SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Gary D.V. Hankins, MD
Garland D Anderson, MD
Distinguished University
Chair in Obstetrics and Gynecology
Professor and Chairman

3.400 John Sealy Annex
301 University Blvd
O 409.772.1957 F 409.772.0974
E ghankins@utmb.edu

MEMORANDUM

Date: September 12, 2018

To: Congressman Michael Burgess

From: Gary D.V. Hankins, MD

Chairman, Department of OB/GYN

RE: Maternal Mortality Testimony

I greatly appreciate Congressman Michael Burgess providing me the opportunity to submit written testimony to the Health Subcommittee of the United States Congress. By way of introduction, I am currently the Chairman of Obstetrics and Gynecology at the University of Texas Medical Branch in Galveston, Texas where I have practiced for the last 22 years. Prior to coming to UTMB I was on active duty in the United States Air Force for 22 years, again serving a practicing obstetrician gynecologist. I am trained both as an OBGYN physician as well as having subspecialty training in Maternal Fetal Medicine and in Critical Care medicine. Additionally, I most recently served as Vice Chair for the state of Texas Maternal Morbidity and Mortality Review Committee.

Having spent considerable time looking at maternal mortality in the United States, it is clear that substantial improvement is needed and should be accomplished. The mortality within the United States is more than twice that in other areas of the industrialized world and greater than 6 times that in Sweden. While it is unlikely that we could ever achieve the maternal mortality in the United States that can be achieved in a country as small as Sweden, it is clear to me that concentrating in the three areas that I will detail below, would substantially (I estimate by at least 50%) reduce maternal mortality in the United States.

1. Interpregnancy care; The provision of healthcare to many pregnant women within the United States, particularly those on government programs such as Medicaid, is episodic. That care begins only with the diagnosis of pregnancy and ends within a relatively short period following the conclusion of pregnancy. As such, women often enter into the pregnancy with uncontrolled or only partially controlled diabetes, hypertension, thyroid disease, and many other medical conditions. It is these complications of pregnancy which translate not only to a poor outcome for the women but also a poor outcome for the baby, often to include potential fetal malformations

as well as premature deliveries. The cost burden of not providing pregnancy care and control of these chronic conditions is staggering and would greatly exceed the cost to control these diseases and conditions before the woman ever enters into pregnancy. As a specific example, failure to control Diabetes Mellitus carries a substantial risk that the fetus will have either a midline CNS developmental defect i.e., cleft lip, cleft palate, spina bifida, or a cardiac anomaly. These fetal malformations can be reduced to near zero if the diabetes is controlled prior to pregnancy. This is but one example of where dollars could be very well spent. The return on investment on quality of life and a reduction on long-term expenditures are very substantial.

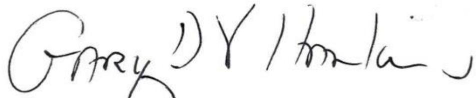
2. Regionalization. The fact that regionalization of medical care to concentrate getting the patient to the appropriate level facility works has been demonstrated by the pediatricians and neonatologists for at least 30 years. It is largely through regionalization that the neonatal survival rates have been markedly increased at the same time that long term morbidity has been decreased for premature infants. This same model is applicable to pregnancy and the transfer of women with substantial complications to regional centers with the appropriate staffing! By way of one example, major maternal cardiac conditions should be sent to centers with specialized ability to provide care for these highly complex and complicated women. Such care is available through the input of teams of physicians with expertise to include maternal fetal medicine specialists, cardiologists, and intensivists to name a few. As an immediate first step towards reducing maternal mortality, the combination of providing interpregnancy care and regionalization of the care system hold the promise of significant immediate improvement in maternal mortality & morbidity.

3. Mental Health Services. In the review on the state of Texas Maternal Morbidity and Mortality Committee it was a surprise to me as a clinician that almost half of the deaths occurring were as a result of either a drug overdose or suicides/homicides. In the majority of these cases the women had either not been referred for mental health services or had not gained access to facilities capable of providing mental health services. It was clearly my misperception that the overwhelming majority of maternal deaths were as a result of the classic issues of obstetric hemorrhage, poorly controlled hypertension and/or infection as is still taught in many medical schools. To the contrary, almost half of maternal deaths relate to the mental health of the woman. Accordingly, while the first two strategies that I've outlined above *would* make a significant impact on the actual medical conditions, that would (at max) affect only about half of maternal deaths during pregnancy. Attention to provision of mental healthcare when needed is essential.

I would conclude by briefly addressing the disparity in outcomes based upon race and ethnicity. There can be no debate but that the healthcare outcomes for the Native American population and for the African American population is far worse than for the Caucasian population. Similarly, the outcome for Hispanics, especially if first generation, actually exceeds that of Caucasians in the United States. Accordingly, specific populations are readily identified where a greater impact on the outcome certainly should be able to be achieved. I'd also point out that throughout the United States even in those states with the lowest maternal mortality, this disparity in outcomes persist and sometimes is even worse. Finally & sadly, the disparities in these outcomes based upon race and ethnicity is the absolute worst in our Nation's Capital.

I want to thank Dr. Burgess and the committee for allowing me to express my thoughts on this issue. I commend you for undertaking this difficult task and stand ready to assist you in any fashion I might.

Regards,



Gary DV Hankins, MD