



What to reject when you're expecting

10 procedures
to think twice
about during
your pregnancy

February, 2013



Dear Employee—

Consumer Reports is excited to work with the National Business Group on Health and your employer to bring you some of the most important health stories we have recently published. For 77 years, Consumer Reports has published information that helps consumers make better choices about the things they buy. We think it's time that consumers approach health care the same way.

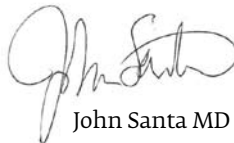
Over the last year, we shared stories about heart disease, hospital safety, improving the patient-doctor relationship, supplement safety, and making sense of health insurance. Our current article focuses on maternity care, the most common “medical event” in the lives of most people and the most important one in shaping the future health of our children and families.

Over the past several decades, hospitals and obstetricians have become more willing to intervene in the natural processes of pregnancy and childbirth. That includes scheduling cesarean sections and inducing labor, sometimes even before the 39th week of pregnancy, without any pressing medical reason. Those and other interventions can harm mothers and babies. In some cases, it appears doctors and patients are putting convenience ahead of health and safety. That should never happen.

The solution starts with prospective parents and families understanding the importance of allowing pregnancy to unfold on its own, without unnecessary medical interventions. It's hard to beat a process that has had tens of thousand of years to evolve. That doesn't mean that C-sections and other interventions should never happen. When done appropriately, they can be life saving. But if all is well, we should leave well enough alone. The article we share with you was first released in 2012 and received the largest social media response of any health article in Consumer Reports history. We have updated it for your use.

We look forward to hearing any thoughts you have about this article or others you will see in the future. Contact us by sending an e-mail to HealthImpact@cr.consumer.org.

Sincerely,



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What to reject when you're expecting

10 procedures to think twice about during your pregnancy

DESPITE A HEALTH care system that outspends those in the rest of the world, infants and mothers fare worse in the U.S. than in many other industrialized nations. The infant mortality rate in Canada is 25 percent lower than it is in the U.S.; the Japanese rate, more than 60 percent lower. According to the World Health Organization,

America ranks behind 41 other countries in preventing mothers from dying during childbirth.

With technological advances in medicine, you would expect those numbers to steadily improve. But the rate of maternal deaths has risen over the last decade, and the number of premature and low-birth-weight babies is higher now than it was in the 1980s and 1990s.

Why are we doing so badly? Partly because mothers tend to be less healthy than in the past, “which contributes to a higher-risk pregnancy,” says Diane Ashton, M.D., deputy medical director of the March of Dimes.

But another key reason appears to be that convenience has grown to take priority over the best outcomes. Our health care system has developed into a highly profitable labor-and-delivery machine, operating according to its own timetable

rather than the less predictable schedule of mothers and babies. Childbirth is the leading reason for hospital admission, and the system is set up to make the most of the opportunity. Keeping things chugging along are technological interventions that can be lifesaving in some situations but also interfere with healthy, natural processes and increase risk when used inappropriately.

For example, while a full-term pregnancy goes to at least 39 weeks, over the last two decades it's become common practice to artificially induce labor sooner than Mother Nature intended. Between 1990 and 2007, births at 37 and 38 weeks increased 45 percent, according to the March of Dimes. At the same time, full-term births dropped by 26 percent.

“Being able to schedule labor is really appealing,” says Maureen Corry, M.P.H., Executive Director at Childbirth Connec-

Contents

- **10 overused procedures**Page 4
- **10 things you should do during your pregnancy**Page 8
- **5 things to do before you become pregnant** Page 10
- **Success stories**Pages 6, 8
- **Resources**Page 11

tion, a nonprofit organization that promotes evidence-based maternity care. “Hospitals can plan for staffing, doctors can work during daylight hours, and women can schedule around their work and families.” But that convenience comes at a cost, says Corry. “Women who are induced early are more likely to need other interventions and to wind up delivering their babies surgically through a cesarean section and the infants are more likely to require intensive care.”

In fact, the increase in planned early deliveries is one reason that the rate of C-sections has risen steadily over the past two decades to the point that nearly one out of three American babies enters this world through a surgical incision.

Ever-more-alarming statistics on unnecessary interventions have spurred public health organizations into action. In February 2013, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP), as part of a campaign called Choosing Wisely, publicly warned against the overuse of planned early deliveries and inducing labor without a strong medical reason.

And as of 2013, hospitals will have greater accountability. The Joint Commission, an independent, nonprofit group that accredits hospitals, has added important maternal and infant quality measures, including the number of elective deliveries and C-sections for first-time births, to the list of those health care sys-

tems can choose to report to a public database. In 2014 that reporting will be mandatory for hospitals with 1,100 or more births yearly.

