

# dialogue



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

October 2009

## Annual meeting offers experts on a plethora of topics

By Robin de Regt, MD  
President, WSOA

Please mark your calendars and plan to join us for the Washington State Obstetrical Association's Annual Meeting December 11 and 12 in Seattle.

■ On Friday, our guest professor from California will be **Peter Callen**, a world expert in obstetrical ultrasound. He will address some of the medico-legal issues surrounding ob-gyn ultrasound, which should be

### Learn more about the medical-legal issues with ob-gyn ultrasound.

pertinent for all offices that perform ultrasound. In his second lecture, he will identify some common office problems and how to handle them.

- **Vivienne Souter** will help everyone be prepared to offer appropriate genetics screening tests and to manage common office genetics issues.
- **Penny Simkin**, well known in Washington for her work on family centered care and labor management, now has some fascinating information on perinatal issues faced by women who have experienced sexual abuse.

- **Chuck Drescher** will discuss management of adnexal masses in both the pregnant and the gyn patient.
- **Robert Murray** will bring the internist's perspective on management of pregnant women with thyroid dysfunction.
- **Martin Walker**, who has a keen interest in fetal therapy and management of monochorionic twins, will describe how identical twins are not always identical.

The luncheon panel should be provocative as two clinicians discuss their experiences with an electronic medical record. A representative of Physicians Insurance will identify some of the risks and challenges surrounding utilization of an EMR.

Saturday will follow with several more guest speakers from out of town.

*Annual meeting offers experts . . .  
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## dialogue is going electronic

This is the last hard copy of *dialogue*. In an effort to save money and paper we will begin sending *dialogue* electronically. (We are testing our current email addresses with this issue; you may receive both a hard copy and an electronic version.)

For those who don't use email (or for whom we don't have an email address), you can periodically check the website (we publish quarterly) or let us know you'd like a postcard reminder. We update our contact data annually with our dues statement. Please check to be certain the email address entered is correct.

2010 statements will be mailed in December.

Please contact us at [wsoa@comcast.net](mailto:wsoa@comcast.net) or 206.232.9517 with suggestions and feedback about this change. □

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## Annual meeting offers experts . . .

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- **Michael Greene**, who has written many insightful NEJM editorials, will join Lucky Jain, neonatologist from Georgia, after their lectures to provide a point-counter-point exchange about the management and consequences of the delivery of the late preterm infant. Dr. Greene will also address the rising C/S rate and can it be reversed? Audience questions and discussion are expected to be vigorous on these topics.
- **Durlin Hickok** will review the current research and expectations that free fetal DNA will eliminate the need for most genetic amniocentesis.
- **Kent Heybourne** comes from Colorado to discuss HELLP syndrome and the use of adjunctive therapies. Drew Robilio's luncheon talk on ethical dilemmas should be stimulating.
- Lastly, **Tom Benedetti** will discuss obstetric simulation and its potential benefits for the provider.

The annual meeting should provide some excellent education and an opportunity to network with friends. □

## dialogue

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## Learning why political advocacy matters

By Leslie Carranza and Kate Mclean

**A**s senior residents in obstetrics and gynecology, we have the privilege of serving some of Washington state's most socially and economically disadvantaged patients, both at the University of Washington Medical Center and at Harborview Medical Center.

To our endless frustration, we are often unable to provide adequate treatment to those who need it the most, largely because of financial concerns or complete lack of insurance.

It is easy to feel overwhelmed and overpowered when we are unable to help the patient sitting in front of us. To our delight, we have found that becoming involved in advocacy at the state and national level has opened our eyes to a larger picture and provided us with an effective and rewarding avenue to promote change.

The American College of Obstetricians and Gynecologists sponsors a congressional leadership conference each year that is devoted to improving

health care for women. While attending this conference, we learned that our national legislators listen and count on physicians to provide information that shapes policy that might benefit our patients.

We then brought this knowledge and enthusiasm back to our state and assisted in organizing an ob-gyn Resident Legislative Day in Olympia. This event focused on better access to basic prenatal and preventive care here in Washington state, giving a voice to all the patients for whom we so desperately hope to improve their health care.

