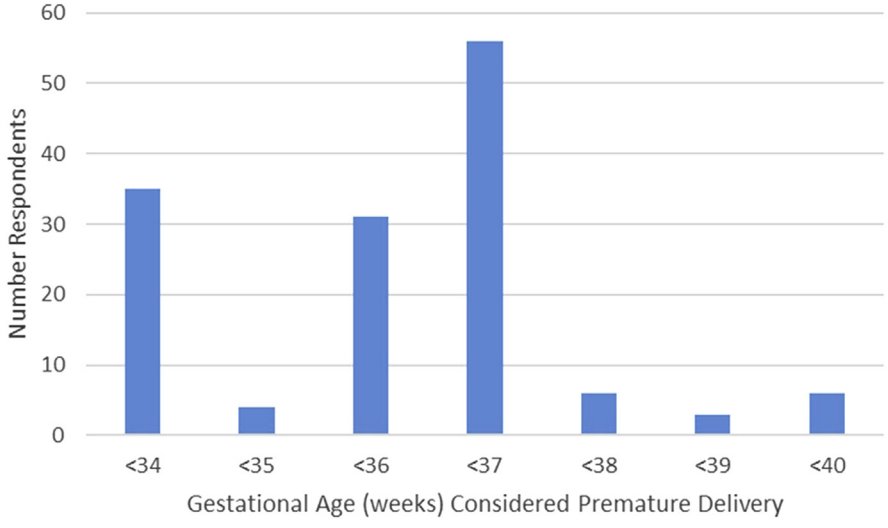
Variation in waiting period for Medicaid postpartum sterilizations: results of a national survey of obstetricians-gynecologists

OBJECTIVE: The Medicaid Title XIX sterilization forms were mandated in 1976 to protect vulnerable women from coercive sterilization.[1-3] The forms require a 30 day waiting period between when the form is signed and when sterilization can occur but does allow for a shorter 72 hour interval prior to postpartum sterilization following premature delivery.[1,2] Given the infrastructure of Medicaid, variation could potentially exist in defining the term, premature delivery, in a federally mandated but state-based form. Therefore, we sought to survey the practices of obstetricians-gynecologists surrounding the waiting period for postpartum sterilization in the Medicaid population. We hypothesized that there would not be variation in the definition of premature delivery, given the federal nature of the consent form.

STUDY DESIGN: This is a prospective, electronic survey-based study of 1000 obstetrician-gynecologist members of the American College of Obstetricians and Gynecologists (ACOG), half of whom are members of the Collaborative Ambulatory Research Network (CARN). CARN members are a demographically representative group of practicing ACOG members and were randomly selected. Non-CARN members were selected by utilizing proportionate random sampling by ACOG district. The survey instrument was developed in an iterative fashion and pilot tested. A unique survey link was sent electronically to all participants along with an introductory e-mail message. Five reminder e-mails and links were sent on a weekly basis if a participant did not complete the survey previously. Responses were anonymous and excluded if incomplete. All analyses were performed using R version 3.3.0.[4] This study was deemed exempt by the Institutional Review Board of MetroHealth Medical Center (Cleveland, OH).

RESULTS: A total of 218 of 957 surveyed physicians (22.8%) responded to the survey, after accounting for exclusions. Of these, 165 (75.7%) were CARN members; 5.9% of respondents were in solo practice, 34.6% in group practice, 18.6% in multispecialty group practice, 13.3% in hospital-based practice, and 18.1% in university-affiliated practice. A total of 89.4% of respondents perform sterilization in their practice. Of those who perform sterilization, 18.6% of respondents utilized delivery prior to 34 weeks, 2.1% utilized 35 weeks, 16.4% utilized 36 weeks, 29.8% utilized 37 weeks, 3.2% utilized 38 weeks, 1.6% utilized 39 weeks, and 3.2% utilized 40 weeks as the definition of premature delivery, thus permitting a 72 hour rather than 30 day waiting period (Figure). The remaining 25% of respondents answered not applicable to this

FIGURE
Frequency of responses for gestational age used to define premature labor and allow for a 72 hour rather than a 30 day waiting period for postpartum sterilization



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question. There was variation among respondents from within the same state regarding the gestational age they utilized to define premature delivery. Overall, there were no consistent patterns for the variation within or between states by physician or practice demographic characteristics. There were also no significant associations between region of the country for either training or current practice and waiting period utilized. In addition, 43% of respondents answered that their hospital had a policy regarding postpartum sterilization. Presence of a hospital policy was associated with the use of delivery prior to 37 weeks' gestation as the definition of premature delivery ($P = .014$).

CONCLUSION: While caution should be utilized in interpreting statistical relationships because the response rate to our survey is low, it is surprising that there was variation both within and between states regarding the gestational age utilized to define premature delivery. Rationale for this variation was unable to be obtained by the empirical survey methodology. Use of an earlier gestational age leads to a more restrictive sterilization policy and may serve as a barrier to sterilization fulfillment. Additionally, intrastate variation suggests a lack of uniform application of state policy, which is ethically problematic in terms of justice or fairness concerns. We recommend individual obstetricians-gynecologists consistently utilize the waiting period required by their state as well as consider implementing hospital policies to standardize the approach. ■

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