The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 456 • March 2010
(Reaffirmed 2017)

Committee on Ethics

Forming a Just Health Care System

ABSTRACT: In this Committee Opinion, the Committee on Ethics of the American College of Obstetricians and Gynecologists endorses the College's ongoing efforts to promote a just health care system, explores justifications that inform just health care, and identifies professional responsibilities to guide the College and its members in advancing the cause of health care reform.

If Medicine is to fulfill her great task,
then she must enter the political and social life (1).

The 2008 Reform Agenda of the American College of Obstetricians and Gynecologists, "Health Care for Women, Health Care for All," advocates accessible and affordable health care for everyone in the United States, regardless of citizenship or residency status (2). This position is an evolution of the College's long-standing call for universal access to maternity care, a call first made in 1971. In this Committee Opinion, the College's Committee on Ethics endorses the College's ongoing efforts to promote a just health care system, explores justifications that inform just health care, and identifies professional responsibilities to guide the College and its members in advancing the cause of health care reform. The following five statements summarize the main points made in this Committee Opinion:

1. Creating a just health care system through necessary health care reform is *primarily* a moral issue, even though it is also political and economic in nature. The principle of justice (individuals' obligations to treat one another fairly) underlying the College's call for a sustainable just health care system requires that patients be treated without discrimination by medical professionals and policy makers.
2. A just health care system and the health care reforms necessary to obtain it are grounded in the appropriate goals of medicine. These include the physician's traditional duties to promote health, cure disease, and prevent suffering. Meaningful health care reform must include significant emphasis on prevention and wellness promotion as well as innovative and efficient practice mechanisms.
3. The ancient concept of covenant is also relevant to conceptualizing just health care and health care reform measures. Traditional notions of the physician's covenant (based on trust and the physician's primary commitment to his or her patient) should be expanded to include a social covenant. The social covenant reflects community-oriented values regarding what each person, as a fellow human being, owes to another—given that all persons are ultimately dependent on the care of others for their health needs. The social covenant also engages humanitarian and pragmatic concerns for global health.
4. A just health care system provides universal coverage in the form of affordable and effective health care for all residents of the United States regardless of citizenship or employment status.
5. The College and its membership represent expert voices in the social process of health care reform and creating and sustaining a just health care system, and they have a wide range of opportunities to advocate for and advance the goal of just health care.

Background

The moral imperative of access to health care has been recognized for decades in the United States and for more than a century elsewhere in the world (3–5). Organizations and advisory bodies such as the World Health Organization, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the Institute of Medicine, the American Nurses Association, the American Medical Association, and, more recently, the President's Council

on Bioethics have joined the College in engaging the problem of universal access to health care (4–12).

The spectrum of inadequate access to health care in the United States ranges from those who are uninsured or uninsurable due to eligibility exclusions or immigration status to those who are underinsured or occasionally insured by virtue of employment contingencies (13). The effects of inadequate access on the health of women across the life cycle in the United States are disproportionate to those of the general population and are particularly egregious. They are starkly illustrated in the Reform Agenda document "Women and Health Insurance: By the Numbers," in ACOG Committee Opinion 416 "The Uninsured," and in the most recent U.S. Census Bureau report on health insurance coverage (2, 14–16). For the purposes of this discussion it is minimally sufficient to note that one in five women of childbearing age in the United States lacks health insurance, a rate far greater than that of all uninsured Americans. Women of color, especially Latina women; younger women; those with a low income; those who are foreign born; and those who are not citizens are at particular risk of being uninsured and thus experiencing adverse health outcomes. Working women, as opposed to working men, are less likely to be eligible for employer health plans as they are more likely to work part-time, have lower incomes, or depend on spousal coverage (making them vulnerable in the event of loss of a spouse) (14). Unmet health needs both occasion and exacerbate chronic illness for nonelderly and elderly women.