Our experts say those measures, along with changes in the way healthcare providers are paid (see the box below), will help bring about real maternal health reform.

In the meantime, knowledge is power. “Surveys show that women want to know risks and benefits of procedures, but often

are very poorly informed and may feel hesitant to question their providers,” says Kathleen Simpson, Ph.D., R.N.C., a perinatal clinical nurse specialist at Mercy Hospital in St. Louis, Missouri and a researcher with interests in safe maternal care. “I believe in empowering women by giving them the information they need to navigate the system and work together with their providers to make the best choices for themselves and their babies.”

▶ 10 overused procedures

Of course, the idea is not to reject all interventions. The course of childbirth is not something that anyone can completely control. In some situations, inducing labor or doing a C-section is the safest option. And complications are the exception, not the norm. But when they’re not medically necessary, the interventions listed below are associated with poorer outcomes either for moms, babies, or both.

1. An elective early delivery. Because nearly all babies born a few weeks early survive and eventually thrive, many doctors have traditionally not seen the harm in moving up a delivery date to fit a schedule. “Although we knew 39 weeks or later was the optimal time for delivery, until recently there wasn’t good evidence show-

ing that a lot of maturation took place after 37 weeks,” says Ashton of the March of Dimes, who terms research from the last five years “eye opening.”

Late preterm babies “may look like full-term babies,” she says, “but they are different in important ways.”

It turns out that carrying an infant to term has health benefits for both moms and babies. Research shows that babies born at 39 weeks or later have lower rates of breathing problems and are less likely to need neonatal intensive care. Full-term babies may also be less likely to be affected by cerebral palsy or jaundice, have fewer feeding problems, and have a higher rate of survival in their first year. Some research even suggests that full-term infants benefit from cognitive and learning

When it’s profitable to do too much

One roadblock to improving maternal health care is the fee-for-service system common in the U.S., which pays providers more for doing more, even if doing that makes mothers and babies sicker.

But under many current payment systems, providers who eliminate unnecessary interventions, improve outcomes, and increase safety, may also lose money doing it. A 2011 report detailing the experience of the Intermountain Healthcare system, a network of 23 hospitals and 160 clinics in Idaho and Utah, is telling.

By reducing the rate of inappropriate early inductions from 28 percent to 2 percent, the health care system decreased C-sections and admissions to the neonatal intensive care unit (NICU), and slashed yearly health care costs in Utah by \$50 million yearly. But those quality improvements cost Intermountain \$9 million yearly in lost revenue.

“NICUs are a significant revenue generator for many hospitals,” says Elliot Main, M.D., chairman of the department of obstetrics and gynecology at the California Pacific Medical Center and director of the California Maternal Quality Care Collaborative. “And if you stop the

practice of intentionally delivering babies at 37 to 38 weeks, you will see a significant decline in NICU admissions. Which is, of course, good for the baby but not so good for the bottom line.”



Several approaches for reforming payment systems that would reward quality outcomes rather than reward performing more services are now being evaluated. One such payment model would bundle payment for the full episode of childbirth for both mothers and newborns, regardless of the mode of delivery and regardless of NICU admission. The hope is that would eliminate financial incentives for intervening in the natural course of childbirth when it is not medically necessary—ultimately saving ever-shrinking health care dollars while improving outcomes.

And physician organizations like the American College of Obstetrics and Gynecology are urging members to put their professional priorities first rather than convenience and hospital profits.

“There truly are ways you can save money by doing the right thing,” says Kathleen Simpson, Ph.D., R.N.C., a perinatal clinical nurse specialist at Mercy Hospital in St. Louis, Missouri.

The U.S. health care system has developed into a profitable labor-and-delivery machine that operates on its own timetable—not the schedule of mothers and babies.

advantages that continue through adolescence.

Perhaps because late preterm infants have more problems, mothers are more likely to suffer from postpartum depression. In addition, the procedures required to intentionally deliver a baby early—either an induced labor or a C-section—also carry a higher risk of complications than a full-term vaginal delivery. “There is just much more chance of things going wrong if you interrupt the normal course of pregnancy,” says Catherine Spong, M.D., chief of the pregnancy and perinatology branch at the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

