News Round-Up for Participants in the 2007 National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women.

The New York Times
November 23, 2006
Oxygen Monitor Fails to Help Doctors Detect Birth Risks
By DENISE GRADY

A device that measures a baby's blood oxygen during labor has failed to meet doctors' hopes that it would lead to fewer Caesarean sections and safer deliveries, a new study has concluded. But the study's results will still help women and infants by discouraging the use of an invasive procedure that does no good, researchers said.

The device, with a sensor that was inserted into the uterus to rest on the baby's face, had added to the array of tubes, wires and monitoring belts that have already come to define modern childbirth.

"It's important that we found out now that this is a technology which does not appear to provide any meaningful benefit to mothers or babies," said Dr. Steven L. Bloom, the lead author of the study and the chairman of obstetrics and gynecology at the University of Texas Southwestern Medical Center in Dallas. "We had hoped it would serve as an important adjunct or additional tool for obstetricians to use to assess the health of a baby during labor, but we didn't quite find that."

The study and an editorial about it are to be published today in The New England Journal of Medicine.

"The good news here is that we have properly, critically evaluated a new technology, found it to offer no benefit, and therefore we're not going to use it," Dr. Michael F. Greene, the author of the editorial, said in an interview. "As opposed to many other new technologies that get adopted uncritically at great expense, only to find out decades later, 'you know what, it didn't really help us none.' " He is the director of obstetrics at the Massachusetts General Hospital.

The device, a fetal pulse oximeter, was meant to be used with fetal heart-rate monitoring, which is performed in 85 percent of births in the United States. Despite its routine use, the heart monitoring is controversial, because doctors adopted it in the 1970s without rigorous testing and then kept using it even after studies found that it led to higher Caesarean rates but not healthier babies. The heart monitors can create false alarms that lead to Caesareans.

Researchers had hoped that the fetal pulse oximeter would improve that situation -- that monitoring both the oxygen level and the heart rate would help doctors do a better job of deciding when a baby was in trouble and needed to be delivered in a hurry. But it did not, the study found.

Dr. Bloom and other researchers said that when the oximeter was developed, doctors were excited about it, because the idea of tracking a baby's oxygen level seemed so logical.

"It would be so nice to have a monitor or a device of some sort that can provide us useful information during labor to know that the baby is doing well," said Dr. Catherine Y. Spong, an author of the study who is also a specialist in high-risk pregnancies and the chief of the

pregnancy and perinatology branch of the National Institute of Child Health and Human Development. "This held great promise."

But at the same time, many experts worried that the doctors' enthusiasm would lead to widespread use of the technology before it could be thoroughly tested.

"Once something gets ingrained into practice, it's really hard to take it back even if it doesn't have any benefit," Dr. Spong said.

The oximeter was made by Nellcor, a division of Tyco Healthcare, and approved by the Food and Drug Administration in 2000. But the approval was granted on the condition that the company do further research. In 2001, the American College of Obstetricians and Gynecologists also called for more research, and refused to endorse the device.

'People were waiting for this paper, because it was a very large, very well-designed, randomized, controlled trial, to see whether fetal pulse oximetry made a difference," said Dr. Sarah J. Kilpatrick, the vice chairwoman of the college's obstetric practice committee, and head of obstetrics and gynecology at the University of Illinois, Chicago.

"Is it the kiss of death?" Dr. Kilpatrick said. "Based on the data that's published, you cannot argue that there's an indication for this device right now."

The new study included 5,341 women with full-term pregnancies at 14 hospitals around the country. The oximeters were used with fetal heart monitors at each birth -- but in half the cases, the doctors were not shown the readout from the oxygen monitor.

The idea was to find out if the Caesarean section rate or the babies' health differed between doctors who knew the oxygen levels and those who did not. But there were no differences. The study was halted early because it became apparent that the information from the oxygen monitor was not helping anybody.

In January 2006, Nellcor discontinued the oximeter. A spokeswoman for the company said component problems and "a lack of widespread acceptance" were the reasons.