Fragmented care for pregnant women is equally disturbing given that the sequelae of inadequate perinatal health care reach far beyond women and their newborns to their families, their communities, and to future generations. Gaps in services occur in the interconception (between pregnancies) as well as the postpartum periods. Lack of insurance coverage is one of the largest barriers to interconception health care, which aims to reduce risks and improve maternal and fetal outcomes in subsequent pregnancies. Loss of health insurance is one of the most frequent challenges faced by new mothers (17). The challenges of fragmented care continue despite the best efforts of the National Healthy Start Association (with almost 100 federally funded projects in the United States) and others (18, 19). This void in the health care system affects all those living in the United States. Considerations of collective welfare have motivated the College to prioritize coverage for pregnant women and infants within its Reform Agenda.

The Nature of the Problem

Moral problems are embedded in daily life, medical practices, and health care institutions. Issues of morality do not arise de novo, but emerge from any number of particular perspectives that enable and inform conscientious decision making. Understanding of moral problems and the solutions to them arises from a number of sources. For each person, the answer to the question, "What should I do?" when faced with a moral issue generally reflects the values that have been absorbed from families, peers, communities, religion, education, or the political philosophy upon which the government rests (20).

The resultant question, "*Why* is that what I should do?" requires that actions be justified based on some sort of rationale or framework and is the realm of moral theory (13, 20). Applying moral theories, and the principles and rules they engender to resolve concrete, real-life problems, is the task of applied ethics. While most individuals do not consciously invoke moral theories when they make personal or professional decisions on a daily basis, it is important that collective moral decisions, such as health policy, be well thought out and grounded in concepts that can be justified, explained, and revisited.

The Committee on Ethics believes that achieving and maintaining a just health care system is primarily a moral concern. Just health care and the health care reforms needed to achieve it are problems of moral theory. They are also subjects of applied ethics given that it must be determined what methods to use to achieve the goal of sustainable just health care. Currently in the United States, justice in health care is best characterized as a complex, multifactorial, and unsettled issue. Debate exists about the fundamental nature of the problems that underlie it—for example, whether needed health care reforms are substantively issues of morality, politics, economics, or some combination thereof (12). Other second-order disagreements cascade from this foundational one.

If, as the Committee on Ethics maintains, achieving a just health care system with necessary health care reforms is primarily a moral concern, how is the problem best conceived within the broad framework of "morality"? The Committee on Ethics holds that the answer to this question is "justice," that is, that the ethical principle of justice (individuals' obligations to treat one another fairly) is the moral basis for health care reform.

Justice can be defined in many ways. It can, for example, be framed in egalitarian (fair opportunity) or libertarian (free market) terms. If, as the Committee on Ethics recommends, justice in health care is viewed as a concern of fairness and equality, how then should the application of these concepts be balanced? What does it mean to be "fair" or "equal" in terms of just health care? If one embraces an egalitarian, or fair opportunity, framework, is the problem best defined as one of equal access to *all* health care services, or of access to a decent minimum of care, or by some other criterion?

In exploring the moral justifications for just health care, the Committee on Ethics examines the foundational assumptions of the College's Reform Agenda and its resultant concerns. The Reform Agenda espouses universal health insurance coverage. It is thus concerned with removal of barriers to access to health care. It is concerned with women, and in particular with pregnant women and

infants. It is equally concerned with the nature and distribution of health services to all, including the underserved and the vulnerable. It exhorts the use of preventive and primary care services. A just health care system provides universal coverage in the form of affordable and effective health care for all residents of the United States regardless of citizenship or employment status.

Does, however, or should a just health care system promote the attainment of individual health—a framework that invokes both social and biological determinants of health, and collective responsibilities above and beyond the issue of access to clinical services? Should the Reform Agenda's project examine the appropriate goals of medicine—an approach that might challenge the "technological imperative" that drives indiscriminate use of advanced technology (11)? Should it articulate and reflect individuals' obligations towards one another as a matter of professional or social covenant? Each of these questions represents a unique way of framing and thus resolving the problem of unmet health needs and is explored in the sections that follow.

Ethical Justifications for a Reform Agenda

Ethical justifications for health care reform might be broadly organized into three categories: those of justice based on rights or entitlement claims; those concerned with the appropriate goals or ends of medicine; and those based in covenant, which is grounded in obligation and trust. The Reform Agenda can be understood to rely on each of these categories.

