The Obstetrical Society of Philadelphia

To embrace our legacy, foster collegiality, and share expertise to improve the health of women in Philadelphia and beyond

NOVEMBER 2017

Newsletter

VOL. 44, NO. 2

President's Message

As the days grow shorter and the memories of warm summer days fade in the rearview mirror, I have been finding more time to catch up on my reading. I recently completed an interesting article discussing a new book by medical historian Paul A. Offit, titled *Pandora's Lab: Seven Stories of Science Gone Wrong*. The author presents an interesting historical perspective on a number of different supposed scientific breakthroughs that ultimately resulted in unintended consequences. A particularly interesting discussion centered on the evolution of the concept of a "heart healthy diet" including the admonition against a diet high in saturated fat in favor of a diet high in unsaturated fat. "Margarine is better than butter" became the well-known mantra despite the fact that the science behind these recommendations was less than solid. An explosion in use of partially hydrogenated vegetable oil and trans fats created an even greater threat to cardiac health. Awareness of this fact began in 1981 when the first reports appeared linking diets high in trans fats to heart disease. On July 10, 2002, the Institute of Medicine issued a report recommending that no amount of trans fat was safe, and recommended an upper intake level of zero. In 2006, the FDA implemented rules requiring manufacturers to list the quantity of trans fats on nutrition labels which has led to a rapid decrease in the use of trans fats. This is a laudable development but untold numbers of people have incurred cardiovascular disease because our purported knowledge led us in the opposite direction of physiologic reality.

Shortly thereafter, and while completing this year's maintenance of certification reading assignments, I found my previously held notions shaken yet again. An article published in the June issue of the *American Journal of Obstetrics and Gynecology* evaluating the use of 17-alpha hydroxyprogesterone caproate (17 OHP-C) for the prevention of recurrent preterm birth was reported. This prospective cohort study of 430 women found that weekly injections of 17 OHP-C did not impact the prevention of recurrent preterm birth and was found to lead to a higher rate of gestational diabetes in treated women.

In response to these recent experiences, I began to reflect on other examples of therapies embraced and abandoned when they were proven to be ineffective or downright dangerous. We need to look no further than the use of interventions such as ethanol or magnesium sulfate infusions for tocolysis, terbutaline pumps, and home uterine activity monitoring for examples of promising therapies, widely employed and ultimately abandoned. Finally, one of the most tragic examples in the care of women was the well-intended use of DES with its initially unknown but ultimately disastrous effects.

All of this has led me to think a good deal about a concept that I have come to identify as the uncertainty of certainty. While we endeavor to do what is best for our patients and to use evidence-based medicine to achieve that goal, we must acknowledge that our science is many times imperfect and incomplete. I do not mean to suggest we should abandon the scientific method but rather we must remain diligent and circumspect in our consideration of all of the available evidence as we strive to achieve the prime directive of *primum non nocere*. Perhaps Lord Byron provided us with the best advice when he said, "In short, I deny nothing, but doubt everything". We must come to accept the reality that the incontestable knowledge of today may well become the folly of yesteryear.

I believe my notion of the uncertainty of certainty will also underpin much of our November's meeting presentation on Cultural Competence and Unconscious Bias. Arthur Breese and Antwan Williams will guide us through an exploration of this pervasive phenomenon and help us to understand how it impacts our day-to-day decisions and how we view and interact with those around us. Of special importance is how unconscious bias influences the care of our patients. I hope you will be able to join us for what will be a thought-provoking evening. I look forward to welcoming you!

A. George Neubert, M.D.
President

Upcoming Lecture:
"Culture Competence and Unconscious Bias"

November 9, 2017

Arthur W. Breese, MS

Antwan D. Williams, MHSA

Geisinger Health System

IN THIS *Issue*

The following excerpt was (finally) selected from "Transactions of the Philadelphia Obstetrical Society" from October 1, 1896 to October 7, 1897:

THE TREATMENT OF FIBROID TUMORS OF THE UTERUS.*

By W. Easterly Ashton, M. D., Philadelphia.

Medical treatment can not be advised in every instance, and it would be equally wrong to urge an operation on every woman who presented herself with a uterine fibroid.

Again, even when operative interference is demanded there is much to consider before deciding upon the form of operation.

The proper management of these cases depends upon a careful study of each patient, and, although I am strongly of the opinion that a large number of uterine fibroids demand some form of operative interference, yet there is also a fair proportion in whom the indications are in favor of palliative measures.