Dr. Spong and other researchers said that part of what drove them to study the oxygen monitor was the desire to avoid repeating what happened with fetal heart-rate monitoring: it became a mainstay of medical practice and training despite a lack of evidence that it was effective. Obstetricians embraced heart monitors because they believed that lack of oxygen was a major cause of cerebral palsy, and that monitors would help prevent it by showing when a baby lacked oxygen and needed to be delivered right away.

But as it turned out, fetal heart monitoring did not reduce cerebral palsy rates; it has since become clear that lack of oxygen is rarely the cause of the problem. And it has also become clear that the readings from the machines can be tricky to decipher.

In his editorial, Dr. Greene noted that when asked to interpret the same oxygen monitor readout on different occasions, experts frequently disagreed with one another and sometimes with their own interpretations.

But, for lack of anything better, most obstetricians depend on the heart monitors. Many insist that certain patterns are a clear signal that a baby is in trouble.

Dr. Greene said heart monitors had never been proved more effective than a trained nurse with a stethoscope. But he doubted that his profession would ever return to those days.

"It might add more of a human touch to it, which many people miss in modern obstetrical care," Dr. Greene said. "But at this point it would be like ruthlessly yanking Linus's blanket away from him."

New York Times
November 29, 2006
The Weighty Responsibility of Drinking for Two
By JULIA MOSKIN

IT happens at coffee bars. It happens at cheese counters. But most of all, it happens at bars and restaurants. Pregnant women are slow-moving targets for strangers who judge what we eat — and, especially, drink.

“Nothing makes people more uncomfortable than a pregnant woman sitting at the bar,” said Brianna Walker, a bartender in Los Angeles. “The other customers can’t take their eyes off her.”

Drinking during pregnancy quickly became taboo in the United States after 1981, when the Surgeon General began warning women about the dangers of alcohol. The warnings came after researchers at the University of Washington identified Fetal Alcohol Syndrome, a group of physical and mental birth defects caused by alcohol consumption, in 1973. In its recommendations, the government does not distinguish between heavy drinking and the occasional beer: all alcohol poses an unacceptable risk, it says.

So those of us who drink, even occasionally, during pregnancy face unanswerable questions, like why would anyone risk the health of a child for a passing pleasure like a beer?

“It comes down to this: I just don’t buy it,” said Holly Masur, a mother of two in Deerfield, Ill., who often had half a glass of wine with dinner during her pregnancies, based on advice from both her mother and her obstetrician. “How can a few sips of wine be dangerous when women used to drink martinis and smoke all through their pregnancies?”

Many American obstetricians, skeptical about the need for total abstinence, quietly tell their patients that an occasional beer or glass of wine — no hard liquor — is fine.

“If a patient tells me that she’s drinking two or three glasses of wine a week, I am personally comfortable with that after the first trimester,” said Dr. Austin Chen, an obstetrician in TriBeCa. “But technically I am sticking my neck out by saying so.”

Americans’ complicated relationship with food and drink — in which everything desirable is also potentially dangerous — only becomes magnified in pregnancy.

When I was pregnant with my first child in 2001 there was so much conflicting information that doubt became a reflexive response. Why was tea allowed but not coffee? How could all “soft cheeses” be forbidden if cream cheese was recommended? What were the real risks of having a glass of wine on my birthday?

Pregnant women are told that danger lurks everywhere: listeria in soft cheese, mercury in canned tuna, salmonella in fresh-squeezed orange juice. Our responsibility for minimizing risk through perfect behavior feels vast.

Eventually, instead of automatically following every rule, I began looking for proof.

Proof, it turns out, is hard to come by when it comes to “moderate” or “occasional” drinking during pregnancy. Standard definitions, clinical trials and long-range studies simply do not exist.

“Clinically speaking, there is no such thing as moderate drinking in pregnancy” said Dr. Ernest L. Abel, a professor at Wayne State University Medical School in Detroit, who has led many studies on pregnancy and alcohol. “The studies address only heavy drinking” — defined by the National Institutes of Health as five drinks or more per day — “or no drinking.”

Most pregnant women in America say in surveys that they do not drink at all — although they may not be reporting with total accuracy. But others make a conscious choice not to rule out drinking altogether.