Justice

In general terms, "justice is a way of considering the big picture, but from a point of view somewhere within it" (20). Justice is grounded in beliefs about oneself and society and is often understood in terms of equality or fairness. It is manifest in how individual and communal decisions are made as to what someone is due or owed and what they may subsequently claim as entitlements or rights (21, 22). In many societies, health care is construed as a right, or a public good, because health is necessary in order for persons to flourish (23). Health might be understood as a background condition for the realization of other goods. It is a prerequisite in order for each person to achieve the fullness of well-being—to attain and maximize the benefits of such social goods as political freedom, education, and employment (13).

The principle of comparative or formal justice has its origins in Aristotelian philosophy. It demands that equals be treated equally and that unequals be treated unequally. The principle of formal justice identifies what to do—treat equals equally—but does not describe how to do so. It lacks content, which ultimately derives from individuals' beliefs about themselves relative to other persons. In order to apply the formal principle of justice, first a characteristic upon which it is pertinent to act must be specified. Are, for example, persons treated equally based on *need*? On the basis of *merit,* or *benefits they have provided others*? On the basis of *vulnerability*, or *risk*? These characteristics all have been identified as potentially pertinent. A prerequisite to applying the formal principle of justice is to specify a pertinent "material" principle to guide behavior.

The governing political philosophy should illuminate material principles that differentiate the importance of health relative to other social goods. The Constitution of the United States and the principles under which U.S. citizens are governed are informed by a particular concept of justice known as egalitarianism. Egalitarianism is concerned with equality, especially in the context of competing interests. The idea that all in U.S. society are "created equal" is interpreted to mean that there should be no discrimination in individuals' claims to life, liberty, or other social goods. Historically, the most flagrant violations of egalitarian social philosophy have been based on race and gender. The current need for health care reform represents continued discriminatory practices in the allocation of health care services and goods based on a number of factors, including race, gender, and socioeconomic status.

Justice within the health care context has been defined in a prior Committee on Ethics Committee Opinion as "a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner" (24). In applying this concept to the medically underserved, the College invokes a form of justice known as distributive justice, or the distributive paradigm, which is concerned with the fair allocation of society's benefits and burdens.

The Reform Agenda identifies and incorporates a number of material principles that guide the application of the formal principle of justice within the distributive paradigm. It considers discrimination against women as a class to be morally untenable. Similarly untenable is discrimination based on race, ethnicity, socioeconomic status, or sexual orientation (2). The aspiration to eliminate discriminatory health practices is an application of the "fair opportunity" rule, which prohibits denial of social benefits based on characteristics or differences such as nativity (birthplace), age, race, or sex—characteristics for which a person is not responsible (13).

The Reform Agenda is also concerned with the collective welfare of society, recognizing that the consequences of a marginal health care system affect all in the society. The Agenda continues to promote a shared responsibility model for universal health insurance coverage. The College's model requires employers to provide coverage, individuals to accept coverage, and the government to ensure that quality coverage is made affordable for everyone.

The College's approach is consistent with the preferences of the majority of Americans and American employers (25). Arguments in support of the shared

responsibility approach center on improved employee health and consequent benefits to morale and productivity. Employers benefit from enhanced employee recruitment and retention and from decreased absenteeism and loss of trained personnel (14). Assuming affordable coverage for essential benefits, the Reform Agenda promotes both individual and social responsibility for health care (2).

As with most health care reform schema, shared responsibility for health care is a subject of dispute. It has been dismissed by some critics as a myth and as the foremost impediment to meaningful health care reform in the United States (26). The real costs of health care, such critics argue, are met not through employer-provided health insurance but by employees themselves through lowered wages and higher prices; costs are shouldered not by federal or state governments through health care subsidies but by citizens through tax increases. Critics of the shared responsibility model argue that the primary social and political obstacle to health care reform in the United States is the belief, held by many Americans, that the costs of health care benefits are borne by someone else and that health care is in some way "free." This belief, they submit, fosters indifference towards the costs, inefficiencies, and quality lapses of the health care system and undermines political will for reform.