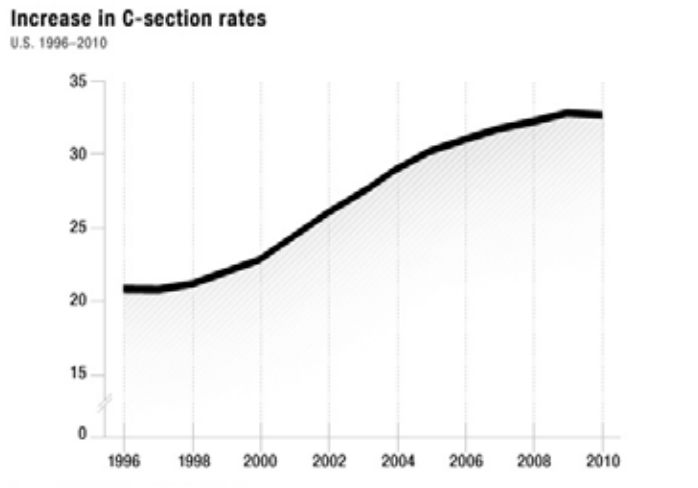
For all those reasons, several professional medical organizations are now urging physicians and women to avoid planned early deliveries when possible. For example, when panels of experts at ACOG and AAFP were asked to identify five tests or procedures that they think are overdone, number one on the list was elective early delivery.

Of course, some babies arrive sooner than expected and complications during pregnancy, such as skyrocketing blood pressure in the mother, can make early delivery the safest option. But hastening the conclusion of an otherwise healthy pregnancy—even by a couple of days—is never a good idea.

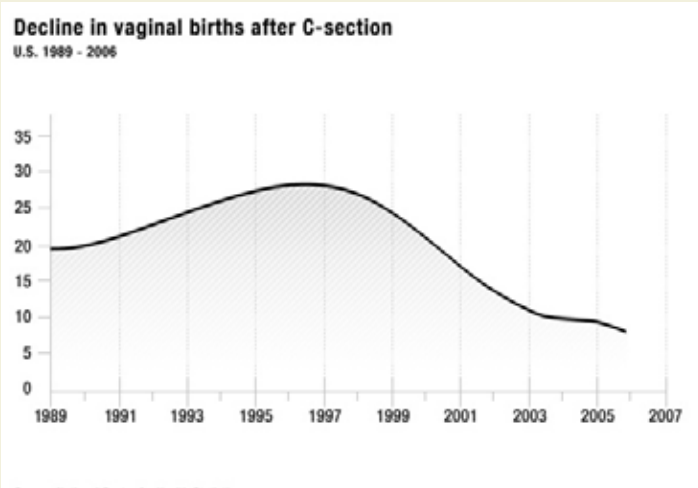
The rate of early deliveries varies widely among hospitals. For example, the table to the right shows the percentage of early deliveries that were done without a medical reason in the six Utah hospitals that report this data to the Leapfrog Group.

See the rates of planned early deliveries for the hospitals in your state on the Leapfrog website, www.leapfroggroup.org.

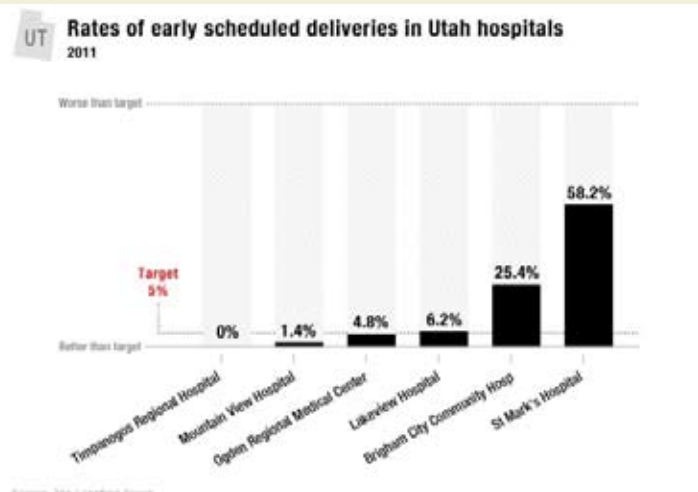
Child birth by the numbers



About a third of the babies born in the U.S. are now delivered by C-section.



Vaginal births after a C-section have declined sharply since the late 1990s.



The rate of scheduled early deliveries varies widely in six Utah hospitals.

2. Inducing labor without a medical reason. The second procedure to question according to ACOG's and AAFP's Choosing Wisely lists is inducing labor without a strong medical reason, even if a woman has reached the 39-week point in her pregnancy that is considered full term.

The percentage of births resulting from artificially induced labor more than doubled from 1990 to 2008. "In many ways the system has become centered on convenience rather than evidence-based care," says Carol Sakala, Ph.D., director of programs at Childbirth Connection. She points out that it's no coincidence that more babies are born on Tuesdays than any other day of the week. "The births are scheduled so that parents and providers can all be home by the weekend."

But whether artificially induced or

spontaneous, labor is labor, right? "Absolutely not," says Debra Bingham Dr.PH., R.N., vice president of the Association of Women's Health, Obstetric and Neonatal Nurses. She points out that women who go into labor naturally can usually spend the early portion at home, moving around as they feel most comfortable. An induced labor takes place in a hospital, where a woman will be hooked up to at least one intravenous line and an electronic fetal monitor. In addition, most hospitals don't allow eating or drinking once induction begins.

