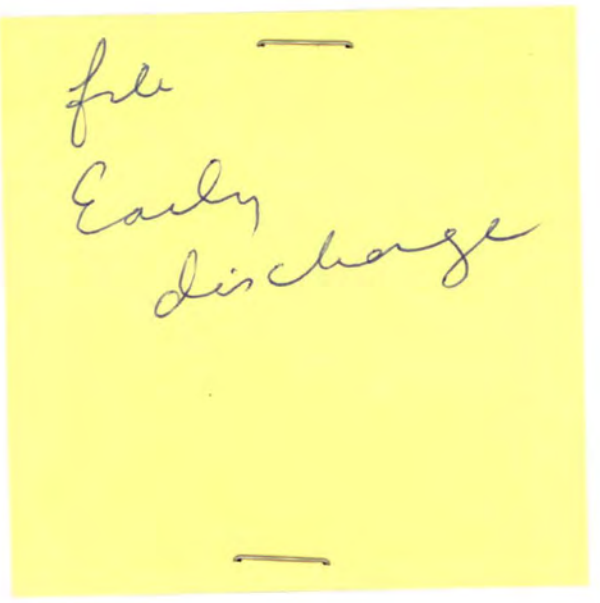
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The American College of Obstetricians and Gynecologists

May 23, 1995

STATEMENT ON DECREASING LENGTH OF HOSPITAL STAY FOLLOWING DELIVERY

The American College of Obstetricians and Gynecologists (ACOG) is concerned about the decreasing length of time following delivery when mothers and newborns are discharged from the hospital. Although the trend to short hospital stays has been jokingly referred to as "drive through delivery," it is not a laughing matter.

As an organization dedicated to the primary health care of women and to insuring the optimal outcome of pregnancies, ACOG believes that changes in practice such as early discharge following obstetrical delivery should be based on sound scientific data that demonstrate good outcomes for mother and infant, as well as being cost effective. As yet, these data do not exist. Until they do, the burden of proof of safety of early discharge rests with those who are driving the change.

A recent analysis by the Centers for Disease Control and Prevention (CDC) found that between 1970 and 1992 the median length of stay for women who gave birth vaginally decreased by 46 percent (from 3.9 to 2.1 days), and for those who had a cesarean delivery by 49 percent (from 7.8 to 4 days).[1] Because the data included complicated deliveries, the median length of stay for uncomplicated vaginal deliveries or cesareans was probably considerably shorter.

Guidelines for Perinatal Care, a collaborative document between ACOG and the American Academy of Pediatrics (AAP), indicates that in otherwise uncomplicated deliveries the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean delivery, *exclusive of the day of delivery*.[2] Yet it has become common for insurers to limit length of stay to up to only 24 hours following vaginal delivery and up to 72 hours following cesarean delivery. ACOG's concern is heightened by reports of insurers proposing 12 hour stays following uncomplicated vaginal delivery and 48 hour stays following uncomplicated cesarean delivery, and by indications that some insurers are considering 6 hour stays for routine deliveries.

Although the move toward earlier discharge began in response to consumer demand during the 1970s -- to decrease medical interventions surrounding childbirth and provide a more family-centered birth experience -- the recent trend to even shorter length of stay following delivery appears to be driven primarily by financial motivations. At a time when obstetrical delivery is the most frequent cause of hospitalization in the United States, the shortening of a woman's hospital stay holds obvious appeal to insurers.

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Length of hospital stay may affect the recovery of the mother, and the newborn's stabilization and screening tests. Significant maternal physiologic changes and newborn adaptation occur during the first few days of life. Not all serious maternal or newborn problems or complications are evident within the first 12 or 24 hours following birth. ACOG is concerned about anecdotal reports of serious problems in newborns, such as dehydration and undetected jaundice, following early discharge.

ACOG is also concerned that opportunities for educating new mothers in the care of their newborns are lost when early discharge is inappropriate. For example, the initiation of breast-feeding and lactation is a very important process that occurs over the first few days following birth. Home care services should provide education regarding maternal recovery and newborn care. However, the availability, structure and content of home visits and services vary widely across the country. Moreover, such instruction may not always be an effective substitute for "on-demand" education provided in the hospital.

In other instances, a mother may be discharged to go home first, without her baby, or an inappropriate early discharge may result in separate readmission of either the mother or newborn. Such separation, while temporary, can come at a critical phase in the development of the mother-infant relationship.

ACOG acknowledges that selective, early discharge is safe and desirable for some mothers and babies. However, a decision for early discharge should be *individualized* and should be a mutual decision between the patient, her family, and the obstetrical provider -- taking into account medical risk factors, support systems for the family, and the readiness of the mother to care for herself and her newborn.

The routine imposition of a short and arbitrary time limit on hospital stay that does not take maternal and infant need into account could be equivalent to a large, uncontrolled, uninformed experiment that may potentially affect the health of American women and their babies. There is relatively little scientific data on the ideal length of hospital stay for delivery. A critical review of existing literature indicates that studies have not yet conclusively demonstrated the safety of early discharge.[3]

For this reason, ACOG believes that the American health care system should call for a moratorium, or a "time-out," on further reduction in hospital stays following delivery, until we have the data that clearly demonstrate the safety of early discharge for women and their babies.

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[1] CDC. Trends in length of stay for hospital deliveries - United States, 1970-1992. MMWR May 5, 1995; 44: 335-337.

[2] AAP and ACOG. Guidelines for Perinatal Care. 3rd ed. 1992 (4): 105-111.

[3] Braveman P, Egerter S, Pearl M, Marchi K, Miller C. Early discharge of newborns and mothers: a critical review of the literature. Pediatrics 1995 (in press).

The New York Times DATE JUN 29 1995

New Mothers Gain 2d Day In Hospital

Whitman Signs a Bill To Fight Curbs on Care

By JON NORDHEIMER

TEANECK, N.J., June 28 — Gov. Christine Todd Whitman came to Holy Name Hospital today to sign a bill requiring insurers to pay for a second day of hospital care for mothers and their newborns, making the state the second in the nation to regulate what critics have called "drive-through deliveries."

It was the latest result of the growing public backlash against the decision by health maintenance organizations to cover only 24 hours of hospital care after normal births. A decade ago, most women and their infants remained in a hospital for three or four days for rest, observation and tests.

Pressure for political action is spreading. On Tuesday, Senator Bill Bradley, Democrat of New Jersey, filed a bill to make 48-hour maternity stays the national minimum. But the medical world is divided on when discharge is safe and practical. Several physicians' groups, including the American College of Obstetricians and Gynecologists, have recently called for curtailment of early discharge until more hard research is collected on the safety issue.

"The plain facts are no one knows exactly what is happening," said Rachel M. Schwartz, director of research for the Perinatal Information Center in Providence, R.I. "Early discharge has happened so quickly, the community of payers has gotten ahead of clinicians and everyone is now scrambling to play catch-up with the facts,'

Dr. Ciro V. Sumaya, head of the Federal Health Resources and Services Administration in Washington, said he will soon seek approval to develop a more comprehensive investigation into problems associated with shortened stays, especially incomplete screenings of babies to detect genetic diseases, breast feeding difficulties and inadequate follow-up care at home.

"This issue is moving very fast and all we have to work with is anecdotal information that point to potential problems," Dr. Sumaya said in a telephone interview.

After visiting the maternity ward here, Mrs. Whitman spoke to a crowd of about 200 physicians, politicians, parents and stomping and crying children. "I have two children — one by C-section — and I know that 24 hours is not enough," she said, adding that the bill uses "common sense to give women a chance to recover and babies a chance to get a good head start."

A woman discharged too early after birth, she continued, "is going to come back to the hospital time and time again with more serious problems."

Last month, Maryland became the first state to extend the 24-hour stay to two days. But the New Jersey law is the first to give a mother, not her physician, the final say on whether to stay one or two days. Sponsors of the bill said they added that clause because it was felt H.M.O. physicians labored under too much pressure to cut costs.

In addition to the 48 hours for routine births, the bill, which becomes effective immediately, extends the minimum insurance-financed hospital stay to 96 hours after a Cesarean section.

The bill provides that a one-day hospital stay is sufficient if an insurer covers three visits by a registered nurse to a family's home. A single day in a hospital may cost $1,000; three home visits by a nurse may be half that sum, medical officials said.

Proponents of the new laws tell of babies dying shortly after returning home from one-day hospital stays. A case often cited is the death last month of Michelina Alanna Bauman, who succumbed to a strep infection two days after birth and a day after her mother brought her home from a Gloucester County Hospital.

Insurers counter that these are rare incidents in an otherwise safe process, and point to available studies that indicate there has not been an increased in the readmission of mothers and babies after early discharge.

Critics point out, however, that these studies were limited in scope and dealt chiefly with middle-class women who chose to leave the hospital and had help at home from family, friends or medical professionals.

"The essential ingredient is an appropriate support system once a mom and newborn check out of a hospital," said Robert A. Knuppel, chairman of the obstetrics and gynecology department at Robert Wood Johnson Medical School in New Brunswick. "If discharge is only after eight hours, it can be done if proper support is there."

Dr. Knuppel said that a second night in the hospital is particularly helpful to first-time mothers and those from disadvantaged homes whose babies run a disproportionate risk of being readmitted with medical problems days after discharge. "The mother's stay in the hospital may be the only access she has to this information," he said.

Elaine Deigmann, director of nurse midwifery program at the School of Health Related Professions in Newark, agreed. "A 14-year old inner city mother from an unstable home environment — how can you think about sending someone like that home without a lot of help?"

Until today, Medicaid patients stood a better chance of getting an extended maternity stay than those covered by many health maintenance organizations, Dr. David Butler, chief of obstetrics and gynecology at Holy Name, said. The hospital was chosen for the bill signing because it was the site of a rally against early discharge in March rally.

Dr. Knuppel and others said a 48-hour hospital stay is no magic answer. Jaundice, a problem for some newborns, is usually not observable until 72 hours, they pointed out, and dehydration caused by breast feeding difficulties may not be observable until after the third day, when a mother's milk becomes abundant. For these reasons, they added, nursing care at home over a three-day period may be preferable to two hospital days if mother and child are healthy enough to go home after 24 hours.

Managed care companies say they are as interested as parents in preventing complications that return discharged patients to expensive hospital care. "But these decisions shouldn't be made on a cookie-cutter basis by legislators," said Susan Pisano, director of communications for Group Health Association of America, a trade group for health maintenance organizations. "There are times when health care can be provided safely and more appropriately in the home."

Whitman joins the fight against 'drive-through deliveries' in maternity cases.

Biotechnology Gets a Boost

TRENTON A bill intended to stimulate the development and expansion of biotechnology and other high-tech industries in New Jersey was signed into law yesterday. The bill authorizes the State Economic Development Authority to establish a financial assistance program for new and growing companies that are often considered too high-risk to meet the agency's criteria for loans, said State Senator Robert W. Singer, a Republican of Ocean County and one of the bill's sponsors. "This is a response to where we felt we were going as a state as to future jobs," Senator Singer said.