While disagreement exists about the financial realities of shared responsibility, recent data reflect robust public consensus on the need for health care reform in the United States. Commonwealth Fund survey data show that eight of ten adults believe that the health care system should be either fundamentally changed or completely rebuilt (25). The College's Committee on Ethics believes that the goals of both proponents and detractors of the shared responsibility model have strong moral grounding that should not be overshadowed by tactical differences. While differences between these groups are substantive, they do not diminish the ethical imperative that they share, achieving coverage for all persons living in the United States.

In the pursuit of this end, distributive justice may not suffice as a singular approach to health care reform. Some critics of the distributive paradigm argue that, as a health care reform mechanism, it is too procedurally oriented and lacks sufficient content to be effective. The primary critique is that principles of distributive justice do not indicate how to understand or balance equality of opportunity. Does universal access mean access to a decent minimum of health care or to a level of care with the best achievable health outcomes? Does access to a decent minimum of health care guarantee health?

Long-term studies in England show that social inequality plays a role in worse health outcomes given equal access to health care. Data from the Whitehall Study of civil servants in England show a severe inverse relationship between social class and mortality from a number of diseases (27). This finding argues for a focus on health and the social determinants of health rather than access alone. It supports consideration of the goals of medicine as a complementary framework in resolving issues of access and health disparities in the United States.

Creating a just health care system through necessary health care reform is *primarily* a moral issue, even though it is also political and economic in nature. The principle of justice (individuals' obligations to treat one another fairly) underlying the College's call for a sustainable just health care system requires that patients be treated without discrimination by medical professionals and policy makers.

The Appropriate Goals of Medicine

The goals of western medicine grew out of Platonic notions of individual and social obligations to one another in achieving the good life (and thus the goods in life) (28). Intrinsic to the concept of what an ethical physician owed his or her patients was a sense of the appropriate limits of medical knowledge. The "art" of medicine entailed acceptance and practice of the limits of medicine. Central to this ideology was a focus on promoting and achieving health. An appropriate balance is evident in the Socratic articulation of the aims of medicine: to provide cure sometimes, relieve often, care always. A modern interpretation of this dictum is the duty to promote health, cure disease, and prevent suffering.

Many in the current health care reform movement argue that the fragmented health care system in the United States results from confusion about and an imbalance among the appropriate goals of medicine (11, 12). This confusion is manifest in an inordinate focus on cure and technological development as opposed to prevention and health promotion. Bioethicist Daniel Callahan holds that gaps in health insurance coverage are fostered by ever-rising costs of health care, costs that result directly from the pursuit and application of new technology. Callahan decries what he terms the "infinity model of medical progress," which derives from "the idea that health can and should be improved indefinitely, even to the exclusion of other goods" (11).

Driving this engine is the strong individualism rooted in the political philosophy governing the United States. Many patients feel entitled to unlimited intensive and highly technological health care regardless of its cost or effectiveness. In the clinical context, this engenders what has been described as the "technological imperative," that because technological interventions are available, they should or must be used (11, 12, 29). It also reflects a bias towards the unlimited pursuit of medical knowledge, often at the expense of preventive and primary care. The result, as Callahan has observed, is "a powerful bias towards cure, rather than care; acute, rather than chronic, disease; length of life rather than quality of life; individual benefit rather than population benefit … subspecialty medicine, rather than primary and family care; and increased medicalization of life and social problems" (11). A concern for the appropriate goals of medicine is

reflected in the Reform Agenda's call for an investment in primary and preventive care, continuity of care, and effective, quality care through evidence-based medicine.

A just health care system and the health care reforms necessary to obtain it are grounded in the appropriate goals of medicine. These include the physician's traditional duties to promote health, cure disease, and prevent suffering. Meaningful health care reform must include significant emphasis on prevention and wellness promotion as well as innovative and efficient practice mechanisms.

Covenant and Community

The notion of medical and social covenant has been promoted as a new "third way" between individualism and egalitarianism (30). It is based on critiques of egalitarianism and its emphasis on rights and entitlements and of individualism and its overly thin account of communal interests. Critics of individualism argue that prioritizing individual over communal health interests has resulted in the commodification of health care, medical entrepreneurism, health disparities, and national isolationism and disregard for the health of others around the globe (29, 31).

