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In Delivery Rooms, Reducing Births of Convenience

By TINA ROSENBERG
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San Francisco General is largely a hospital for the poor. It's the city's safety net hospital, known for providing free care for all who can't afford it, and for its display — while you wait and wait — of the parade of humanity in all its glory.

It might be surprising, then, that according to data compiled by the state (pdf) it is probably the safest place in California to have a baby. Not the most luxurious, certainly — the labor and delivery ward in the famously dilapidated complex of buildings is strictly industrial. Since the hospital doesn't accept money from formula companies — the usual providers of baby swag — mothers go home with blankets and baby caps made by volunteers from the Baby Love Ministry at Grace Episcopal Church in Napa, and diaper bags filled with breast pads the hospital purchased using money from a grant.

While San Francisco General's maternity ward does not provide luxury, it does something else very well: evidence-based medicine.

The evidence says doctors should do far fewer cesarean sections — the American College of Obstetricians and Gynecologists sets a target rate of 15.5 percent for first-birth low-risk C-sections.

Sometimes C-sections are necessary. Most are probably not. They are done (very rarely) for the convenience of the mother, or, far more commonly, for the convenience of the doctor. But this practice isn't benign. Having a C-section puts a woman at increased risk for hysterectomy, hemorrhage, infection and deep vein thrombosis, and the risk rises with each subsequent C-section. They are also more expensive. The California Maternal Quality Care Collaborative, a group that works to improve birth outcomes, said commercial insurers pay 60 percent more for a C-section than a vaginal delivery — and this is the most commonly performed surgery in America.

Here's a paradox, though: Despite the fact that unnecessary C-sections produce worse outcomes for more money, America's C-section rate is growing fast — it has risen 50 percent in the last 10 years and now is used in a third of all births. This is not because of aging mothers or assisted reproduction — these make up a small fraction of births. Nor is it due to rising obesity — the two trends don't track each other. The biggest increase in C-section rates is among women under 25. Most of the increase has come in low-risk births. (One sign of progress, though: a successful campaign to decrease early elective deliveries has helped to halt the rise in C-section rates in the last few years.)

Another puzzle is the enormous disparity in C-section rates. In 2012, — the most recent year for which data is available (pdf) — Los Angeles Community Hospital did C-sections in 62.7 percent of the lowest-risk births: mothers who have never had a C-section, single baby, normal presentation, full term. The comparable rate for San Francisco General Hospital was 10.1 percent. (Hospitals with low rates of C-section have no difference in outcomes for babies, and better outcomes for mothers.)

San Francisco General has the state's best rate on another crucial measure: vaginal births after C-section, or V.B.A.C. At General, 36.6 percent of women who have had a previous cesarean section deliver vaginally. The state average for V.B.A.C. is just under 10 percent, but many hospitals do zero — they have a policy of never letting a woman who had a C-section try labor. Obstetric experts believe that V.B.A.C.s are vastly underused, and that most women who have had a C-section, or even two, should be allowed to try labor. Yet V.B.A.C. rates nationwide today are only a third of what they were in 1996.

The scarcity of V.B.A.C. means that a first C-section puts a woman on track to have every child by C-section. A doctor may choose a C-section casually for a first birth knowing that it carries very little risk — for that particular birth. But the risk rises with each subsequent C-section; that first decision may have medical consequences a baby or two later.

If cesarean rates for low-risk births vary by 500 percent from hospital to hospital, then clearly hospital policies matter. Examining what San Francisco General does to achieve its low rates might show what other hospitals could do as well.

Probably the single most important factor is that doctors at General are salaried and on shifts. Their pay doesn't vary by the number of patients they see or tests they order. They're paid for their time: 12-hour shifts during the weekday, 24 hours on weekends. (Since it is a teaching hospital for the University of California-San Francisco, residents can handle routine business when attending

physicians need to nap.)

Paying doctors for their time removes the two most powerful incentives encouraging private-practice doctors to do C-sections. One is money. California's Medicaid program, Medi-Cal, wisely pays the same for all births, so doctors have no financial incentive to do a C-section with Medi-Cal patients. That's not the case with commercial insurers, according to the Maternal Quality Care Collaborative.

But this is not the most important way that the financial incentives push doctors in the wrong direction. Perhaps more important is the fact that most of what a private-practice ob-gyn doctor earns from taking care of a pregnant woman comes from the delivery. That means doctors have a strong financial incentive to deliver their patients' babies themselves.

How is this a problem? It leads to more C-sections scheduled for the doctor's convenience, and scheduled inductions of labor that often end in C-sections. Even for unscheduled deliveries, it contributes to the most important syndrome behind unnecessary C-sections: failure to wait.

At General, physicians have no incentive to rush a delivery. "We're here no matter what," said Juan Vargas, chief of obstetrics. "There's no time that a woman needs to be delivered by."

Private practice physicians aren't "here no matter what." They have an office full of other patients to see during the day, and they also like to see their families and sleep. (So do shift doctors, of course, but they aren't called when they're off.)

In one common scenario, the nurse calls to say that a birth is imminent or there is a problem. The doctor rushes to the hospital. It turns out to be a false alarm. Does the doctor go home or back to the office, knowing it will be necessary to have to come back to the hospital again — and possibly do the C- section anyway? Better to do the C-section now.

