

dialogue



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

June 2006

A topic to worry about: Depression in pregnancy

By President Mark Sauerwein, MD
WSOA President

I have a child in my practice who, I'm pretty sure, was adversely affected by exposure to an SSRI during her mother's pregnancy. This child, now three years old, seems to be doing well at this point. However, I remember being concerned about subtle jitteriness that persisted for around a year after her birth, along with non-purposeful motor activity. Neurobehavioral pediatricians with whom I consulted did not suggest a known disorder. I also know that as I cared for the mother during her pregnancy, she was nearly disabled with depression and anxiety and convinced that something awful was happening to her. She improved significantly with SSRI therapy, at the time a choice supported by pretty good safety data. I still am waiting to see how this child will do in school as she develops.

Recently a number of articles and new information have been published about depression in pregnancy and the use of SSRIs during pregnancy. There is cause for concern on both fronts. The messages are that we can't ignore depression in pregnancy and that arbitrarily stopping antidepressants leads to a significant amount of relapse.¹ Depression can occur in 10-15% of women during and after pregnancy. We are more familiar with postpartum depression but less comfortable with the depressed pregnant

woman or the woman who enters pregnancy with known mood disorders. In Cohen's study¹, 68% of women studied with depression relapsed when their antidepressants were stopped.

On the other hand, there are new reports of safety issues for SSRIs, including the increased rate of persistent pulmonary hypertension recently reported in NEJM.² The FDA recently changed pregnancy labeling of paroxetine to a D instead of a class C, citing concerns about increased risk of cardiac and other malformations.³ Further recommendations have been made to taper SSRIs at or near term to avoid problems with poor neonatal adaptation, which includes problems with jitteriness, poor feeding, decreased tone and respiratory distress.⁴

On the whole, antidepressants of all classes have not been shown to be

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Disciplinary problems and ob-gyns

By Hampton Irwin, MD
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Practicing Washington physicians understand that their state medical board has the authority to investigate and judge them for the conduct of their medical practices. But in the rush of daily obligations, physicians are unlikely to dwell on that reality until they receive notice of a complaint and a request for patient records. From then on, it is damage control to protect reputations and livelihoods while dealing with a confusing bureaucracy.

That is the bad news.

The good news is that members of the Medical Quality Assurance Commission—our state medical board—are exceptionally qualified, intelligent, and compassionate searchers for the real story behind each complaint. I offer myself as an example. As a com-

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Depression in pregnancy

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teratogenic.⁵ There are groups of patients studied with tricyclic exposure during pregnancy without evidence of adverse effects. Venlafaxine also has not been shown to have significant issues, so far, in a multicenter prospective study.⁶ Bupropion equally does not appear to have reports of adverse events.⁷ Information on these medications are being collected in a number of databases in an ongoing effort.

After reviewing this information, I am going to be more cautious with antidepressant use in pregnancy. I will use available tools or consultants to help me assess depressed patients and use non-pharmacologic approaches when possible. I will attempt to taper antidepressant use before delivery, especially with SSRIs. I will look for more literature and expert advice regarding medications to use and probably will avoid SSRIs whenever possible.

The WSOA program committee will offer a presentation on the topic at this year's meeting.

References

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6. Pregnancy outcome following gestational exposure to venlafaxine: a multicenter prospective controlled study. Einarson et al. Am J Psychiatry. 2001 Oct;158(10):1728-30.

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Put Dec. 1 and 2 on your calendar

The annual Washington State Obstetrical Association meeting, Dec. 1 and 2 at the Fairmont in Seattle, is one of the best meetings in the Northwest for obstetrical CME and a great bargain. Nonetheless, the WSOA executive committee has observed a decline in attendance over the last seven years as well as a general decline in our membership.

All of us receiving this newsletter should recruit one physician or certified midwife to join our organization and register for this year's meeting.

If a colleague registers for new membership, he or she can attend the meeting at the member price even before being voted into membership.

Our capacity for the meeting is around 300 and we have had only around 200 attending recently. Let's fill up the Fairmont this year!!

The WSOA application is on the Web site, <http://www.wsoaonline.org/>. Sign the "recommended by" line and give it to a colleague with a personal word of encouragement to join.

Hope to see the applications coming in. This is the time to do it!

Mark Sauerwein, MD

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missioner with a background in obstetrics and gynecology I am dedicated to making fair and unbiased assessments of physician performance. My caseload is large and made up of mostly of ob-gyn-related complaints, which is why your editor believes my thoughts about MQAC will be of interest to many readers.

