State of the Specialty: 12 ObGyns describe critical challenges to their work

PAUL ZWOLAK FOR OBG MANAGEMENT

It's no quiet time in the specialty. More and more chronically ill patients, falling reimbursement, a struggling economy, rapid evolution of guidelines, and other issues are devouring your time and attention. Twelve physicians tell OBG MANAGEMENT what they each think is the most pressing challenge facing the specialty. They offer solutions, too.

Robert L. Barbieri, MD, members of the OBG MANAGEMENT Board of Editors and Virtual Board of Editors, and Janelle Yates

Dr. Barbieri is Chief of the Department of Obstetrics and Gynecology at Brigham and Women's Hospital and Kate Macy Ladd Professor of Obstetrics, Gynecology, and Reproductive Biology at Harvard Medical School in Boston. He is Editor-in-Chief of OBG MANAGEMENT. Ms. Yates is Senior Editor of OBG MANAGEMENT.

We are at the threshold of a new era in American medicine. Federal health legislation will catalyze changes that will reconfigure how we provide care to our patients. At such a critical juncture, we thought it was important to explore the professional and personal challenges of our colleagues, a few of which are offered here. The perspectives of our fellow ObGyns are illuminating and inspiring. They reflect the high quality of physicians in our field, and their deep commitment to providing the best care for their patients.

We are the few, the proud, the ObGyns!

—Robert L. Barbieri, MD

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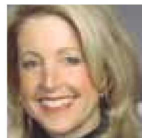
CHALLENGE 1

Maintaining the privilege of private practice



Barbara S. Levy, MD
Dr. Levy practices gynecology in a solo private practice in Federal Way, Wash, where she also serves as Medical Director of the Women's Health Center for Franciscan Health System. She serves on the OBG MANAGEMENT Board of Editors.

Of the many challenges ObGyns face today, the "monopolization" of medicine may be the most pervasive. In Federal Way, Washington, where I practice, the local hospital system has acquired many of the private primary care practices in town, including many of those that regularly recommended my practice to their patients. Once they become part of the hospital system, these practices are encouraged to refer patients to ObGyns in that system.

Many older physicians are throwing in the towel and selling their practices to the hospital system, and many younger physicians, just entering the workforce, would prefer not to have to run a business, and so they go to work for a hospital.

Although I still see a full slate of patients in my solo private practice, I have noticed that people aren't booking appointments as far in advance as they used to, and the number of patients sent to me by other practitioners has declined. In response, I've beefed up my Web site for marketing purposes, and I do my best to keep it up to date and to ensure that it is well listed in the search engines. I also work with my patients to increase word-of-mouth recommendations, and I work with vendors of slings and other products I regularly utilize in my practice to encourage them to support public education symposia and materials that market my practice.

As patient volume declines, it obviously becomes more difficult for a gynecologist to maintain competence in surgical procedures. If this trend continues over the long term, I wonder whether GYN generalists are going to be able to maintain competence in every aspect of the job—or are subspecialists going to be the only ones who have enough experience to perform surgery safely and effectively? It would be a shame if general ObGyn care lost the surgical component.

Here's to preservation of the private practice!

Dr. Levy reports no financial relationships relevant to this article.

CHALLENGE 2

Adhering to revised guidelines

Raksha Joshi, MD
Dr. Joshi is Chief Medical Officer and Medical Director of Monmouth Family Health Center in Long Branch, NJ. She serves on the OBG MANAGEMENT Virtual Board of Editors.

Physicians and patients have followed mammography and Pap testing guidelines comfortably for a number of years—that is, until the US Preventive Services Task Force (USPSTF) revamped mammography screening guidelines in November 2009. The USPSTF now recommends biennial mammography rather than annual screening for women 50 to 74 years old, no mammography for women younger than 50 years (unless it is indicated), and the elimination of self breast examination from the list of recommendations.[1]

Shortly after the USPSTF made its revisions, ACOG announced changes to Pap screening guidelines, moving the age for the first Pap test to 21 years (rather than 18 years or 3 years after sexual debut), followed by biennial screening. ACOG also recommended that women 30 years and older who have had three consecutive negative Pap tests switch to screening every 3 years.[2]

What I tell my patients

I continue to teach self breast examination and encourage women to "know their breasts." Many of my patients have noticed changes that merited a workup and sometimes led to discovery of a malignancy—even before the age of 40.

