Steve Calvin, "On the Need for a Real Choice," *The Journal of Clinical Ethics* 24, no. 3 (Fall 2013): 291-2.

Personal Perspective

On the Need for a Real Choice

Steve Calvin

ABSTRACT

For low-risk mothers who do not wish to give birth in a hospital, a nearby birth center led by midwives is an excellent option.

When talk turns to healthcare reform, pregnancy is what I know best. Each year, nearly 4 million women in the United States deliver a baby.[1] Pregnancy and related diagnoses account for a large percentage of hospital admissions and costs.[2] The total national cost of pregnancy and newborn care is at least $50 billion.[3] At least $20 billion is paid for by public programs.[4] The piles of dollars spent have not translated into satisfied mothers or the rational use of medical interventions. Reform in the delivery of pregnancy care is long overdue.

We currently have a system that maximizes the chance of an expensive, uncomfortable, inconvenient, and impersonal experience for most pregnant women. If more women knew that there was a patient-friendly alternative, change would happen quickly.

During medical school the joke was that pregnancy was a disease curable only by cesarean section. Thirty-three years later, the 33[4] percent rate of cesarean section in the U.S. is not a laughing matter. The intensity of medical training also makes it easy for physicians to slip into impersonal references to patients by their diagnosis rather than their name. It is important to remember that pregnancy really is a momentous normal biological process that most often ends with a healthy mother and baby.

Spontaneous labor clearly maximizes the chances for a normal vaginal birth (even if it inconveniently happens in the middle of the night). Unless there are clear medical reasons to induce labor, doing so increases the risk of unnecessary cesarean section. Often the best advice for birth attendants is, "Don't just do something, stand there."

On the other hand, years of obstetrical experience with a specialization in high-risk pregnancy care have shown me the disasters that can befall a pregnant women and her baby. Some are predictable and preventable, but many arise out of normal situations that rapidly go wrong. If birth is a journey, then it pays to utilize safety measures.

Some call for more home births attended by midwives as the best solution. Less than one in 100 deliveries nationally occurs at home in the U.S.[5] The problem is that 10 to 15 percent of the women and babies cared for at home or in a distant birthing center will need transfer to a hospital. These women

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are often unfairly referred to as "failed home births." Although home births should remain an option, the best option is an accredited birth center in close proximity to a hospital.

Many hospitals call their delivery suites "birth centers," but their presence in a hospital guarantees increased costs and a higher likelihood of intervention. The best solution is to utilize midwife-led, homelike, patient-friendly birth centers, near but independent of a hospital. This provides support for natural birth, true cost savings, as well as a pre-arranged medical safety net for those who need it. Better a five-minute wheel chair ride than a harrowing half hour trip in an ambulance.

What is comes down to in 2013 is that mothers should have real choices of careprovider and location. Whether delivered by midwives, family practice physicians, or obstetricians in hospitals or birth centers, I believe that the best care is delivered by arranging a seamless obstetrical safety net. This makes it much easier to avoid the routine medicalization of pregnancy. With the growth of these options throughout the country, we have reached the tipping point to a better pregnancy care system.

NOTES

1. *http://www.cdc.gov/nchs/fastats/births.htm,* accessed 9 September 2013.
2. *http://transform.childbirthconnection.org/resources/datacenter/factsandfigures/,* accessed 9 September 2013.
3. *http://transform.childbirthconnection.org/reports/cost/,* accessed 9 September 2013.
4. *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Pregnant-Women/Pregnant-Women.html,* accessed 9 September 2013.
5. *http://www.cdc.gov/nchs/data/databriefs/db84.htm,* accessed 9 September 2013.