

Chair's Message

News from the Chair

by Charles Castle, MD



The Pennsylvania Section continues to work with the Pennsylvania Medical Society (PAMED) on several issues. In the spring newsletter, I discussed legal actions that PAMED filed against the Commonwealth regarding the Governor's action of taking funds out of the Mcare fund to balance the state budget. I'm

pleased to provide an update that on April 15, 2010, the Pennsylvania Commonwealth Court ruled 4-1 in favor of the Pennsylvania Medical Society (PAMED) in two separate legal actions for physicians filed jointly by PAMED and The Hospital and Health System Association of Pennsylvania (HAP). At issue were funds removed from two accounts related to the state-run liability insurance program for physicians and hospitals (Mcare). The total amount taken by the state is estimated to be between \$566 and \$716 million. The funds were withdrawn by the current administration in Harrisburg to cover budget shortfalls for the current year's budget.

One lawsuit contended the administration under-funded the abatement program by at least \$400 million, and also contended that the administration wrongly transferred \$100 million from the Mcare Fund to the general fund.

Essentially, PAMED won the argument that the Mcare Fund raid took dollars that were paid out of physicians' pockets for medical liability coverage (not taxes) and used them to balance the budget.

In the second lawsuit, the court found that the Commonwealth failed to transfer up to \$616 million from

the Health Care Provider Retention Account to the Mcare Fund to pay for premium relief enacted by the General Assembly between 2003 and 2007. The court found that physicians had a vested right to that relief which could not be overturned by a subsequent act of the legislature. The exact amount of the abatement under-funding has yet to be determined by the courts. The Rendell administration has already said that it will appeal this decision to the State Supreme Court.

The Pennsylvania Section would like to thank the District III Advisory Committee as well as the ACOG Executive Committee for their support behind this issue as well as allowing the Pennsylvania Section to sign onto the amicus brief supporting the position of PAMED.

On the legislative front, PA ACOG had another exciting win, as SB1074 was passed and signed by the Governor. This legislation prohibits the shackling of pregnant inmates during labor and delivery except in the most unusual and extreme circumstances. Shackling during labor would be permitted only if the inmate presents a danger to themselves, their newborn, or to the staff attending them.

Also on the legislative front, PA ACOG is planning its Annual Legislative Day on Tuesday, September 28 in Harrisburg. This is a great opportunity for physicians to make their voices heard. Please see Dr. Coslett-Charlton's article for additional information.

Finally, I would like you to know that this is the final "Chair's Report" I will be sending to you. My term as
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Pennsylvania ACOG Vice Chair Report

by Sherry L. Blumenthal, MD, FACOG, Vice Chair, Pennsylvania Section, ACOG

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Note: If you have an important announcement of interest to Pennsylvania ob-gyns, send it to Jan Reisinger at the PA Section of ACOG office.



I attended a meeting of the State Board of Medicine in June as the PA ACOG representative. The Nurse Midwives were seeking an expansion of their scope of practice to include routine Gyn care in addition to pre-conception counseling and obstetric services, and they already do contraception prescribing and counseling. Before the meeting, they submitted a copy of insurance regulations including them as "Primary Care" providers, however, this was not in the Board of Medicine scope of their practice. The Pennsylvania Medical Society had concerns, and asked us to have a representative present at the June meeting. Our major concern was that there would not be any challenge to the concept of collaborative agreements with obstetricians.

The midwives' position was that they could handle routine Gyn care of women of all ages, including menopausal counseling and treatment. They claimed that their training was sufficient. Dr. Carol Rose, the head of the State Board, questioned the amount of training in Gyn during the Masters Program in Nurse Midwifery at HUP.

My concern was the complexity of providing Gyn care for women at all ages. There are many intercurrent illnesses affecting older women. I also believe that Nurse Midwives are becoming more essential in provision of the care in which they are trained, i.e., obstetric care and delivery of normal, low-risk women. There are several counties in PA in which there are no OBs, and more hospitals have closed labor and delivery facilities. A recent closure is the only hospital in Carbon County that provided OB services. There is only one Obstetrician left in that area, and now he can only do deliveries in

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News from the Chair

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Pennsylvania Section Chair is over in early October, coincident with the Annual District Meeting. I have thoroughly enjoyed this opportunity to work on issues of importance to the Fellows, Junior Fellows, and the women of Pennsylvania for the past three years. I would particularly like to thank Jan Reisinger, the Executive Director for PA ACOG whose daily efforts on our behalf often go unrecognized, but which are crucial to the success of our Section. Jan, thanks so much for everything you did to assist me and all the members of PA ACOG for the last three years, and hopefully for many years into the future. Thanks also to Kristi Spargo, Jan's assistant, who has stepped up regularly to help us. The Section will be led by our new Section Chair over the next three years, Dr. Sherry Blumenthal. Sherry brings dedication and enthusiasm to her new role. Please join me in wishing her, and all our new Section officers, every success.