"An induced labor may also occur prior to a woman's body or baby being ready," Bingham says. "This means labor may take longer and that the woman is two to three times more likely to give birth surgically." Induced labor frequently leads to

further interventions—including epidurals for pain relief, deliveries with the use of forceps or vacuums, and C-sections—that carry risks of their own.

For example, a 2011 study found that women who had labor induced without a recognized indication were 67 percent more likely to have a C-section, and their babies were 64 percent more likely to wind up in a neonatal intensive care unit, compared with women allowed to go into labor on their own.

Induction is justified when there's a medical reason, such as when a woman's membranes rupture, or her "water breaks," and labor doesn't start, or when she's a week or more past her due date.

3. A C-section with a low-risk first birth.

Nearly one out of every three American babies now enters the world through a surgical birth. And while C-sections are generally quite safe, "the safest method for both mom and baby is an uncomplicated vaginal birth," Spong says.

The best way to reduce the number of C-sections overall is to decrease the number of them among low-risk women who are delivering their first child. That's because having an initial C-section "sets the stage for a woman's entire reproductive life," says Main. "In this country, if your first birth is a C-section, there's a 95 percent chance all subsequent births will be as well," he says.

A C-section is major surgery. So it's no surprise that as rates for the procedure go down, so do the numbers for several complications, especially infection or pain at the site of the incision. Rare but potentially life-threatening complications include severe bleeding, blood clots, and bowel obstruction. A C-section can also complicate future pregnancies, increasing the risk of problems with the placenta, ectopic pregnancies (those that occur outside the uterus), or a rupture of the uterine scar. And the risks increase with each additional cesarean birth.

Babies born by C-section can be accidentally injured or cut during the procedure and are more likely to have breathing problems. They are also less likely to breast-feed, perhaps because of the challenges of starting in a post-surgical setting.

In some situations, such as when the mother is bleeding heavily or the baby's oxygen supply is compromised, surgical delivery is absolutely necessary. But women can maximize their chances of avoiding

Success stories

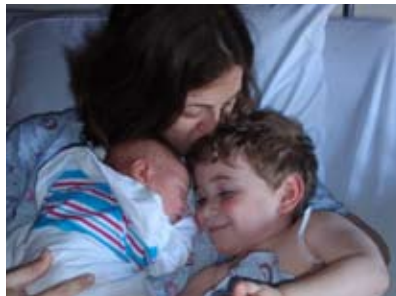
Emily Timmel Croton-on-Hudson, N.Y.

Emily Timmel describes her first pregnancy as totally normal. Although laboring for more than 24 hours had left her exhausted, she was still up for a vaginal birth. She only got to push twice. "The baby was in distress," she recalls. "The doctor tried a vacuum extraction, but when that didn't work, I was wheeled into another room for an emergency C-section, and knocked out with gas." She would learn that her bouncing baby boy was fine when she was reunited with him two hours later.

Timmel's own recovery was complicated by a series of infections at her incision site. "The first two months were pretty rough," she says. She admits to second-guessing her choices, wondering if she could have done anything to have a vaginal birth. But ultimately she was reassured that because the umbilical cord had been "wrapped like a noose" around her baby's neck, the doctor took the steps necessary to save his life.

Timmel was considered a great candidate for a vaginal birth with her second child because the problems related to her first childbirth were not likely to occur. Still, not everyone was supportive. An obstetrician she knew told her that a VBAC would be unwise, Timmel says. "She told me all these horrible scary stories—that I wouldn't be able to push the baby out or that my uterus would rupture," she said.

Timmel was reassured by her own maternal-care team that going into labor in a hospital setting was a reasonable option. This time, she came fully prepared.



"I engaged a doula for support," she said. "I also had a wonderfully supportive midwife and husband." Everything went like clockwork. Labor started at 3 a.m., she went to the hospital at 9 a.m., and by 10:45 a.m. had what she calls "an amazing experience" giving birth to her second son.

Timmel credits the hospital she chose for helping to make her second childbirth much better all-around. "Staff at the first hospital started talking to me about interventions from the second I walked in the door," she says. "They had a very condescending attitude about natural childbirth," adding that they were also not supportive of breast-feeding and despite her protests kept trying to give the baby a bottle.

The difference between that experience and the second hospital was "like night and day" Timmel says. "Every nurse supported me as a mother and supported bonding with my baby, including breast-feeding. It was such a gift."

It's no coincidence that more babies are born on Tuesdays. The births are scheduled so the parents and providers can all be home by the weekend.

an unnecessary cesarean by finding a caregiver and birthing environment that supports vaginal birth.

