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# Women and Children First

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## LEGAL ISSUES IN MEDICINE

# WOMEN AND CHILDREN FIRST

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IN the lore of the sea there are few events that have so exemplified heroism and self-sacrifice as the acts of the soldiers and sailors of the British ship *Birkenhead* when it sank in 1852. The soldiers of the 74th Highland Regiment stood at attention on deck (with the band playing) "while the women and children were saved and the captain very properly went down with his ship."[1] More than 450 lives were lost, and the phrase "women and children first" was introduced into the language as part of the "*Birkenhead* drill." As Kipling put it in his poem "Soldier an' Sailor Too": "to stand an' be still to the *Birken'ead* drill is a damn tough bullet to chew."[2]

In the rapidly evolving lore of managed care, the *Birkenhead* drill's rule of women and children first has taken on a new meaning with respect to childbirth as so-called drive-through deliveries are required by more and more health plans. (Elsewhere in this issue of the *Journal*, Parisi and Meyer discuss the question of the length of stay after delivery.[3]) These plans often restrict hospitalization benefits to 24 hours after a vaginal delivery and 48 hours after a cesarean section. The primary rationale is not to benefit mother and child, but to enable the health plan to retain more insurance-premium dollars. The new drill is that the passengers must sacrifice for the captain and crew; women and their newborns are expected to chew the tough bullet.

### THE CURRENT CULTURAL CONTEXT

Why have women and children become the focus of the first major public debate over market-driven managed-care medicine? The answer is that this population group is an irresistible target for both health care entrepreneurs and politicians. In the current budget-cutting fever in Congress, welfare "reform," which directly affects mainly poor women and their children, was passed by both the House and Senate as a way to reduce spending on the current programs. Similar strategies are to abolish Medicaid and to push more poor women into managed-care settings. The only group for which mandatory screening for the human immunodeficiency virus has been seriously proposed is pregnant women and their newborns. Poor women and children, who do not have the political influence or financial resources to resist even draconian actions against their interests, are easy targets. Although drive-through deliveries also affect only women and children, the affected women are not limited to the poor but also include the insured middle class, who can fight back. Moreover, politicians have found middle-class women and their children "telegenic and sympathetic," in a way that allows this issue to serve as a surrogate for more pervasive (and dangerous) problems with market-driven medicine.[4]

The rush to embrace the ideology of the marketplace is based on the theory that Americans are motivated primarily by money; therefore, changing financial incentives will change behavior. True believers in the market think this is so in every phase of life. Women will decide not to have more children, at least at the margin, if the government refuses to increase welfare payments; physicians will discharge women and their newborns from hospitals early if the insurance company refuses to pay the physician and hospital for longer stays. It is difficult to predict how the 24-hour rule (or even a 12-hour or 6-hour rule) will affect the health of mothers and newborns, because there is little more than anecdotal data available to help determine the appropriate length of stay after delivery. One retrospective study, however, has shown no increase in readmissions for babies discharged within 24 hours after vaginal delivery, but a very large increase (from 1.3 percent to 4.3 percent) in readmissions for babies delivered by cesarean section who were discharged within 24 hours.[5] In the absence of conclusive data, it is not surprising that health plans push to minimize their costs and that physicians fight to retain decision-making authority over hospital discharges.

### IN-HOSPITAL DELIVERIES

Childbirth in the hospital was not widely promoted until the 20th century. The major reasons for the shift from home delivery were greater safety for mother and child, relief from pain, convenience for physicians, efficiency, the rise of scientific medicine, and the need for a regular supply of patients to train medical students.[6] But gains for women were purchased "at the expense of being processed as possibly diseased objects."[6] By the 1950s, in-hospital delivery had become "unpleasant and alienating. . . . women were powerless . . . playing a social role of passive dependence and obedience."[6] A movement to regain some control began. Women were behind the shift to natural childbirth, to the routine participation of fathers in the delivery room, and to drastic cuts in the length of stay in the hospital after delivery.