I also make it a point to discuss the possible "harms" of screening mammography

with my patients. So far, every one of them has been happy to undergo additional testing—including biopsy—for the reassurance of knowing that they do not have cancer.

My great fear? That insurers will use the USPSTF recommendations to deny screening mammography—even though, so far, they have asserted that they will not do so. Who among us has not seen at least one case of early—and, therefore, curable—breast cancer detected by an annual mammogram when the previous year's test was perfectly normal?

Will women fall through the cracks?

The new Pap testing guidelines are easier to accept because we are learning more about HPV, the causative agent of cervical cancer. Nevertheless, I worry that many women will fall through the cracks as we extend the Pap testing interval to 2 and 3 years and that we will become static in the battle against this almost completely preventable cancer. And because the ObGyn is the only physician many women of reproductive age see with any regularity, screening for diabetes, hypertension, and other chronic conditions often falls to us. These conditions may all go undetected if the woman does not come to see us for a Pap test. Cancer of the cervix may not kill her, but a stroke or myocardial infarction certainly can!

> **"I worry that many women will fall through the cracks as we extend the Pap testing interval to 2 and 3 years."**
> **—Raksha Joshi, MD**

Guidelines are just that—guidance. I am mindful of the new recommendations, but I tailor my advice to the risk profile of the individual and remain cognizant of the prevalence of diseases in the population I serve.

Dr. Joshi reports no financial relationships relevant to this article.

CHALLENGE 3

Responding to atypical glandular cells

Larry C. Kilgore, MD
Dr. Kilgore is Gynecologic Oncologist at the University of Tennessee Medical Center in Knoxville, Tenn. He serves on the OBG MANAGEMENT Board of Editors.

From my vantage point as a gynecologic oncologist, one of the most pressing issues facing gynecologists and primary care providers who screen patients for cervical cancer is ensuring proper management of women whose Pap smears reveal the presence of atypical glandular cells (AGC). In more than 30% of cases involving AGC, a serious condition is present. Although squamous cancer precursors are the most common finding, other possibilities include:

- adenocarcinoma in situ or adenocarcinoma of the cervix
- hyperplasia or adenocarcinoma of the endometrium
- adnexal malignancy, including ovarian and tubal carcinoma.

The general application of liquid-based Pap testing has not led to proper identification or adequate protection of women against glandular malignancy of the reproductive tract. At a time when the proportion and absolute number of patients who have glandular malignancy of the cervix are on the rise, the clinician is challenged to appreciate the gravity of these findings and follow management guidelines closely.

Regrettably, many practitioners do not adhere to the latest guidelines on AGC, last updated in 2006. According to these guidelines, the clinician is obligated to:

- perform colposcopy on each patient who has a test result classified as AGC
- obtain an endocervical curettage, regardless of the patient's age
- test for HPV at the time of evaluation
- obtain an endometrial biopsy in women who are older than 35 years or who have unexplained uterine bleeding.

It is not appropriate to repeat the Pap test or otherwise delay thorough evaluation.

In addition to proper management, the gynecologist should educate other primary care health professionals who perform cervical cancer screening about the importance of following AGC guidelines. Proper respect for this important clinical issue is imperative.

Dr. Kilgore reports no financial relationships relevant to this article.

CHALLENGE 4

Meeting the specialty's research needs

Anita L. Nelson, MD
Dr. Nelson is Professor of Obstetrics and Gynecology at Harbor–UCLA Medical Center in Torrance, Calif. She serves on the OBG Management Virtual Board of Editors.

Research in women's health has grown tremendously since the late 1980s, when the Government Accountability Office (GAO) issued several reports revealing that women were being deliberately excluded from clinical trials. Despite a greater emphasis on women's health since then, research is sorely needed in many areas.