We realize that health care may change a great deal over the next few years. These opportunities provided us the chance to understand this process and to potentially steer the direction of future legislation. □

## Applications for membership

**T**he following applications for membership have been reviewed by the Executive Board and will be recommended for vote at the WSOA annual meeting:

### For regular membership

Mark Aversa, Puyallup  
Matthew Banfield, Everett  
Darin Blackburn, Puyallup  
Nancy Grubb, Puyallup  
Jennifer Knowles, Puyallup  
Joshua Nathan, Everett  
Kevin Taggart, Puyallup  
Daniel Wells, Puyallup  
Rodney Wells, Wenatchee  
Christine Werner, Issaquah  
Christopher Young, Puyallup

### For life membership

Philip Mead, Wenatchee

Additional applications received by November 15, 2009 will also be reviewed and presented for vote. □

### 2009 WSOA Officers

*President* Robin de Regt, MD  
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*President-elect* Andrew Castrodale, MD  
Grand Coulee, (509)  
633-1911, CastroA@coulee  
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*Vice President* Tom Easterling, MD  
Seattle, (206) 543-1521,  
easter@u.washington.edu

*Secretary* Ann Begert, MD  
*Treasurer* Edmonds, (425)  
745-4750, dra1ann@netscape.net

### Elective Executive Committee

*Two years* Brigit Brock, MD Seattle,  
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*Two years* Rita Hsu, MD Wenatchee  
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## A LOOK AT THE LITERATURE . . . FROM THE EDITOR

### Elective delivery before 39 weeks gestation

By Thomas Benedetti, MD

**D**elivery of infants between 37 and 38+6 weeks gestation (early term delivery) has been increasing and now accounts for as many as 17% of live births in the United States. Studies have shown that delivery of early term infants accounts for as many as 28% of elective deliveries in some centers. Several recent papers have shown elective delivery before 39 weeks is associated with increased morbidity in newborn infants<sup>1-3</sup>.

The American College of Obstetricians and Gynecologists (ACOG) has recently revised its guidelines to define more clearly practice patterns with reference to elective delivery after 37 weeks gestation. It recommends induction of labor or cesarean delivery for logistical reasons (rapid labor history, long distance from hospital) or psychological reasons only when fetal lung maturity has been established or when term gestation has been confirmed by one of three methods:

- Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test.

The new bulletin specifically states that the presence of pulmonary maturity by amniotic fluid analysis in the absence of appropriate clinical indications does not justify delivery before 39 weeks.

The appropriate implementation of these recommendations is dependent on generally agreed-upon defini-

tions of elective delivery and logistic reasons. The bulletin gives several examples of agreed upon indications for delivery before 39 weeks. The list, however, is not exhaustive, nor should it be. Unfortunately some organizations have used previously published lists as the only justifiable basis for delivery before 39 weeks. Based on the National Quality Forum's list of acceptable indications for early term delivery, the Leapfrog Group has asked hospitals to apply an algorithm to determine each hospital's percentages of elective delivery prior to 39 weeks.

Furthermore, beginning in April 2010 the Joint Commission will change its required quality measures



#### AGOC guidelines, NQF

#### indicators and Joint

#### Commission measures on early elective deliveries.

in obstetrics. One of these measures is elective delivery prior to 39 weeks. Each hospital obstetrics committee should become familiar with how these indicators are calculated and to do quality checks on the accuracy of coding in each hospital. As the current algorithm for early term delivery is written there are some "opportunities for improvement" to reflect obstetric practice as recommended by ACOG. An example is the elective delivery for "logistic reasons." The NQF algorithm would define this as elective, without medical justification. However, ACOG recognizes that delivery for rapid labor history and remote living circumstances are appropriate reasons in some patients.

Although not specifically recog-

nized by ACOG, perinatal centers find that elective delivery of babies with congenital anomalies to coordinate specialized neonatal care is good medicine. None of these are recognized by NQF as appropriate reasons for early term delivery.

Each hospital and each practitioner should review their practices with reference to the new Joint Commission indicators.

At the UW we have conducted our first analysis of elective delivery prior to 39 weeks. We found a number of clinical situations we felt justified early term delivery that were not considered in the currently used algorithm. For instance, a patient with prior cesarean delivery and planned repeat cesarean presented at 38+ weeks with contractions and a 2 cm cervix. A repeat C-section was performed. This was coded as an elective delivery because she was before 39 weeks and a diagnosis of labor was not made. In addition, several medical conditions (chronic maternal lung diseases, autoimmune diseases) and fetal conditions (abnormal antepartum testing) are not listed as indications for delivery.

Based on the recently published articles the pendulum has clearly swung too far toward unjustified early term delivery with resulting significant infant harm. However, only with appropriate professional practice oversight and reasonable feedback to the monitoring agencies will physicians be able to preserve some individual decision making with which to help our patients. Let's not lose the opportunity by becoming angry and refusing to participate.