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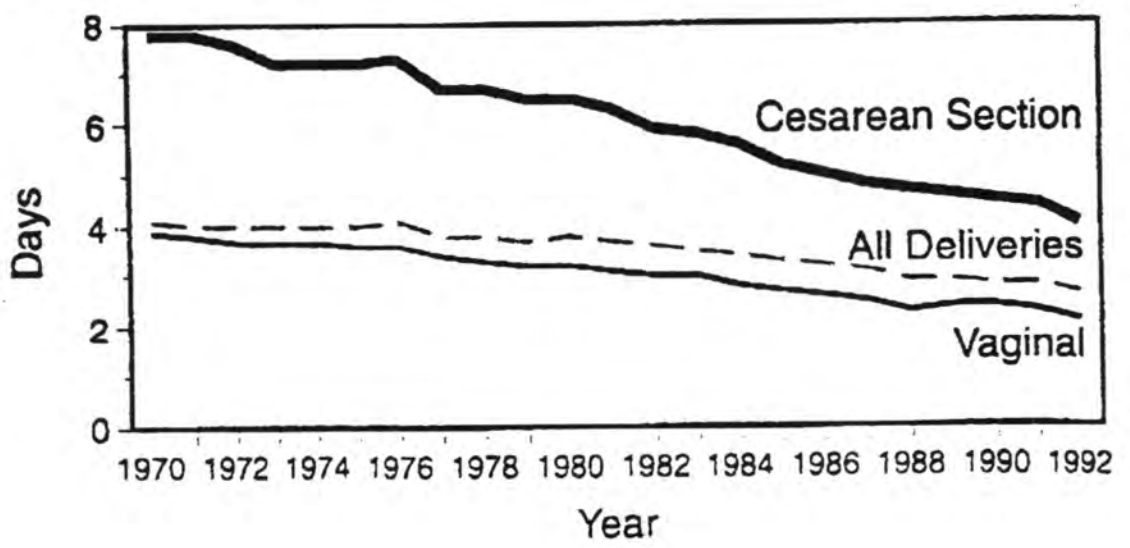
Trends in Length of Stay for Hospital Deliveries — United States, 1970–1992

Obstetric delivery is the most frequent cause of hospital admission in the United States, reflecting the approximately 4 million births in this country each year (*1*). Because of steadily increasing hospital costs, overall lengths of hospital stay have declined. To assess national trends in length of stay for hospital deliveries, data were analyzed from CDC's National Hospital Discharge Survey (NHDS) from 1970 through 1992, by method of delivery. This report summarizes the results of the analysis.

Since 1965, the NHDS has collected data from U.S. nonfederal, short-stay hospitals. Each year, approximately 200,000 inpatient records are selected from approximately 400 hospitals; data are weighted to represent all hospitalizations nationally (*2,3*). Selected patient information (e.g., medical diagnoses and surgical procedures) is abstracted from each record. For this analysis, the NHDS provided information about mother's age and race/ethnicity; method of payment; and the hospital's ownership, size, and location. Estimates for average length of stay were derived from the 20,000–33,000 deliveries each year among all records sampled. Hospital stays of <24 hours were recoded as 0 days; these hospitalizations accounted for <1% of all deliveries and were relatively constant by year (i.e., 0.3% in 1970 to 0.7% in 1992). The proportion of all deliveries that occurred outside of hospitals also was stable from 1975 (0.9%) to 1990 (1.1%) (*4*).

In 1970, the average length of stay for all hospital deliveries was 4.1 days (median: 4 days). By 1992, the average had decreased by 37% to 2.6 days (median: 2.0 days). The average length of stay for women who gave birth vaginally decreased by 46% (from 3.9 to 2.1 days) and for those who gave birth by cesarean section by 49% (from 7.8 to 4.0 days) (Figure 1). The decrease in the average length of stay for all deliveries was smaller than that for either method because the percentage of deliveries by cesarean section increased from 5.5% to 23.5% during this period (*5*).

FIGURE 1. Average length of stay for hospital deliveries, by delivery method — United States, 1970–1992



Hospital Deliveries — Continued

The average length of stay also was analyzed by mother's age (<20, 20–29, 30–39, and >39 years), race (white or black)*, hospital location (Northeast, Midwest, South, or West regions), hospital ownership (proprietary, government, or nonprofit), and hospital size (<100, 100–299, 300–499, and >499 beds). From 1970 through 1992, the average length of stay decreased similarly for all these groups; decreases ranged from 39% to 52% for vaginal deliveries and from 38% to 53% for cesarean deliveries. NHDS began collecting information about method of payment (i.e., Blue Cross/Blue Shield†, other private insurance, Medicaid, and self-paying) in 1977. From 1977 through 1992, the average length of stay decreased for these payment groups; decreases ranged from 35% to 38% for vaginal deliveries and from 32% to 47% for cesarean deliveries.

Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Prevention Effectiveness Activity, Epidemiology Program Office, CDC.

Editorial Note: The length of stay associated with hospital deliveries steadily decreased during 1970–1992. Early hospital discharge results in reduced health-care costs and enables mothers to return home sooner with their newborns. However, careful postpartum follow-up is necessary to ensure prompt diagnosis and treatment of any maternal or neonatal complications. Early discharge should not preclude efforts traditionally conducted during postpartum hospitalization to educate women about breastfeeding, family planning, care of their newborn, and other topics important for new mothers.

The optimal length of stay for uncomplicated deliveries reflects several factors, including the presence of others in the home who can support the mother after discharge, the mother's awareness of complications, and access to health-care services. Guidelines published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists suggest that, when there have been no complications, the duration of postpartum hospital stays range from an average of 48 hours for vaginal delivery to an average of 96 hours for cesarean birth (excluding the day of delivery) (*6*). In addition, specific criteria should be met for a woman to be discharged early, especially within 24 hours of delivery.

One potential limitation of the analysis in this report is that data from the NHDS on length of stay does not distinguish the postpartum period from the rest of the hospitalization. Therefore, this analysis could not determine whether the decrease in the average length of stay resulted from a shorter antepartum stay or postpartum stay. However, since 1970, most of the efforts to decrease length of stay for hospital deliveries has been directed toward the postpartum period.

Since 1970, the rate of health-care costs has increased more rapidly than that of general inflation; efforts to decrease hospital health-care costs by reducing length of stay will probably intensify. Most studies have not detected an increased rate of morbidity in association with early postpartum discharge (*7–9*). However, these studies—which were conducted among carefully selected women at low risk for postpartum complications—documented rates of complications of up to 14% among women and 11% among their infants (*7*). In addition, home visits by nurse practitioners after discharge (a practice not routinely used by health-care providers) ensured

*Numbers from other racial/ethnic groups were too small for reliable analysis.

†Use of trade names and commercial sources is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

Hospital Deliveries — Continued

prompt diagnosis and treatment of postpartum complications. These findings underscore the need to ensure adequate follow-up care for women and infants and to maintain the educational activities traditionally provided during postpartum hospitalization. The prevalence of complications also should be monitored to accurately determine the costs and benefits of early postpartum discharge.

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Deaths from Melanoma — United States, 1973–1992

Approximately three fourths of all skin cancer-associated deaths are caused by melanoma. During 1973–1991, the incidence of melanoma increased approximately 4% each year (*1*). In addition, the incidence of melanoma is increasing faster than that of any other cancer (*2*). To characterize the distribution of deaths from melanoma in the United States, CDC analyzed national mortality data for 1973 through 1992. This report summarizes the results of that analysis.

Decedents for whom the underlying cause of death was melanoma (*International Classification of Diseases, Adapted, Ninth Revision,* codes 172.0–172.9) were identified from public-use, mortality data tapes from 1973 through 1992 (*3*). The denominators for rate calculations were derived from U.S. census population estimates (*4,5*). Rates were directly standardized to the age distribution of the 1970 U.S. population and were analyzed by state, age group, sex, year, and race. To increase the precision of the rates presented, race was characterized as white and all other races because approximately 98% of deaths from melanoma occurred among whites.

From 1973 through 1992, the overall percentage increase in the rate of deaths from melanoma (34.1%) was the third highest of all cancers; for males, the percentage

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NEWSLETTER

VOL. 39 NO. 8 AUGUST 1995

A historical look at alcohol and pregnancy

According to ACOG-Ortho History Fellow Janet Golden, PhD, the social mores of the early 19th century led to assumptions that women did not drink alcohol to excess. As a result, the effects of drinking during pregnancy were not readily considered by their physicians.

Dr. Golden is conducting a historical analysis of how medical ideas are shaped by the culture's view of women. Her research project, entitled "From Relief from Breeding Sickness to Fetal Alcohol Syndrome: Implications of Alcohol Use During Pregnancy and Lactation, 1790–present," is slated to culminate in a book. Dr. Golden is an assistant professor of history at Rutgers University in Camden, NJ.

Dr. Golden contends that, despite early knowledge of the detrimental effects of alcohol on pregnancy outcomes, these effects were ignored. "There were early reports in the medical literature that alcohol had bad outcomes for pregnancy and there was a relationship between maternal inebriety and mental retardation in the offspring," Dr. Golden explains. "I suspect, however, that there was an assumption that women didn't drink. It was assumed that alcohol abuse was a male problem—that men drank up the family wage, and beat their wives. Additionally, physicians did

Continued on page 2

States join effort to oppose insurer-mandated early postpartum discharge

Maryland and New Jersey enact laws requiring insurers to allow a 48-hour minimum stay.

The issue of third-party payers dictating inappropriately short lengths of hospital stays following labor and delivery has been a growing concern among physicians and patients. In an effort to curb this practice, legislation was recently passed in two states, New Jersey and Maryland. Legislators in other states, among them New York and California, are considering similar laws. Many view this legislation as an effective effort to reduce insurer intrusion into accepted medical practice. At the same time, however, others feel that legislation should remain a remedy of last resort for these types of concerns, lest laws interfere too far into medical practice and patient care.

Medical consensus—as spelled out in the ACOG-American Academy of Pediatrics joint publication, *Guidelines for Perinatal Care*—recommends hospital stays of up to 48 hours following uncomplicated vaginal delivery and up to 96 hours following uncomplicated cesarean delivery. Nevertheless, some insurance companies now specify lengths of stay of up to 24 and 72 hours, respectively, and some insurers are reported as recommending discharge at 12—and even as early as 6—hours after delivery.

Current state legislation

New Jersey's antidote to this troubling trend takes the form of a bill approved last spring by the state's senate and assembly and signed into law by Governor Christine Todd Whitman on June 28. It requires all health plans—except those that provide benefits for in-home postpartum care—to allow a woman to stay in the hospital for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours following cesarean delivery. Prior to the signing, the governor's office was besieged with calls from new and expectant mothers supporting the bill.

In Maryland, a similar measure has also been signed into law. It is considered the preferable of the two laws because, unlike New Jersey's, it forgoes the naming of specific time lengths and simply states that postpartum hospital length of stay should conform to *Guidelines for Perinatal Care* (thereby obviating the future need to pass another law if those guidelines change). Also unlike New Jersey's, the Maryland law applies only to health maintenance organizations. Both laws allow for earlier discharge if the physician and mother see fit.

Michael T. Mennuti, MD, Chair of ACOG's Committee on Obstetric Practice, doesn't see any other easy answers to this problem. "Apart from legislating medical practice," he says, "a process to pressure in-

Continued on page 8

Inside:

State legislation aimed at insurers mandating shorter hospital stays

Continued from page 1

surers, with consumers joining forces with providers, might have been effective," he says. "However, this would be a difficult effort to organize and would likely take an inordinately long time."

ACOG's efforts

College Fellows and staff have worked hard to convey the desire that postpartum length of stay follow accepted guidelines, and that changes in this practice be based on sound scientific data. The Department of Public Information held a press briefing on the issue (with Dr. Mennuti and ACOG Executive Board Public Member Sarah S. Brown, MPH) at the Annual Clinical Meeting, and later released a press statement. On the legislative front, ACOG's New Jersey Section was heavily involved in getting that state's law enacted.

Pointing to a recent analysis by the Centers for Disease Control and Prevention, the ACOG statement explains that "between 1970 and 1992 the median length of stay for women who gave birth vaginally decreased by 46 percent (from 3.9 to 2.1 days), and for those who had a cesarean delivery by 49 percent (from 7.8 to 4 days)." (1)

This shift toward earlier discharge began in response to consumer demand during the 1970s, to decrease medical interventions surrounding childbirth and provide a more family-centered birth experience. More recently, however, the trend to even shorter lengths of stay following delivery "appears to be driven primarily by financial motivations," says the statement.

ACOG's concerns revolve around the effects such mandated early discharges might have on the detection of maternal and newborn complications. In addition, many mothers who go home early are deprived of instruction in basic infant care and breast feeding.