By the 1990s, as Ellen Goodman has put it, "with shorter and shorter hospital stays, the postpartum world isn't just like home, it is home."[7] If this trend continues, we could move full circle, with home birth again becoming the norm. This is not necessarily bad for women at low risk for complications of labor and delivery. Hospitals are expensive, and long stays are often, perhaps almost always, unnecessary. The central issue, however, is not only the cost, but also the quality of care: how can we make the experience of childbirth responsive to the needs and wishes of women, rather than to the wishes of health care entrepreneurs or politicians?

The proponents of discharging new mothers and

their babies more quickly from the hospital argue that the long hospitalizations of the past were both unnecessary and potentially dangerous (because of the increased risk of nosocomial infections) for both mother and child. They point, quite rightly, to past excesses in terms of the length of stay and argue that increases in efficiency can be achieved without adverse effects on mother and child. The average length of the hospital stay for childbirth has already fallen from approximately four days in 1970 to two days in 1992 for all vaginal deliveries and from eight to four days for cesarean deliveries.[8] Since childbirth is the most common reason for inpatient care in the United States, billions of health care dollars could potentially be saved if the average length of stay for mothers and babies were further shortened. Nor is it only the for-profit plans that have cut the length of stay. Kaiser Permanente, a nonprofit health plan that has a solid track record of taking care of its patients over the long run, also sees shorter stays after delivery as cost-effective, safe medical care. Its physicians and nurses have reportedly been instructed to encourage new mothers to leave the hospital by saying that "hospital food is not tasty," that the mother can have "unlimited visitors at home," and that she will sleep better in her own bed.[9] This is all true, and almost all women will prefer to leave the hospital as soon as possible, especially if good follow-up care at home is available.

Opponents of early discharge have turned to the law to change the practice. At both the state and federal levels, legislation has been introduced (and some has already been enacted) to modify or limit drive-through deliveries by requiring health plans to pay hospitals for longer stays under certain conditions. The early success of these efforts is worth examining, because it may hold lessons for other legislative action in the managed-care arena.

## State Legislation

In May 1995, Maryland became the first state to enact legislation to curtail 24-hour–discharge policies. As one of its primary reasons for acting, the legislature noted that "hospital stays of less than 24 hours after childbirth typically result in unsatisfactory PKU specimens [for phenylketonuria testing] as a result of insufficient milk feedings" and that "the state's statutes and regulations direct the screening of newborn infants for hereditary and congenital disorders in the hospital prior to discharge"[10] (Maryland is perhaps the country's leader in newborn screening). The law, entitled the Mothers' and Infants' Health Security Act, specifically requires insurance plans to provide coverage for maternity and newborn care, including inpatient stays "in accordance with the medical criteria outlined in the most current version of the *Guidelines for Perinatal Care* prepared by the American Academy of Pediatrics [AAP] and the American College of Obstetricians and Gynecologists [ACOG]."[10] Because the AAP and ACOG now recommend a 48-hour stay for uncomplicated deliveries, the law, which took effect on October 1, had the effect of eliminating provisions for shorter lengths of stay by insurance companies and health plans.

Also in May 1995, the ACOG urged a moratorium on further shortening of hospital stays after delivery until their safety is established, saying:

> 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.[11]

The second state to enact legislation was New Jersey. On June 29, Governor Christine Todd Whitman went to Holy Name Hospital in Teaneck to sign a bill that specified minimal lengths of stay that insurance companies must cover. She told the audience at the hospital, "I have two children — one by C-section — and I know that 24 hours is not enough."[12] She added that the new law used "common sense to give women a chance to recover and babies a chance to get a good head start."[12] Unlike the Maryland law, which followed medical standards as set by the AAP and ACOG, the New Jersey law specified that insurance plans must cover "a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child in a health care facility."[13] The law further specifies that such coverage is not required unless the care either is "determined to be medically necessary by the attending physician" or "is requested by the mother."[13] The provision that women themselves make the final decision represents a legislative determination that their obstetricians and pediatricians cannot exercise appropriate medical judgment when under intense pressure to contain costs. From the physicians' and patients' perspective, however, it will probably be more important how the financial incentives are structured and whether any financial benefit accruing to the health plan goes to enrich investors or to improve services.

