

dialogue

Washington State Obstetrical Association
Washington Section, American College of Obstetricians and Gynecologists

August 2007

Time to embrace one change: Constrained work/duty hours

By Mark Schemmel, MD
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I've often heard people say, with a sigh, that the only thing that is constant in life is change. I think most of us have shared that sentiment at one time or another. It seems to be in our nature to resist change.

Over the course of my eleven years in practice, change has been constant in many areas of medicine. I have seen shifts, adjustments, transformations and modifications in overhead, reimbursement, the length of hospital stays and prescribing practices and that only begins to scratch the surface.

Among the transformations are those related to more carefully circumscribed work/duty hours. Introduced to residency training about two decades ago, fixed and constrained hours of work have now come to affect every level of medical training, and, indeed, have begun to transform the very face of medical practice. I see this evolving almost every day in the residents and medical students whom I encounter in the hospital and in my office.

Like many of you, when I trained, I was expected to complete the work of caring for my patients and then, time permitting, go home. I don't intend to imply that this was necessarily all good or all bad, it was just how it was. Certainly, there is ample reason to believe that this approach to

patient care led (and still leads) to many fatigued and thus, impaired physicians who may make mistakes and compromise patient safety.

Today, we are more and more aware of the many issues related to patient safety, and we may be participating in one of the multiple systems-based approaches attempting to improve patient safety. The drive toward limiting work hours is a significant and, I believe, a necessary component of this effort.

Limits on work /duty hours for

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**Maintaining
excellence while
adjusting the
way training is
carried out.**

Don't miss these meetings

Sept. 28-29. *Washington Section/ ACOG and Seattle Gynecological Society fall assembly*, Washington Athletic Club, 1325 6th Avenue, Seattle.

Dec. 7-8. *WSOA Annual Meeting, Fairmont Olympic Hotel, Seattle.*
Out-of-state faculty: James R. Scott, MD, editor-in-chief of the Green Journal, obstetrical care of transplant patients and patient-requested cesarean; Michael Policar, MD, UCSF, preconception care; and Thomas J. Garite, MD, UC Irvine, ob hospitalists.

Local faculty: Thomas J. Benedetti, MD, and Brian Ross, MD, Seattle, ob emergencies; Michael Fox, RN, Seattle, ob preparedness; Steven Brisbois, MD, Spokane, robotics in benign gyn; Pamela Paley, MD, Seattle, robotic surgery in gyn oncology; David Eschenbach, MD, vulvar pain and James S. Walsh, MD, Seattle, narcotics abuse/ addiction in ob patients

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WSOA backs bill to license genetic counselors

In late August WSOA President Mark Schemmel, MD wrote the following letter to State Representative Shay Schual-Berke (D-33rd District) who serves on the House Health Care Committee and is the only physician in the legislature.

Dear Representative Schual-Berke:

I am writing this letter as president of and on behalf of the Washington State Obstetrical Association to endorse and support House Bill 2015, "Licensure of Genetic Counselors."

As providers of obstetrical care, we have come to depend on genetic counselors working in a prenatal setting to assist with the evaluation of patients and families regarding the likelihood of inherited disorders or birth defects in a particular pregnancy. Following the birth of a baby with a previously undetected congenital abnormality or chromosomal defect, referral to a genetic counselor enables the parents to obtain further knowledge regarding the condition and frequently, important information pertaining to the availability of prenatal fetal assessment in future pregnancies.

Genetic counselors are responsible for assisting patients who elect to undergo testing to understand the nature of those tests, including the risks and limitations, and also to provide supportive counseling to those who are concerned about a fetal abnormality or have received abnormal genetic results. It is very important that the public have assurance that those providing information to couples who are making potentially life-altering decisions meet a minimum standard.

Accredited training programs for genetic counselors include academic and practicum experience in non-directive counseling. Completion of their training results in a master's degree. After providing genetic counseling under supervision and documenting 50 cases, these individuals can apply to

the American Board of Genetic Counseling for active candidate status. Passing board examinations results in board certification by the American Board of Genetic Counseling.

Genetic counselors strive to present all options to families and assist families in making decisions most appropriate for them based upon the family's individual's moral, ethical, and religious values. In many maternal fetal medicine practices, it is a genetic counselor who meets with a pregnant woman and her partner to discuss amniocentesis or chorionic villus sampling. The chance of having a child with the kind of problems that these procedures can detect is discussed as well as the risk of the procedures. Some couples opt not to proceed with an invasive procedure after speaking with the genetic counselor and others opt to proceed.