Below I comment about selected complaint categories that have been problematic and need change.

Large settlement cases

During my first years on the board, VBAC complications surfaced when physician-run insurance companies reported very large dollar settlements for uterine rupture and related catastrophes. An unappreciated downside of VBAC, cases of uterine rupture appeared in several West Coast states during a two-year period.

As I studied the medical records of uterine rupture in Washington, I was surprised at how much time passed before these serious cases were reported to our state medical board. This situation, I was told, is because reporting is not enforced until dollar settlements are reported. Injured parties can complain to MQAC in addition to filing suit, but plaintiff attorneys usually prefer that their clients not do so. Multimillion-dollar settlements of cases come to MQAC for evaluation as long as seven years after the fact. This situation will not change until the legislature mandates early reporting of all bad outcome cases.

Good doctors, bad outcomes

Obstetrical cases are often very complex. And because devastated families are so tragically afflicted with pathologic anger, the search for credible causation can get derailed during litigation. Using my own expertise derived from 40 years of private practice, I can confidently present cases to be closed (i.e., without a finding of negligence) by an MQAC panel of MDs, PAs and public

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A LOOK AT THE LITERATURE . . . FROM THE EDITOR

Howling at the wind

By Thomas J. Benedetti, MD

For three consecutive days in March, I struggled out of bed at 5 a.m., fired up my computer and prepared to view my first Web cast. The object of my masochism was the National Institutes of Health State of Science Conference on Cesarean Delivery on Maternal Request (CDMR). As physicians reading this article know, some patients are asking their obstetrician-gynecologist about performing elective cesarean section for a variety of personal reasons. The NIH assembled a group of “experts” to review the literature and prepare a consensus recommendation on this evolving trend.

During the three-day conference I observed a combination of theater, science, indignation and obfuscation. Speakers presented “evidence-based” reports on maternal short-term and long-term consequences, fetal and neonatal consequences and economics, ethics and choices. Investigators who generally had published papers on as-

sociated topics gave 20-minute presentations on subcategories of the larger topics. Maternal mortality and morbidity, sexual function, anal and urinary incontinence, stillbirth, birth trauma, neonatal developmental outcomes, economic implications, and the ethics of permitting or limiting maternal choice were specifically addressed.

Sparse evidence and data comparing risks and benefits of planned vaginal birth versus “cesarean delivery on maternal request.”

The audience actively participated, but as often happens at these events, a small group of individuals consumed over half of the airtime. A less biased observer might have seen this as a battle of the naturalists versus the cesareanists. My favorite line was the audience member who indignantly asked Dr. Gary Hankins, after his presentation on hypoxic ischemic encephalopathy and birth injury, “I have only one question for you, Have you no shame?”

When all the rhetoric was completed, the previously picked group of experts met to produce a state of the art statement, which you can read at the NIH Web site, <http://consensus.nih.gov>. You can also view a recording of the entire event.

The main findings of the report are quite discouraging and may surprise some of you: “With the exception of three outcome variables with moderate quality evidence (level 2 of 4) all of the remaining outcome assessments considered were based on weak (level 3 of 4) evidence.”

Those three variables were maternal hemorrhage (which favored planned cesarean delivery), maternal length of stay, and neonatal respiratory

morbidity (which favored planned vaginal birth).

The final conclusions were that “the available evidence and data comparing risks and benefits of planned vaginal birth versus CDMR were sparse and provided few clear conclusions. After thorough discussion and review, CDMR may be a reasonable alternative to PVD.” At the end were a long list of future research directions to add to the sparse data available on CDMR. The other final conclusion that merits comment was that although the cesarean section rate had risen to 29% in 2004, the contribution of CDMR was difficult to quantify.

How high will the cesarean delivery rate go in the United States?? In 1972 as a 4th year medical student doing a month-long obstetric clerkship at the University of Texas at San Antonio, I lived with Joe Seitchik, chairman of obstetrics and gynecology. He taught me that about 1 in every 3 women needed the assistance of a skilled obstetrician to give birth.

At that time the cesarean section rate was below 10% and the forceps rate was 20-25%.

Based on this observation, plus the increasing size of women giving birth and changing societal expectations for birth outcomes, I would predict that by 2010 the cesarean rate would be near 35% with the operative vaginal delivery rate dropping to 5%. The rise in cesarean section rates is so complex that I view the idea of limiting the cesarean rate in the U.S. to some arbitrary number as being equivalent to “howling at the wind.” It may feel good emotionally or intellectually, but it is highly unlikely to reduce the rate. □

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2006 WSOA Annual Meeting

Washington State Obstetrical Association Annual Meeting December 1-2, Fairmont Olympic Hotel, Seattle. Contact: Leena Der Yuen (206) 232-9517/ www.wsoaonline.org.