The environment of a patient must be considered, other things being equal. Thus, a wealthy woman may afford to try palliative measures before resorting to more radical means, while a poor woman must of necessity seek immediate relief from symptoms which interfere more or less with her earning a living.

Commentary by Luisa Galdi DO, Assistant Professor of OB/GYN at Drexel University College of Medicine

We can identify disease, even with its variable presentation from one person to another. Our evaluation process considers age, weight, comorbidities, past surgeries, allergies, and concurrent medications.When the treatment of choice fails, the obvious next step is to implement the alternative. Traditional medical training is based on science, methodology, and evidence. But Dr. Asthon knew, long before it became a theme of prodigious newsletters, that to provide the most effective patient care there is more to consider.

The term "cultural competence" first emerged in a 1989 publication by social work leaders at Georgetown University. It took another 13 years after that for cultural sensitivity to be included in medical education curricula. Yes, our patients are biologically different. But they also possess non-biological inequalities that may not conform to the science, the methodology, and the evidence one might impose. Every patient has different values, beliefs and practices based on individual or collective factors, such as race, ethnicity, nationality, age, religion, ability, disability, sexual orientation or socioeconomic status. An awareness and understanding of various cultures can lead to improved communication, enhanced patient care experiences, and more successful diagnosis, treatment and management.

Interested in learning more? On the ACOG website search "WEBTREATS: Cultural Competency."

Foster Collegiality

"Pregnancy Complications: a window into a woman's cardiovascular future"

Speaker: Katie Hawthorne, M.D.
Lankenau Cardiac Group

Photos from our October 12, 2017 Meeting

Society President, A. George Neubert, M.D. and speaker, Katie Hawthorne, M.D.
Dr. Hawthorne signs *The Book*


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EXIT

Share Expertise

'Pause' and Reflect on Menopause Education



Jonathan Saperstein[1] Xuezhi Jiang, M.D., Ph.D.[2,4] Peter F Schnatz D.O.[2-5]

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The number of women in the United States who have reached and completed menopause has been steadily increasing over the years. As the population continues to age, it is estimated that there will be approximately 50 million postmenopausal women in this country by the year 2020. (1) There is no question that managing the unique health problems of this demographic is important, not only for OB/GYNs, but for all types of physicians. However, there exists an overall lack of knowledge in dealing with these patients, especially among newly trained primary care attendings. Moreover, it is not uncommon for female patients to feel that health care providers are ill-equipped to handle their menopause needs. (2) The question remains: why does this problem exist? The answer lies in the fact that there is insufficient menopause instruction at multiple levels of medical education and training.

Poor exposure to menopausal women and their specific health needs begins while students are in medical school. At the University of Connecticut School of Medicine, a study was conducted from 2002 to 2007 to assess medical student experiences in various obstetric and gynecologic topics during their required third year clerkship. While 95% of students reported exposure to normal labor management and 97% to routine gynecologic care, only 60% reported seeing menopausal patients. Interestingly, 87% of students reported experience with leiomyomas during their clerkship, a condition that has a prevalence of just 20% in the female population. By the year 2020, the prevalence of menopause is estimated to be at 43% and eventually affects all women if they live long enough. Hence, these students were more often exposed to a condition that affects significantly fewer women. The results of this study led UConn to take action via the implementation of required menopause lectures during the third year clerkship. Moreover, menopause was to be included as a required patient encounter that students were to log, thus ensuring appropriate exposure for each and every medical student. (2)

The Indiana University School of Medicine conducted a similar study aimed at measuring student preparedness in regards to various health topics. Third year medical students were surveyed during their family medicine rotation, and it was found that of the women's health conditions that were seen in clinic, menopausal and premenopausal disorders represented the third most common, at 7.4% of encounters. However, students rated their women's health encounters as "unskilled" or "marginally confident" nearly 10% of the time, as opposed to only 6% for all other encounter types. (3) This once again serves as a poor reflection of medical school training of not only topics in menopause, but in women's health overall.