Consider unwanted pregnancy as a disease that, every year, kills and mutilates millions of women worldwide and orphans untold numbers of children. We need new, inexpensive, reliable, convenient methods of birth control that are rapidly reversible and that do not require extensive training to implement. One option might be an intracervical contraceptive device. In addition, choices in injectable contraception should be expanded, and studies are needed to understand (and control) unscheduled spotting and bleeding.

Research is also necessary to find better ways to motivate couples to control fertility, and to plan and prepare for pregnancy. For women who have infertility, we need better, less expensive techniques that can be shared with low-resource regions.

Other areas ripe for research:

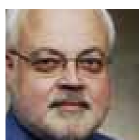
- **Obstetrics.** Given that preterm labor is one of the greatest challenges in the United States, it is amazing to realize that we do not yet understand what factors control the onset of labor. In addition, extended research on the pathophysiology of preeclampsia and eclampsia is needed to develop effective treatments and reduce the serious complications caused by these processes.
- **Oncology.** Ongoing efforts to identify new markers to detect gynecologic cancers at a very early stage need to be amplified. Simple interventions to prevent those cancers in high-risk women should also be studied. For example, obese postmenopausal women have a high risk of endometrial cancer; clinical trials of prophylactic progestin therapies are vital.
- **Application of the Human Genome Project.** The information that we glean about individual risk should be translated into targeted approaches to promote health and to tailor therapies to the individual patient.

And the list goes on....

Dr. Nelson reports that she receives grant or research support from Bayer HealthCare, Medicines 360, Pfizer, and Teva. She serves as a speaker for Bayer, Merck, Pfizer, and Teva, and as a consultant or advisor for Bayer, Pfizer, Ortho-McNeil, and Teva.

CHALLENGE 5

Providing targeted care to adolescents



Daniel M. Avery, MD
Dr. Avery is Associate Professor and Chair in the Department of Obstetrics and Gynecology at the University of Alabama School of Medicine in Tuscaloosa, Ala. He serves on the OBG Management Virtual Board of Editors.

Among the challenges of providing quality ObGyn care to adolescents are **1)** preventing, identifying, and treating sexually transmitted infection (STI) and **2)** screening for cervical cancer. The Centers for Disease Control and Prevention estimates that there are approximately 19 million new cases of STI each year in the United States—almost half of them in people 15 to 24 years old.[3] Chlamydia and gonorrhea are the two most prevalent STIs.[3] In my practice, where roughly 20% of my patients are adolescent, chlamydia is a major concern. I test patients annually for this STI.

"Given that preterm labor is one of the greatest challenges in the United States, it is amazing to realize that we do not yet understand what factors control the onset of labor."
—Anita L. Nelson, MD

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As for Pap testing, what we tell adolescents next year may be different from what we tell them this year. Guidelines have changed regularly enough that ObGyns must make an effort to stay on the cutting edge. For example, late last year the recommended age for the initial Pap test moved to 21 years, regardless of the patient's age at sexual debut.[2]

We have also learned to manage Pap tests less aggressively in adolescents. We perform fewer colposcopies, biopsies, and loop electrosurgical excision procedures (LEEP) than ever before because data indicate that many cervical changes spontaneously regress in these patients; moreover, unnecessary treatment can lead to incompetent, fibrotic, and scarred cervixes. The risk of invasive cervical cancer in women younger than 20 years is 1 in 40,000.

Nevertheless, our medical school referral practice has seen two women younger than 20 years who had invasive cervical cancer. One year after I vaccinated a 16-year-old virgin against HPV, she became sexually active and got pregnant. Her initial Pap test—during prenatal care—showed low-grade squamous intraepithelial lesions, and her postpartum Pap test was classified as atypical squamous cells of undetermined significance; a postpartum HPV test was negative for high-risk strains. This patient did not see me again for 1 year, at which time a repeat Pap smear showed atypical squamous cells with a high risk of neoplasia. Colposcopically directed biopsies were suspicious for invasive cervical cancer, which was confirmed by LEEP. The patient underwent a radical hysterectomy with pelvic and peri-aortic lymph node dissection when she was only 19 years old.