North Carolina became the third state to enact legislation on July 28, providing simply that "a health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight hours after vaginal delivery and a minimum of ninety-six hours after delivery by cesarean section."[14] On November 21, Governor William Weld of Massachusetts signed legislation similar to the New Jersey law. Other states with legislation pending or under study on this topic include California, Connecticut, Delaware, Illinois, Kentucky, Michigan, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, and Wisconsin.

States probably do not have the legal authority to require this type of benefit for employee group plans provided by corporations that are self-insured, because the Employee Retirement Income Security Act (ERISA)

precludes the application of state mandated-benefit laws to self-insured employee-benefit plans.[15] On the other hand, courts may consider this a health-and-safety measure (especially laws like Maryland's) rather than a mandated-benefit law.[16] Whatever the final outcome, however, ERISA does not limit the ability of the federal government to require uniform health care benefits across the country. Accordingly, federal legislation would be most effective in this area.

## Federal Legislation

Shortly after New Jersey adopted its law, Senator Bill Bradley (D-N.J.), together with Senator Nancy Kassebaum (R-Kans.), introduced a proposed federal law to be entitled the "Newborns' and Mothers' Health Protection Act." At the Senate hearing on the bill in September, Bradley argued that uniform federal legislation that covered all American women and children was needed. Horror stories help drive legislation. In dramatic testimony, Michelle and Steve Bauman of New Jersey told the committee how their daughter had died from a streptococcus B infection two days after she was born. She and her mother had been discharged 28 hours after the baby's birth. Although there may be no way to know for sure, the Baumans believe that their daughter would have been properly cared for had they spent another 24 hours in the hospital. Mrs. Bauman said that "her death certificate listed the cause of death as meningitis when it should have read: 'Death by the system.'"[17]

Senator Bradley's bill follows the New Jersey model in that it requires all insurance plans that provide benefits for childbirth "to ensure that coverage is provided for a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of in-patient care following a cesarean section for a mother and her newly born child in a health care facility." The bill also contains the same waiver of the minimal lengths of stay when care is not deemed medically necessary and is not requested by the mother. The managed-care industry opposes the bill on the grounds that government should not interfere with the market in this area. Silent on similar legislation until very recently, the American Medical Association supports the bill as "a good first step" to ensure that women are not discharged until they and their physicians think it appropriate.[18]

## When Legal Regulation Is Necessary

In the most general sense these bills represent classic government regulation of the market and can be seen as following in the tradition of child-labor laws, laws protecting workers' health and safety, and minimum-wage laws. Because the market has no inherent morality, whenever the market is used to produce and distribute goods and services, government regulation is required to protect the welfare of both workers and consumers. Specific regulations, like those outlined in these bills, are inevitable when society sees industries, especially for-profit corporations, going too far in pursuing their own goals at public expense.

These bills also reflect a concern about power. At least since World War II, physicians have held most of the decision-making power in medicine. The informed-consent doctrine has sought to move decision making toward a model of partnership between physicians and patients, and at least in situations like childbirth, when the woman is not sick, there have been notable successes, including the increase in natural childbirth. In most managed-care settings, insurance companies and health maintenance organizations (HMOs) are attempting to take decision-making authority away from physicians and their patients and to put more of it in the hands of managers, who base their rules on cost–benefit analysis. But cost–benefit analysis in medicine is still rudimentary, and it is now being used primarily on a trial-and-error basis, seeing how much can be cut before physicians and their patients begin complaining bitterly.