Once medical students become residents, it is expected their knowledge of and exposure to menopausal patients should improve; however, this is not always the case, even among OB/GYN trainees. One nationwide study sought to evaluate the competence of OB/GYN residents in regards to taking care of menopause patients. Using a web-based survey, hundreds of residents around the country rated their knowledge of various topics within menopause medicine. Not surprisingly, a majority of them reported limited knowledge in these fields, such as pathophysiology of symptoms (67.1%), hormone therapy (68.1%), and bone health (66.1%). And while fourth-year residents reported a slightly higher level of confidence in these subject areas, there were still large knowledge gaps for these soon-to-be clinicians, who at the time of the survey were only two months from graduation. (4) This is consistent with recent trends in CREOG examination scores, which have been found to be significantly lower for the menopause and climacteric questions as compared to the rest of the exam among fourth year residents. (5)

This lack of preparation in menopausal medicine during residency training is not specialty-specific. A study done by Yale in 2009 examined the responses of the institution's own residents from internal medicine (traditional, primary care, and IM-Pediatrics tracks) to assess their comfort levels in dealing with women's health issues. These topics are ones they should see regularly and, as such, be comfortable managing; they ranged from medical complications of pregnancy to urinary incontinence and pelvic floor disorders, and, of course, included menopausal symptoms. Of the 100 residents who responded, only 50 reported feeling confident in their ability to manage these patients. Moreover, 81% of these residents reported having limited training opportunities with menopause patients, and 97% of them reported five or fewer encounters involving menopause symptom management in the prior six months. (6) **Such numbers once again highlight the lack of sufficient menopause training taking place at residency programs around the United States.**

So what can be done to combat this issue of sending under-educated clinicians out into the workforce? The solution may actually be quite simple: create menopause-specific centers where students and residents alike can train and gain the necessary exposure to effectively treat this patient population. Such clinics are already in existence and are making a significant change in the way trainees are learning about the management of menopause. The Women's Life Center in Hartford, Connecticut is a prime example of this. While not a free-standing establishment, the center provides services within a larger women's clinic. Created in 2001, the center was designed to be open one afternoon a week and to utilize a team approach with residents and ancillary staff from a number of specialties and backgrounds to address a broad spectrum of women's health issues related to menopause-specific care. This included conditions such as osteoporosis, breast disease, urogenital disorders, incontinence, sexual dysfunction, cardiovascular disease risk assessment, and age appropriate screening. (7) In order to measure the effectiveness of the training provided by the center, residents from three specialties (OB/GYN, internal medicine, and family medicine) were given examinations before and after completing a rotation that involved a number of sessions at the menopause clinic. From 2004 to 2007, data was compiled on 73 residents, and it was determined that regardless of the number of sessions attended or specialty of the resident, the residents' posttest scores increased significantly, by an average of 14%. (8) This result suggests that the clinic was quite successful in educating the young physicians in menopausal topics. The Hospital of the University of Pennsylvania also runs a similar menopause-specific clinic where its OB/GYN residents complete rotations. The program conducted a study to assess the skills and knowledge of those residents who had rotated in the clinic and compared to those who had not due to scheduling concerns. In an online exam, participants scored significantly higher than non-participants (nearly ten percentage points higher). Moreover, the results of an accompanying survey showed that participants gained more experience with the management of hormonal therapy and sexual dysfunction and felt more competent

with topics such as vaginal dryness, fracture prevention, and depression/sleep issues. (9) With the recognition of the value of these clinics, along with an expressed desire to help start more programs, the North American Menopause Society (NAMS) is sponsoring a mentor/mentee program to facilitate this goal. Many physicians from NAMS who have been involved in starting and/or running a menopausal program or clinic have volunteered to mentor members who desire to do the same.

While menopause-specific clinics may signal hope for the future, they are not the only method being used by programs to better prepare their residents. The Johns Hopkins OB/GYN residency program recently developed a two-year menopause medicine curriculum for its residents, which consists of both lectures and labs involving cases and role-playing scenarios. The first batch of residents who participated in the program took pre- and posttests to assess their knowledge and comfort levels of core topics. Not only did they see an average increase in their scores by over 21%, the overwhelming majority (95.2%) rated the curriculum as "extremely useful." (10)

Menopause education needs to be strengthened across all specialties of medicine because it is a topic that affects nearly all practicing physicians. Clearly, this problem seems to arise early on in medical education and training. **By forming more specialized clinics in which residents and students across specialties can train and revising medical school and residency curricula to include more menopause-specific lectures, programs may be able to remedy the problem by producing physicians who can provide better care to menopausal women.**

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Spotlight: Drexel Study on Unconscious Bias

Everyday Bias

Arthur Breese, Director of Diversity and Inclusion for Geisinger Health System, will be joining us for our November meeting and will be presenting on the topic of Cultural Competence and Unconscious Bias. In advance of his presentation he has provided the following preview of his presentation.