When choosing a practitioner and hospital or birthing center, ask about C-section rates, particularly rates for low-risk women having their first child. The target rate for that population should be around 15 percent, according to ACOG. Although it can be difficult to find a hospital with a C-section rate that low, you might be able find one that meets the more modest goal of about 24 percent, which was set by the government's Healthy People 2020 initiative.

4. An automatic second C-section. Just because your first baby was delivered by C-section doesn't mean your second has to be, too. In fact, most women who have had a C-section with a "low-transverse incision" on the uterus are good candidates for a vaginal birth after cesarean (VBAC), according to ACOG. (Note that a "bikini scar" on the skin does not indicate the type of uterine scar.) About three quarters of such women who attempt a VBAC are able to deliver vaginally.

Yet the percentage of VBACs has declined sharply since the mid-1990s, particularly after ACOG said in 1999 that they should be considered only if hospitals had staff "immediately available" to do emergency C-sections if necessary. And some obstetricians don't do VBACs because they lack hospital support or training, or because their malpractice insurance won't provide coverage. So women seeking a VBAC delivery might have trouble finding a supportive practitioner and hospital.

"It's tragic, really," Main says. "In many parts of the country, the option has all but disappeared."

In response, ACOG recently relaxed its guidelines. For example, it makes clear that while it's preferable for staff to be at

the ready, hospitals can make do with a clear plan for dealing with uterine ruptures and assembling an emergency team quickly. Experts we spoke with say it's too early to tell if the move will lead to a change in clinical practice.

Although some women turn to home births as an alternative, our experts say that isn't a good idea in this situation. "The risk of uterine rupture is low," Main says, "but if it happens, it can be catastrophic."

Instead, if you had a C-section, find out whether your obstetrician and hospital are willing to try a VBAC. Let them know that you understand that your baby will be monitored continuously during labor, and ask what the hospital would do if an emergency C-section became necessary.

5. Ultrasounds after 24 weeks. Unless there is a specific condition your provider is tracking, you don't need an ultrasound after 24 weeks. Although some practitioners use ultrasounds after this point to estimate fetal size or due date, it's not a good idea because the margin of error

increases significantly as the pregnancy progresses. And the procedure doesn't provide any additional information leading to better outcomes for either mother or baby, according to a 2009 review of eight trials involving 27,024 women. In fact, the practice was linked to a slightly higher C-section rate.

6. Continuous electronic fetal monitoring. Continuous monitoring, during which you're hooked up to monitor to record your baby's heartbeat throughout labor, restricts your movement and increases the chance of a cesarean and delivery with forceps. In addition, it doesn't reduce the risk of cerebral palsy or death for the baby, research suggests. The alternative is to monitor the baby at regular intervals using an electronic fetal monitor, a handheld ultrasound device, or a special stethoscope. Continuous electronic monitoring is recommended if you're given oxytocin to strengthen labor, you've had an epidural, or you're attempting a VBAC.

7. Early epidurals. An epidural places anesthesia directly into the spinal canal,



ULTRASOUNDS The tests usually aren't necessary after 24 weeks.

so that you remain awake but don't feel pain below the administration point. But the longer an epidural is in place, the more medication accumulates and the less likely you will be able to feel to push. Epidurals can also slow labor. By delaying administration and using effective labor support strategies, you might be able to get past a tough spot and progress to the point you no longer feel it's needed. If you do have an epidural, ask the anesthesiologist about a lighter block. "Ideally, a woman should still be able to move her legs and lift her buttocks," Main says.

8. Routinely rupturing the amniotic membranes. Doctors sometimes rupture the amniotic membranes or "break the waters," supposedly to strengthen contractions and shorten labor. But the practice doesn't have that affect and may increase the risk of C-sections, according to a 2009 review of 15 trials involving 5,583 women. In addition, artificially rupturing amniotic membranes can cause rare but serious complications, including problems with the umbilical cord or the baby's heart rate.

9. Routine episiotomies. Practitioners sometimes make a surgical cut just before delivery to enlarge the opening of the vagina. That can be necessary in the case of a delivery that requires help from forceps or a vacuum, or if the baby is descending too quickly for the tissues to stretch. But in other cases, routine episiotomies don't help and are associated with several significant problems, including more damage to the perineal area and a longer healing period, according to a 2009 review involving more than 5,000 women.

10. Sending your newborn to the nursery. If your baby has a problem that needs special monitoring, then sending him or her to a nursery or even an intensive care unit is essential. But in other cases, allowing healthy infants and mothers to stay together promotes bonding and breastfeeding. Moms get just as much sleep, research shows, and they learn to respond to the feeding cues of their babies. Allowing mothers and babies to stay together is one of the criteria hospitals must meet to be certified as "baby friendly" by the Baby-Friendly Hospital Initiative, a program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

▶ 10 things you should do during your pregnancy

Families don't have to wait for the whole system to change to seek out practitioners who are already following more patient-centered models of care. "We need to raise women's awareness that there will be a big difference in how they are cared for depending on who is in charge and what policies are in place," Bingham says. Below are 10 steps you can take to ensure the best possible experience.

