Internists Join Obstetrics Team

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Women's and Infants Hospital is the epicenter of obstetric medicine in the United States, with the oldest and largest obstetric medicine service and a 2-year fellowship that has prepared 14 fellows to start obstetric medicine practices across North America.

"Having this department has really done only good things for the care of women in Rhode Island," said Dr. Bowling of Brown University, Providence. Founded 14 years ago, the department now has six full-time obstetric medicine physicians. The hospital's staff also includes a gastroenterologist who can practice obstetric medicine, psychiatrists with expertise in treating pregnant women, and other subspecialists with skills related to pregnancy.

Paul Gibson, M.D., a general internist who completed the obstetric medicine fellowship in Rhode Island, recently served as a liaison between obstetricians and cardiologists for a pregnant patient with Wolff-Parkinson-White syndrome, a cardiac electrical abnormality. As the woman's quiescent disease became much more active, with frequent bouts of tachycardia, "I quarterbacked her pregnancy," said Dr. Gibson of the University of Calgary (Alta.).

He was attracted to obstetric medicine because it added an area of expertise to his practice as a general internist and because of personal experience—his wife developed hypertension in all three of her pregnancies. He spends much of his time teaching and doing research on medical complications in pregnancy.

There always has been a need for medical specialists who are unafraid to treat pregnant women, Dr. Powrie added. Few internal medicine programs formally train residents to manage health problems in pregnant women.

Out of the hundreds of patients he saw during his own internal medicine training, he vividly recalls the face of the one pregnant patient he treated, and the fear that he felt in prescribing her medicine, worrying that it might harm her fetus. That experience is typical of internists, he said.

Dr. Bowling agreed: "Once a patient becomes pregnant, many internists don't want to take care of them."

In the past, obstetricians might refer a pregnant patient with diabetes to an endocrinologist, and a patient with renal problems to a nephrologist, if they could find willing subspecialists. Obstetric medicine offers one-stop consultations.

Since the country's second division of obstetric medicine opened at Saint Peter's University Hospital in New Brunswick, N.J., obstetric medicine services have spread to Denver; Davis, Calif.; Buffalo, N.Y.; Minnesota; and Calgary, Alta., among other places. Obstetric medicine fellowships have sprung up in Toronto and Vancouver, B.C. North America lags behind Australia, New Zealand, and Great Britain in obstetric medicine.

An obstetric medicine fellow can 'quarterback' the pregnancies of women with chronic medical conditions.

DR. GIBSON

Although the number of obstetric medicine specialists still is small, "We're growing exponentially," said Dr. Powrie, also of Brown University.

He likened the field's growth to that of geriatrics. At first, physicians managed plenty of elderly patients but they had no particular training in this area, and just kind of muddled through care. Interest in the area grew and developed into a subspecialty. "Now you can't find a major medical center that doesn't have a geriatrics program," he noted.

Some obstetric medicine practitioners would like to see their field become a subspecialty, but Dr. Powrie doesn't think that's necessary. He would be happy if every major center that teaches internal medicine made sure that pregnant women with medical problems get the care they need. "So that when obstetricians call on internists, they don't get a blank, empathetic stare," which is what too often happens, he said.

As a medical resident, Jeffrey Pickard, M.D., saw two consecutive patients who developed postpartum thyroid disease. That prompted him to study obstetric medicine as part of a self-constructed fellowship. Today, he is a general internist and teaches residents at Presbyterian/St. Luke's Hospital, Denver. He consults a half-day each week in obstetric medicine at Denver Health Medical Center, which serves a largely uninsured population. There he sees more than the usual caseload of hypertension, diabetes, and other medical problems in pregnancy. One patient who had just returned from abroad needed treatment for malaria. Another recent patient had a pituitary adenoma complicating her pregnancy.

Lois Jovanovic, M.D., an endocrinologist, designed her own fellowship in diabetes and pregnancy years ago, and had to justify her plan to officials at Cornell University, New York. "I did this as a pioneer," but now the existence of the Rhode Island program makes it easier for others to follow in their footsteps, said Dr. Jovanovic, of the University of Southern California, Los Angeles.

She is director of a Santa Barbara diabetes research institute that focuses on metabolic disorders in pregnancy, and she also teaches residents and sees patients at the county's diabetes and pregnancy clinic.

Dr. Jovanovic said that many obstetric medicine specialists are happy to have medical colleagues join them for a 2-week apprenticeship if they have their own funding. "It gets them a lot more confident" in treating pregnant women, she said.