Unconscious bias, also called implicit bias, affects health care providers every day, especially when they are stressed or tired. Swift and automatic, it can reduce quality of care and even lead to medical errors. Implicit bias stems from subconscious associations gathered over a lifetime that can override conscious beliefs and cause people to unknowingly act in ways that are inconsistent with their true values.

Jennifer Taylor, PhD, MPH, CPPS, Associate Professor in the Department of Environmental and Occupational Health, Dornsife School of Public Health at Drexel University has kindly shared a summary of a recent study that she co-authored that provides further insight into this important issue.

Why Black Men Don't Get the Same Treatment in Healthcare

While healthcare disparities have been the topic of scientific inquiry for over 40 years, understanding the contribution of bias and discrimination to the patient-provider relationship has remained elusive largely due to methodological limitations. In past quantitative studies, after controlling for severity of illness, insurance, and income, Black men are less likely to receive cardiac medical procedures such as cardiac catheterizations and coronary angioplasties compared to White men presenting with identical symptoms.

In the recent study "Healthcare Providers' Formative Experiences with Race and Black Male Patients in Urban Hospital Environments," researchers at Dornsife School of Public Health at Drexel University explored the potential influence of bias on provider interactions with Black male patients. Published by the *Journal of Racial and Ethnic Health Disparities*, results from this study provide compelling information about the potential role of racial biases within the realm of healthcare.

Using qualitative methodology to engage providers in conversation, this study illuminates how health providers' formative childhood, personal, and professional experiences with race and Black men potentially influence their interactions with Black male patients. The research team interviewed physicians, nurses, and medical students from two urban university hospitals. They found themes across the interviews that were reflective of personally-mediated racism and concluded with findings of how the perception of Black males and cognitive dissonance appear to influence providers' approaches with Black male patients.

Both Black and White providers described examples when Black male patients were treated differently based on race. For example, one physician noted, *"I've had ... a Black patient who I think had not been offered a procedure because of either where he was economically or where he was assumed to be economically because of his race. He clearly needed to be catheterized for his presentation and it was suggested that we do medical management. I spoke with the cardiologist and as soon as we started talking, he said, "oh well, of course, we'll cath him." And so, like that, it changed...[I] certainly have enough anecdotal experience to think that people are probably [being] treated differently based on race."*

Furthermore, White providers described experiencing a sense of fear or discomfort and discussed their lack of exposure to Black males. In contrast, Black providers shared their frustration with media portrayal of Black men, the pressure they feel to avoid confirming negative stereotypes associated with Black culture, and instances of patients discriminating against them.

The qualitative nature of this study allowed the authors to explore where previous quantitative findings ended. By gaining insights into the patient-provider encounter, this study suggests the need to develop curricula in health professional schools that address provider racial bias. Understanding the dynamics operating in the patient-provider encounter will enhance the ability to address and reduce health disparities.

Jennifer Taylor, PhD, MPH, CPPS
Associate Professor in the Department of Environmental and Occupational Health, Study Co-author
Dornsife School of Public Health at Drexel University

Delaware and Pennsylvania at The Forefront of Efforts to Reduce Teen Pregnancy Despite Federal Cuts

Larry Glazerman, M.D.
Medical Director of Planned Parenthood of Delaware

Teen pregnancy continues to be a significant issue both nationally and locally. Even though the teen birth rate decreased by more than half in the United States (from 61.8 to 22.3 per 1,000 teens) from 1991 to 2015 1the **U.S. teen birth rate is still higher than that of many other developed countries, including Canada and the United Kingdom.**

The Centers for Disease Control and Prevention report nearly one in five teen births involve teenagers who are already mothers.

Specifically, in Philadelphia, 73% of teen pregnancies are unintended, and 20% of teen mothers have 2 children.

At Children's Hospital of Philadelphia (CHOP), a grant from the March of Dimes is funding referrals for contraception during pediatric visits. Several studies have shown that even though many new mothers are lax in obtaining postpartum care, they are more consistent in attending checkups for their infants. This program will provide for referrals for contraceptive care during routine pediatric checkups, with the hope that more teens will then use effective contraception, preventing repeat pregnancy.

In Delaware, the Division of Public Health and national nonprofit, Upstream USA, partnered to create Delaware Contraceptive Access Now (CAN). Delaware CAN aims to reduce unintended pregnancy by increasing same day access to the full range of contraceptive methods for women of all ages, including teens, especially the most effective, IUDs and the implant. Delaware CAN has trained 511 clinicians and 1137 support staff located at 160 public and private facilities statewide. **Funded by Upstream, Delaware CAN provides contraceptives for all patients at participating health centers at no cost, regardless of their insurance coverage or lack thereof.** The goal of Delaware CAN is to transform the way contraceptive care is delivered in Delaware so that women can achieve their goals and become pregnant only when and if they want to.