1. Set your due date. If you aren't positive about the date of conception or your last menstrual period, get an ultrasound early in the pregnancy to establish your due date.

Subsequent ultrasounds might suggest other dates, but that first ultrasound provides the most accurate one. "If we aren't sure about the dates," Spong says, "it can turn into a real mishmash in the end."

2. Make a plan—and have a backup. For example, if you've had a C-section and would like to consider a vaginal birth, discuss that up front because not all doctors and hospitals provide care for VBACs. A birth plan can help you talk about concerns and desires with your provider and with hospital staff. Look for a template that is current, applicable to your situation, and flexible.

Success stories

Laura Sundstrom New Haven, CT

Laura Sundstrom was surprised that her expertise as a nurse midwife didn't fully prepare her for her own pregnancy and childbirth. "I felt humbled, fresh, naive—less like a midwife and much more like one of my patients taken over by this powerful change happening inside me," she says.

The next surprise was that despite a healthy pregnancy and excellent care, the birth of her first child did not go according to plan. When the baby wouldn't budge after hours of pushing, she was delivered by C-section. After attending the vaginal births of so many of her patients, Sundstrom expected her own child to come into the world the same way. But she has no regrets. "I feel fortunate in that I had one of those C-sections that is truly medically necessary," she says.

Fast forward three years and Sundstrom, pregnant with her second child, found that not everyone in her professional community was supportive of her choice to again try for a vaginal birth because of the risks she encountered the first time. "Even I had a hard time believing I could go through with it," says Sundstrom, who put herself in the hands of a skilled colleague who reminded her to "allow for normal." In addition to her midwife, she also consulted with a team of doctors who were supportive of VBACs, and she and her caregivers put together a comprehensive plan for a hospital birth.

This time everything went smoothly, and



Sundstrom says the mood in the delivery room was upbeat. In between contractions, she was excited, joyful even, right up until she needed to push. "At that point, all my fears and anxieties came flooding back," she says. "If I could have gotten up and left, I would have. I just didn't believe I could do it." Her midwife then encouraged her to do the same thing Sundstrom had advised so many of her own patients to do—reach down and feel the baby's head. In that moment, the possibility of a natural birth became real. She recalls feeling "so much calmer, really at peace."

Her son was born about 10 minutes later. "Going into the second birth, I was totally prepared for another C-section and would have been OK with it," Sundstrom says. "But I didn't realize until the moment it happened how incredible it was to receive that fresh, warm baby. I was elated. It was fabulous."

You'll find an example from the California Pacific Medical Center at www.cpmc.org/services/pregnancy/information/birthplan.html. But remember that things rarely go exactly as planned, so have a backup in mind. For example, you might want to have a delivery without pain medication, but consider what you will do if it turns out you need it. Finally, think about breast-feeding when planning. "An important thing a mother can do is learn about breast-feeding while she is pregnant," says Rebecca Manne, a lactation coordinator at the University of Oklahoma Medical Center. "Providing advice and support prenatally is a key time that is often missed."

3. Consider a midwife. If your pregnancy is low-risk, consider using a certified midwife, a health professional who can provide a range of women's health care during pregnancy, childbirth, and the postpartum period. Certified nurse midwives (CNMs) and certified midwives (CMs) have graduate degrees, have completed an accredited education program, and must pass a national certification exam. CNMs also have a nursing degree. Certified professional midwives (CPMs) have special training in delivering babies outside of hospitals, but may not have nursing or advanced degrees.

Midwives practice in diverse settings—including homes, hospitals, and birthing clinics—and provide many of the same services as physicians, including prescribing medication and ordering tests. The care that midwives provide is based on the philosophy of not intervening unless there is a current or potential health problem. That approach has several benefits, according to a 2009 review of 11 studies involving more than 12,000 women. Women who used midwives were more likely to be cared for in delivery by their primary provider (rather than whoever was on call) and were more likely to have a spontaneous vaginal birth without the need for an epidural, forceps, or vacuum extraction. They are also more likely to report feeling in control during their birth experience and to initiate breast-feeding.

Most health insurance plans cover midwife care and include some in their list of covered providers. The American College of Nurse-Midwives maintains a list of CNMs and CMs on its website, www.midwife.org. Make sure the midwife you're considering is licensed to practice in your state. CNMs are licensed in every state, but CPMs and CMs are not.