Obstetric medicine is not meant to compete with maternal-fetal medicine, Dr. Powrie explained. Obstetric medicine specialists do not deliver babies, but they are better diagnosticians of medical problems in pregnancy, he said.

Dr. Gibson said his colleagues in maternal-fetal medicine and in perinatology were big supporters of his training in the obstetric medicine fellowship. "They're too busy doing prenatal diagnosis and fetal care" to manage medical problems in pregnancy, he said.

Dr. Bowling said it's not uncommon to comanage a pregnant patient with both obstetric medicine and maternal-fetal medicine colleagues. For a patient with chronic hypertension, she might consult the former to prevent development of preeclampsia and consult the latter to advise her on the best time for delivery if an ultrasound shows intrauterine growth restriction, which occurs more frequently in women with chronic hypertension. "I've never looked at them as competing departments. I've looked at them as complementary, and have utilized them that way," she said.

Nadine Sauve, M.D., another general internist who completed the Rhode Island obstetric medicine fellowship, said she tries to schedule appointments for patients who are being comanaged by a maternal-fetal medicine specialist so that she can see them on the same day.

She spends 10-15 hours per week on obstetric medicine in one to three clinics, shared with another obstetric medicine specialist. A third soon will join them at the University of Sherbrooke (Que.) medical facilities, where Dr. Sauve started the obstetric medicine service.

Nearby Montreal claims four obstetric medicine specialists. "It is a growing specialty," Dr. Sauve said. "There is a real need in any center doing deliveries, especially in tertiary care centers."

With fewer than 2,000 maternal-fetal medicine specialists in the United States, and most of them concentrated in urban centers, their numbers are insufficient to meet the medical needs of pregnant women, Dr. Powrie said.

By the time maternal-fetal medicine specialists are brought into a case, most of the issues related to the effects of medical treatments or medications are finished, he added. "If you show up 18 weeks pregnant having stopped or continued medications, it almost doesn't matter anymore," because most effects on the pregnancy will have occurred.

Obstetric medicine specialists usually see patients much earlier in pregnancy and can help manage medical illnesses in ways that won't harm the fetus, he explained.

Outreach to maternal-fetal medicine specialists, anesthesiologists, and others has helped build working relationships. The North American Society of Obstetric Medicine presents a scientific forum on the topic at each annual meeting of the Society of Maternal-Fetal Medicine. ■

Homeopathy Has Only Placebo and Context Effects, Study Says

BY NANCY WALSH

New York Bureau

The clinical effects that many alternative practitioners and patients report for homeopathy are placebo and context effects, and further attempts to scientifically justify the 200-year-old system should now be abandoned, according to the authors of a new analysis.

A group of European investigators led by Aijing Shang, Ph.D., of the University of Berne (Switzerland), identified 110 placebo-controlled trials of homeopathy and matched the trials with 110 conventional medicine trials that studied similar disorders and used similar outcome measures. The average sample size was about 65 participants for both the homeopathy studies and the conventional trials.

The studies were parallel group in design and were placebo controlled, with random or quasi-random assignment of subjects.

The authors postulated that the effects of homeopathy could be explained by methodologic deficits and reporting bias, and that the effects of conventional medicine treatments could not be explained by these factors.

Initial analyses suggested that both homeopathy and allopathy showed beneficial effects, but a meta-regression of those trials considered to be of higher methodologic quality suggested that bias played a larger part in the homeopathy trials. The authors wrote, "When analyses were restricted to large trials of higher quality, there was no convincing evidence that homeopathy was superior to placebo, whereas for conventional medicine an important effect remained" (Lancet 2005;366:726-32).

But the authors went on to say that the clinical effects of homeopathy extend beyond the specific effects that the studies were designed to detect. "Context effects," they noted, can be a significant aspect of therapeutic interventions, with the relationship between the patient and homeopath being a particularly important component. "Practitioners of homeopathy can form powerful alliances with their patients, because patients and caregivers commonly share strong beliefs about the treatment's effects, and other cultural beliefs, which might be both empowering and restorative."

They recommended that further research focus on these context effects and the potential place of homeopathy in the overall health care system, rather than on additional placebo-controlled trials and metaanalyses.

An unsigned editorial that accompanied the report echoed that sentiment. The Lancet editors wrote, "Surely the time has passed for selective analyses, biased reports, or further investment in research to perpetuate the homeopathy versus allopathy debate. Now doctors need to be bold and honest with their patients about homeopathy's lack of benefit, and with themselves about the failings of modern medicine to address patients' needs for personalized care." ■