Neither organized medicine nor the public wants managers to decide how individual patients will be treated. The Maryland legislation attempts to put decision making back in the hands of physicians by requiring that health plans and insurance companies accept as necessary any care that is so designated by physicians and that is consistent with professional medical guidelines. Since both the AAP and ACOG also endorse collaborative decision making grounded in informed consent, this approach may be seen as the traditional model. The New Jersey law (and the federal proposal based on it) is different, however. Although it bows to the historical ability of physicians to determine medical necessity, it moves beyond this concept by directly empowering patients to make their own decisions, based on their own values, regardless of their physicians' views of medical necessity. Specifically, even if 48 hours in the hospital after delivery is determined not to be medically necessary by a woman's attending physician (and the child's pediatrician), the woman and her child may still stay 48 hours if this is what the woman wants. This is a powerful endorsement of patients' rights. Of course, the hospital is not a prison, and women are not required to stay for the entire authorized time period. Doctors and hospitals can also use incentives, such as improved prenatal education and home care and child care after delivery, to make leaving the hospital early more attractive to women. If they do so, this could be an example of a change that benefits both patients and the health plan's bottom line.

## Cost, Quality, and Access

But what about cost containment? Do not laws like these undercut efforts to save money? The answer to this question, of course, is that it depends on your perspective. Specifically, it depends on such things as the contract that the insurance company has with the hospital, and whether the hospital is owned by the HMO.

In terms of actual cost to the hospital for a healthy woman and her baby to spend an additional 24 hours in the hospital, the amounts in question are probably closer to $100 than $1,000, at least if the hospital has excess maternity-bed capacity. University Medical Center in Stony Brook, New York, for example, has adopted a new policy guaranteeing mothers a stay of at least 48 hours if they wish it.[3] If the insurance company does not pay for the second day, the hospital will absorb the estimated $300 in added cost.[19] At least one major hospital, Tampa General, in Florida, has gone even further by offering all its maternity patients an extra 48 hours of post-delivery care after discharge from the hospital, at no cost to the patient.[20] The patients who opt for this program will be cared for in a hotel-like unit, named the Family Suites, which can now accommodate eight women and could be expanded. The local competitors of this hospital have charged that the program is simply a marketing technique to attract more obstetrical patients. Nonetheless, to the extent that it meets the needs of women and children in a reasonable and compassionate way, it is to be applauded. It is also consistent with the New Jersey model of putting more control in the hands of women, and thus forcing managers to deal directly with women when refashioning obstetrical care.

Drive-through delivery legislation is a sideshow in the debate over health care–financing reform that will have little real effect on cost, quality, or access to health care by women and their children. Although the length of stay is important, especially after a cesarean section, it is not a sufficient measure of the quality of care. It has, nonetheless, taken on a life of its own for the public and politicians because it can be easily understood and because it illustrates the general problem of premature hospital discharge. Moreover, and perhaps most important, action on this front permits politicians to appear to be doing something positive to protect women and children that costs the government no money.

We cannot solve either the real or the perceived problems with market-driven medicine by passing statutes dealing with single aspects of care (e.g., the length of stay) or single reasons for hospitalization (e.g., childbirth). No one, I take it, would consider it reasonable for Congress to enact legislation on types of treatment and minimal stays for coronary bypass or treatment of head injuries, although these will probably have a much greater impact on the overall quality of care than stays after childbirth.

Unlike the proposals regarding hospital stays after childbirth, which arbitrarily use the total number of hours in the hospital as a surrogate for quality, Congress was on much firmer ground when it adopted the Emergency Medical Treatment and Active Labor Act, requiring hospitals to admit women in active labor for childbirth whenever there was either "inadequate time to effect safe transfer to another hospital prior to delivery" or when a "transfer may pose a threat [to] the health and safety of the patient or the unborn child."[21] Under this law, judgments about the health and safety of the woman in labor must be made by a physician, and a hospital may not lawfully transfer a woman in active labor (or any other patient requiring emergency care) unless the patient requests the transfer or the physician, in exercising reasonable medical judgment, determines that the benefits to the patient that could be "reasonably expected" to result from transfer outweigh the increased risks.[22] This legislation puts the protection of patients first and does so by supporting decisions made within the doctor–patient relationship.

