STATEMENT of the
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Presented by
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to the

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
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UNITED STATES SENATE

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RE: SAFE MOTHERHOOD

Good afternoon Mr. Chairman and distinguished members of the committee. I am Dr. Thomas Gellhaus. I appear before you on behalf of the American College of Obstetricians and Gynecologists (ACOG). I am currently in practice at Obstetrics and Gynecology Specialists, PC, in Davenport, Iowa, and teach in the Department of Obstetrics and Gynecology at the University of Iowa's College of Medicine.

I am honored to be here today, and on behalf of ACOG, we couldn't be more pleased with the attention and commitment to women's health consistently demonstrated by members of this committee and by the scheduling of this important hearing. The American College of Obstetricians and Gynecologists (ACOG) represents 44,000 physicians dedicated to improving women's health care. Ninety-five percent of board-certified obstetricians and gynecologists in the United States are members of ACOG.

I have been asked to focus my comments specifically on the issue of "safe motherhood" and issues related to pregnancy and women's health, but I should add that the full range of issues explored by this hearing is important to ACOG members. As ob-gyns we not only care for and treat patients during their pregnancies but throughout their lifetime. We believe that improving women's health is a vital investment.

Safe motherhood is a necessarily broad term but in the context of this discussion my remarks will narrow the focus of safe motherhood to refer to a woman's ability to have a safe and healthy pregnancy, delivery, and postpartum period free of life or health threatening complications.

Approximately 4 million American women become pregnant each year, and more than 10,000 give birth each day. Most women can count on having a healthy pregnancy. However, every pregnancy faces risks: every pregnant woman—regardless of income or education – can develop sudden, life-threatening complications that require high quality obstetric care. Although rates of maternal morbidity and mortality decreased dramatically in the United States between 1950 and 1990, the last two decades have seen little progress.

Each year in the United States, 30% of pregnant women have pregnancy-related complications before, during, or after delivery that often lead to long-term health problems. Approximately 1,000 of these women die each year. Over half of pregnancy-related deaths could be prevented through improved health care access, improved quality of care, and changes in maternal health and lifestyle habits.

The importance of legislation to help ensure a safe pregnancy for all women in the United States must not be underestimated and ACOG fully supports these efforts. Unfortunately there is still much we do not know about pregnancy and its complications. Why do some women have life-threatening complications? Why do some women survive them and others do not? Why are there racial and ethnic disparities in maternal morbidity and mortality? How do the factors of age, marital status, and education levels affect maternal health? What causes certain complications and how can we treat them?

Reducing Maternal Morbidity through Coordinated Federal Action

ACOG has a long history of collaborating with the Centers for Disease Control and Prevention (CDC) on the development and publication of educational materials regarding mortality reviews at the state level, and we have collaborated with the American Academy of Pediatrics, March of Dimes, and others to promote healthy pregnancy. We appreciate the efforts to broaden this focus to include morbidity and to take it to the next level by formalizing collaborative partnerships among government agencies, physicians, and community groups. We strongly support grants to assist states' transition to a national standard of tracking pregnancy-related deaths through certificates of death. States can improve identification of cases, review of pregnancy-related deaths, and interpretation of the findings. These efforts will go a long way toward implementing systemic change in improving pregnancy outcomes.

It is essential that we seek to understand what trends and differences between populations may play a role in maternal mortality. Through community partnerships we can provide information and direction for public health efforts to improve women's health. For example, ectopic pregnancy, when the fetus develops in the Fallopian tube instead of the uterus, is the leading cause of death during the first trimester. While collecting data on these pregnancies is imperative, ectopic pregnancies are currently the only maternal complication regularly monitored in the U.S. We must work together to broaden the scope of the data available for other common complications.

Increased Funding for Research

We are pleased with the recognition for increased funding for research in every aspect of safe motherhood. Each day in the United States between two and three women die of pregnancy related causes. And each year at least 30% of pregnant women in the United States have a pregnancy-related complication before, during, or after delivery. These complications can cause long-term health problems even when they do not result in death. According to the CDC, childbirth remains the most common reason for hospitalization in the United States, and pregnancies with complications lead to more costly hospitalizations.