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members. On the other hand, when I feel strongly that a bad outcome was caused by negligence, I make arrangements for an expert independent review of the entire record.

I have learned not to equate large settlements as proof of malpractice.

Group practice issues

Along with the benefits of more humane work schedules and administrative efficiencies, obstetricians working in shifts also introduce more opportunities for system errors and dilution of physician/patient rapport.

A typical case of complicated labor management gone wrong might involve an incomplete hand-off from one physician to a colleague. If the departing physician fails to warn the reliever of suspected signs of fetal distress, the new physician may not pay sufficient attention at the outset and fail to intervene in a timely fashion and perhaps prevent an irreversible fetal injury. As more physicians practice in large groups, passing the baton of responsibility must become an imbedded art form.

Surgical complications

Complications happen to the best as well as the worst operators. Ureters get tied off; bowel and bladder can get perforated; lasers and cautery can disrupt any intra-abdominal organ. What interests me as I evaluate such cases has more to do with physician response to the earliest signs of trouble rather than evidence proving that mistakes were made. Here is a fictional example to illustrate a common presentation:

A surgeon completes his last operation, a laparoscopic oophorectomy, at 3 p.m. Although hurting, the patient elects to go home at 5 p.m. so her husband can go to work.

When called the next day, the patient says pain and bloating kept her awake. She thinks she has too much "gas." She is advised to continue her pain medications and call the next day.

On the third post-op day the pa-

tient is readmitted with fecal peritonitis from a perforated colon.

Negligence of this kind has to do with a breakdown of the total care system, when an employee who does not understand the significance of unusual pain and peritoneal inflammation is assigned for next-day callback duty. Even severe disruptions can be repaired for good outcome when discovery and expert intervention is prompt.

Physician response

MQAC jargon calls the involved physician a "respondent" implying that a response by the physician is central to the entire process. This is the chance for the respondent to tell the entire story, untainted by anger or sarcasm, to a receptive commission member.

Physicians need to review the ancillary touches and remarks they habitually indulge in that have no diagnostic or management purpose.

I look for legible written explanations for decisions and judgments that deviate from usual procedure. Too often, I am presented with checklists and scribbles.

Computerized logs are speedy but of no help to a reviewer who simply wants to know what was in the doctor's mind as he or she reached a management decision.

Branching out for more office revenue

Shrinking profit from third-party payers is a fact of life for most office-based physicians. Procedures that can be billed directly to patients have tempted a number of practitioners to offer cosmetic procedures in their offices.

Others are introducing bariatric services to exploit the current fixation on obesity. Problems with these enterprises most often arise from the hubris of a doctor who wanders unprepared into an unfamiliar discipline.

Of greatest concern to me are physicians who convert office space to

include an operating room in another attempt to increase profit. Office-based surgery has become a national worry because of experience reported in other states. Such surgery is essentially unregulated by Washington statute. There is no effective peer review system to modulate the actions of isolated surgeons. I will continue to involve myself in the matter of office-based surgery until these units are registered and involved in a reporting system.

Sexual misconduct

This hot-button issue has received much media attention. MQAC issued a policy recently after years of discussion. It is available on the Department of Health Web site. My plea to fellow physicians is to be cognizant of the two categories of sexual misconduct: sexual violation and sexual impropriety.

Violation can put the perpetrator in jail. Impropriety, while far less invasive, can lead to socioeconomic disaster! Starting with the use of chaperones, physicians need to review all the ancillary touches and remarks they habitually indulge in that have no diagnostic or management purpose. Extra effort is required to make social interaction with patients totally insulated from misinterpretation.

MQAC is primarily a complaint-driven regulatory agency. To come to our official attention, some person, entity, hospital staff, civil authority or even another state must lodge a complaint against a Washington physician or physician assistant. As the process cranks up, a letter announcing the complaint goes to the licensee and investigation begins. Investigators gather records and conduct interviews in sufficient detail for an assigned MQAC commissioner to either confirm the evidence or close the case for lack of evidence. Either way, the complaint becomes part of the physician's record with the state indefinitely.

Dr. Irwin, an obstetrician-gynecologist, has been a member of MQAC since 1997. □