4. Reduce the risks of an early delivery. Women who have a history of spontaneous premature delivery can reduce the risk of another preterm birth by about one-third by taking a special form of progesterone weekly starting at 16 to 20 weeks. In addition, women with a significant risk of delivering their baby early—due to their water breaking, for example—and who are between 23 and 34 weeks pregnant can reduce risks to the baby by taking corticosteroids such as betamethasone and dexamethasone. If your doctor doesn't prescribe those medications ask why not, and get a second opinion if necessary.

5. Ask if a breech baby can be turned. Because a baby delivered buttocks- or feet-first can be in danger, many practitioners recommend a C-section when the baby is not coming out head first. But by using a technique called external version, a skilled practitioner can often turn a breech baby in the last weeks of pregnancy. Because it carries some risk—membranes might rupture, for example, or in rare cases the baby can become tangled in the umbilical

Newborns who get skin to skin contact stay warmer and are more likely to be breastfed.

cord—it should be done in a hospital, where both mother and baby can be monitored closely. With the increasing use of C-sections, some practitioners have little training or experience with the external version procedure. If yours is not, consider asking for a referral to someone who is.

6. Stay at home during early labor. Discuss with your provider at what point in labor you should go to the hospital or maternity center. Don't be disappointed, though, if the staff checks you and sends you home. "Until a woman's cervix is dilated to 3 or 4 centimeters, she usually doesn't need to be in the hospital setting," Main says. "She'll usually be more comfortable and labor will even progress more smoothly at home."

7. Be patient. Mothers are likely to be in labor longer than their grandmothers were, recent research suggests. That may

be because they tend to be heavier or older when they give birth, or it may be a side effect of epidural anesthesia. In any case, most doctors learned about the course of labor from timetables set in the 1950s. "Obstetricians may be too quick to intervene because they think labor is not progressing as quickly as it should," Main says. Talk with your practitioner as well as anyone who will be supporting you in advance about your desire to allow your labor to progress on its own.

8. Get labor support. Women who receive continuous support are in labor for shorter periods and are less likely to need intervention. The most effective support comes from someone who is not a member of the hospital staff and is not in your social network—a doula, or trained birth assistant, for example—according to a systematic review of 21 studies involving more than 15,000 women in a range of circumstances and settings. Ask your provider for a referral, and see if your insurance company will cover doula care.

9. Listen to yourself. Walking, rocking, or moving during contractions, and changing positions between contractions, can make you more comfortable and speed labor along. "Each labor coping strategy, such as walking or showering, tends to last for about 20 minutes," Main says. "It's good to plan five or six strategies and then rotate through them." When it comes time to push, being upright or on your side rather than flat on your back allows your pelvis to open and keeps you working with rather than against gravity. Hollywood-style pushing, in which the woman is coached to hold her breath and push hard according to someone else's count, turns out to be less effective than trusting your instincts. "Self-directed pushing, in which the mother can push when she feels like it in the way that feels right to her, can actually make things go faster," Bingham says.

10. Touch your newborn. Placing healthy newborns naked on their mother's bare chest immediately after birth has numerous benefits for both of them, according to a review of 30 studies involving nearly 2,000 mother-infant pairs. Babies that get skin-to-skin contact interact more with their mothers, stay warmer, cry less, and are more likely to be breast-fed and to breast-feed longer than those that are taken away to be cleaned up, measured, and dressed.

▶ 5 things to do before you become pregnant

One approach to improving birth outcomes is to focus on improving health before pregnancy. “Entering pregnancy healthy gives you the best possible chance to stay that way yourself and have a healthy baby,” Spong says. “If you have medical problems, get those under control. Get yourself in as good shape as you can for that baby.”

And if you aren’t planning a pregnancy in the near future? There’s no downside to optimizing your health. Plus, over half of all pregnancies are unplanned, so it only makes sense for women who are sexually active to consider their reproductive health.

A two-year collaborative effort by experts from government agencies, national medical organizations, and nonprofits such as the March of Dimes yielded recommendations for health-care providers and consumers to improve preconception health and care. Here are the top five.

1. Take folic acid. Aim for 400 mcg a day

starting at least 3 months before becoming pregnant to cut the risk of neural tube defects by at least half.

2. Stop bad habits. That means smoking, drinking alcohol excessively, and using illegal drugs. Smoking is associated with premature birth, low birth weight, and other pregnancy complications. It’s never safe to smoke or use recreational drugs during pregnancy because those substances can harm the developing fetus even before you realize you are pregnant. Any alcohol during pregnancy—especially during the second half of the first trimester—puts your baby at risk for fetal alcohol syndrome, according to a recent study.