A commitment to research in maternal health could shed light on a breadth of issues that could save women's lives. Pre-term labor is one of the leading and most profound complications affecting pregnancy, yet little is known about causation of this condition or possible preventive treatments. Likewise, pre-eclampsia, pregnancy-induced high blood pressure and swelling, is a very common complication, and there is the same paucity of research on how we can prevent it. Studies of maternal behavioral practices could lead physicians to new interventions against alcohol, cigarette, and drug use during pregnancy. More information on the causes and the diagnoses of postpartum depression could educate physicians on appropriate preventive and follow-up care for at risk women.

Perhaps one of the most alarming trends we need to address is the disparity in maternal mortality and morbidity in relation to race and ethnicity. African American women are 4

times more likely than Caucasian women to die from pregnancy-related causes. Hispanic women are 1.7 times more likely to die than their Caucasian counterparts. Racial and ethnic minority women, as well as women with low incomes, are already at increased risk to develop chronic disease. This risk, compounded with high risk for poor pregnancy outcomes, creates an inequality that we can no longer ignore.

Family Planning as Preventive Health

Biologically, most women can become pregnant for nearly forty years of their lives. Without contraception, the average women could become pregnant more than twelve times, a prospect that would carry an unnecessary amount of risk for most women.

Family planning is critical to improved maternal health by allowing women to space the number and timing of their pregnancies. Studies show that women who conceive within six months following childbirth increase the risk of pregnancy complications. According to the November 2000 *British Medical Journal*, "women who became pregnant less that six months after their previous pregnancy were 70% more likely to have membranes rupture prematurely and had a 30% higher risk of other complications."

Pregnancy can be life threatening for women with serious medical conditions such as heart disease, diabetes, lupus, and high blood pressure. For these women, family planning can be life saving. It can help them prevent pregnancy altogether, or it can help these women postpone pregnancy until they are healthy enough to support a pregnancy.

One half of all pregnancies in the U.S. are unintended. Effective contraception can give women suffering from chronic disease more autonomy over their own health decisions. These women have the chance for better health outcomes, whether they choose to become pregnant or not.

Pregnancy and Drug Interaction

As a practicing physician, I applaud your effort to increase knowledge and data on the effects of drugs on pregnant women. Pregnant women get sick just like we all do. The difference is that for even the most commonly prescribed medications, there is very little information available to help doctors know what the best dose of a particular medicine is for pregnant women and how that medication may affect the developing fetus.

Currently, approximately 2/3 of all drugs fall into Category C, under FDA guidelines. Drugs in this category are considered potentially unsafe to use during pregnancy, either because no studies demonstrating their safety for pregnant women are available or because they have been shown to harm animal fetuses. In prescribing medications to my patients, I can only make my best judgment based on the little data that is available.

Many women who become pregnant discontinue their medications during pregnancy, for example allergy medications or dermatological drugs. Yet women who suffer from chronic diseases like epilepsy, HIV, or depression do not have the luxury of going

without treatment for nine months. Indeed, pregnancy actually can exacerbate conditions like asthma and high blood pressure, making it even more critical for the physician to make informed decisions about the treatment of their pregnant patients. In addition to general questions about safety, almost no information is available to help doctors know what the best dose of a particular medicine is for pregnant women. Changes in the body's physiology during pregnancy have the potential to require that doses be increased or decreased.

Physicians make the best decisions we can with the information available. We are trained to make medical decisions based on professional judgment. Yet, I cannot overstate the need for more research and data in this area. Pregnant women are the last population for which we don't have drug information.

Conclusion

Thank you for giving me the opportunity to testify on behalf of my patients and ACOG on this important subject of safe motherhood. The goals of the legislation being introduced today, with the support of so many other groups committed to women's health, are laudable and overdue. Together, physicians, advocates, and government agencies can make a difference in maternal mortality and morbidity rates.

Despite our best efforts to decrease pregnancy-related complications, we have reached a plateau in the past decade. It is time to move forward with new research, new interventions, and new cooperation to ensure that women and their doctors have the best information available to make informed decisions about their lives and their pregnancies.

I thank the Chair and this Committee for holding this hearing today and for allowing me the opportunity to testify. This legislation is critical to the health of our nation's women.