For me, the desire to drink turned out to be all tied up with the ritual of the table — sitting down in a restaurant, reading the menu, taking that first bite of bread and butter. That was the only time, I found, that sparkling water or nonalcoholic beer didn’t quite do it. And so, after examining my conscience and the research available, I concluded that one drink with dinner was an acceptable risk.

My husband, frankly, is uncomfortable with it. But he recognizes that there is no way for him to put himself in my position, or to know what he would do under the same circumstances.

While occasional drinking is not a decision I take lightly, it is also a decision in which I am not (quite) alone. Lisa Felter McKenney, a teacher in Chicago whose first child is due in January, said she feels comfortable at her current level of three drinks a week, having been grudgingly cleared by her obstetrician. “Being able to look forward to a beer with my husband at the end of the day really helps me deal with the horrible parts of being pregnant,” she said. “It makes me feel like myself: not the alcohol, but the ritual. Usually I just take a few sips and that’s enough.”

Ana Sortun, a chef in Cambridge, Mass., who gave birth last year, said that she (and the nurse practitioner who delivered her baby) both drank wine during their pregnancies. “I didn’t do it every day, but I did it often,” she said. “Ultimately I trusted my own instincts, and my doctor’s, more than anything else. Plus, I really believe all that stuff about the European tradition.”

Many women who choose to drink have pointed to the habits of European women who legendarily drink wine, eat raw-milk cheese and quaff Guinness to improve breast milk production, as justification for their own choices in pregnancy.

Of course, those countries have their own taboos. “Just try to buy unpasteurized cheese in England, or to eat salad in France when you’re pregnant,” wrote a friend living in York, England. (Many French obstetricians warn patients that raw vegetables are risky.) However, she said, a

drink a day is taken for granted. In those cultures, wine and beer are considered akin to food, part of daily life; in ours, they are treated more like drugs.

But more European countries are adopting the American stance of abstinence. Last month, France passed legislation mandating American-style warning labels on alcohol bottles, beginning in October 2007.

If pregnant Frenchwomen are giving up wine completely (although whether that will happen is debatable — the effects of warning labels are far from proven), where does that leave the rest of us?

"I never thought it would happen," said Jancis Robinson, a prominent wine critic in Britain, one of the few countries with government guidelines that still allow pregnant women any alcohol — one to two drinks per week. Ms. Robinson, who spent three days tasting wine for her Masters of Wine qualification in 1990 while pregnant with her second child, said that she studied the research then available and while she was inclined to be cautious, she didn't see proof that total abstinence was the only safe course.

One thing is certain: drinking is a confusing and controversial choice for pregnant women, and among the hardest areas in which to interpret the research.

Numerous long-term studies, including the original one at the University of Washington at Seattle, have established beyond doubt that heavy drinkers are taking tremendous risks with their children's health.

But for women who want to apply that research to the question of whether they must refuse a single glass of Champagne on New Year's Eve or a serving of rum-soaked Christmas pudding, there is almost no information at all.

My own decision came down to a stubborn conviction that feels like common sense: a single drink — sipped slowly, with food to slow the absorption — is unlikely to have much effect.

Some clinicians agree with that instinct. Others claim that the threat at any level is real.

"Blood alcohol level is the key," said Dr. Abel, whose view, after 30 years of research, is that brain damage and other alcohol-related problems most likely result from the spikes in blood alcohol concentration that come from binge drinking — another difficult definition, since according to Dr. Abel a binge can be as few as two drinks, drunk in rapid succession, or as many as 14, depending on a woman's physiology.

Because of ethical considerations, virtually no clinical trials can be performed on pregnant women.

"Part of the research problem is that we have mostly animal studies to work with," Dr. Abel said. "And who knows what is two drinks, for a mouse?"

Little attention has been paid to pregnant women at the low end of the consumption spectrum because there isn't a clear threat to public health there, according to Janet Golden, a history professor at Rutgers who has written about Americans' changing attitudes toward drinking in pregnancy.

The research — and the public health concern — is focused on getting pregnant women who don't regulate their intake to stop completely.

And the public seems to seriously doubt whether pregnant women can be trusted to make responsible decisions on their own.

"Strangers, and courts, will intervene with a pregnant woman when they would never dream of touching anyone else," Ms. Golden said.