Respectfully submitted,

Charles A. Castle, MD, FACOG, Chair, Pennsylvania Section ACOG

Legislative Report

by Lynn Coslett- Charlton, MD, PA ACOG Secretary and Legislative Committee Chair



We have an active agenda for legislative activity this fall, the highlight being our annual **Legislative Day on September 28.**

This is a wonderful opportunity for PA ACOG members to have their voices heard about issues important to our patients and practices. We will begin at the Pennsylvania Medical Society

headquarters in Harrisburg, where we will then outline pressing issues within our specialty. Afterwards, we travel to the Capitol and meet with our legislators to educate them about important concerns in women's health. Each year our numbers grow and we always have enthusiastic participation from our residents, which leaves a great impression on policy-makers.

The fall also brings a wonderful opportunity to advance our legislative activity within the Section, with the direction

of National ACOG. The State Legislative Roundtable is held in Washington D.C. in late September. This well-organized meeting brings together state legislative chairs and lobbyists from across the country to a forum where we can discuss strategy, important current issues and political threats to our specialty.

We are happy to report our success in supporting SB 1074, which limits the inhumane practice of restraining pregnant incarcerated patients in labor. This important bill was recently signed into law by Governor Rendell. Other issues which we are actively working on include our support of legislation for "opt out" in HIV testing, supporting breastfeeding in the workplace, and opposition of legislation which singles out OB/Gyn providers with Hemophilia and von Willebrand's disease screening. We continue to oppose on behalf of our

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Late-Preterm Births: Five Take Home Points

by Stephen Smith, MD, PA ACOG Secretary-Elect and John Botti, MD

Your multiparous patient presents at 36+ weeks with irregular contractions. Her cervix is 3 cm dilated, 70% effaced. After observation, it is clear that she is not in labor but she is pleading with you to deliver her. You think to yourself, "She's almost term and this baby will do well." You acquiesce to her demand. Is this acceptable?

Late-preterm births (LPTB) are a significant contributor to the preterm birth rate in this country. Because LPTB infants are at higher risk of developing medical complications, it is imperative that un-indicated late-preterm births be avoided. The management in the example above was obviously unacceptable, but represents a potential trap into which obstetricians may fall. To emphasize the important points about LPTB, I posed six questions to John Botti, MD, Professor of Obstetrics and Gynecology and member of the Division of Maternal-Fetal Medicine at the Penn State Milton S. Hershey Medical Center.

1) **What is the definition of LPTB?**

LPTB is defined as birth between 34 0/7 and 36 6/7 weeks of gestation.

2) **The overall preterm birth rate in the United States in 2007 was 12.7%, an increase of 16.5% since 1990. What is the contribution from LPTB?**

Almost 75% of all preterm births are LPTB. The U.S. late preterm birth rate increased more than 20% since 1990, accounting for 8% of deliveries in the U.S. annually—approximately 350,000 newborns.

3) **What are the causes of LPTB?**

Most LPTB are due to preterm labor or preterm rupture of the membranes, but about 40% of LPTB occur as a result of iatrogenic interventions for medical or obstetric complications. Significantly, up to 18% of LPTB appear to be associated with non-urgent medical or obstetric conditions or elective indications for delivery. Most elective and potentially avoidable LPTB are performed between 36 and 37 weeks and account for up to 8% of all LPTB. Elective repeat cesarean deliveries are an important contributor. (Holland MG et al. Am J Obstet Gynecol, 2009; 201:404.e1-4).

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OPINION: ACGME Proposed Common Requirements: New Standards for Resident Supervision, Duty Hours and Program Director Oversight

by Mark B. Woodland, MS, MD, Education Committee Chair, Associate Dean GME, Drexel University College of Medicine

On June 23, 2010, Dr. Thomas Nasca, the CEO of the ACGME and the Vice Chair of the Task Force, sent an open letter to the academic medical community to accompany the draft Proposed Common Requirements. He reflects on the emphasis of the new standards to be;

“a cohesive and comprehensive package of interrelated standards that are designed to accomplish three goals.