With Federal funding for teen pregnancy prevention programs reportedly in jeopardy, it's refreshing to report on two local programs designed to continue the drop in unintended teen pregnancy.

A Delco Chapter of PAHCOM event **December 7, 2017**

Two Great Sessions in One Afternoon:
The Curious Case of Dr. Oblivious: An Interactive Mock Trial
Legislative, Regulatory and Payer Issues

The Curious Case of Dr. Oblivious: An Interactive Mock Trial

Norris McLaughlin & Marcus, P.A. Attorneys At Law

Presented by: Norris McLaughlin & Marcus, P.A.

Dr. Oblivious has been sued by Nurse Ratched for violations of HIPAA, the PHRA, the ADA, and the FMLA.Will the Practice be liable? Will Dr. Oblivious be liable? You will be the jury. You will decide! Learn how to protect your practice from potential legal liability for similar issues related to your employees. Have some fun at the same time!

12:30 – 1:00	**Registration Desk Open**
1:00 – 1:15	**Welcome and Introductions**
1:15 – 2:30	**Interactive Mock Trial**
2:30 – 2:45	**Restroom and snack break**
2:45 – 3:45	**Interactive Trial – Continued** Jury Instructions, Jury Deliberations, Teachings
3:45 - 4:00	**Deposit Machine Demonstration (M&T Bank)**
3:30 - 5:00	**Legislative, Regulatory, and Payer Issues**

COCKTAIL PARTY

Post Event ***Cocktail Party*** for Delco Chapter Members for Incoming Officer Installation. Delco Chapter Members are Free, Guest Fee $20.00 All must register for this extra event.

Location: The Desmond Hotel & Conference Center
1 Liberty Boulevard
Malvern, PA 19355

Legislative, Regulatory, and Payer Issues

The Pennsylvania Medical Society will share trends with various insurance claims issues; payment policy updates; and Quality Measurement Caveats.

Managers are challenged by the ever changing healthcare environment and the more we can stay on top of changes, trends, and upcoming modifications the better we can help our physicians provide patients with the best care possible.

Brought to you by the DelCo Chapter of PAHCOM • **Please Print Information: (copy form for each person)**

Name: _____ Title: _____

Practice/Organization: _____ Specialty: _____

Address: _____

Phone: _____ PAHCOM Member: ☐ Y ☐ N

Email: _____ *Conference qualifies for 4 PAHCOM CEU credits*

Registration deadline is 11/20/17

FEE: $99 for ½ day seminar (incl: beverages & snacks)

Fax registration form to: 610-649-4735

Make check payable to: DelCo Chapter of PAHCOM

Mail check to: Linda DuBois, CMM, 70 Glenn Road, Aston, PA 19014

Email questions to: Jill Venskytis, CMM, HITCM-PP
Subject line: Delco Event
Address: jillv@DrexelHillPeds.com

☐ Attending Chapter ***Cocktail Party*** ☐ Add guest #_____

2017-18 Meeting Schedule

Dinner Meetings

November 9, 2017 — ***Culture Competence and Unconscious Bias***
Arthur Breese, MS, Geisinger Health System

January 11, 2018 — ***Joint OB/PARES Meeting***
ACOG, Yesterday, Today and Tomorrow
Hal C. Lawrence, III, MD, ACOG

February 8, 2018 — ***Providing Care for Transgender and Gender Nonconforming Individuals***
Lin Fan Wang, MD, Mazzoni Center

March 8, 2018 — ***Providing Patient Centered Care***
Daniel Davis, PhD, Geisinger Health System

April 12, 2018 — ***Women's Reproductive Health – Historical Perspectives/Future Challenges***
Philip Darney, MD, MSC, University of California, San Francisco

The venue for the dinner meetings is the Philadelphia County Medical Society Building, 2100 Spring Garden Street. There is **free parking** in the lot adjacent to the PCMS building.

Sesquicentennial Gala at the College of Physicians!

May 10, 2018 — ***150 Years of Contributions by Philadelphia Physicians to Women's Health***
Anthony Tizzano, MD, Cleveland Clinic Foundation

Resident Education Day

Friday, May 4, 2018 — Reading Hospital will host. Look for exciting changes, specifically to the Resident Bowl and the return of the Mock Trial, this time focusing on *"The Anatomy of a Deposition"*.

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