3. Take control of chronic disease. If you have a medical condition such as asthma, diabetes, epilepsy, or high blood pressure, be sure to get it under control. For example, losing excess weight before pregnancy decreases the risk of neural tube defects,

preterm delivery, gestational diabetes, blood clots, and other adverse effects. Also be sure that your vaccinations are up to date; rubella (German measles) and chicken pox can cause birth defects and complications if you get them while pregnant.

4. Watch for harmful drugs and supplements. Talk with your doctor and pharmacist about any over-the-counter and prescription medicine you are taking, including vitamins and other dietary or herbal supplements. Some medication, such as the acne drug isotretinoin (Accutane), can cause miscarriages and birth defects and shouldn’t be taken by women who are—or might become—pregnant. For other medication, your doctor may prescribe a lower dosage or an alternative drug.

5. Avoid toxins. Those include hazardous chemicals or potentially infectious materials at work or at home. Stay away from solvents such as paint thinner. Don’t change the litter in your cat’s box; let someone else do it. And avoid handling pet hamsters, mice, and guinea pigs because they can carry a virus that can harm your baby.



FOLIC ACID Taking 400 mcg a day of this B vitamin can cut the risk of neural tube defects at least by half.

Resources

The care you get during pregnancy depends in part on where you live. For example, among 757 hospitals that voluntarily share data, the rate of elective early deliveries ranges from 5 percent to more than 40 percent, according to the Leapfrog Group, a national quality watchdog organization. "What we are seeing is extreme disparities in the quality of care," says Carol Sakala of Childbirth Connection. "It varies from state to state, from hospital to hospital, and sometimes even within the same hospital."

The good news is that when there's a concerted effort to follow best practices, the numbers improve—often significantly. Elliot Main, M.D., chairman of the department of obstetrics and gynecology at the

California Pacific Medical Center, has developed and led quality-improvement initiatives at 20 hospitals in the Sutter Health System in northern California, says "We've reduced the rate of early elective deliveries from 22 percent to 6 percent, with many hospitals at or near zero." Sutter Health also reduced the rate of episiotomies from 45 percent to 14 percent in first-time births.

How do the hospitals you are considering stack up? You can ask about key performance measures such as the number of elective inductions and C-sections for first-time births. In addition, many states make comparison data available to consumers on the web; try entering "maternal health data" and the name of your state in a search engine.

General resources

Baby Friendly USA. Includes a map of hospitals in the U.S. that have been certified as "Baby Friendly," meaning that they follow best practices to establish and support breastfeeding. Go to babyfriendlyusa.org.

Centering Healthcare Institute. Provides a list of Centering Pregnancy Centers, which provide assessment, care, and support in a group setting. Go to centeringhealthcare.org.

Childbirth Connection. Nonprofit organization that provides evidence-based information on maternity care. Go to childbirthconnection.org.

Health4Mom. Consumer information site sponsored by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). Go to health4mom.org.

March of Dimes. Nonprofit organization dedicated to education and research. Go to marchofdimes.com.

Resources for hospital data, by state

California. Comprehensive site includes rates for C-section, episiotomy, breastfeeding, and NICU admission; VBAC availability, and ratings based on maternity patient experience. Ratings for patient care. Go to calhospitalcompare.org/.

Florida. Bare bones information on cost, length of stay, and volume. Go to floridahealthfinder.gov.

Illinois. Allows you to easily compare hospitals by rates of total C-sections, first C-section, and VBACs. Go to healthcarereportcard.illinois.gov.

Maryland. Provides basic information on types of deliveries by hospital, but you have to calculate rates and perform your own comparisons. Go to mhcc.maryland.gov/consumerinfo/hospitalguide.

New York. Provides C-section rates and compares them to state average. Go to myhealthfinder.com/newyork10/full.php?table=21#REGO.

Ohio. Allows you to easily compare hospitals on numerous maternity measures. Go to ohiohospitalcompare.ohio.gov.

Tennessee. Provides data on C-sections and vaginal deliveries, including mortality, infection, and readmission rates. Go to bcbst.com/tools/hospital-quality/service.do.

Utah. Provides information on C-section and VBAC rates, hospital costs, and some patient safety measures. Go to health.utah.gov/myhealthcare/reports/2009/maternityUpdate/index.htm.

Virginia. Rates hospitals based on C-sections, episiotomy, length of stay, and cost, as well as several prenatal and postpartum measures. Go to vhi.org/ob_guide/ob_intro.asp.

Washington. Limited to data on early elective deliveries. Go to wacommunitycheckup.org/choosing-your-hospital/where-to-go-for-inpatient-care/deliveries.



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This What To Reject When You're Expecting report is published by Consumer Reports, the nation's expert, independent, and nonprofit consumer organization. It is part of a health communication program created by Consumer Reports for members of the National Business Group on Health, based on articles that originally appeared in Consumer Reports magazine or other Consumer Reports publications.

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