- 1. To assure the safety and quality of care rendered to patients in our teaching hospitals today;**
- 2. To assure the safety and quality of care rendered to patients of our current residents in their future independent clinical practice; and**
- 3. To assure the provision of a safe and humanistic educational environment for our residents to learn and demonstrate professionalism and effacement of self interest.”**

The good news is that the new standards emphasize the experiential nature of resident training, and while not stating it directly, implicitly implies the fact that residency, like any other profession, needs an apprenticeship type period in which young clinicians can learn from direct clinical care under the supervision of more seasoned and learned clinicians.

The proposed standards add new definitions for professionalism and supervision, and purport new standards in transitions of care, fatigue oversight and

education, and limitations on duty hours. On the surface, the proposed standards look to be not only reasonable but substantive in potentially improving educational programs and highlighting areas of potential problems in providing care for patients.

The problem is in the way these standards are written. They imply that there has been limited oversight to date and that there have been studies or analysis that has been done to test these standards as to their educational and clinical benefits. The fact is, there have not been these studies and in fact, we as an academic medical community are trying hard to make a better system based upon our best guess as to what might make a difference. In doing so, we are setting up new standards that increase the administrative work of the institutions, program leaders and the residents; decrease or limit the potential direct clinical experience essential for residency education; increase the numbers of transitions in care; establish the potential for junior residents to be on different schedules than their senior counterparts and potentially increase the liability of the residents, faculty and institutions sponsoring residency programs.

Not to mention the economic impact of these proposed standards has not been adequately studied as yet;

“Finally, the economic impact assessment is being conducted by an outside agency. As soon as the impact statement is received from the research team, it will be posted on the ACGME website, and

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Plan To Attend the PA ACOG Legislative Day!

PaACOG Legislative Day is open to physicians who want to get involved and speak with their elected representatives about the serious issues facing ob/gyns today. The meeting is scheduled for **Tuesday, September 28**, and will include an informational briefing session, meals, and transportation to the Capitol to meet with your elected official.

Please plan to attend and to bring your colleagues, we need to have a strong and united effort to effectively reach the decision-makers! Call the PA ACOG office at 888-726-2496 for registration information.

Pennsylvania ACOG Vice Chair Report

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Lehigh County. In addition, with the new Health Care Regulations providing insurance for more people, there will be a greater need for more Obstetrics providers, at a time when there will probably not be substantially more Obstetricians.

There was no disagreement about collaborative agreements. I hope we can maintain a dialogue with the Nurse Midwives, and I reiterated our support for the Certified Nurse Midwives in PA.

I am also continuing to work on the OBesity Project. We have six ACOG members who have agreed to participate by outlining the specific issues in their subspecialties/ areas of expertise. Stephen Smith, MD, has outlined the effects of Obesity in Pregnancy and Delivery, and Larry Barmat, MD, has contributed an outline about obesity in both infertility and reproductive endocrine problems. Sharon Mass, MD, has provided an outline on the benefits

of breastfeeding on post-partum weight loss and on childhood obesity. In addition, Mitchell Edelson, MD, has agreed to present the issues in Gyn Oncology, Miles Murphy, MD, will summarize Urogynecology problems, and Lamar Ekblad, MD, is working on contraceptive efficacy in obese women. Donna Brown, MD, our Junior Fellow Chair, will work on the resident teaching module for the project. I will recruit a Nutritionist and a Nurse Practitioner to help with the patient module.

I welcome any other members of ACOG who wish to participate in the project. Please e-mail me at sherry.blumenthalmd@gmail.com. We hope to produce an excellent power point presentation and patient education brochure. Based upon the work done so far, it appears the effort will be very successful.

Once this project is done, I hope we can produce a program helping our colleagues deal with the "Second Victim" issue, of how do we get the support we need when something goes wrong or when we are sued, and how can we get support in a system which is becoming more invasive and overrun with protocols and paperwork?

Legislative Report

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membership any legislation attempting to delegate physician practice. In coalition with the Pennsylvania Medical Society, we of course continue our fight for Mcare abatement monies and oppose legislation which further

jeopardizes and undermines our abilities to practice regarding liability.

We encourage all members of PA ACOG to have a voice and become active in our legislative efforts. Our PA ACOG Lobby Day is a great start to getting involved. As always, please contact us with any legislative concerns regarding our specialty.

Opinion: ACGME Proposed Common Requirements

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an email announcement and link to the analysis will be forward to the entire GME community."

The timeline for the new proposed requirements is defined. Since their release, the website has been open for comments and input. This ends on August 9, 2010. The draft will go back to the task force for possible reconsideration and revision and then go to the respective Residency Review Committees (RRC). The RRCs may add their own interpretation and further standards such as we currently have in OBGYN requiring 24/7 attending in house oversight for our programs.