Due to the advances in screening tests and ultrasound, some couples already know of a problem in the pregnancy when referred to a high-risk center. For those couples who learn of an abnormality during pregnancy, genetic counselors provide information about the abnormality identified, the treatment available, the natural history of the condition and the options available to the family. The recent advances in molecular genetics have resulted in the availability of testing for an increasing number of inherited disorders. This complex field is poorly understood by all but a few practitioners, most of whom are board-certified clinical geneticists or genetic counselors.

An example of the value of genetic counselors is in cases of the relatively common birth defect of spina bifida (where part of the spinal cord exposed). The problems that a child with this condition may encounter depend on whether this is an isolated defect or if it is part of a genetic syndrome that may include other congenital abnormalities. If the spina bifida is isolated, the ultimate degree of disability will depend on the size and location of the defect in the spine. The

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trainees and students clearly create an imperative to adjust the way in which training is carried out. The burden and obligation falls to those of us involved in training to maintain high levels of excellence in our programs despite the reduction in hours spent in the hospital by our charges.

Furthermore, the experience residents and medical students have in training, in terms of shorter work hours, will very likely carry over to their post-residency careers and change the way ob gyn is practiced. Nonetheless, those of us carrying on the daily effort—and at times, struggle—to succeed in private practice must try to maintain a high level of excellence in the care we provide to our patients in the face of ever-increasing demands on our time.

I do not have all the answers on how best to adjust, but I do believe fewer hours of work is ultimately the future of medical practice, and that our patients will benefit from the change. □

dialogue

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A LOOK AT THE LITERATURE . . . FROM THE EDITOR

A new game of whack-a-mole

Treating depression in women of reproductive age

By Thomas J. Benedetti, MD, MHA

In the last decade, much attention has been given to the identification and treatment of depressive disease in women. The development of new medications for treatment of these disorders has improved the quality of life for countless women and their families. However, as with any new treatment in reproductive-age women, these medications have to be viewed in terms of risk versus benefit not only for the women but also for their unborn fetuses. Recent papers have identified a number of risks of therapy that have caused many of us to feel like we are playing a game of “whack-a-mole.”

Why not just stop medication during or preceding the first trimester?

The best long-term studies of major depression in women show some disturbing numbers when antidepressants are discontinued. Sixty-eight percent of previously stable women on antidepressants (70% taking an SSRI) who discontinued their medication in anticipation of pregnancy or early in the first trimester can be expected to relapse during pregnancy, most in the first trimester. Even women who stay on their medications will need to be monitored for depressive symptoms, as the number who relapse during pregnancy while maintaining their medication is 28%.^(1,2) After statistical adjustments between the groups, this represented a five-fold increased risk of depression relapse associated with stopping successful medication because of pregnancy.

What are the risks of not stopping medication?

First trimester.

First trimester exposure to SSRIs has been reported in some retrospective studies to be associated with increased risks of anencephaly (adjusted odds ratio [OR] 2.4; 95% confidence interval [CI] 1.1-5.1), craniosynostosis, (OR 2.5; CI 1.5-4.0), omphalocele (OR 2.8; CI 1.3-5.7)⁽³⁾ and cardiac septal defect (paroxetine only) (OR 1.6; CI 1.05-2.53, from the Swedish Medical Birth Registry). The excess incidence of congenital heart defects associated with paroxetine may be about 1%. The other anomalies (NTD, skull and abdominal wall) were not confirmed by a second paper and in other reports looking at the same defects.

Second and third trimester. Even if SSRI exposure is avoided in the first trimester, the fetus is still at potential risk for postnatal problems. Persistent pulmonary hypertension (PPHN) presents as respiratory failure in term newborns. The background risk of PPHN is 1-2/1000. PPHN is lethal in 10-20% of cases and the risk is increased in women taking SSRI after 20 weeks' gestation (OR 6.1; CI 2.2-16.8).⁽⁴⁾ Despite this increased risk, the attributable risk is low. Some 99% of women taking SSRI in the third trimester will not have infants affected by PPHN.

What to do?

What is the well-meaning physician to do when faced with an increasing number of women on SSRIs who present when pregnant or, less commonly, present for preconception counseling? We have discussed this in the Division of Obstetrics and Gynecology at the University of Washington and after reviewing the literature, we advise the following:



- Inform patients of the high risk of depression relapse if antidepressants are discontinued.
- Offer a thorough fetal anatomic survey to patients who elect to continue medication.
- Insure careful psychiatric follow-up of women who elect to discontinue medication.
- Insure expert neonatal resuscitation expertise at the birth of all women taking an SSRI in the third trimester.
- Suggest psychotherapies that have been shown to be effective in pregnancy (e.g., cognitive behavioral therapies, interpersonal therapy) as alternatives to SSRIs to patients who are interested and have therapists available.