The statement concludes: "ACOG believes that the American health care system should call for a moratorium... on further reduction in hospital stays following delivery, until we have the data that clearly demonstrate the safety of early discharge for women and their babies."

At its annual meeting last June, the American Medical Association concurred with ACOG, releasing a statement that said in part, "Discharge of mothers and infants should be determined by the clinical judgement of attending physicians, and not by economic considerations."

For now, legislation appears to be the only way to force insurers to recognize the needs of patients and the clear consensus of physicians on the issue of postpartum hospital stays. Nevertheless, Dr. Mennuti and others hope that such laws will not always be required. "While the New Jersey and Maryland laws are good pieces of legislation, I find it unfortunate that this change could be brought about in this manner," he says. Among his concerns is that a state might unintentionally misinterpret the guidelines and suggest that women must be made to stay for 48 hours, in his words, "essentially incarcerating them."

1. CDC. Trends in length of stay for hospital deliveries: United States, 1970–1992. MMWR. 44:335–337

Additional ACM Awards

In addition to those announced in the July *Newsletter*, the following awards were presented during the 1995 Annual Clinical Meeting.

SYNTEX "ISSUE OF THE YEAR" AWARD
For a thoroughly researched and referenced background paper on a specific issue in ob-gyn

Richard E.N. Sedwick, MD, Harrisonburg, VA
"Models of Primary Care Practice"

COMMITTEE ON SCIENTIFIC PROGRAM AWARDS
For the highest caliber scientific paper presentations

First Prize: "Pregnancy Outcomes Following False Positive Marker Screening Tests"
Shelley J. Chapman, MD; Cynthia G. Brumfield, MD; Katherine Wenstrom, MD; Mary B. DuBard, MA
The University of Alabama at Birmingham

Second Prize: "Immunohistochemical Characterization of Oncoprotein (P35, HER2/NEU) Expression and Proliferative Activity (PCNA) in Uterine Papillary Serous Carcinoma"
Susanna M. Walsh, MD; Michael Jones, MD; Hector Tarraza, MD
Maine Medical Center, Portland

Third Prize: "Salpingo-Oophorectomy Following Previous Hysterectomy: Clinical, Surgical and Pathologic Findings"
John C. Jennings, MD; Jay Moodley, MD; Robert Chin, MS
University of Texas Medical Branch, Galveston

ACOG ANNUAL AUDIOVISUAL AWARDS
For the highest caliber films

ACOG-Davis and Geck Film Festival Award
"Management of Multiple Gestation"
Frank A. Chervenak, MD, New York, NY

Committee on Scientific Program Film Awards
"Office Laparoscopy (Optical Catheter) and Laparoscopic Presacral Neurectomy Techniques"
Joseph R. Feste, MD, Houston, TX

"Shoulder Dystocia Drill"
William W. Young, MD; Joan Crane Barthold, MD; Michelle Dion, RNC, BS; Eileen Kirk, MD; Deborah Piper, CHM, MPH; Mindy Schorr, CNM; Lebanon, NH

This Patient Education Pamphlet was developed under the direction of the Committee on Patient Education of the American College of Obstetricians and Gynecologists. Designed as an aid to patients, it sets forth current information and opinions on subjects related to women's health. The information in this pamphlet does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice may be appropriate.

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thetic. This is called an ***episiotomy***. It is one of the most common operations in the United States.

Sometimes the doctor needs to help delivery along. In these cases, forceps or vacuum cups can be used.

A forceps looks like two large spoons. The doctor puts the forceps into the vagina, places it around the baby's head, and gently delivers the baby.

Vacuum cups can be used instead of forceps. In this method, a plastic cup is attached to the baby's head by using a vacuum pump. The baby is gently pulled from the vagina.

Delivery may be assisted with forceps (above) or vacuum cups (below).

Cesarean Delivery

In some cases, a cesarean birth may be needed. Cesarean birth is delivery of the baby through a cut made in the abdomen and uterus.

Sometimes the decision to have a cesarean birth can be made before labor begins for several reasons:

- The position of the fetus in the uterus makes it difficult to come through the vagina.
- A woman may have a medical condition that would make it harmful for her to go through labor.
- A certain type of cut was used to deliver the baby in a past cesarean birth.

Sometimes a cesarean birth may be needed if labor is not going well. The baby may be too large for vaginal delivery. Sometimes, opening of the cervix may be slow or incomplete. Some babies have a problem coping with the stress of labor. The fetus's heart rate may drop or slow for a long time. Cesarean birth may also be needed because of a problem for the woman, such as heavy bleeding.

At one time, it was thought that once a woman had a cesarean birth, she would have to give birth the same way in any later pregnancies. Today, though, most women who have had cesarean births are being urged to try to give birth through the vagina. Most of these women have vaginal births with no problem.

Postpartum

Right After Delivery

After delivery you will be watched closely to be sure that there are no problems. Your temperature, pulse, breathing, and blood pressure will be checked often. During this time, you can begin getting to know your new baby.

Unless you or your baby are having medical problems, you will be able to hold the baby. If you had planned to breast-feed, you may be able to start now. It

is good for you and your partner to look at, hold, and talk to your baby just after birth.

Hospital Stay

Most women spend about 1–2 days in the hospital after a vaginal birth. If you had a cesarean birth, or if problems occur, you will likely stay longer.

Hospitals vary greatly on visitor rules. Some allow only the baby's father and grandparents to visit. Many also will allow brothers and sisters to see the new baby. Others may let anyone visit. You may choose not to have visitors for a while. This gives you more time to rest and to learn about your baby.

Help may be available to teach you some of the beginning skills of being a parent. You may learn about feeding, bathing, and changing the baby. This can help you to feel more comfortable in the way you handle your newborn.

Before you go home, your baby may begin to get vaccines. They protect against diseases like rubella and hepatitis. Be sure you know what shots your baby should receive, and when.

Car Safety Seats

Plan to bring your baby home from the hospital in a special safety seat. Child safety seats and belts decrease the chances of an injury in a car accident by over 80%. Because of this, these seats are required by law. Check with your doctor, hospital, car dealer, baby stores, or local consumer safety group about buying or renting one before you go into the hospital. Be sure the seat is approved for use by newborns.

Breast-Feeding

Breast-feeding is the best way to feed newborns. It protects them, too. Mother's milk helps the baby resist disease and allergies. Breast-feeding is also more convenient and cheaper than bottle-feeding. It can form a bond between mother and baby.

Don't be upset if nursing is not easy right away. Both you and the baby need to get comfortable. If the baby calms down after nursing, makes urine, and is growing, he or she is getting enough milk.

Some women supplement breast-feeding with bottle-feeding. Once breast-feeding is established (a few weeks after birth), you can keep producing breast milk by breast-feeding the baby at least twice a day.

If you are breast-feeding, you will have special nutrition and calorie needs. Now is not the time to try to lose weight. You need food for your own body plus extra food to produce milk for your baby. This means you need about 500 more calories a day than before pregnancy. This is about 200 more calories than you needed during pregnancy. It is easy to add the extra food you need if you are already eating a healthy diet.

Calcium is very important for nursing mothers. It is found in milk used as a drink or in cooking. Yogurt, cheese, cottage cheese, and ice milk are other good sources. If you do not like milk products or if they make you sick, your doctor can suggest other sources of calcium. Tobacco, alcohol, and other drugs can hurt the baby if you breast-feed. If you smoke, drink alcohol, or take drugs, be sure to discuss this with your doctor. Do not smoke around the baby.

Breast-feeding may not be for all women. Many factors are involved in each woman's decision: life style, desire, attitude, time, and support. Even breast-feeding only for a few weeks has health benefits for the baby.

Discomforts

During your first days after birth, you may feel uncomfortable at times. These discomforts are common and often don't last long.

Afterbirth Pains. The uterus contracts and relaxes as it begins to return to normal. This can cause afterbirth pains. These pains may be increased by breast-feeding. The contractions usually are mild with first babies. They are stronger with the next babies. They last only a few days. To feel more comfortable:

- Change your position.
- Lie with a pillow under your abdomen.

- Empty your bladder often.
- Take medication if prescribed by your doctor.

Breast Swelling. Your breasts may be full and hurt a bit about 2–4 days after delivery. Wearing a well-fitting support bra will help. If you are not breast-feeding, ice packs may also be used. Some doctors may give medication that keeps milk from being produced. Do not stimulate or pump your breasts. This will only make the problem worse. The discomfort will go away in about 3 days.

Constipation. Constipation may still be a problem after you give birth. An episiotomy or hemorrhoids may make a bowel movement painful. A diet high in fiber and plenty of water, milk, and juices—such as prune juice—can help.

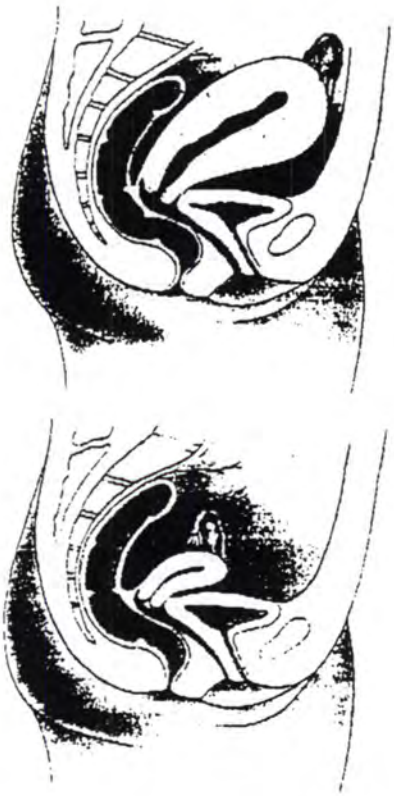
Episiotomy. Use of cold packs right after delivery can help ease discomfort. Later, heat can also make you more comfortable and help you heal. Either a heat lamp or warm sitz baths (sitting for a short time in warm water) can help. You will be taught how to clean this area very carefully to help prevent infection.

Hemorrhoids. Hemorrhoids can stick out or swell and hurt during pregnancy, labor, and delivery. Sprays, creams, and dry or wet heat (as for the episiotomy) provide some relief. Witch hazel compresses are also very soothing. The hemorrhoids will gradually shrink and may possibly disappear.

Physical Changes

While you were pregnant, changes in your body and the growth of the fetus took place over 40 weeks. Now that your baby has been born, your body goes back to its usual state much more quickly. Many changes begin right after delivery. Following are some of the changes that may be happening to you.

Abdomen. After delivery, your cervix is still open and stretched. In just 1 week, the size of its opening will be about the size of a dime. Your uterus is still hard and round. It can be felt around your navel and weighs about 2 ½ pounds. In 6 weeks, it will weigh only 2 ounces. It will no longer be felt by pressing on your abdomen. But,



Just after birth, the uterus measures about 7 inches long and weighs about 2 pounds (top). It can be felt just below the navel. In 6 weeks (bottom), it has returned to its normal size of about 3 inches long, weighing about 2 ounces.

it will take some time for the stretched abdomen muscles to become tight again. Doing simple exercises will help. You may tend to get a backache until the abdominal muscles tighten up and once again help your back muscles to keep an erect posture.

Hair Loss. A few weeks after delivery, you may find that you are losing large amounts of hair. This is not unusual. Your hair will soon return to its normal growth cycle.

Lochia. After delivery, you will have a vaginal discharge. This is called lochia. It is made mostly of blood and what is left of the uterine lining that was needed during the pregnancy. For the first few days, the discharge is bright red. After 2 or 3 days, it becomes pinker and decreases in amount. In about 10 days or so, the discharge changes to a white or yellow color. It gradually decreases until the flow has stopped. (Some women, however, may have a brief period of increased bleeding 7–10 days after delivery.) The length of time the discharge lasts is different for each woman. Do not use tampons while the flow is heavy.