In my practice, I emphasize education, vaccination against HPV, chlamydia detection and prevention, abstinence, and barrier contraception.

I am candid with adolescent patients about the risks they face and I view education as paramount to their health and well-being.

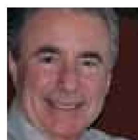
Dr. Avery reports no financial relationships relevant to this article.

"I try to help patients understand that insurance companies are in business only to make money. No matter how welcoming and sincere their commercial enticements may appear, they are not on the side of the patient."

—Ed Cohen, MD

CHALLENGE 6

Dealing with the insurance beast



Ed Cohen, MD

Dr. Cohen practices obstetrics and gynecology in Los Altos, Calif. He serves on the OBG Management Virtual Board of Editors.

The letter from the insurance company began promisingly enough:

> The approved services listed above are medically necessary.

Then it turned ugly:

> However, prior authorization was not obtained in a timely manner. Benefits will be reduced by $500.

This particular letter was dated Feb. 17, 2010, but it is not the first—or even the latest—unfriendly communiqué one of my patients has received from an insurer. Over the 30 years that I have practiced ObGyn, hundreds of tearful patients have asked for my help in resolving insurance-related issues. It has been my experience that the insurers rarely relent and do the right thing—even after appeal. They only tighten the thumbscrews.

In counseling patients, I try to help them understand that insurance companies are in business *only* to make money. No matter how welcoming and sincere their commercial enticements may appear, they are not on the side of the patient.

If insurers were acting in good faith and on the patient's behalf, would they erect so many obstacles?

I invite any insurer to adequately and honestly explain why it makes any difference whether they are notified of a procedure on Tuesday instead of Wednesday. If the services are approved and covered and deemed to be necessary, why should reimbursement be reduced?

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This is the main problem I've had with insurers, whose employees receive substantial "incentive pay" as long as the company remains profitable. Their real incentive should be to serve their customers, the insured. Instead, they make every effort to pay out less and put the difference in their own pockets.

Earlier this year, Rep. Henry Waxman (D-Calif) "blasted WellPoint Inc. executives for publicly stating that the country's economic turmoil and rising health care costs was the reason its Anthem Blue Cross subsidiary intended to move forward with a massive rate increase in California, when the company's own documents say otherwise."[4] WellPoint had only recently announced an eightfold increase in profit for the last 3 months of 2009.[5]

You don't need a PhD in economics to understand the motivation for that rate hike.

Dr. Cohen reports no financial relationships relevant to this article.

CHALLENGE 7

More about the beast: Coping with shrinking reimbursement

George T. Matsuda, MD
Dr. Matsuda practices obstetrics and gynecology in Pasadena, Calif. He serves on the OBG Management Virtual Board of Editors.

I've been in practice since 1992 and, like much of the rest of the ObGyn workforce, face many challenges. One of the biggest is providing quality care in an environment of shrinking reimbursement.

Insurance companies are increasingly difficult to deal with. Claim denials and delays in processing payment are frequent. Medicare is threatening a 21% cut in payments. Higher patient deductibles make collecting payments more difficult. On top of these issues, many people have lost jobs and medical coverage. Others struggle financially and cope by delaying routine medical care. The result is fewer office visits by established patients.

Overhead expenses continue to skyrocket. Good medical coverage for the staff has become a major expense. And the move into electronic health records has added another layer of expense and training we had not anticipated.

How do I manage? For one, I see more patients for less reimbursement. I also work longer hours to complete chart documentation and make follow-up calls to patients. And I moonlight at the local hospital 2 days each month.

I realize I could also add cash procedures or new products or services to generate new income, but I have not yet done so.

To ensure that each patient gets my full attention, I try to make efficient use of time. I make eye contact and speak directly. I allow the patient to ask questions and do my best to give clear answers. My greatest struggle is keeping on schedule and reducing wait times.

My most important strategy? I remind myself daily why I became an ObGyn: to make a difference in the lives of my patients by providing quality care.

Dr. Matsuda reports no financial relationships relevant to this article.