The medical covenant is an ancient concept best understood as a clinician's *promise* to help his or her patient (30). It engenders trust in the primacy of the physician's commitment to his or her patient. Recent arguments in the health care reform arena would expand the concept of physician covenant to that of social covenant; from the physician's obligations to his or her patient, to what each individual, including a patient in relationship with her caregivers, and individuals as members of society owe one another. Social covenant, it is argued, is motivated both by notions of obligation and, it could be said, by self-interest, based on the reality that each person will, at some point, be a patient dependent on the care of others.

In response to these concerns and to the challenges posed by managed care in the 1990s, leaders in organized medicine and bioethics exhorted the medical profession at large to reaffirm the physician's covenant (32):

> …We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

By way of its Reform Agenda and its long-standing call for universal access to maternity care, the College continues to affirm its covenant with patients in the United States. Subjects for future organizational consideration include the promotion of health, in addition to access to care, and a global perspective on health needs.

The ancient concept of covenant is also relevant to conceptualizing just health care and health care reform measures. Traditional notions of the physician's covenant (based on trust and the physician's primary commitment to his or her patient) should be expanded to include a social covenant. The social covenant reflects community-oriented values regarding what each person, as a fellow human being, owes to another—given that all persons are ultimately dependent on the care of others for their health needs. The social covenant also engages humanitarian and pragmatic concerns for global health.

The Role of the College and Its Membership in Advancing the Reform Agenda

By virtue of its Reform Agenda and their professional covenant, the College and its members advocate for the goods and services that patients need to achieve good health outcomes. The College and its membership represent expert voices in the social process of health care reform and in creating and sustaining a just health care system. A host of opportunities exists to advance the goal of just health care. To the extent practicable and within a wide range of possibilities, the College and its members could:

- Become conversant with the tenets of the Reform Agenda
- Strive to provide and promote effective, safe, and evidence-based interventions
- Be prudent in use of health care resources
- Advocate through social and political mechanisms for the sick and the vulnerable
- Ultimately, in concert with the professional covenant, prioritize the interests of patients and strive in daily practice and through social and political action to uphold the ethical values of the profession

References

1. Virchow RL, Leubuscher R. Die medicinische Reform: Ein Wochenschrift: 1. Und 2. Jahrgang, 1848/49. Repr., Berlin: Akademie-Verlag, 1983.
2. American College of Obstetricians and Gynecologists. Health care for women, health care for all: a reform agenda. Washington, DC: ACOG; 2008. Available at: http://www.acog.org/departments/govtrel/HCFWHCFA-ReformPrinciples.pdf. Retrieved June 4, 2009.
3. Derickson A. Health security for all: dreams of universal health care in America. Baltimore (MD): Johns Hopkins University Press; 2005.
4. World Health Organization. Achieving universal health coverage: developing the health financing system. Technical Briefs for Policy Makers No. 1. Geneva: WHO; 2005. Available at: http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf. Retrieved June 2, 2009.