Menstrual Periods. Your menstrual periods will usually return 7–9 weeks after delivery. They may be shorter or longer than before. Gradually, they will return to what is normal for you. If you are breast-feeding, your periods may not return for several months, maybe not until you stop breast-feeding. Your ovaries may begin to function soon after delivery, though. You can become pregnant even if you do not have a period, so you should use some form of birth control.

Warning Signs

Watch for any odd changes in your health. Call your doctor if you notice any of the following:

- Fever over 100.4°F (38°C)
- Nausea and vomiting
- Painful urination, burning, and urgency (sudden, strong need to urinate)
- Bleeding heavier than your normal period
- Pain, swelling, and tenderness in the legs
- Chest pain and cough
- Hot, tender breast
- Pain between the vagina and rectum that gets worse with time

Emotional Changes

After the first week or so, you may begin to notice mood changes. Changes in hormones, being tired, and feeling overwhelmed with all the new responsibilities can make you feel depressed. This is called postpartum or baby blues. These are normal feelings that will go away in a few weeks. Some women, though, develop a more serious condition called postpartum depression. If the blues last longer than 2 weeks or if they seem serious, you should discuss them with your doctor and take steps right away to get the support and help you need.

Sex and Birth Control

You can usually have sex again when everything, including your episiotomy, is healed and you feel comfortable. This usually takes about 3–4 weeks. You may need to use some type of lubrication, especially if you are breast-feeding.

You can get pregnant even if you are breast-feeding or your periods have not yet started. This means that you need to choose some form of birth control before you have sex for the first time.

Discuss birth control options with your partner and doctor. Choose a method that meets your needs:

- Birth control pills
- Contraceptive implants
- Contraceptive injections
- Intrauterine device (IUD)
- Barrier methods
  - — Diaphragm
  - — Cervical cup
  - — Condom
  - — Female condom
  - — Vaginal sponge
  - — Spermicidal cream, jelly, foam
- Periodic abstinence (also called natural family planning)
- Sterilization
  - —Male (vasectomy)
  - —Female (tubal ligation)

Keeping Healthy

Getting enough rest is one of the most important things to do—and often the hardest. Try to nap when the baby does, even if it means not doing something else. You may need help around the house so that you do not become too tired. Ask your partner, a friend, or a relative to take over some chores, such as laundry, dishes, or meals, until you are back on your feet.

You may weigh a few more pounds than you did before pregnancy. Good eating habits and exercise will help you regain your shape and lose weight gradually. Cut calories from junk foods, not from basic nutrients. Drink plenty of fluids. If you are breast-feeding, you need even more calories than when you were pregnant. Do not try to lose weight until you stop breast-feeding.

Exercise can help you get your muscles get back in shape. Easy exercises can be done as soon as 24 hours after delivery. Harder exercises are started later. If you had a cesarean birth, talk to your doctor or nurse before you start to exercise. As always, exercise must be started slowly and increased gradually. Your doctor may suggest some exercises or you may learn some in a childbirth class.

Finally...

You can improve your chances of having a healthy baby by leading a healthy lifestyle during pregnancy and getting proper prenatal care. Learn as much as you can before the birth of your baby. Know your own body and what to expect during pregnancy, labor, and delivery.

Glossary

Amniotic Sac: Fluid-filled sac in the woman's uterus in which the fetus develops.

Areola: The darker skin around the nipple.

Birth Control (Contraception): Method to prevent pregnancy.

Cervix: The lower, narrow end of the uterus.

Chloasma: The darkening of areas of skin on the face during pregnancy.

Down Syndrome: A genetic disorder caused by the presence of an extra chromosome and characterized by mental retardation, abnormal features of the face, and medical problems such as heart defects.

Episiotomy: A surgical incision made into the perineum (the region between the vagina and the anus) to widen the vaginal opening for delivery.

Fallopian Tubes: Tubes through which an egg travels from the ovary to the uterus.

Fetus: A baby growing in the woman's uterus.

Hormones: Substances produced by the body to control the functions of various organs.

Induced Abortion: The planned termination of a pregnancy before the fetus can survive outside the uterus.

Miscarriage: The spontaneous loss of a pregnancy before the fetus can survive outside the uterus.

Neural Tube Defect (NTD): A fetal birth defect that results from improper development of the brain, spinal cord, or their coverings.

Nutrients: Nourishing substances supplied through food, such as vitamins and minerals.

Obstetrician–Gynecologist: A physician with special skills, training, and education in women's health. The initials FACOG mean that he or she is a Fellow of the American College of Obstetricians and Gynecologists.

Ovaries: Two glands, located on either side of the uterus, that contain the eggs released at ovulation and produce hormones.

Placenta: Tissue that connects woman and fetus and provides nourishment to and takes away waste from the fetus.

Uterus: A muscular organ that is located in the female abdomen and contains and nourishes the developing embryo and fetus during pregnancy.

Vagina: A passageway surrounded by muscles leading from the uterus to the outside of the body.

NO.052 P002/014

American Academy of Pediatrics

AAP NEWS

Volume 11 Number 8 THE OFFICIAL NEWSPAPER OF THE AMERICAN ACADEMY OF PEDIATRICS August 1995

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Current insurance policies might place newborns at risk

Minimum 48-hour postpartum coverage urged

by GERRY CLARK
Assistant Editor

Physicians and legislators are aiming to alter managed-care policies dictating maximum 24-hour postpartum hospital stays, claiming the practice might harm newborns and mothers.

In recent months, the insurance industry has come under fire for its postpartum hospital-stay coverage policies. Managed-care organizations frequently will only insure a 24-hour stay, which many medical experts regard as insufficient time to monitor potential newborn health problems as well as educate mothers on proper breastfeeding techniques.

American Medical Association (AMA) officials, with AAP input, passed a postpartum discharge policy at their annual meeting in late June. AAP officials are currently developing updated guidelines for determining when mothers and newborns should be discharged from hospital care after delivery.

Legislators also are interested in ensuring longer stays. Two states recently passed legislation requiring insurers to cover specific durations of postpartum hospital stays and other states are considering similar measures. Senators and representatives alike have recently introduced federal postpartum-stay legislation.

Current policy

Current AAP policy, contained in *Guidelines for Perinatal Care* (Third Edition), a joint effort of the Academy and the American College of Obstetricians and Gynecologists, states that the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean delivery, excluding the day of delivery and provided no complications exist. The guidelines spell out a list of conditions that should be met for early discharge, particularly if it occurs within 24 hours of delivery.

The earliest the proposed AAP policy

See Hospital stays, p. 8

Bill Bisley

A mother and newborn leave the hospital. Federal and state legislators want to require insurers to cover postpartum hospital stays up to 48 hours.

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Hospital stays

Continued from p. 1

statement, tentatively titled "Hospital Stay for Healthy Term Newborns," might be released in late August. AAP Committee on Fetus and Newborn Chairperson William Oh, M.D., said.

While providing a general outline of the proposed policy statement, Dr. Oh would not offer specifics on what the new guidelines might indicate.

"It's a little premature at this time," Dr. Oh said in early July. "The one thing I'm sure is we are spelling out the guidelines that must be fulfilled before discharge can occur."

"We'll be spelling out specific follow-up guidelines and who should be doing it," Dr. Oh said.

"Right now, it's not spelled out in the guidelines, so the insurance companies do what they want," he said.

Once a policy statement is in place, Dr. Oh predicts that insurance firms would face potential legal or medical risks if they establish policies significantly different from the Academy's stance.

Legislation

New Jersey legislators passed a bill in late June mandating that insurers provide coverage for at least 48 hours of inpatient hospital care following vaginal delivery, and a minimum of 96 hours of inpatient care after cesarean delivery.

Maryland officials recently approved legislation requiring insurers to cover maternity stays in accordance with "the most current version" of the *Guidelines for Perinatal Care*. Managed-care organizations may authorize shorter hospital stays provided the newborn child meets the criteria for medical stability as outlined in *Guidelines for Perinatal Care*.

Bills related to postpartum hospital stays have been introduced into the

Massachusetts and Pennsylvania state legislatures. States whose legislators are considering similar legislation when their sessions resume in 1996 are Illinois, California, Iowa and Georgia, AAP officials said.

At the federal level, Sen. Bill Bradley (D-N.J.) introduced legislation in late June titled "New Borns" and Mothers' Health Protection Act of 1995." Co-sponsored by Sens. Nancy Kassebaum (R-Kan.) and Jay Rockefeller (D-W. Va.), the bill would require insurers to provide coverage for a minimum of 48 hours of inpatient care after vaginal delivery and a minimum of 96 hours of inpatient care after cesarean delivery for a mother and newborn.

A proposed amendment to the Employee Retirement Income Security Act of 1974 (H.R. 1955), was introduced into the House in late June by Representative Peter DeFazio (D-Ore.) and several co-sponsors. It calls for the same coverage as Bradley's bill. Exceptions may occur if certain post-delivery care is provided, such as follow-up visits at home or in a physician's office.

A legally nonbinding House concurrent resolution, introduced by Rep. Bernard Sanders (I-Vt.) and others, has received AAP endorsement. The resolution states "the sense of the Congress" is that the Maternal and Child Health Bureau should "promptly" collaborate with national organizations to encourage studies to identify safe practices regarding hospital discharge of mothers and newborns.

Bradley introduced the Senate bill following discussions with the health-care union, Hospital Professionals and Allied Employees of New Jersey/AFT, according to Bradley spokeswoman Victoria Streitfeld. The union represents 3,500 New Jersey nurses.

"What we've seen is with the new rules of managed care, mothers and babies were being forcibly discharged after 24 hours," Ann Twomey, president of Hospital Professionals and Allied Employees of New Jersey/AFT, said.

Bradley recognizes that "there are potential health problems" with early discharges, Streitfeld said, and the senator regards the insurance industry as a source of the problem.

"(Insurance companies) have been the motivating force behind early discharge," she said.

Penalties would not be imposed on

> ***"What we've seen is with the new rules of managed care, mothers and babies were being forcibly discharged after 24 hours."***
>
> ***– Ann Twomey, President, Hospital Professionals and Allied Employees of New Jersey/AFT***

hospitals that discharge early under Bradley's bill, Streitfeld said.

"It just mandates that insurance pays for 48 hours," she said.

"Very brief" meetings have occurred between Bradley and the insurance industry, Streitfeld said, but she would not provide details on those discussions.

Physicians should decide

While AMA officials and Dr. Oh applaud Bradley's intent, they say physicians, not legislators, should be in charge of making medical decisions.

"It's good that the legislator is getting into the act on this, but physicians should take care of the medical issues," Dr. Oh said. "I just don't think it's right to legislate medical practice. We should take the lead in medical practice."

Physicians should have the flexibility to exercise medical judgment outside of managed-care or legislative restraints, AMA Board of Trustees member John Nelson, M.D., M.P.H., said.

"What we're looking for is what I call 'clinical wiggle room,' " Dr. Nelson, an obstetrician-gynecologist in private practice in Salt Lake City, said.

"I think the intent (of Bradley's bill) is laudable," he said. "I simply argue it's the wrong vehicle."

But New Jersey nurses are happy with their state's postpartum legislation, Twomey said.

"We hope this becomes a model for the rest of the country," she said.

The recently approved AMA policy states that "in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgment of attending physicians and not by economic considerations." The document states that the AMA "is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe."

"In the last few years, I think managed care and HMOs have precipitated (early discharge) for the financial benefit," Dr. Oh said. "The insurance companies are having a field day right now. They can dictate, (with) a normal delivery, you have to leave in 24 hours."

No magic number

Health Insurance Association of America (HIAA) officials agree with the AMA that postpartum hospital stay legislation is a bad idea. Twenty-four-hour stays are often good medicine, HIAA leaders contend.

"We have a hard time with legislators making these decisions, when it should be a medical (decision)," HIAA spokesman Dan DiFonzo said.