CHALLENGE 8

The threat of litigation that hangs over us always

Paul Copit, MD
Dr. Copit practiced ObGyn for many years in Philadelphia before relocating to Palm Desert, Calif. He serves on the OBG Management Virtual Board of Editors.

> **"I began to view any complication that arose as a personal legal threat and became preoccupied with the measures I had to employ to lower the risk of my being sued."**
> **—Paul Copit, MD**

When I was younger, in early practice, I felt genuinely sorry for patients who developed a complication related to childbirth or surgery. I still do, of course. But with the ever-escalating volume of lawsuits against physicians, hospitals, and other entities that provide medical care, I started feeling sorry for myself, too. I began to view any complication that arose as a personal legal threat and became

preoccupied with the measures I had to employ to lower the risk of my being sued.

Many areas of the United States, such as Philadelphia, are inundated with lawyers, making for a lucrative legal industry that has a constant need for new cases. There was—and still is—a political climate and social culture that foster the perception that someone must be held responsible whenever an unfortunate event occurs. And whoever that someone turns out to be is expected to compensate the "victim."

I think there's a better way to handle these negative outcomes. If society deems that everyone who experiences such an outcome should be compensated, then *everyone* should participate, and taxpayers should shoulder the burden. The tort system is unwieldy, uncertain, and time-consuming. When it comes to compensation, lawyers are the big winners. Most of the dollars involved in insurance premiums go to support the legal system, not to help needy patients.

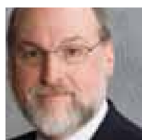
Under the scenario I propose, for example, a special board would award the money needed for the care of an infant born with cerebral palsy (which is caused by an intrapartum event in no more than 10% of cases, by the way), regardless of the clinical circumstances. No dollars would go to lawyers or legal system.

This approach would provide certainty, be vastly less expensive, and lessen or eliminate the need to practice defensive medicine.

Dr. Copit reports no financial relationships relevant to this article.

CHALLENGE 9

Creating a bias-free FDA



James A. Simon, MD, CCD, NCMP
Dr. Simon is Clinical Professor of Obstetrics and Gynecology at George Washington University and Medical Director of Women's Health & Research Consultants in Washington, DC. He serves on the OBG Management Board of Editors.

Most OBG Management readers likely believe your most pressing issues are business-related (i.e., the exorbitant cost of professional liability insurance, which was only given lip service [money to study the problem] in the new health plan). Or maybe you are thinking about poor reimbursement, often less than the Medicare allowable. (As I write this, Medicare is subject to a 21.3% cut.) Or perhaps you think your biggest challenge is the rising cost of office space, equipment, supplies, etc.

Well, I'd like to draw your attention to a more insidious and potentially harmful problem: the FDA. You might expect me to simply repeat the conclusions of a recent GAO report, which advised the FDA to improve performance, recruit better employees, modernize IT, maintain pace with scientific advances, and revise the approval process for medical devices. Or you might think that I am merely going to criticize the agency for its over-emphasis on safety to the near exclusion of new drug approvals. (Only 25 new molecular entities were approved in 2009, of which six were biologics and none were drugs in women's health.)

Instead, has it ever occurred to you that, by virtue of its very existence, the FDA has a direct conflict of interest, even as it hides behind a façade of "safety at all costs"? Given that the US government, through Medicare and Medicaid, spends more than $800 billion each year, making it the largest purchaser of health care in the United States, doesn't the FDA have a direct conflict of interest in regulating the approval of new therapies? Won't there be political pressure to stick with generics already on the market, just to save money?

> **"Has it ever occurred to you that, by virtue of its very existence, the FDA has a direct conflict of interest?"**
>
> **—James A. Simon, MD, CCD, NCMP**

You don't believe that the FDA bends to political pressure, you say? Remember that during the Bush administration ("W"), then junior Senator Hillary Clinton called the federal government—including the FDA—an "evidence-free zone"? Clinton's committee held up Dr. Lester Crawford's nomination to lead the FDA until he called for a vote (thumbs up or down) on the over-the-counter sale of Plan B. "What we are witnessing is the FDA being run not on the basis of science, but on ideology," Clinton reportedly said.