If Congress and the states are serious about protecting the welfare of women and children, there are clear steps that should be taken, the most important of which is the guarantee of basic health care services to all children and their mothers. Moreover, although it makes no sense for Congress to regulate the details of specific medical interventions, it is reasonable for Congress to require all health plans to offer the same minimal benefit package to all subscribers; this requirement could help protect patients both by guaranteeing this minimum and by encouraging health plans to compete on the basis of the quality of care and their responsiveness to patients' needs and wishes, rather than on the basis of cost alone.

## Conclusions

In the Navy it is traditional to fire a shot across the bow of a ship before taking more aggressive action. The symbolic legislative initiatives on the length of hospital stays after childbirth, which will almost certainly sweep the country state by state if federal legislation is not soon enacted, are a shot across the bow of marketplace medicine. The signal can be ignored only at the peril of the new health care industry; politicians will not remain their captives forever. The message is that patients are patients, not customers. Patients need care, not management. And patients should have a central role in deciding how our new health care system will operate.

The 74th Highland Regiment went down with the ship to save the women and children aboard. We expect no such heroics from our government leaders. It should not be too much to expect of ourselves, however, that instead of helping to raise symbolic flags like legislation regulating drive-through deliveries, we renew our efforts to provide decent health care for all Americans. Since this effort must be made piecemeal, it seems reasonable to pass legislation to guarantee the right to a decent minimum of health care for women and children first.

## References

1. Simpson AWB. Cannibalism and the common law. Chicago: University of Chicago Press, 1984:97.
2. Kipling R. Complete verse: definitive edition. New York: Doubleday, 1940: 432.
3. Parisi VM, Meyer BA. To stay or not to stay? That is the question. N Engl J Med 1995;333:1635-7.

4. Krauthammer C. The inevitability of rationed care. Washington Post. September 22, 1995:A19.
5. Hospital length of stay and readmission rates for normal deliveries and newborns. Baltimore: Health Care Investment Analysts, 1995.
6. Wertz RW, Wertz DC. Lying-in: a history of childbirth in America. New York: Free Press, 1977.
7. Goodman E. Lower speed limit on highway to drive-thru deliveries. Boston Globe. July 9, 1995:63.
8. The Epidemiology Office of the Centers for Disease Control and Prevention. Trends in length of stay for hospital deliveries — United States, 1970–1992. MMWR Morb Mortal Wkly Rep 1995;44:335-7.
9. Wilkie D. Delivery hospitals know where mom can have all comforts of home. San Diego Union Tribune. June 26, 1995:A3.
10. 1995 Md. Laws ch. 503.
11. Rovner J. USA divides over early discharge of mothers. Lancet 1995;346: 171-2.
12. Nordheimer J. New mothers gain 2nd day of care. New York Times. June 29, 1995:B1.
13. Ch. 138 Laws of New Jersey, 1995.
14. 1995 N.C.S.B. 345, Sec. 58-3-170.
15. Shaw v. Delta Airlines, 463 U.S. 85 (1983).
16. New York Blue Cross Plans v. Travelers Insurance Co., 115 S. Ct. 1671 (1995).
17. Arnold L. N.J. leads 'drive thru delivery' fight. Asbury Park Press. September 13, 1995:A3.
18. Bye-bye baby. American Medical News. August 7, 1995:13.
19. Maier T. 2-Day maternity stays promised. Newsday. June 22, 1995:6.
20. Hagigh J. TGH lets mothers stay put. St. Petersburg Times. August 29, 1995: 1A.
21. 42 U.S.C.A. 1395dd (1987), amended by 41 U.S.C.A. 1395dd (1991).
22. Burditt v. U.S. Dept. of Health and Human Services, 934 F.2d 1362 (5th Cir. 1991).