This system makes it nearly impossible to do V.B.A.C.s. If a patient with a previous C-section tries labor, a doctor must be readily available the whole time. That means waiting around for many hours — in many cases, only to do a C-section anyway.

"Over half the hospitals in the U.S. do not have obstetricians on site all the time," said Christine Morton, a research sociologist at Stanford University. "The nurse calls in updates to the physician. That's why a lot of hospitals don't do V.B.A.C.s. Physicians don't want to wait around all night."

How can other hospitals adopt San Francisco General's practices? One way is to become a teaching hospital —– they are much more serious about evidence-based

medicine. Here's a slightly more practical suggestion: Switch from fee-for-service medicine to salaried doctors. Better birth practices are far from the only reason to consider paying doctors a salary — the model is getting a lot of attention in the debate about how to lower health care costs and reward high-quality care instead of high volume of patients and tests. The giant in California is the widely admired Oakland-based Kaiser Permanente. Kaiser hospitals employ their physicians on straight salary; while fee-for-service encourages unnecessary care, the Kaiser model discourages it. Kaiser hospitals' rates of C-section and V.B.A.C. are excellent.

Although there is now a wave of physicians who are becoming hospital employees, in most cases this means hospitals take ownership of a private practice, but it's largely still business as usual: Hospitals pay doctors a salary, but also reward these physicians according to the number of patients they treat and tests they order.

The exceptions are physicians who are hospitalists. Obstetric hospitalists are salaried doctors with no practices of their own who work shifts in the hospital in the labor and delivery wards. The hospitalist can monitor the laboring mother, calling the private-practice doctor in at the very end. (And if the hospitalist ends up delivering the baby, the private-practice physician still collects the fee, paying a small amount to the hospital.) The presence of a hospitalist allows a private-practice doctor to be patient and wait for labor to take its course.

Since OB hospitalists spend all their time delivering babies, they are also expert in vaginal operative deliveries with forceps or vacuum — skills that can prevent C-sections. "If the baby's shoulders are stuck, they call me and I stand by the door while the delivery goes on," said Rob Olson, an OB hospitalist in Bellingham, Wash. "If I hear the baby cry I can leave. If I hear the doctor cry, I go deliver the baby."

Brian Iriye, an OB who is managing partner of the Las Vegas High Risk Pregnancy Center, led a study of another Las Vegas hospital that found that when it hired hospitalists, the C-section rate decreased by 27 percent. The hospital had first tried having its private practice doctors take rotating shifts. Even though that model, too, guaranteed that a physician was always present, it had no effect on C-section rates. Iriye speculated that doctors didn't want to let their competitors deliver their patients' babies. Hospitalists, by contrast, have no patients of their own and are not seen as competitors. "It makes V.B.A.C. possible," said Iriye.

Hospitalists are a fairly new phenomenon. Olson, who is founder of the Society of OB/Gyn Hospitalists, said that eight years ago he knew of only 15 hospitals that employed OB hospitalists, and now 212 do. But that's still a tiny percentage of American hospitals.

This article (free registration required) discusses Iriye's study, and other studies showing that hospitalists are associated with reductions in "adverse events" — hospital-speak for maternal deaths and babies' severe neurodevelopment impairment. Also —— a point that gets hospitals' attention — hospitalists in one study were associated with a 90 percent reduction in malpractice payouts.

If you are a patient at General in a normal pregnancy, you can choose a nurse-midwife as your primary caregiver — you'll see a doctor only if there are complications. Nationally, nurse-midwives are rare; Morton says they attend 7 percent of all births. Even rarer is General's model of an autonomous nurse-midwife service with its own caseloads.

The clout of nurses at General is another way the hospital encourages labor to take its course. The hospital's chief executive officer is a nurse, as was her immediate predecessor. Nurse-midwives teach in the medical school in addition to the school of nursing. In the labor and delivery ward, nurse-midwives led a successful effort to greatly decrease the use of episiotomies and were co-leaders in developing new guidelines for V.B.A.C.s. The nurse-midwife service implemented CenteringPregnancy group medical appointments for prenatal care — the groups meet not in the hospital, but in community centers in the neighborhoods where General's patients live.

Patients at General learn early in their pregnancies about the risks of C-sections. Ana Delgado, a certified nurse-midwife who is assistant director of inpatient obstetrics, said that midwives are trained in "the art of doing nothing, well. Patients get the message from the beginning: We will intervene when needed, but if you don't need it, we don't."

"A lot of us recognize that midwives are the real experts in labor," said Vargas, the OB chief at General. "I trained as a high-risk obstetrician. I'm best at dealing with complications. So I stand by and try to be patient." San Francisco General encourages and rewards patience. Any hospital wishing to bring down its C-section rates might start there.

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Tina Rosenberg won a Pulitzer Prize for her book "The Haunted Land: Facing Europe's Ghosts After Communism." She is a former editorial writer for The Times and the author, most recently, of "Join the Club: How Peer Pressure Can Transform the World" and the World War II spy story e-book "D for Deception."

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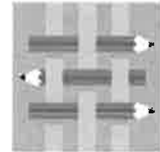

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