So here and now, I call for abolishment of the FDA in its current form and creation of a true public-private partnership with robust firewalls on both the public and private sides. Get the FDA out of the US government! The agency has a direct conflict of interest in regulating drugs and devices that will be paid for by the largest health-care insurance company, the US government! Failure to eliminate this conflict will leave us in the situation we have right now, and under such circumstances, can the FDA function as a truly objective advocate for the public good?

Would you allow the fox to guard the hen house?

Dr. Simon reports grant or research support from BioSante, Boehringer Ingelheim, FemmePharma, GlaxoSmithKline, Nanma/Tripharma/Trinity, Novartis, Proctor and Gamble, QuatRx Pharmaceuticals, and Teva Pharmaceutical Industries Ltd. He has served as a consultant or advisor to Allergan, Alliance for Better Bone Health, Amgen, Ascend Therapeutics, Azur Pharma, Bayer, BioSante, Boehringer Ingelheim, Concert Pharmaceuticals, Corcept Therapeutics, Depomed, Fabre-Kramer, GlaxoSmithKline, Graceway Pharmaceuticals, KV Pharmaceutical, Lipocine, Meditrina Pharmaceuticals, Merck, Merrion Pharmaceuticals, Nanma/Tripharma/Trinity, NDA Partners, Novo Nordisk, Novogyne, Pear Tree Pharmaceuticals, QuatRx Pharmaceuticals, Roche, Schering-Plough, Sciele, Solvay, Teva Pharmaceutical Industries Ltd, Ther-Rx, Warner Chilcott, and Wyeth. He has also served as a speaker for Amgen, Ascend Therapeutics, Bayer, Boehringer Ingelheim, GlaxoSmithKline, KV Pharmaceutical, Merck, Novartis, Novogyne, Sciele, Teva Pharmaceutical Industries, Ther-Rx, Warner Chilcott, and Wyeth.

CHALLENGE 10

The quest for a healthy work-life balance

Serena H. Chen, MD
Dr. Chen is Director of the Division of Reproductive Endocrinology, Department of Obstetrics and Gynecology, at St. Barnabas Medical Center in Livingston, NJ. She serves on the OBG Management Virtual Board of Editors.

As a reproductive endocrinologist in a busy IVF practice with too much weekend call, 50 employees, and research and teaching obligations, I see work-life balance as an important goal. In addition to my work, I am the mother of two teenage boys who have too much homework and too many activities; I am also the wife of a man who has an overly long commute.

I have been searching for work-life balance for most of my professional career.

People often ask me, "How do you do it?" They mean, of course, how do you maintain calm among throngs of stressed-out women on excessive doses of hormones; give lectures; write papers; go to meetings; run the practice (billing, collections, hiring, firing etc.); make sure that the 13-year-old and the 15-year-old do all their homework and get to activities on time with the requisite baked goods in hand (why is there such a frequent demand for baked goods?); see your husband often enough that he remembers your name; make time for friends; and so on. I usually just smile and say, "Well, I am never bored!"

Perhaps the trick is to find balance in the moments between the chaos—a moment in which you share a belly laugh with your husband or hang out with the kids on the couch or connect with a patient on a personal level about something other than her diagnosis or treatment.

Perhaps we should stop struggling to find something that might not exist. Perhaps it is enough to enjoy the *search* for balance, to revel in the energy and chaos now and understand that work-life balance will eventually materialize and is perhaps not three words but one: retirement.

Dr. Chen reports no financial relationships relevant to this article.

CHALLENGE 11

Caring for the indigent

Takeko Takeshige, DO
Dr. Takeshige is Physician in Charge of Ambulatory Care in the Department of Obstetrics and Gynecology at Lincoln Medical and Mental Health Center in Bronx,

New York, and Assistant Professor of Clinical Obstetrics and Gynecology at Weill Medical College of Cornell University in New York City. She serves on the OBG MANAGEMENT Virtual Board of Editors.