"This is the kind of a situation where there's not a lot of empirical data showing (an ideal hospital stay)," DiFonzo said. "There's no real magic number. They should be looked at on a case-by-case basis."

Several arguments exist for discharging women and newborns early, DiFonzo said. Evidence shows that women convalesce faster at home and that shorter stays reduce the risk of children contracting airborne diseases. Health-care workers should educate women about proper breastfeeding before delivery, not during hospital stays, he said.

Real-life demonstration is superior to anything mothers could read in a brochure, Twomey said. And since mothers don't begin lactating until after delivery, such education is impossible prior to their hospital stays.

"It should be done before as well as after," Twomey said.

Medical experts say that such conditions as jaundice or congenital heart

> ***"It's good that (Sen. Bradley) is getting into the act on this, but physicians should take care of the medical issues. I just don't think it's right to legislate medical practice."***
>
> ***– AAP Committee on Fetus and Newborn Chairperson William Oh, M.D.***

disease do not reveal themselves within 24 hours, and that longer stays are needed to monitor for such problems.

"Twenty-four hours is just generally too, too short," Twomey said. "We've too many mothers coming (back) in with complications, and it didn't have to be the case. It's a classic example of cost over quality."

HIAA officials question whether long hospital stays are needed to properly monitor newborns' potential health problems.

"Is it necessary for the baby to be in there three days, or is it OK to be home and go back in in two or three days?" DiFonzo said. "Do you keep a baby in the hospital a week to get those tests?"

Physicians who disagree with an insurance company's policy are not powerless, he said.

"Doctors can overrule the insurance companies," DiFonzo said. "They are in a position to appeal. It is their professional responsibility to do that."

However, appealing insurance company decisions is not an easy task, Twomey said, based on her experience dealing with New Jersey managed-care organizations.

"For the mother to stay, she would have to show complications such as high fever, bleeding," she said.

The proposed AAP policy should provide physicians with better negotiating power to obtain longer hospital stays for mothers and newborns, Dr. Oh said.

"They can use this as the guideline to negotiate or discuss with the insurance companies: 'This is what the Academy recommends. We have to do this.' "

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REPORT 5 OF THE COUNCIL ON SCIENTIFIC AFFAIRS (A-95)
Impact of 24-Hour Postpartum Stay on Infant and Maternal Health
(Resolution 135, A-94)
(Reference Committee E)

EXECUTIVE SUMMARY

A variety of sociological and economic factors have converged to shorten dramatically the length of postpartum stays for most American women and infants. Some evidence exists that mothers may prefer shorter stays, and some researchers have concluded that complication rates for abbreviated postpartum stays are no higher than for traditional stays.

During the first 72 hours of life, a variety of important tasks must take place for mothers, infants, and families. Evaluating the impact of discharge in under 24 hours has been complicated by a host of factors. These include definitional problems, lack of randomized studies, and difficulty in operationalizing a good outcome. Most studies have focused on rehospitalization as the only outcome measure. Further, the available data have been collected on women prescreened for low medical risk and who volunteered to be discharged early.

The failure to find differences in readmission rates for perinatal complications has been interpreted by many authors to mean that shorter lengths of stay are safe. Sample sizes have, however, been too small to yield adequate power to accept the null hypothesis.

A group of interested experts, government agencies, and medical and health organizations have begun to examine the issue of early perinatal discharge as it affects the health of mothers and infants. The Council on Scientific Affairs supports this process and recommends that the following statements be adopted as policy:

1. The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.

2. In the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, and determination that adequate feeding is occurring. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.

3. The AMA urges all state neonatal screening programs to institute procedures that provide for timely follow-up screening for infants whose initial samples are obtained in the first 24 hours of life

4. Well designed experimental studies are needed to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.

5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period.

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 5 - A-95

Subject: Impact of 24-Hour Postpartum Stay on Infant and Maternal Health (Resolution 135, A-94)

Presented by: W. Douglas Skelton, M.D., Chair

Referred to: Reference Committee E (Howard A. Richter, MD, Chair)

Resolution 135 (A-94), introduced by the District of Columbia Delegation, was referred to the Board of Trustees. Resolution 135 called for the AMA to review existing data or, if such is insufficient, deliver a survey of the impact of insurance-driven discharge of mothers and newborns within 24 hours of delivery with particular emphasis on (1) health of the infant, (2) health of the mother (physical and emotional), (3) issues dealing with instruction/education, i.e., breast feeding, well baby care, immunizations, (4) effects on remainder of family members, and (5) personal and financial effects. In response, Board Report 24 (I-94) directed the Council on Scientific Affairs to study the issue of 24-hour postpartum discharge of mothers and infants, to evaluate the impact of this practice on infant and maternal health, and to report back to the House of Delegates at the 1995 Annual Meeting.

Background

A variety of sociological and economic factors have converged to shorten dramatically postpartum stays for most American women and infants. Typical hospital stays used to be four or five days for normal vaginal births and one to two weeks for cesarean births. Over the past decade this decreased, and in the last three or four years typical hospital stays have dwindled to 24 hours or less for uncomplicated vaginal deliveries and two to three days for Cesarean deliveries. The driving force behind these changes has been largely socioeconomic. However, some evidence exists that mothers may prefer shorter stays, and some researchers have concluded that complication rates for abbreviated postpartum stays are no higher than for traditional stays.

The first 72 hours of life are a time of significant transition and stabilization for newborn infants. It is during this period that a variety of important tasks must take place. The mother goes through a period of rest and recuperation and is further educated about infants, breastfeeding, and parenting. The child is observed for ductal and cardiac abnormalities, respiratory difficulties, infections, jaundice, adequacy of feeding, and gastrointestinal anomalies. Newborn screening occurs, and the mother-child dyad is assessed for evidence of biological and environmental risk factors. If any of these preventive measures do not occur, potential risk to mother or child increases.

The first issue in examining the question of "early discharge" is attempting to define it. The Guidelines for Perinatal Care, jointly published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), define early

discharge as discharge within 48 hours of birth. It refers to discharge in less than 24 hours as very early discharge.[1]

Empirical studies have varied in their definition of early discharge. Most research examines the impact of discharge within 48 hours of vaginal delivery. Most expressions of concern have targeted discharges occurring in substantially less than 24 hours. Consequently, the available literature is limited and often does not focus on the populations of specific concern. Further complicating the analysis is the fact that most studies have had rigorous inclusion and exclusion criteria and have been conducted on mothers requesting early discharge. There is therefore only limited ability to evaluate scientifically the effects of shortening postpartum stays.

When evaluating the clinical effects of shorter stays, the following considerations are appropriate:

- health effects on and complication rates in the infant
- health effects (both physical and psychological) on the mother
- extent of opportunity for maternal and infant-care education
- physical and psychological effects on other family members
- extent of opportunity for maternal and child psychosocial assessment.

Available Research

Studies examining the issue of early discharge have tended to examine model programs that included a pre-screening process to identify low-risk mothers and infants, some degree of prenatal instruction or education, and some degree of follow-up care. The exact nature of these interventions, however, varied from program to program. Follow-up care, for instance, ranged from one home visit and a phone call to three home visits in the first three days home, and telephone consultation available 24 hours a day for two weeks.[2]

Methods of participant selection also varied from program to program. In almost all cases, however, the women chose whether they wanted early discharge or traditional hospital stay and the option was only available to a selected population. One study did use a randomized method of participant selection, but the authors acknowledge that "sample sizes were too small to detect significant differences in the outcomes."[3]

There are several factors that make interpretation of the available research tentative at best:

- discrepant definitions of "early discharge"
- exclusion of women and infants likely to have birth-related complications
- absence of random assignment
- no or flawed control groups
- provision of compensatory services in early discharge groups that may mask or alter the effects of more rapid discharge.

Type I vs. Type II Error

Another important question is the issue of where the burden of proof should lie. Is it sufficient that a change in practice fail to create significant adverse consequences, or should it be demonstrated to be "safe?" At the heart of this debate is the issue of Type I vs. Type II error--failure to reject the null hypothesis does not mean that the null hypothesis is correct. In other words, evidence that early discharge is not unsafe does not mean that it is safe.

In a review commissioned by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration, Paula Braveman concludes that insufficient statistical power is a methodological flaw common to all published studies of early discharge programs--"None of the studies in the literature had adequate power to detect even a doubling of the neonatal readmission rate."[4]

Despite this problem, most researchers in the field of early discharge have concluded that early discharge is safe, based on failure to demonstrate significant differences in neonatal readmission rates.

What is a Good Outcome?

One issue that bedevils outcome research is the difficulty in operationalizing a positive outcome. With regard to the issue of early discharge, the outcome variable generally selected is readmission of the infant within the first year of life. Information about morbidities not requiring rehospitalization is generally unavailable. Further complicating the issue is the economically driven trend to treat problems on an outpatient basis as much as possible, which may result in shifting criteria for readmission over the study period. An argument can also be made that readmission in the context of a follow-up visit is a good outcome, in that problems are being diagnosed and treated that might otherwise have been missed.

Health of the Infant

Within this shifting empirical landscape, a few studies have drawn conclusions about the impact of abbreviated postpartum hospital stays. The preponderance of available literature addresses the health status of infants going home after shorter vs. longer hospital stays.

Clearly, early discharge minimizes the risk of nosocomial infection (for both infant and mother).[5] However, it may not provide adequate time for routine medical and social assessment of the dyad.[6] Most researchers have concluded that early discharge (discharge within 48 hours of delivery) is generally safe for low-risk infants, based on a lack of "significant differences in the levels or types of mortality or readmissions for the early discharge and control groups."[2]

A review of all postpartum early discharge program outcomes in the United States published between 1960 and 1985 concluded that discharge prior to 48 hours (most within 24 hours) was not associated with an increase in neonatal morbidity.[2] None of the programs included in this review, however, had adequate sample sizes for good statistical power, and at least two thirds of the programs lacked a control group.[4] A more recent study (1990) found no significant difference in infant morbidity between infants randomly assigned to be discharged after 12-24 hours, 25-48 hours, and four days. However, small sample size limits the utility of these

results.[3]

Almost all instances of infant readmission (in all studies) were due to hyperbilirubinemia, with variability due to differences in the definition and treatment of hyperbilirubinemia. Complicating this finding is the fact that hospitalization is no longer considered to be the gold standard for treating moderate hyperbilirubinemia in neonates. Norr and Nacion report that "of a total of 84 infant readmissions reported by all of [the] studies, 71 were for hyperbilirubinemia and only 13 were for all other causes, including transient tachypnea, bradycardia, and hypothermia, with no one cause predominating." Norr and Nacion further report that morbidity from causes other than hyperbilirubinemia is low. Superficial skin infections, feeding problems (lack of weight gain), and hypothermia are cited as the most common problems. Less common problems include diarrhea, pneumonia, convulsions, and respiratory difficulties.[2]

There are many anecdotal reports about other serious problems such as failure to thrive, missed diagnoses of metabolic disorders such as phenylketonuria, and serious bleeding from circumcision wounds, but these have not as yet been documented empirically.

Perinatal Screening

Mandated neonatal screening varies from state to state, but all screening programs are designed to prevent morbidity and mortality through early diagnosis of medical problems and congenital disorders that can have serious sequelae. Adequate screening programs require universal participation, prompt diagnosis, and mechanisms for parental notification and education. Common screening tests include those for persistent hyperphenalalaninemias, including phenylketonuria, galactosemia, maple syrup urine disease, congenital adrenal hyperplasia, and congenital hypothyroidism. Some states also mandate screening for sickle cell disease and various sexually transmissible infections.