As Michael F. Greene, MD said in a NEJM editorial about the two most recently published papers on SSRI and pregnancy, there is no “clear line between risk and no risk” when talking about SSRI and treatment of depression in pregnant women. However, the absolute risks of fetal defects are small and SSRI medications are not in the same class as the major teratogens isotretinoin and thalidomide.⁽⁵⁾

References

- (1) Relapse of Major Depression During Pregnancy; Cohen LS, Altshuler LL, et al JAMA 2006; 295:499-507
 - (2) First Trimester Use of SSRI and Risk of Birth Defects, Louik C, Lin A, et al NEJM 2007; 356:2675-2683
 - (3) Use of SSRI in Pregnancy and Risk of Birth Defects, Alwan S, Reefhuis J, et al NEJM 2007; 356: 2684-2692
 - (4) SSRI and Risk of Persistent Pulmonary Hypertension of the Newborn, Chambers C, Hernandez-Diaz, S, et al NEJM 2006; 354:579-587
 - (5) Teratogenicity of SSRIs—Serious Concern or Much Ado about Little, Greene MF NEJM 2007; 356:2732-2733
- My thanks to Jennifer Melville, MD for her review of this manuscript and helpful suggestions about content. □

WACOG NOTES Remembering a friend

Reflections on grieving

By Sandra Reilly, MD

After 22 years of the practice of medicine and countless counseling sessions with patients and families about “bad news,” I found myself several months ago in the surprising position of needing help in finding a way to grieve.

I did not lose my husband or a family member. I lost Aaron Schulte, a 27-year-old employee who had worked with me for four years, to an aggressive cancer. He was a friend to us all. I have grieved with a company of 100 people, not quite knowing how best to memorialize him, but knowing that we must. He was fun loving. He was the person who always organized the group on Friday afternoons.

He made his aunt promise that instead of a funeral, she would have a party for his memorial service. That is where I went on a rainy weekend

in April. Perhaps the Irish had it right all along—maybe that is the best way to grieve for someone lost.

Later, our company, Northwest Kinetics, found the way to memorialize Aaron. We sponsored an American Cancer Society Relay for Life Tacoma team. We walked our way to a first place award for on-line donations as well as a third place award for corporate donations. We raised over \$25,000 for cancer research in his name in two months. We still miss Aaron, but we smile every time we pass the crystal plaques that sit on the coffee bar, as we remember him. □



Bill to license genetic counselors

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collection of such multifaceted data and its presentation to the parents is the function of a genetic counselor.

The range of options for couples with a known fetal anomaly might include no changes to routine prenatal care, or continuing the pregnancy with special planning of the delivery (for example, in a tertiary care center rather than a home birth), to deciding to terminate the pregnancy. The information and possible choices are typically explained by the genetic counselor.

Medical practitioners field questions and concerns about breast and gynecological cancer risk and surveillance. When personal and family history suggests an inherited susceptibility to cancer in a patient, genetic counselors are uniquely trained to determine the likelihood that a BRCA or other genetic mutation may be the explanation for cancers in the family. They can guide a patient or family through the process of education, decision making regarding testing and coping with what may be

very high cancer risks. The decision to undergo predictive genetic testing is complex and emotionally difficult. There are serious medical decisions to face if a mutation is found (including prophylactic surgeries). The results of this kind of testing influences decisions and risks for family members as well.

Licensure would identify to patients, physicians, other medical providers and the public those individuals who are qualified to provide genetic counseling services. The need to provide such services has already resulted in their integration into medical practice. We strongly support licensure of genetic counselors in order to establish a high standard of counseling and to assure accountability in information and support to women and their families. Genetic counselors are an integral part of an obstetrics practice. Their skill set allows compliance with the WAC 246-680-020 which mandates genetic counseling for some prenatal diagnostic procedures. Thank you for sponsoring this bill. □

Family affair at UW Maternal Fetal Medicine

After 25 years under the leadership of the “Two Toms”—Dr. Tom Easterling and Dr. Tom Benedetti—the University of Washington Division of Maternal Fetal Medicine recently welcomed back former resident and perinatal fellow Michael Gravett, MD as the new division director. Dr. Gravett is an internationally recognized expert in infectious diseases and the causes of preterm birth. The division also welcomed two former UW medical students as new fellows in MFM: Suzanne Peterson (residency at University of Pittsburgh) and Kerry McMahon (residency at University of Utah). Dr. Calla Holmgren, who has ties to the Pacific Northwest, recently finished her MFM fellowship at University of Utah and has joined the UW faculty. □

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