Serving patients in the inner city is a big challenge, even with full implementation of electronic health records. I practice in a hospital where the majority of patients are immigrants, many of them undocumented and with limited education. Compliance with medical care is a major issue. Pregnant patients often seek prenatal care late—or show up in labor without any care. It is extremely difficult to initiate evaluation and treatment of these patients, particularly in cases involving intrauterine fetal demise, preeclampsia, uncontrolled diabetes, abruptio placenta, or drug overdose, when the well-being of both mother and baby is compromised. The same holds true for women who have significant gynecologic pathology but wait as long as possible before seeking care.

Despite our best efforts and thorough medical evaluation, follow-up of these patients is difficult. They often give us inaccurate contact information. Some reside in shelters, and others relocate frequently. Explaining the importance of follow-up care to these patients is sometimes complicated by their limited language ability or education.

To meet these challenges, our hospital has:

- assigned a prenatal care coordinator to follow up patients referred for poor compliance or complicated obstetric care
- initiated classes as a means of educating patients about their medical condition and plan of care
- taken a proactive approach to gynecologic care, conducting the work-up, planning treatment, and counseling the patient in regard to medical and surgical management at the same visit
- provided on-site social services
- performed laboratory testing and imaging studies on the day of the visit to improve compliance
- updated contact information at every visit.

Our specialty faces many challenges ahead. Therefore, it is imperative that we recognize our practical needs and implement new ideas to meet these challenges. Ultimately, an optimal patient outcome depends on the patient as well as the medical team.

Dr. Takeshige reports no financial relationships relevant to this article.

CHALLENGE 12

And last, managing high-risk pregnancy

Marwan Saleh, MD
Dr. Saleh is Senior ObGyn Resident at Crouse and SUNY Upstate University Hospital in Syracuse, NY. He serves on the OBG MANAGEMENT Virtual Board of Editors.

High-risk pregnancy is an increasingly common challenge in obstetric practice, with approximately 5% to 10% of all pregnancies in the United States falling into this category.[6] In referral centers, that figure can be much higher. For example, at Crouse Hospital in Syracuse, New York, where I practice, 18.3% of deliveries in 2009 were considered high-risk, and the total number of new high-risk patients seen for a consultation at the outpatient regional perinatal center in Syracuse rose from 2,047 in 2005 to 2,963 in 2009—an increase of 44.7%!

The rising prevalence of high-risk pregnancy is of concern because perinatal mortality is twice as high in these gestations as in normal pregnancy.[7] With proper care, however, 90% to 95% of high-risk pregnancies produce healthy, viable infants.[6]

Among the variables contributing to the rise in high-risk pregnancy are advanced maternal age, morbid obesity, and an increasing prevalence of chronic maternal conditions such as heart disease, hypertension, and diabetes.

Timely identification of a high-risk pregnancy ensures that women who need medical care receive it in a specialized cen-

ter. Ideally, a patient's level of risk should be determined before pregnancy and assessed at each antenatal visit. Once a high level of risk is identified, appropriate treatment or surveillance, or both, should be initiated as soon as possible to improve maternal and fetal outcomes, and a specialist in maternal-fetal medicine should be involved in care.

Management is challenging and must be individualized, based on the patient's overall health and particular risks. Not infrequently, inpatient management is required, and ethical challenges may be involved, such as a conflict between maternal and fetal health. Therefore, extensive counseling is vital to help the patient cope with any anxiety or depression, or both, that arises.[8]

In rare cases, a woman with a complex medical condition such as severe heart failure may consult an ObGyn about her desire to conceive. When that happens, the provider's role consists *only* of counseling; the final decision about whether to proceed with childbearing lies with the patient. The same is true for women who have a lethal congenital abnormality.

In generalist practice, we can help reduce the rate of high-risk pregnancy by counseling our patients to lose weight, exercise, eat sensibly, and pay attention to other lifestyle factors under their control. We should also encourage them to plan their pregnancy and seek early and regular prenatal care. Only a few women may actually follow our advice—but that's a few less high-risk pregnancies to worry about.

Dr. Saleh reports no financial relationships relevant to this article.

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