Historically, these screening samples have been taken on the second or third day after delivery. This time period was established to optimize the sensitivity of the tests. PKU screening, for example, has a false negative rate that is quite high (about 33%) during the first 12 hours of life and drops to less than 1% after 48 hours. In contrast, early screening for congenital hypothyroidism, especially using thyrotopin (TSH) as the primary screen, may have a high false positive rate because of the normal TSH surge that accompanies parturition. Some experts argue that screening samples taken in the first 24 hours of life serve merely to notify the system of the existence of the infant. Follow-up screening for PKU or congenital hypothyroidism, for example, must then be completed in a timely fashion, no later than two weeks after birth.[1] Loss of infants to follow-up screening is a serious concern, but data regarding the rates of missed rescreening are not yet available.

Health of the Mother

Methodological flaws also plague the few studies examining the impact of early discharge on the physical health of the mother. Research has shown that very few mothers (less than two percent) require rehospitalization after discharge.[2,7] When they do, the problems are often fairly serious, including significant infection and hemorrhaging. The majority of mothers who did require readmission in one review suffered from endometritis.[2] In that review, six of the ten readmissions reported in four studies were for endometritis. (Two of the other four

women were readmitted for postpartum hemorrhages, one for severe postpartum depression, and one for a severely abscessed episiotomy.)[2] Again, however, these findings are not necessarily conclusive

The MCHB report points out that these studies had "comparison groups . . . [that] were likely to differ on relevant characteristics . . . [and/or] sample sizes were inadequate."[4] The data on maternal morbidity treated on an outpatient basis are even less certain. Many studies do not provide specific information about complication rates; others provide no information at all.[2,3] Of the studies that did offer information about morbidity that did not require hospitalization, the most common problems included mild hypertension, anemia, breast or episiotomy problems, and fatigue.[2,3,7] In a 1990 study that included a control group, the mothers experienced a generally healthy postpartum course, regardless of the time of discharge.[3]

The impact of early discharge on the emotional health of the mother is a similarly important area of concern. Emotional health includes such things as postpartum depression, mother-child separation, the mother's confidence in her ability to be a good parent, stress management, and the need for external support. In the randomized, controlled study that compared discharge at 12-24 hours, 25-48 hours, and four days, the mothers discharged 12-24 hours after giving birth reported themselves to be significantly less depressed at one month postpartum than the two later groups. In addition, the earliest group reported higher levels of confidence at one week postpartum than the other two groups. At one month postpartum, however, the three groups did not differ significantly with respect to levels of confidence. This suggests that women who assume total responsibility for their baby sooner after delivery may feel more confident initially than those who do not, but the direction of causality is unclear.[3]

Another study, which compared women who had domiciliary care after early discharge to women who had hospital care until discharge, found that the difference between the emotional health of mothers in both groups was not statistically significant.[8]

Although many of the studies mention other aspects of emotional health such as mother-baby bonding and the mother's support system, they do not provide data. A second document commissioned by MCHB reports on an October 1994 consensus meeting in Boston. There, a group of experts with "intimate knowledge of both hospital and community based care for mothers and newborns" found that "women who are from high risk social environments and with limited social support structures may not be best served by a one-day stay." In addition, "separation due to the need to observe either the mother or the newborn was deemed unacceptable. Policies that would result in increased rates of separation were viewed by the group as detrimental to mother infant bonding, infant and maternal health, and threatening to breastfeeding. Clinicians recognized a distinction between 24 hours and 72 hours because mother/infant bonding occurs during this early and critical time period."[9]

Education

Many experts express concern that early discharge will reduce the degree to which health care providers can offer parental education and instruction. The decreased length of hospital stay associated with early discharge significantly increases the importance of comprehensive and continuous prenatal and postpartum care.[10] Such care includes breastfeeding instruction, early discharge planning, and educating the mother about immunizations, well-baby care, and bodily changes

All of the studies reported in the literature included fairly extensive prenatal and follow-up care. No data are available about the relative educational needs of women who present for delivery without benefit of prenatal care, regardless of length of hospital stay.

Impact on Other Family Members

The impact of early discharge on the rest of the family is not as well documented as the impact on the mother and the infant. The studies do cite family togetherness and the involvement of the father in caring for the new baby as sources of parent satisfaction.[5,8,11-13] These studies, however, focus on the effect of early discharge on the mother and not on the rest of the family. The existing research does not sufficiently examine the impact of early discharge on other family members.

Cost-Effectiveness

The cost-effectiveness of early discharge programs is the final consideration examined in the literature. The literature only investigates the cost-effectiveness for the hospital. It does not address the impact on the patient's costs. Some studies conclude that reduced lengths of stay and the resulting increase in the number of beds available for other patients render early discharge programs cost-effective.[13,14] Other authors claim that no one has thoroughly analyzed whether early discharge programs truly provide a way to contain costs.[12] Again, the existing data are sketchy and inconclusive.

Conclusions

We still do not know how much and what kind of follow-up is needed for maternal and infant safety.[12] In the MCHB review, Braveman "categorized studies of early discharge according to the type of compensatory service provided in the early post-discharge days . . . [b]ecause conclusions from studies about early discharge in the presence of a given compensatory service cannot be generalized to early discharge in the absence of that service."[4] The reviewed studies that included post-discharge services did indicate that most women were generally satisfied with the care they received for both early discharge and traditional stay. At least two studies (both with postpartum home visiting) report that mothers who were discharged early were more satisfied than mothers who had traditional hospital stay.[3,8] Satisfaction, however, depends upon expectations, and studies show that the expectations of women who choose early discharge often differ from those of women who choose a traditional hospital stay. This suggests that women should be allowed to choose the maternity care which best suits their individual needs.[8]

While we can therefore conclude that some women prefer to be discharged sooner than later, definitive studies regarding the safety of doing so are not available at this time. The limitations of the existing research are significant. Inadequate statistical power, absence of random assignment, careful participant selection, and unstable definitions of "early" and "good outcome" render scientific conclusions highly unreliable. One of the major limitations of the studies is that most of the early discharge programs were voluntary. Norr and Nacion acknowledge that "it is likely that families who choose early discharge not only have favorable attitudes about coming home early, but also the resources and social support needed to make the discharge go smoothly."[11] Second, very few researchers have studied the effects of early discharge on disadvantaged populations -- most participants are either middle-class or upper

middle-class, healthy, well-educated, and living in a stable home environment.[2,3] The outcomes of the studies, therefore, cannot be generalized to high-risk populations. Further, there is no national consensus on what constitutes "low-risk" versus "high-risk." The October 1994 consensus meeting concluded that "neither the AAP/ACOG Guidelines for Perinatal Care regarding eligibility for 24 hour discharge nor the specifications concerning follow-up seemed adequate from the perspective of clinicians."[9]

Some physicians worry that the current trend toward reduced hospital stays will have dire results. Arthur Eidelman, MD, for example, notes that "it is assumed [that] the mother will be discharged into a supportive family unit where another responsible adult is present and where there exists an accessible medical care system for follow-up and ongoing care." Fully aware that many women do not enjoy such luxuries, Eidelman warns that allowing high-risk mothers such as "an adolescent primipara, or a single mother subsisting on welfare . . . into a system that does not have any backup visiting nurse program or community health clinics is simply committing medical and social suicide."[6] Eidelman's concerns reinforce the necessity of limiting early discharge to low-risk mothers or providing comprehensive care that would ensure a safe and healthy discharge for high-risk patients.

The commissioned MCHB review concludes, "Although many studies have examined early discharge, when standard scientific criteria are applied it becomes clear that the currently available literature provides little scientific knowledge to guide discharge planning for apparently well newborns and their mothers. . . . Rigorously designed studies are needed to examine the impact of early discharge and a range of post-discharge practices not only on newborns but on mothers and families. . . .[I]nformation from sound research is needed to inform policy addressing third party reimbursement as well as clinical care standards."[6]

In December 1994, the MCHB convened a group that included the American Medical Association and other concerned organizations, academicians, and experts to begin the process of examining the issue of early perinatal discharge. It was agreed that there may be cause for concern in the present trend toward more and more rapid postpartum discharge. Principles agreed upon at that meeting include:

- Discussions of an acceptable vs. unacceptable number of postpartum hours are unproductive and should be replaced by work to identify the essential prerequisites for timely and appropriate perinatal discharge of mother and infant

- Discharge policies that result in separations between mothers and infants due to staggered hospital releases are undesirable

- There needs to be concentrated work on developing national standards for adequate and sufficient care during the early neonatal period

Recommendations

The Council on Scientific Affairs recommends that the following statements be adopted in lieu of Resolution 155 (A-94) as policy and that the remainder of this report be filed.

1. The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.

2. It is the policy of the AMA that in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, and determination that adequate feeding is occurring. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.

3. The AMA urges all state neonatal screening programs to institute procedures that provide for timely follow-up screening for infants whose initial samples are obtained in the first 24 hours of life.

4. The AMA should encourage well-designed experimental studies are needed to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.

5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period.

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(11) REPORT 5 OF THE COUNCIL ON SCIENTIFIC AFFAIRS - IMPACT OF 24-HOUR POSTPARTUM STAY ON INFANT AND MATERNAL HEALTH (Resolution 135, A-94)

* Adopted changes to orig: Report

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Report 5 of the Council on Scientific Affairs be amended by insertion and deletion on page 8, lines 9-10, to read as follows:

2. It is the policy of the AMA that in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, ~~and~~ determination that adequate feeding is occurring, and with consideration of the mother's social and emotional needs and preferences. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by AAP and ACOG.

HOD DECISION: Adopted recommendation of Reference Committee

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations contained in Report 5 of the Council on Scientific Affairs be adopted as amended in lieu of Resolution 135 (A-94) and the remainder of the report be filed.

HOD DECISION: Adopted recommendation of Reference Committee

CSA Report 5 discusses available research data concerning shorter postpartum hospital stays along with the limitations of these studies. The CSA recommends adoption of the following policy statements: 1) the AMA is concerned about the trend toward shorter routine perinatal hospital stays in the absence of data to demonstrate safety; 2) time of perinatal discharge should be based on the attending physician's clinical judgement and not economic considerations; 3) all state neonatal screening programs should institute procedures to provide follow-up screening for infants whose initial samples are obtained within the first 24 hours of life; 4) the AMA should encourage well designed studies to identify safe postpartum stay hospital discharge practices; 5) the AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other organizations to examine the issue of appropriate medical care during the perinatal period.

Your Reference Committee heard considerable support for this report and its recommendations. Testimony provided information on New Jersey's new state law which requires insurers to pay for a minimum of 48 hours of hospital care after a vaginal delivery and 96 hours after a Caesarian section (Chicago Tribune, Sunday, June 18, 1995). The CSA did not wish to include these specific times in its recommendations because, as noted in Recommendation 2, definitive empirical data is not available to support such specific lengths of stay. The CSA did agree, however, to amend this recommendation to include the importance of consideration of the mother's social and emotional needs and preferences.

Several speakers mentioned the need for appropriate action and implementation of these recommendations. Your Committee did not feel that an additional recommendation requesting a report back at I-95 on implementation status was required, since this information already is provided to delegates in a memo on the implementation of business from the previous House of Delegates meeting. In addition, the CSA plans to monitor the implementation of these recommendations.