Ms. Walker, the bartender, agreed. "I've had customers ask me to tell them what the pregnant woman is drinking," she said. "But I don't tell them. Like with all customers, unless someone is drunk and difficult it's no one else's business — or mine."

New York Times
November 28, 2006
That Prenatal Visit May Be Months Too Late
By RONI RABIN

For years, women have had it drummed into them that prenatal care is the key to having a healthy baby, and that they should see a doctor as soon as they know they are pregnant.

But by then, it may already be too late. Public health officials are now encouraging women to make sure they are in optimal health well in advance of a pregnancy to reduce the risk of preventable birth defects and complications. They have recast the message to emphasize not only prenatal care, as they did in the past, but also what they are calling "preconception care."

The problem, doctors say, is that by the first prenatal visit, a woman is usually 10 to 12 weeks pregnant. "If a birth defect is going to happen, it's already happened," said Dr. Peter S. Bernstein, a maternal fetal medicine specialist at Montefiore Medical Center in New York who helped write new government guidelines on preconception care.

For many women, Dr. Bernstein said, "The most important doctor's visit may be the one that takes place before a pregnancy is conceived."

The new guidelines, issued by the Centers for Disease Control and Prevention last spring, include 10 specific health care recommendations and advise prepregnancy checkups that include screening for diabetes, H.I.V. and obesity; managing chronic medical conditions; reviewing medications that may harm a fetus; and making sure vaccinations are up to date.

Much of the advice directed to women is fairly standard: they should abstain from smoking, alcohol and drugs, and should take prenatal vitamins, including folic acid.

For Diane Jackey, a mother of five from Hempstead, N.Y., maintaining preconception health meant continuing prenatal vitamins between pregnancies, snatching exercise whenever she could and maintaining a balanced diet. “I don’t smoke, and I don’t drink at all,” Ms. Jackey said.

What is new and somewhat controversial about the guidelines is the suggestion that they should apply to women throughout their reproductive years, even when they are not planning pregnancies. (Men should be wary of exposures to toxins that cause birth defects and should avoid sexually transmitted diseases, experts say.)

But while the report was criticized in some quarters for treating all women as though they were eternally “prepregnant,” it also discusses the importance of family planning and child spacing and encourages young people to develop a “reproductive life plan.” Half of all pregnancies in the United States are unplanned, experts say, and preparing for a healthy pregnancy can require behavioral changes that may take months. Even daily supplements of folic acid should ideally be taken for three months before conception.

“It’s not like we have an injection we can give someone” to prepare her for pregnancy, said Dr. Hani Atrash, associate director for program development at the National Center on Birth Defects and Developmental Disabilities at the disease centers. “Some of the interventions, like weight management, need time to happen. You cannot quit smoking in one day.”

The issue of preconception health has taken on added urgency in recent years because while infant mortality rates were on the decline from 1980 to 2000, the proportion of small and preterm babies increased significantly. And low birth weight, which has been linked to maternal smoking and multiple births, is a leading cause of death and disability for infants.

In 2002, the infant mortality rate in the United States increased for the first time in more than 40 years, to 7.0 deaths per 1,000 live births in 2002 from 6.8 deaths per 1,000 live births in 2001. The rate dropped back to 6.8 per 1,000 in 2003. Blacks are at the highest risk for preterm birth and low birth weights, and their infant mortality rates are more than double that of whites.

Meanwhile, rising obesity rates and the tendency to postpone motherhood mean far more women are overweight when they become pregnant and thus are more likely to have high blood pressure, diabetes or prediabetes, which complicate pregnancy.

“There is no question the No. 1 issue for women in America is their weight,” said Dr. Gary Hankins, who leads the committee on obstetrics practice of the American College of Obstetricians and Gynecologists.

Pre-existing diabetes significantly increases the risk of birth defects, but the risk is virtually eliminated if the disease is controlled before conception, Dr. Hankins said. Obese women who become pregnant face a higher risk of developing gestational diabetes and of having a large baby and a difficult delivery.

While doctors have been recommending preconception care for many years, it has never really

caught on. Only one in six health care providers said they had provided preconception care to patients, one study found, and most health plans do not cover it. Medicaid, the government health plan for the poor, often only covers women after they are pregnant.