#### Sources

1. Clark, S.L., Miller, D.D., Belfort, M.A., Dildy, G.A., Frye, D.K., and Meyers, J.A. 2009. Neonatal and maternal outcomes associated with elective term delivery. *Am. J. Obstet. Gynecol.* 200:156-4.
2. Yee, W., Amin, H., and Wood, S. 2008. Elective cesarean delivery, neonatal intensive care unit admission,

## WaACOG NOTES . . . . . Safely reducing C-section rate

### Optimizing obstetric outcomes in Washington

By Jane Dimer MD, FACOG

Early this year, a working group was formed to assess and to champion optimizing obstetric outcomes across Washington state. This group started as a subcommittee of the Perinatal Advisory Committee to the Department of Health and in collaboration with representatives from Washington's hospitals, quality improvement leaders, DSHS, midwifery community, birth educators, and clinicians who care for birthing women.

**A need for tools, data and expanding collaboration from venue to venue, from practitioner to practitioner, to optimize the availability of vaginal trial of labor after prior cesarean.**

When presented with the rising percentage of cesarean births in Washington in the last several years, our working group viewed two salient features in the obstetrical outcome data. First, we saw that the overall cesarean section delivery rate had risen to 28% in recent years and that, second, there was significant geographic variation in this rate in our state.

Beginning with a survey of the hospital and quality leaders in maternity care hospitals throughout the state, our working group has identified opportunities. We have heard clearly, for example, of the need for tools, data and expanding collabora-

tion from venue to venue, from practitioner to practitioner, with regard to optimizing the availability of vaginal trial of labor after prior cesarean.



From the outset, we reviewed studies and recommendations of several of the national experts. For example, we looked to the Institute for Healthcare Improvement's workbook and recommendations for reducing cesarean birth from more than a decade ago. We noted that the practice of obstetrics has changed in significant ways, making the IHI's workbook now obsolete. Where prostaglandin and oxytocin could have been used routinely in vaginal birth after cesarean, today this is no longer the practice.

Before the end of this year, you may be hearing much more about this collaborative working group's activities. In your local hospitals and practice groups, you may be asked to complete follow-up surveys and also to provide input regarding your local quality initiatives in obstetrics. All along the way, we look forward to sharing our knowledge, the findings from these data and educational tools and resources that this group creates.

If you have questions or would like to discuss this work, please email or call me at [jsdimer@comcast.net](mailto:jsdimer@comcast.net) and/or 206.714.7325. As your ACOG champion in this work. I would love to hear from you. □

### Dr. Reisner elected to WSMA leadership post

Dr. Dale P. Reisner, Maternal Fetal Medicine, Swedish Medical Center, Seattle, was elected WSMA assistant secretary-treasurer at the association's annual meeting in Spokane October 4. □

### Elective delivery before 39 weeks . . .

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and neonatal respiratory distress. *Obstet. Gynecol.* 111:823-828.

3. Tita, A.T., Landon, M.B., Spong, C.Y., Lai, Y., Leveno, K.J., Varner, M.W., Moawad, A.H., Caritis, S.N., Meis, P.J., Wapner, R.J. et al 2009. Timing of elective repeat cesarean delivery at term and neonatal outcomes. *N. Engl. J. Med.* 360:111-120.

ACOG Practice Bulletin No. 97: Fetal lung maturity. *Obstet. Gynecol.* 112:717-726 2008

ACOG Practice Bulletin No. 107: Induction of labor. *Obstet. Gynecol.* 114:386-397. 2009. □

### Washington State Perinatal Advisory Committee

By Roger B. Rowles, MD  
Chairperson

The Washington State Perinatal Advisory Committee (PAC) was formed in 1985 as an outgrowth of the Maternal and Infant Health program under the auspices of the Department of Health. Currently, the PAC has representatives from physician and nursing organizations, midwives, hospitals, insurance panels, DSHS, the March of Dimes and many others.

The PAC meets three times a year at the DOH facility in Kent. While the PAC has no statutory authority, it identifies needs, makes recommendations, and provides consultation to DOH and DSHS.

Much of the work of the PAC is done through subcommittees. Currently, three are very active:

- (1) A physician-licensed midwife work group.
- (2) An emergency preparedness committee.
- (3) A very active subcommittee working to reduce regional differences in cesarean rates (see Jane Dimer's article, left).

If you are interested in attending a subcommittee, contact Bat-Sheva Stein, [Bat.Sheva.Stein@doh.wa.gov](mailto:Bat.Sheva.Stein@doh.wa.gov) for agendas and directions. □