

Is It Time to “Bang The Shoe” on Preconception Care

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When Greg Alexander suggested to Hani Atrash that I act as co-editor of this special issue, I was delighted for a number of reasons, not the least of which being the fact that it would give me the opportunity to learn something new about a subject that I had dealt with for more than 40 years, that is, the provision of prenatal care. As many readers might surmise, when I started as an intern at the Cook County Hospital in Chicago in 1960, there was no preconception care. Indeed many of the 20,000 infants we delivered in our 5 delivery rooms were born to multiparous women who had delivered 10 or more children previously.

At that time, prenatal care consisted of taking blood pressure, checking for edema, doing a dip-stick for protein, and listening to heart tones with a De Lee stethoscope affixed to one's head. Routine laboratory work consisted of a urinalysis and the following blood work: hematocrit and hemoglobin (no CBC unless a disease was suspected); Rh factor, VDRL for syphilis and a test for the presence of the sickle cell condition. Counseling about anything was virtually non-existent, because so many of the conditions we deal with routinely now were so poorly understood that there was nothing to say.

The changes in the provision of prenatal care that have occurred in the last 4 decades have undoubtedly been driven by vast improvements in the understanding of certain disease conditions, how to screen for them and how to effectively prevent or treat them. All these changes have become the basis of what is now called preconception care, the topic

which is dealt with in the various papers in this issue. The prevention of neural tube defects is a prime example of the transition from prenatal to preconception care. When I delivered children with spina bifida, my professors and senior residents had little to say about it except that it was an unfortunate occurrence, therapeutic options were limited and the children could be expected to die shortly after birth in the worst cases. Little did we think that the condition could be amenable to virtual elimination thru ingestion of a specific vitamin.

Fast forward to 2006, four and a half decades later. We know the cause of this defect, and how to prevent it. Now the questions are different, and obstetricians routinely are being asked why they are not doing a better job of preventing this condition. The entire medical profession was recently alerted to this need during National Folic Acid Awareness week in January. This week was sponsored by the National Council on Folic Acid, of which the American College of Obstetricians and Gynecologists (ACOG) is a founding member.

Lest readers think that the title of this editorial is strange and wonder what my point is, they can look up the name of the late Nikita Khrushchev, the former Soviet Premier on Google and search for a photo of him banging his shoe on the podium of the United Nations General Assembly during one of his addresses in order to make a point.

This is exactly what I felt like doing when one of the last manuscripts of this special issue passed across my desk this past January (Posner et al: the National Summit of Preconception Care). This summary of the conference says it all, but as I read it, I felt that something was missing, not only from this article but from so many others.

What is that, a cautious reader may ask? The answer is quite simple, and it involves a direct assault on the consumers, the vast American public, by someone in high authority, someone such as the Surgeon General. Precedence

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is there. The public sees warnings on every box of cigarettes and bottle of alcohol. Signs are posted in the Surgeon General's name in bars and establishments that serve liquor. True, these signs and warnings have not stopped individuals from smoking or dinking, but I had something else in mind and it too has precedence.

More than 20 years ago, a famous French Obstetrician, Professor Emile Papiernick, wanted to institute changes in prenatal care whereby the women would become more responsible for themselves and seek a different level of care. His colleagues were not all that in favor of his proposal, but he believed in it and went directly to the public via the press. Rather than use a press conference and obtain coverage that would be over in a minute, he created an advertisement that would be placed on a regular basis in *Marie Claire*, one of the most popular women's magazines and one that crossed the culture from rich to poor, well educated to poorly educated, urban to rural. As they say in show business, "the rest is history." The ad was not only successful, but it generated intense debate and was reprinted for years until the population became saturated with the concept and was asking their doctors for the "new" prenatal care.

It would not be difficult to replicate the French experience here in the USA. The Surgeon General could call a press conference of all the magazines that address women in all languages and at all ages. A simply written one page ad could introduce the concept of preconception care and list five immediate goals, including taking vitamins with folic acid before one gets pregnant as well as throughout the pregnancy.

The magazines could be asked to perform this service for five years running and to divide themselves into 12 groups,

each one of which would be assigned a given month. Voila!! The target population would be saturated in a short time, and, if the TV industry were asked to join, population saturation with information would drive change where it needs to occur, that is, in the minds of the women who are about to become pregnant, as well as the doctors who provide them care when they are pregnant.

The cost of such a program would be minimal. Governmental auditoriums for press conferences already exist, and the preparation of such an ad would not be costly. The magazines and TV industry could do this as part of their public service obligation. Perhaps the most difficult task would be convincing the Surgeon General that it would be in the interest of the public to "bang the shoe."

As good as this plan might seem, it is likely that it may not happen because the Surgeon General may be preoccupied with other national priorities. Should that be the case, then I submit what is colloquially termed "Plan B". In this case, I do not mean emergency contraception, but forming a coalition of private agencies that deal with maternal as well as child health. They can take the plan and run with it. The effect is the same. As I write this, I can think of three for starters: The March of Dimes, The Packard Foundation and, of course, the Bill and Melinda Gates Foundation. I do not know anyone in these organizations, but I am sure that some of the readers of this issue do, and perhaps they would be kind enough to pass on my little suggestion.

In case anyone is wondering, I believe that this is a great issue, and I am honored to have been asked to be associated with it.