5. World Health Organization. Sustainable health financing, universal coverage and social health insurance. Resolution WHA58.33. Geneva: WHO; 2005. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf. Retrieved June 2, 2009.
6. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Securing access to health care: a report on the ethical implications of differences in the availability of health services. Washington, DC: U.S. Government Printing Office; 1983.
7. Institute of Medicine (US). Insuring America's health: principles and recommendations. Washington, DC: National Academies Press; 2004.
8. American Nurses Association. Health system reform agenda. Silver Spring (MD): ANA; 2008. Available at: http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Agenda/ANAsHealthSystemReformAgenda.aspx. Retrieved June 2, 2009.
9. Ethical issues in health care system reform. The provision of adequate health care. Council on Ethical and Judicial Affairs, American Medical Association. JAMA 1994;272:1056–62.
10. Levine MA, Wynia MK, Schyve PM, Teagarden JR, Fleming DA, Donohue SK, et al. Improving access to health care: a consensus ethical framework to guide proposals for reform. Ethical Force Program. Hastings Cent Rep 2007; 37:14–9.
11. Merrill TW. The Council's inquiry into health care: progress to date, key questions, and possible future directions. Staff discussion paper. Washington, DC: The President's Council on Bioethics; 2007. Available at: http://www. bioethics.gov/background/merrill_paper.html. Retrieved June 2, 2009.
12. The President's Council on Bioethics. Session 3: Healthcare—who is responsible? The individual? Society? Both? Washington, DC: PCBE; 2007. Available at: http://www.bioethics.gov/transcripts/june07/session3.html. Retrieved June 2, 2009.
13. Beauchamp TL, Childress JF. Principles of biomedical ethics. 6th ed. New York (NY): Oxford University Press; 2009.
14. The uninsured. ACOG Committee Opinion No. 416. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;112:731–4.
15. U.S. Census Bureau. Income, poverty, and health insurance coverage in the United States: 2007. Current Population Reports P60-235. Washington, DC: USCB; 2008. Available at: http://www.census.gov/prod/2008pubs/p60-235.pdf. Retrieved June 2, 2009.
16. U.S. Census Bureau. Table HI01. Health insurance coverage status and type of coverage by selected characteristics: 2007. In: Current population survey, 2008 annual social and economic supplement. Washington, DC: USCB; 2008. Available at: http://pubdb3.census.gov/macro/032008/health/h01_001.htm. Retrieved June 2, 2009.
17. Kanotra S, D'Angelo D, Phares TM, Morrow B, Barfield WD, Lansky A. Challenges faced by new mothers in the early postpartum period: an analysis of comment data from the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Matern Child Health J 2007;11:549–58.
18. Maternal and Child Health Bureau (US). A profile of Healthy Start findings from phase I of the evaluation 2006. Rockville (MD): MCHB; 2006. Available at: ftp://ftp.hrsa.gov/mchb/HealthystartEval.pdf. Retrieved June 2, 2009.
19. National Healthy Start Association. The Healthy Start Program. Available at: http://www.healthystartassoc.org/hswpp6. html. Retrieved June 2, 2009.
20. Aiken HD. The levels of moral discourse. Ethics 1952;62: 235–48.
21. Liaschenko J. Can justice coexist with the supremacy of personal values in nursing practice? West J Nurs Res 1999; 21:35–50.
22. Fisk M. The problem of justice. In: Justice: key concepts in critical theory. Atlantic Highlands (NJ): Humanities Press; 1993. p. 1–8.
23. United Nations. The universal declaration of human rights. New York (NY): UN; 1948. Available at: http://www.un.org/en/documents/udhr/index.shtml. Retrieved June 3, 2009.
24. The limits of conscientious refusal in reproductive medicine. ACOG Committee Opinion No. 385. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1203–8.
25. How KS, Shih A, Lau J, Schoen C. Public views on U.S. health system organization: a call for new directions. New York (NY): The Commonwealth Fund; 2008.
26. Emanuel EJ, Fuchs VR. Who really pays for health care? The myth of "shared responsibility". JAMA 2008;299:1057–9.
27. Marmot MG, Smith GD, Stansfeld S, Patel C, North F, Head J, et al. Health inequalities among British civil servants: the Whitehall II study. Lancet 1991;337:1387–93.
28. Daniels N. Justice, fair procedures, and the goals of medicine. Hastings Cent Rep 1996;26:10–2.
29. Dougherty CJ. The excesses of individualism. For meaningful healthcare reform, the United States needs a renewed sense of community. Health Prog 1992;73:22–8.
30. May WF. The physician's covenant: images of the healer in medical ethics. 2nd ed. Louisville (KY): Westminster John Knox Press; 2000.
31. Crawshaw R, Rogers DE, Pellegrino ED, Bulger RJ, Lundberg GD, Bristow LR, et al. Patient-physician covenant. JAMA 1995;273:1553.
32. Cassel CK. The patient-physician covenant: an affirmation of asklepios. Ann Intern Med 1996;124:604–6.

ISSN 1074-861X

Forming a just health care system. Committee Opinion No. 456. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;115:672–7.