It seems that the stated proposed standards recognition that:

"However, these residents must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods."

is somewhat incongruous with the rest of the standards that limit resident duty hours and clinical exposure, reduce team interaction, increase transitions of care, and ultimately impact the education of our physicians. We as an academic community must be very careful about how we proceed in creating standards for medical education that are based on appropriate study and analysis while protecting not only the safety and care of our patients, but the reasonable expectations for our health care and educational systems.

The information referenced in this opinion can be found on the ACGME.org website.

Late Preterm Births: Five Take-Home Points

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4) **How does neonatal/infant morbidity and mortality in the late-preterm infant compare with the term infant?**

Compared to term deliveries, immediate complications of LPTB include increased rates of respiratory distress, apnea, hypoglycemia, jaundice, temperature instability, feeding difficulties, and increased neonatal and infant mortality (OR 2.8 compared to term births). Sudden infant death syndrome is increased two-fold in LPTB infants compared to infants of ≥ 37 weeks gestational age. Kernicterus is also increased in LPTB infants. Long-term consequences for LPTB infants include impaired postnatal growth in the first two years, increased hospitalizations for respiratory illness, and adverse neuropsychological sequelae.

5) **Is it reasonable to deliver patients between 37 0/7 weeks and 38 6/7 weeks in the absence of conditions that threaten maternal or fetal well-being?**

The term “early-term” birth was recently proposed to define births occurring between 37 0/7 weeks and 38 6/7 weeks. (Fleischman AR et al. *Obstet Gynecol* 2010; 116:136-9) This definition underscores the concept that gestational age represents a biological continuum of increasing perinatal maturity, as there is evidence that elective delivery between 37 and 39 completed weeks is associated with an increased risk of perinatal morbidity and mortality. Of concern is the fact that more than half of surveyed women believe that full term is reached at 37-38 weeks and that it is safe to deliver before 39 weeks even in the absence of medical or obstetric indications. (Goldenberg RL et al. *Obstet Gynecol* 2009; 114:1254-8) Neonatal mortality rates of early-term infants, while small, are increased two-fold compared to live births at ≥ 39 weeks. Early-term infants also have increased rates of respiratory difficulties and newborn intensive care admissions compared to later term infants (National Center for Health Statistics 2001 data).

6) **What can obstetricians do to reduce the rate of LPTB and early-term delivery? Please describe a Quality-of-Care Initiative that an obstetric department can employ to achieve this goal.**

To prevent complications of LPTB or early term birth, consider simple solutions including:

1. Accurate documentation of gestational age, and dedication to the principle that, *without a medical or fetal indicator for delivery*, no induction of labor should take place before 39 completed weeks, even with documentation of fetal lung maturity;

2. Use fetal lung maturity testing at less than 39 weeks for maternal medical or fetal conditions, but not to justify elective deliveries;
3. Restrict elective inductions at ≥ 39 weeks to a cervical ripening score of ≥ 6 (≥ 8 in nulliparous patients) in order to decrease the rates of failed induction and cesarean delivery;
4. Use cervical ripening agents only for indicated induction of labor (fetal or maternal medical indications or pregnancy ≥ 41 weeks);
5. Prepare the patient for induction of labor, whether elective or indicated, by careful discussion of benefits and risks;
6. Consider referral of pregnancies at risk for LPTB to appropriate centers of care;
7. Provide pre-pregnancy and inter-pregnancy counseling to women with increased risks for LPTB;
8. Process improvement of assisted reproductive technology to reduce the frequency of iatrogenic multiple pregnancies;
9. Supervise scheduling for elective induction of labor to ensure appropriate indications;
10. Peer review of all inductions less than 39 weeks and departmental review of all elective inductions less than 41 weeks.

An excellent illustration of a planned peer-review process improvement program is the recent Magee-Womens Hospital experience in Pittsburgh (Fisch JM et al. *Obstet Gynecol*, 2009; 113:797-803). As a result of a concerted hospital and physician/nurse/scheduling collaboration over a 4-year period, planned elective inductions decreased significantly from almost 25% to less than 17%. Furthermore, the cesarean delivery rate associated with elective inductions decreased from almost 35% to less than 14%. The Ohio Perinatal Quality Collaborative is an example of a statewide quality-of-care initiative, which also resulted in improved outcomes (*Am J Obstet Gynecol* 2010; 202:243.e1-8). Overall, attention by obstetrician/gynecologists, pediatricians, family physicians, nursing staffs and hospitals, focused on subtle features of late pregnancy management may pay substantial dividends in improved newborn outcomes and decreased hospital costs.