Rochelle Carr, 31, a Bronx mother, sought preconception counseling because she worried that her asthma medications might harm a developing fetus. Ms. Carr was also concerned because she had suffered a life-threatening pulmonary embolism, or blood clot to the lung, when she was 29.

Ms. Carr's doctor referred her to a maternal fetal medicine specialist at Montefiore Medical Center. Dr. Ashlesha Dayal reviewed Ms. Carr's medications and advised her to stop taking an asthma drug linked to birth defects and to start taking folic acid daily.

Once Ms. Carr became pregnant, Dr. Dayal prescribed an anticoagulant because Ms. Carr was at high risk for developing another blood clot. The doctor also explained the risks of taking the anticoagulant. "She really put my mind at ease," said Ms. Carr, who delivered a healthy baby, Joshua, on Nov. 29, 2005.

Doctors say that planning pregnancies and using reliable contraception are part and parcel of preconception care, and they are encouraging all health providers — not just obstetricians but emergency room doctors, primary care physicians, cardiologists and endocrinologists — to counsel women of childbearing age about the possibility of pregnancy. "What we're actually talking about," Dr. Atrash said, "is women's health."

Washington Post
An Opening on Abortion?
November 21, 2006
By E. J. Dionne Jr.

If both parties combine wisdom with shrewdness, the election of a new congressional majority should open the way for a better approach to the abortion question.

The bitter political brawling of the past three decades has created an unproductive stalemate that leaves abortion opponents frustrated, abortion rights supporters in a constant state of worry and the many Americans who hold middle-ground positions feeling that there is no one who speaks for them.

But the politics of abortion began to change even before this month's elections. In September, a group of 23 pro-choice and pro-life Democratic House members introduced what they called the Reducing the Need for Abortion and Supporting Parents Act.

Okay, it's not the catchiest title, but you get the point. The bill -- its sponsor is Rep. Tim Ryan (D-Ohio), an abortion opponent, with Rep. Rosa DeLauro (D-Conn.), an abortion rights supporter, a leading co-sponsor -- took a lot of negotiation. Supporters of abortion rights tend to favor programs that encourage effective contraception, which some in the right-to-life movement oppose. Opponents of abortion emphasize helping women who want to carry their children to term.

The Ryan bill, one of several congressional initiatives to reduce the abortion rate, does both. It includes a remarkably broad set of programs aimed at reducing teen pregnancy, promoting contraception and encouraging parental responsibility. But it also includes strong measures to offer new mothers full access to health coverage, child care and nutrition assistance.

The public debate usually ignores the fact that abortion rates are closely tied to income. As the Guttmacher Institute has reported, "the abortion rate among women living below the federal poverty level . . . is more than four times that of women above 300 percent of the poverty level." The numbers are stark: 44 abortions per 1,000 women in the lower income group, 10 abortions per 1,000 women in the higher income group.

In other words: If you truly care about reducing the number of abortions, you have to care about the well-being of poor women.

There are moral and practical reasons for members of both parties, and combatants on both sides of the abortion question, to embrace this approach.

Liberal supporters of abortion rights should be eager to promote a measure that does not make abortion illegal but does embrace goals, including help for the poor, that liberals have long advocated.

In the meantime, the victories that opponents of abortion rights have won do little to reduce the number of abortions. As Rachel Laser, director of the Third Way Culture Project, points out, even those who would ban late-term or "partial-birth" abortions need to acknowledge that very few are performed, meaning that these laws do little to reduce the overall abortion rate. According to one study cited by Laser, only 0.08 percent of abortions are performed in the third trimester.

Parental consent laws affect fewer than a fifth of all abortions, those obtained by teenagers 17 or younger, and it is not clear how many abortions these measures stop, since studies suggest that many parents favor rather than oppose abortion in such circumstances.

Why shouldn't both sides embrace broader steps that, without coercion, could cut the abortion rate by much larger numbers? We know this is possible because it has already happened: Between 1994 and 2000, the abortion rate fell by 11 percent. An ambitious national effort could do more.

There is also the politics of the issue. In her study, Laser points to a group she calls the "abortion grays," i.e., the six voters in 10 who do not see the issue in black-and-white terms. This group tilts pro-choice but does not believe abortion should always be either legal or illegal.