# BOOK REVIEWS

## Stroke Therapy

Edited by Marc Fisher, with contributions by 33 others. 490 pp., illustrated. Boston, Butterworth–Heinemann, 1995. $90. ISBN 0-7506-9575-7.

An early chapter of this book begins with a scenario that is played out every day in emergency rooms throughout the country:

> A patient has arrived who had a sudden onset of aphasia and right hemiparesis three hours before. A CT scan of the brain is performed; perhaps an MRI scan is done if that is fortuitously available on short notice. The scans are normal. Since normal scans are consistent with the diagnosis of acute ischemic infarction at three hours, this clinical diagnosis is made. The patient is admitted to the hospital, the lesion is allowed to ripen for several days, the scan is repeated. . . .

Therapy is not immediately available, and irreversible neuronal injury is assumed to have already occurred.

As the reader explores the 19 chapters in this book, it becomes clear that cases such as this may be handled very differently in the near future. A chapter on the pathophysiology of stroke describes the recently identified biochemical features of the ischemic cascade of neuronal injury and relates recent experimental findings indicating that patients with a stroke that began only three hours earlier may still have a large rim of viable tissue, the ischemic penumbra. The chapter on animal models of stroke therapy reveals that a myriad of new compounds can be administered to "rescue" neurons in the ischemic penumbra and restore function in drug-treated animals.

A chapter on cytoprotective therapy for ischemic stroke chronicles the preclinical and early clinical development of these new neuroprotective medications. A similar chapter on thrombolytic therapy succinctly summarizes the recent clinical experience with both intraarterial and intravenous thrombolytic agents to treat patients within the first few hours after the onset of stroke.

But which of these therapies should be offered to the patient described above, who had negative neuroimaging studies three hours after the onset of symptoms? The answer may be facilitated by the use of new techniques of magnetic resonance imaging that immediately allow the identification of areas of brain ischemia at presentation, as well as the status of brain perfusion. With these techniques, known as diffusion-weighted imaging and perfusion imaging, the ischemic penumbra may be imaged as an area of delayed or decreased perfusion that extends beyond the region of the diffusion abnormality. These techniques are described in a well-written chapter in terms understandable to the nonradiologist. Impressive examples of their use in patients with acute stroke are also provided.

Besides the chapters described above, which provide a road map into the future of stroke therapy, there are numerous other chapters that are useful for the clinician caring for patients with stroke. These include a nice description of risk factors for stroke, medical therapies (anticoagulant and antiplatelet agents) for stroke prevention, intensive care of cerebrovascular disorders, and a summary of the recent trials of carotid endarterectomy.

The book is not limited to the discussion of ischemic stroke; concise summaries of the diagnosis and treatment of subarachnoid hemorrhage and intracranial hemorrhage are also included. New neurointerventional approaches to the treatment and diagnosis of stroke, including endovascular treatments for intracranial aneurysms and vascular malformations, as well as the emerging field of cerebral angioplasty, are summarized and accompanied by numerous excellent figures.

One of the final chapters describes therapy for unusual causes of stroke, such as the antiphospholipid-antibody syndrome, patent foramen ovale, arterial dissection, and cerebral venous thrombosis. Although studies have not provided definitive therapeutic guidelines for most of these, the chapter provides an excellent overview of the data currently available.

The chapters in this book are brief, but generally well referenced and almost uniformly well written. This is not a comprehensive textbook about the diagnosis and management of stroke. It is, however, a book that conveys tremendous optimism, documenting the substantial advances in the diagnosis and therapy of stroke that have occurred over the past decade and promising even more remarkable progress in the years to come.

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## The Axon: Structure, function, and pathophysiology

Edited by Stephen G. Waxman, Jeffery D. Kocsis, and Peter K. Stys. 692 pp., illustrated. New York, Oxford University Press, 1995. $175. ISBN 0-19-508293-1.

This book is an excellent new contribution to the expanding field of neurobiology. Although a number of neuroscience