FOCUS

THE BOSTON SUNDAY GLOBE • JULY 2, 1995

HEALTH CARE

Braking the OB Express

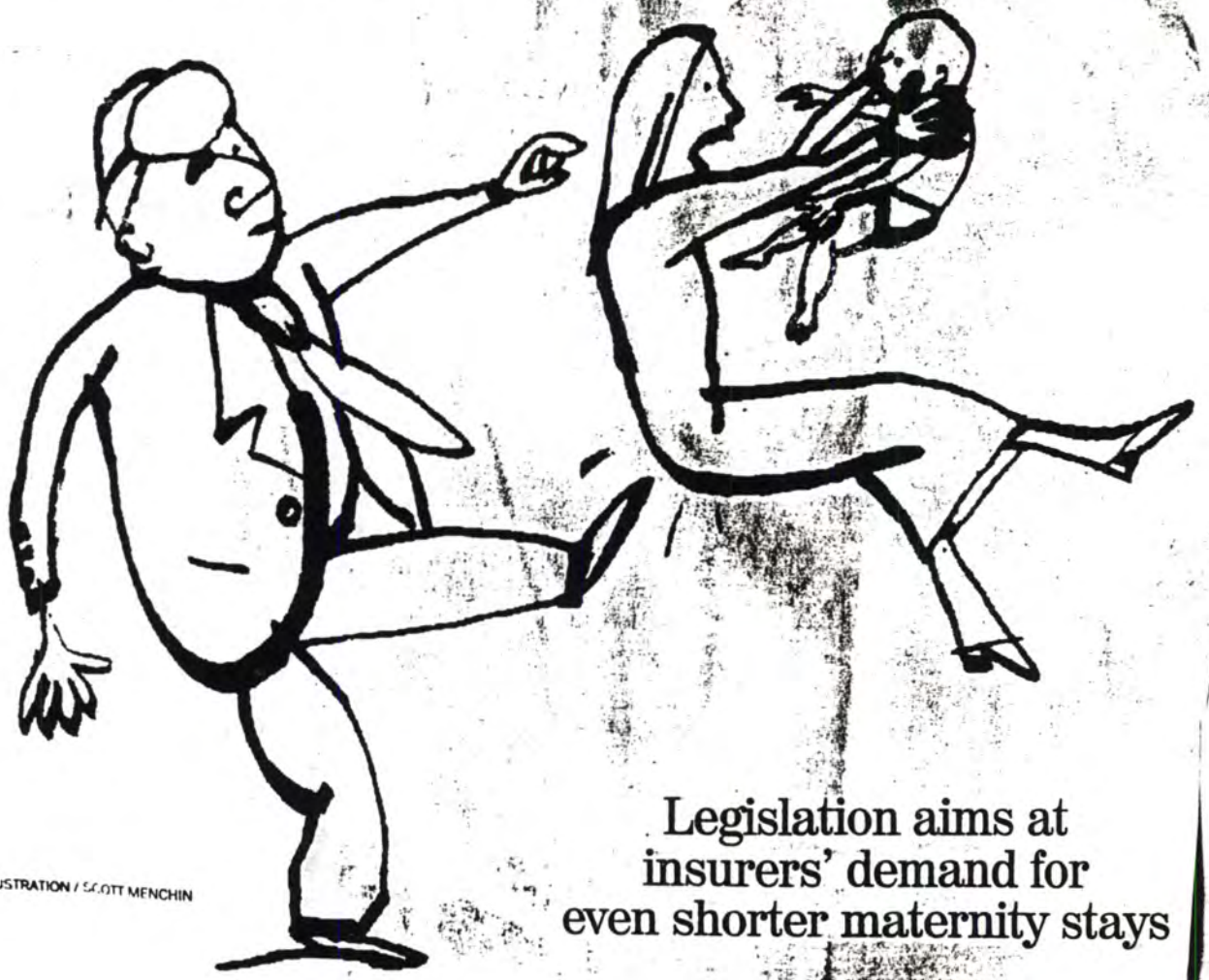

ILLUSTRATION / SCOTT MENCHIN

Legislation aims at insurers' demand for even shorter maternity stays

Putting the brakes on the OB Express

BY SUZANNE GORDON

The quintessential women's health issue – childbirth – is quickly becoming the rallying point for one of the toughest challenges yet to insurance industry control over patient care.

New mothers, tired of being rushed out of hospitals with their newborns as soon as 12 hours after giving birth, have joined health activists, nurses and doctors in demanding that insurers end the practice.

They say that "drive-through delivery" and the "OB Express" – imposed by insurers in the name of cost-cutting – must stop. In recent days and weeks, their efforts have begun paying off on several fronts:

New Jersey Gov. Christine Todd Whitman signed into law Wednesday a bill allowing new mothers to stay in the hospital for 48 hours after a normal delivery, double the previously allowed time. And, in this era of managed care, a nearly revolutionary provision allows women and their doctors to determine when a longer than 24-hour stay in the hospital is medically necessary.

The New Jersey bill follows a similar measure enacted in April in Maryland. On the home front, it inspired two Massachusetts lawmakers to introduce an even stronger version on Beacon Hill last week.

Meanwhile, on Capitol Hill, the issue made its debut last week as an influential Republican, Sen. Nancy Kassebaum of Kansas, teamed up with an influential Democrat, Sen. Bill Bradley of New Jersey, and introduced legislation ending "drive-through delivery" by allowing a 48-hour hospital stay for new mothers who desire it.

And two weeks ago, the American Medical Association's annual policy-making body endorsed this growing consumer revolt in a strongly worded attack on insurance policies that place "economic considerations" above medical ones.

All together, the actions of those opposed t the "OB Express" add up to a broad challenge to insurance companies' ability to dictate not only the terms of patient care but also the prac tice of medicine and nursing. It represents a new effort to roll back "managed care," the phrase used to describe insurance companies' micromanagement of every aspect of health care, from which doctor a patient may choose t how long a patient may stay in the hospital. Critics say a better route to cost-cutting would

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■ CHILDBIRTH

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be a more fundamental overhaul of the health care system.

The challenge was sparked by insurers' recent practice of radically limiting hospital stays for women having babies – the most frequent cause of hospitalization in the United States.

As recently as 1970, women stayed an average of almost four days in the hospital after delivery, unless it was by Caesarean section. By 1992, the median length of stay was about half that, or just over two days. In the last three years, it's been almost halved again, as insurance companies and health maintenance organizations have routinely imposed the one-day limit for normal deliveries, unless an extended stay is deemed "medically necessary."

In some states, such as California, insurers send maternity patients home as shortly as 6 hours after a normal delivery. In all states, a longer stay, such as three days, is allowed after delivery by Caesarean section.

Insurers have argued that besides cutting costs, limiting hospital stays for newborns has a health benefit: It's not good, they say, to expose babies to the germs that necessarily are present in a hospital. Thus it makes sense, they say, to limit hospital stays to 24 hours or less – in California, it's sometimes held between 6 and 12 hours – for women who have a normal delivery.

But for some families, taking home a baby less than a day old has had tragic consequences. For New Jersey lawmakers, it was the wrenching testimony of mothers and family members that most powerfully translated the real costs of managed care. Dominick A. Ruggiero Jr., 62, a retired bus driver, described how his 2-day-old niece died from a massive, treatable infection.

The baby's insurer was US Health Care, a national HMO that reportedly spends less on actual care than any other company – 72.9 cents of every dollar rather than 78 – yet pays its chief executive $9.8 million a year. According to Ruggiero, US Health Care told Michelle Bauman that she and her 24-hour-old baby, Michelina, would have to leave the hospital. The night of her discharge, the baby became increasingly uncomfortable. The next day, their US Health Care nurse was supposed to arrive for a follow-up visit, Ruggiero testified, but she neither called nor came to the Bauman home. Alarmed by the baby's condition, the Baumans repeatedly telephoned their US Health Care pediatrician. Absent any examination, he declared, Ruggiero said, that the baby's discomfort was "normal." Michelina Bauman, 2 days old, died at 5:30 p.m.

"As far as I'm concerned," Ruggiero said, "her death certificate should read: killed by

the health care system."

Ruggiero's account helped convince New Jersey lawmakers to join in a bipartisan effort to extend hospital stays for new mothers. The battle began there last year, when two legislators introduced a bill to regulate the "OB Express." For want of public and legislative support, the bill languished until veteran Assemblywoman Rose Heck, a Republican who chairs the Assembly Advisory Council's Women's Health Group, held a hearing on women's health.

According to Myra Terry, president of the New Jersey chapter of the National Organization for Women, the hearing was the opening many women's health activists had been waiting for. NOW and other groups used the event to raise public and legislative consciousness about what it's like to ride the OB Express.

"Insurers say that a mother and newborn can stay in the hospital for 48 or 96 hours if it's medically necessary," Dr. Holly Roberts, an obstetrician, explained. But to insurers, Roberts said, "medically necessary" only seems to apply when a woman is hemorrhaging or has a high fever. "The fact that a woman has just fainted in the bathroom; that she has a rip from her vagina to her rectum and can barely walk; or is a single mom and has no help at home, none of that matters," Roberts said angrily.

Heck said she was deeply shocked by what she learned at the hearing. "The happiest day of a woman's life was being turned into a nightmare. We felt completely incensed and that we had to move quickly," she said.

The Massachusetts legislation, just introduced by Sen. Lois Pines of Newton and Rep. Harriet Chandler of Worcester, both Democrats, is stronger than the New Jersey law. It would automatically guarantee mothers a 48- or 96-hour hospital stay. It also allows women and their doctors to decide what is medically necessary. If neither asks for a longer stay, insurers may provide less time in the hospital if they offer mothers and babies specific in-home services, including three visits by a nurse.

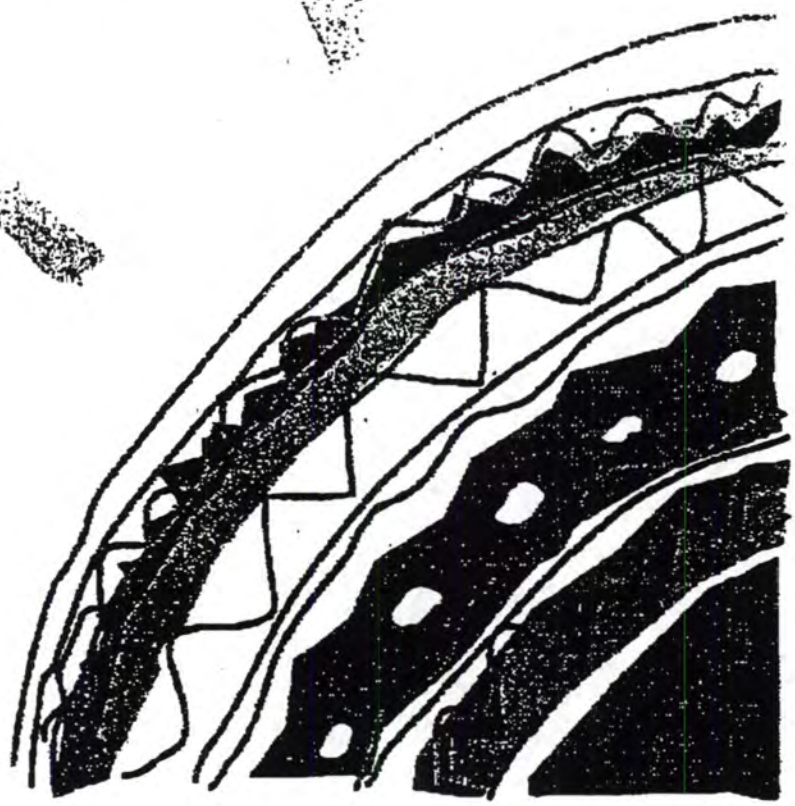
"I believe that the insurance industry's policies of drive-through deliveries are undermining the health and well-being of infants and their mothers," Pines said.

Many doctors agree, and resent what some call economic blackmail by insurers. "We're all under enormous pressure to get patients out of the hospital," Roberts said.

She said that recently a representative of one of the largest HMOs in her area appeared in her office. He bluntly informed her that she would be eliminated from the HMO network if she didn't get her patients out of the hospital more quickly. The message, Roberts said, was clear: It's either you or your patients.

Bright Futures

Guidelines for Health Supervision of Infants, Children, and Adolescents



Chapter 2.

CARING FOR YOUR BABY

YOUR NEW BABY

Getting to know your new baby. Talking to, touching, feeling, and handling your new baby from the start—even right in the delivery room—is good for you and your baby.

Ask to have your newborn placed beside you in bed. Look your baby over from head to foot—with your partner, if he is with you. Caress and pick up your baby. Ask your doctor or nurse to show you how. Get to know how your baby feels. If you plan to breastfeed, this is a wonderful time to start.