For Democrats, this means taking into account that while most of the new members they elected this month favor abortion rights, the party's freshmen include strong opponents of abortion -- among them Sen.-elect Bob Casey (D-Pa.) and about a half-dozen new House members.

Democrats are a party with a pro-choice majority, a significant pro-life minority and a lot of grays.

Republicans are the more antiabortion party but include many pro-choice voters and grays in their ranks. They face a broadly pro-choice country and now have to battle a right-wing image that drove so many independents and moderates to the Democrats.

Taking substantial steps to reduce the abortion rate will not settle the larger ethical argument over the practice. But it could show that politicians are capable of living up to their highest calling, which is to seek practical forms of moral seriousness.

TomPain.com
Politicizing Birth Control
November 27, 2006
Carole Joffe,

Carole Joffe is professor of sociology at the University of California-Davis, and a senior fellow at the Longview Institute.

"Crass commercialization and distribution of birth control is demeaning to women, degrading of human sexuality, and adverse to human health and happiness."

Although the 98 percent of heterosexually active women in the United States who have used birth control would likely take issue with the above statement, this is America, after all, the land of free speech. People and organizations are entitled to their opinions, however unpopular.

But the statement takes on a special meaning when we find out it appears on the website of A Woman's Concern, a fleet of so-called "Crisis Pregnancy Centers" in Boston, whose major function is discouraging women from having abortions. Eric Keroack, the medical director of A Woman's Concern, has just been named deputy assistant secretary of population affairs by the Bush administration. The "DASPA" is the government official who is in charge of federal family planning programs. This official oversees the Title X program which currently disperses some $283 million to clinics for contraceptive supplies and information, as well as breast and pelvic exams, pregnancy diagnosis and counseling and screenings for sexual transmitted infections. Title X funds are targeted toward low-income persons.

So how did we get to this Orwellian situation where the person in charge of helping poorer Americans obtain birth control thinks the major service his office provides is "demeaning and degrading?" In fact, though Keroack's record of opposition to contraception is unmatched by previous DASPAs, the position has long been used by Republican presidents as a relatively pain-free way to reward their extreme rightwing base. The position does not require confirmation by Congress, and thus has served as an ideal "stealth" appointment—one to which most Americans do not pay attention.

By making such a clearly inappropriate—if not bizarre—appointment, President Bush is following in the steps of his father, George H. W. Bush. The DASPA during the latter's

presidency was William Reynolds Archer III, an obstetrician gynecologist who publicly and proudly proclaimed himself sexually abstinent at the age of 37. He was famously quoted in the press as saying that "when it became possible for women to buy contraceptives on their own, men lost their manhood."

In contrast, the DASPA who followed Archer, in President Clinton's administration, was the late Felicia Stewart, a highly respected physician whose major achievement in that office was to convince the FDA to rule on the safety of emergency contraception. EC is a higher than normal dose of oral contraception that, if used within a certain time frame after unprotected sex, is very effective in preventing pregnancy. This finding in turn led to the approval of a dedicated product for EC, now known as "Plan B." In short, Dr. Stewart did what one would expect someone in this position to do—determined the safety and efficacy of contraceptive options and worked to make them more available to the public.

The irony in all this is that, while Archer and Keroack were selected for their long involvement with anti-abortion groups, and Dr. Stewart was a supporter of abortion rights, it was her work as DASPA that actually led to fewer abortions. The highly respected Guttmacher Institute, a private organization that studies reproductive health, estimated recently that some 50,000 abortions per year are averted because of EC. The recent approval of over-the-counter status for EC (for women 18 and over) will presumably increase this number.

Dr. Keroack assumes his post at a time when low-income women are losing ground in their ability to obtain birth control. The Guttmacher Institute recently reported that about half of all poor women who need birth control are unable to afford it. The $283 million now allocated to Title X has not been raised in several years and is not enough to meet the need. If the funding were doubled, the experts at Guttmacher say, that would prevent some 244,000 unintended pregnancies, 116,000 unplanned births and about 98,000 abortions annually. But meeting such contraceptive need is hardly likely to happen on our new DASPA's watch.