

ACOG Reflects on the National Natality and Fetal Mortality Surveys

In 1972, the American College of Obstetricians and Gynecologists (ACOG) formulated a 10-year plan for the specialty and the nation. The first goal of the plan was to reduce perinatal mortality in the United States to 10 for every 1,000 live births by 1982. We missed it, but not by much. The two surveys carried out by the National Center for Health Statistics, in which ACOG was able to play a part, have done much to help us evaluate where we are as a nation and where we are in relation to ACOG's goal.

I believe that soon we will be able to say that perinatal mortality, that universal indicator for the nation, has reached and is moving below 10 for each 1,000 live births and is well on its way toward the 1990 national goal of 9.0, one of the Public Health Service's health objectives for the nation (1).

The papers presented here are among the first published reports from the 1980 National Natality and Fetal Mortality Surveys. While they accurately describe progress to date and how far we have come, they also raise major questions and cause us to reevaluate how we can make better progress in reducing infant mortality and improving morbidity.

Perhaps the most important promise held out by these two surveys is in the analyses and the preparation of scientific papers that have not yet been carried out, but remain to be completed. Understandably, the early analyses of data such as these should be basic and descriptive—a foundation upon which to build further epidemiologic investigations. In the data that were collected on more than 16,000 live births and stillbirths, there is a wealth of information that promises exciting returns for the researchers who will review and analyze it. We know that it is already being used by the researchers at more than half a dozen Public Health Service agencies to get clues to all sorts of tangled problems involving childbirth.

The study of smoking and drinking habits among pregnant women has established the extent of variation in those behaviors according to several maternal characteristics. For example, teenage mothers were found both to smoke and to drink more during pregnancy than older mothers, and this reminds obstetricians of the types of patients that may need special advice when seeking care. Other studies have confirmed that mothers who smoke, in fact, do have smaller babies than those who do not—an average of about 200 grams less for each baby born to

a smoking mother. Furthermore, it seems contradictory that we attempt, as a national policy, to reduce the incidence of prematurity and low birth weight of newborns while subsidizing the raising of tobacco.

The paper on electronic fetal monitoring (EFM) in relation to cesarean section raises some difficult questions. Although the numbers are undeniably correct, I am troubled by the authors' implication that EFM leads to increased C sections and that these interventions are undesirable. Not enough attention is paid to the outcome of labor. These obstetric technologies may have major payoffs for improved fetal outcome. I would like to see risk-benefit analysis of these data relating use of EFM and cesarean delivery to birth outcome. The authors acknowledge this point and cite the Sachs study of Georgia births which found that 172 infants could have been saved if more cesareans had been done (2). This corroborates studies by Williams (3) in California which found that selective use of cesarean delivery improves birth outcome. Although the authors say that they found that EFM is not necessarily used more often in high risk cases, we do see from the study that EFM is used more often if there are "complications of pregnancy," "complications of labor," and long "duration of labor." These are all indications of high risk, and I would expect any competent practitioner to use EFM to gain a more accurate recording of what is happening to help anticipate and prevent bad outcomes.

In reviewing the practices of postpartum sterilization as reported by Dr. Moser and Dr. Keppel, we can see a reflection of a great philosophical change in the nation and the medical community. Thirty years ago, before a patient could be sterilized, the concurrence of two consultants was required. If the patient were under the age of 25, she must already have had five babies. If she were older, she could have a sterilization procedure after fewer babies. In the past two decades, we have embraced a new set of principles and philosophy, particularly with the techniques involving the use of a laparoscope and the so-called "minilap." This new look and new procedures have offered more choices to the woman and her family and have simplified and made sterilization much safer and more desirable as a method of contraception. The Alan Guttmacher Institute has reported that sterilization (both male and female) is now the most prevalent single method of contraception in the United States (4).

The study of radiation procedures during pregnancy begs for additional indepth analyses. Of course, questions of cause and effect cannot be easily answered with these data. Do women receive more X-rays because they

have a condition which may result in a low weight birth, or do women with these conditions have low birth weight infants because of X-rays? Furthermore, it is important to know how many of these radiation procedures were done specifically to determine whether a fetus was viable or not. With the introduction and availability of techniques that can take the place of X-ray, such as diagnostic ultrasound, it is understandable that the use of X-rays during pregnancy has declined over the 1963 to 1980 period. It is particularly critical to differentiate between ionizing and non-ionizing radiation and to avoid lumping them in the same basket. For many years, it has been our position that we should always use the least exposure to ionizing radiation in making a diagnosis during pregnancy. When using X-rays for other diseases during pregnancy, the doses should still be kept to a minimum.

A very important finding has been made by Hutchins, Kessel, and Placek in their paper on trends associated with low birth weight; they point out that the relationship between elective induction and repeat cesarean section is not associated with low birth weight. The major implication of this finding is that modern obstetric technology can be used without iatrogenic side effects.

The fact that seven different Public Health Service agencies were involved in collecting and analyzing the information from these two surveys, which was gathered from 52 States and independent registration areas, is worth noting. That achievement in itself is a major triumph. The Department of Health and Human Services should be proud of the activities of these different agencies in collaborating on the design, funding, and analysis of these surveys. It is also laudable that these studies have been assembled by *Public Health Reports* and made accessible to the public and professional community. The cross-pollination from one aspect of the data analysis to the other is facilitated by so many papers published in one document. For instance, the data in the studies on EFM, cesarean delivery, radiation, and employment during pregnancy can be referred easily to relationships with low birth weight.

The American College of Obstetricians and Gynecologists is pleased to have been able to contribute to these studies, and we are particularly pleased that the public use data tapes are now available for further study. As Hutchins, Kessel, and Placek say in their paper "The NNS provides a unique opportunity to examine on a national scale numerous factors not otherwise available from national vital statistics to add to our knowledge . . . and help us design, implement, and evaluate intervention strategies for the prevention of low birth weight."

Now that the National Center for Health Statistics has made these data available to all researchers, we hope that it will continue to be used well. We also hope that this type of information continues to be gathered in the future so that it can be used as the basis for informed decisions in providing the health care for the nation's mothers and infants.

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AIDS, Drug Abuse, and Mental Health

Acquired immune deficiency syndrome (AIDS)—a disorder characterized by a breakdown in the immune system and the subsequent development of opportunistic infections and neoplasms—has been recognized by Secretary of Health and Human Services Margaret M. Heckler as the Department's highest priority emergency health problem. Few published reports of AIDS take note of the behavioral and psychosocial issues associated with this syndrome (1). The clinical perspective offered by Morin and Batchelor in the January-February 1984 issue of *Public Health Reports*, and the reports by Ginzburg and by Perry and Tross in this issue, make resoundingly evident the significance of drug abuse and mental health issues in relation to AIDS.

Clearly, the fact that intravenous drug users represent a major risk group for AIDS mandates, as Ginzburg notes, a major effort both to examine the nature of the relationship between the biomedical and psychosocial aspects of drug-taking behavior and AIDS and to disseminate important information to members of the drug abuse community, many of whom may be outside medicine's typical communications channels. Perry and Tross