Later, undress and dress your baby, change diapers, give him or her a bath. Babies are really very sturdy. They can take a lot of handling and usually enjoy it. However, you should take care to support your baby's head. If both you and the baby are comfortable, you are doing all right. You will know something is wrong if your baby continues to cry or struggle.

If you or your partner have questions about how to pick up, hold, bathe, dress or undress your baby, ask the hospital staff to show you how. Then do it yourself until you are comfortable. Also, let the staff show you how to take the baby's temperature by rectum, and how to perform other simple tasks such as clipping finger and toe nails.

Get to know the feel and the fun of handling and playing with your baby and breastfeeding while you are in the hospital. Insist on being with your baby as soon as possible and for as long as possible. Your partner should also be there as much as possible. Use this time to learn all you can about your new baby—it will make caring for him or her much easier when you get home.

Newborn tests. Right after your baby is born he or she will be checked for healthiness.

Your doctor or other staff will give your baby a complete physical exam, including checking your baby's

- appearance or color
- reflexes
- breathing
- heart rate
- activity

These factors will help determine whether your baby needs any type of special attention.

Chapter 2. CARING FOR YOUR BABY

Take care of yourself
Involve your family
Love your baby

Take care of yourself. Your own health as a mother is vital to your baby's health and comfort. *Giving birth to a baby is exhausting.* Don't be surprised if you don't feel like yourself for several weeks. Your body will take some time to adjust; you have experienced many physical changes. If you are having any problems, be sure to call your doctor.

Also, some women may feel "blue"—irritable, restless, overwhelmed, teary-eyed or helpless. These feelings may change back and forth between "the blues" and feelings of happiness and energy. Talking with your partner, another family member, another mother, or doctor may help. Be sure to ask your doctor or clinic any questions you may have about your own health or just about taking care of yourself.

Involve your family. Although you will be tired when you get home from the hospital, you will probably have enough strength and energy and time to care for your baby and yourself. But housework, the care of other children, and meal preparation for the whole family are extra tasks that must be taken care of. During the first few days at home, try to get someone else in your family to help with these other responsibilities.

Your partner should be able to take a role in helping, but he will be going through a period of adjustment, too. New responsibilities are stressful for both of you; sharing of feelings between you is very important at this time, when the new baby is often the center of everyone's attention.

If you have other children, you will want some help with your newborn so that you can spend some time with them. Introduce them to the baby. With your help, let them touch and play with their new brother or sister.

You may want to postpone visitors for several weeks in order to reserve your energy for your family.

Love your baby. These first weeks are when new parents and older brothers and sisters should spend time together and with the new baby, getting used to the youngest member of the family. Let everyone get to know the baby by holding, touching, talking, singing or just watching him or her. Brothers and

Brothers and sisters

sisters should be encouraged to enjoy or help care for baby with adult supervision. New fathers need to spend as much time as possible enjoying and getting comfortable with baby, just like new mothers.

Brothers and sisters. You should introduce your new baby to his or her brothers and sisters as soon as possible. Let them touch (or hold, if they are old enough) your baby with careful supervision. It may take them some time to get used to having a baby brother or sister. You'll need to be patient with them during this period of change and adjustment. It sometimes helps young children to be told that when they were babies, you took care of them just the way you are now caring for the new baby.

Brother and sisters

It is normal for older children to be jealous of the time that parents spend with a new baby. They may wonder whether you still love them. Try to find some time to give each of them special attention. Don't be surprised if a child between 2 and 5 years old starts thumb sucking, crying more, wetting pants, or asking for bottles or diapers in imitation of your new baby. He or she is trying to get a share of your attention. Both parents should give older children as much attention as possible, but should discourage a return to baby-like habits.

Young children *should never be left alone with the baby*. They are too young to understand the baby, and may be interested, curious, or jealous. They may pick up and drop, squeeze too hard, sit on, or put dangerous things in the infant's mouth or crib. They may hurt the infant with tools, utensils or furniture. This is not because they are "bad," but because they may not understand what they are doing. Give them the individual attention they need, let them help you and the baby in whatever way they can when you are with the baby, and *never leave them alone with the baby*.

After my baby is born ...

TAKING CARE OF BABY ...

- Talking to, touching, and holding your new baby in the delivery room is good for you and your baby.
- This is a wonderful time to start breastfeeding. Tell your care giver not to let anyone else feed your baby so that your baby will only get your breast milk.
- Your health care giver will examine your baby right after birth, checking appearance and color, reflexes, breathing, heart rate, and activity to see whether your baby needs any special care.
- Ask to have your newborn placed beside you in bed. Touch and hold your baby, and get to know how your baby feels.
- Your baby may look different from the way you expected. Ask the hospital staff if you have questions about the way your baby looks.
- Ask the staff to show you how to take your baby's temperature and read the thermometer.
- All infants should be protected against hepatitis B. Some doctors recommend the first shot be given before going home from the hospital.
- You should take your baby to see the doctor when your baby is about 1 week old unless you are told to come in sooner. Call your baby's doctor right after your baby is born for an appointment.
- Before you and your baby leave the hospital, a few drops of blood will be taken from your baby's heel to check for some rare problems.
- You will need a car safety seat (marked "federally approved") to bring your baby home. It is the law—your baby must always be in an approved safety seat when traveling in a car, van, or truck. Ask your health care giver, the hospital where you deliver, or health department about programs that loan federally approved car safety seats.

If you or the baby's father have any questions about how to pick up, hold, feed, bathe, diaper, or dress your baby, ask the hospital staff to help you.

Your new baby needs all of the love and comfort you can give. You cannot love a baby too much. Your entire family can share in the joy of this love.

Next appointment for my baby: _____

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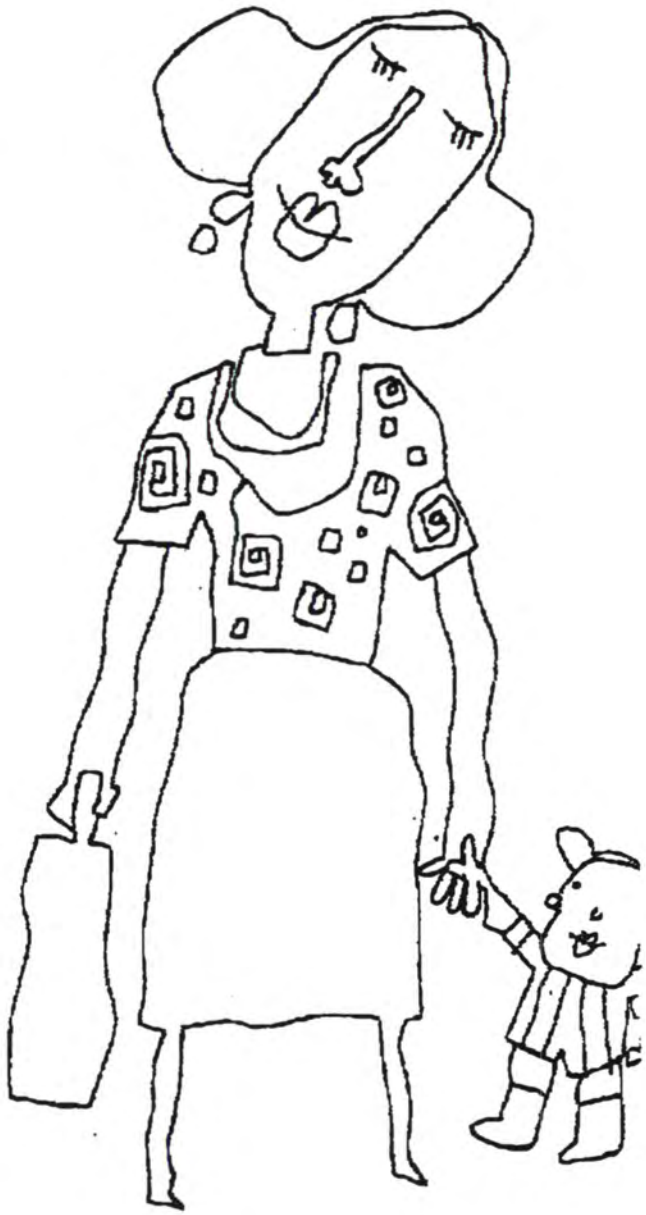

Guidelines for PERINATAL CARE

Second Edition

American Academy of Pediatrics

American College of Obstetricians and Gynecologists

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policy, there is no absolute medical indication for circumcision in the neonatal period, will be modified only if data conclusively demonstrate the value of the procedure.

Parent Education

The hospital experience is to some extent a learning process; however, the reduction in the length of a patient's routine postpartum stay compromises the opportunity for parent education. Hospital resources that have traditionally been extended to parents can no longer be accommodated within the shortened hospital stay. Physicians should be willing to accept, understand, and respond to parent inquiries that arise throughout the perinatal period and make every effort to ensure that educational aspects of care are provided prior to and following hospitalization.

Closed circuit television films previewed and approved by the obstetric and pediatric staff, printed materials, and counseling by hospital personnel (eg, postpartum and nursery nurses, registered dietitians/nutritionists, and physical therapists) have been helpful to parents. Other beneficial activities are group or individual educational sessions held regularly during the postpartum period to teach and discuss patient self-care, including exercises and self-examination of the breasts; parent-infant relationships; infant care, including bathing and feeding; and child growth and development. Family planning techniques appropriate to the patient's needs and desires should be explained in detail.

The newborn undergoes rapid changes in physiology that should be explained to the parents. The neonate's cardiovascular, pulmonary, renal, and neurologic maturation should be observed by the parents with the guidance of qualified personnel. Parents should be familiar with normal and abnormal changes in wake-sleep patterns, temperature, respiration, voiding, stooling, and the appearance of the skin. They should also observe and become familiar with the behavior, temperament, and neurologic capabilities of the newborn. Some believe that parents should also learn infant cardiopulmonary resuscitation techniques.

Visiting

The father or supporting person may be with the mother as much as desired within the constraints of acceptable standards of care and hospital policy. This includes the labor, delivery (including cesarean delivery), recovery, and postpartum periods. Local policies should b

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developed and followed consistently. Flexible and liberal visiting policies for fathers are well accepted and should be encouraged.

Sibling visits may be desirable in the early labor and postpartum periods. Children under 6 years of age frequently experience anxiety when separated from their mother. Furthermore, contact with the mother and newborn while they are in the hospital helps prepare the siblings for the new family member. Physical contact with neonates is a topic of current concern, as such direct sibling contact may transmit viral infectious diseases to the newborn and, potentially, to other neonates if hospitalization should be prolonged. If siblings are allowed to have direct contact with the newborn, the visit may take place in the mother's private room or in a special sibling visitation area if the mother is not in a private room. Parents should share the responsibility of preventing the exposure of their newborn to a sibling with a contagious illness. Contact of the newborn with children other than siblings should be avoided.

Other family members and friends should be allowed to visit and see the newborn according to the established policy of each hospital. Special arrangements may be necessary for other persons important to the new family, such as out-of-town visitors.

Whenever possible, parents of neonates in the continuing care, intermediate care, or intensive care areas should be allowed unrestricted visits. Provisions should be made for feeding (particularly breast-feeding), handling, and holding these neonates.

No adverse effects of sibling visitation in neonatal intensive care units have been noted, but more study is needed before a general recommendation can be made. An institution that allows sibling visitation to the neonatal intensive care unit should have clearly defined written policies and procedures based on information presently available. The following guidelines may serve as the basis for policy formulation:

1. Siblings should not have been exposed to known communicable diseases (eg, chickenpox).
2. Siblings should not have fever or symptoms of acute illness, such as upper respiratory infection or gastroenteritis.
3. Children should be prepared in advance for their visit.
4. Parents are responsible for ensuring that children are properly supervised by an adult throughout their hospital visit.

Because available data are limited, there is a need for continued evaluation and reporting of the risks and benefits of sibling visitation.