



# Ob.Gyn. News


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VOL. 44, No. 9

The Leading Independent Newspaper for the Obstetrician/Gynecologist—Since 1966

JULY 2009



COURTESY LAKELAND REGIONAL MEDICAL CENTER

Dr. Christopher C. Swain's laborist model calls for laborists to evaluate all unscheduled patients arriving in obstetrical triage.

## Laborist Programs Manage Ob. Triage

BY MARY ELLEN SCHNEIDER

When the laborist concept first emerged in 2003, the model called for a small group of physicians working 10- to 14-hour shifts to cover the labor and delivery suite in the hospital.

Today, that model still exists, but so do many others that have been designed to fit the needs of individual hospitals.

Dr. Christopher C. Swain is the founder and president of Ob Hospitalist Group Inc., a Greenville, S.C.-based company that specializes in developing and staffing laborist, or obstetrical hospitalist, programs. He has tried to craft a model for laborist care that responds to some of the concerns physicians and patients have voiced over the last few years.

With his approach, the laborist cares for unassigned patients in labor and unassigned patients in need of emergent gynecologic surgery or hospital admission.

The laborists are also on hand to manage labor until a patient's regular physician arrives.

One of the key elements of this model is that the laborist evaluates all of the unscheduled patients arriving in the obstetrical triage area. Currently, most pregnant women who come into the emergency department are not examined by a physician, but instead are monitored by a nurse who consults with the patient's regular ob.gyn. by phone.

That situation offers "a lower level of care for a higher level of risk patient," Dr. Swain said.

The program designed by Dr. Swain's group benefits private physicians in the community because it is built around those tasks that most ob.gyns. would prefer not to do, such as dealing with unassigned patients, he said.

Because the program includes care of women in the hospital's obstetrical triage area, this type of laborist program is generally able to pay for itself, unlike

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## CA 125 Testing Not Helpful After Ovarian Cancer

Study found no advantage at follow-up.

BY MARY JO M. DALES

ORLANDO — Routine measurements of CA 125 conferred no survival advantage in the follow-up of ovarian cancer patients, according to the results of a large, double-blind, prospective, placebo-controlled study presented at the annual meeting of the American Society of Clinical Oncology.

CA 125 screening is essential for the diagnosis of ovarian cancer at a stage that is potentially curable. But when used as a monitoring tool for early detection of recurrent cancer in patients in remission, measuring CA 125 actually causes women

to undergo more cycles of chemotherapy with no improvement in their survival and a decline in their quality of life, said Dr. Gordon J. Rustin, who reported the data.

This is level 1 evidence that women need not continue to have quarterly measures of CA 125 outside the realm of a clinical trial, commented the invited discussant for the paper, Dr. Beth Y. Karlan, who is professor of obstetrics and gynecology at the University of California, Los Angeles.

The importance of this study cannot be overemphasized, Dr. Eric P. Winer said during a press

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## Health Reform Fate Could Hang on Public Plan Option

BY MARY ELLEN SCHNEIDER

such a plan is one of the major sticking points.

The chances of passing health reform legislation this year could depend on whether lawmakers can resolve their differences over the public insurance plan option.

The decision on whether to include a government-sponsored health plan that would compete against private insurance has become a major wedge in the health care debate, according to observers. And how much to pay physicians under

"It could wind up bringing down the whole agenda," said Grace-Marie Turner, president of the Galen Institute, a non-profit research organization that advocates for free market ideas in health care.

Ms. Turner, who opposes the public plan option, said that although Democrats have control of the presidency and both chambers of Congress, there is disagreement within their own ranks, with many moderate and

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## Less Screening Can Cut Costs

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conference at the meeting. These findings can potentially improve the quality of life for all women with stages III and IV ovarian cancer, as well as result in substantial economic savings.

Dr. Rustin of Mount Vernon Cancer Centre, Middlesex, England, presented the data on behalf of the MRC OV05 (Medical Research Council OV05) and EORTC 55955 (European Organisation for Research and Treatment of Cancer 55955) trial investigators. The trial registered 1,442 patients at 59 sites in 10 countries and was designed to determine whether there were benefits from early treatment of recurrent cancer based on a confirmed elevation of CA 125 levels, compared with delaying treatment until clinical symptoms were noted.

Women who had ovarian cancer that was in complete clinical remission after first-line platinum-based chemotherapy and a normal CA 125 value were registered in the study. Most were 6 months post diagnosis and had advanced FIGO stage III or IV cancers and serous histology, the type of ovarian cancer expected to relapse. CA 125 was measured every 3 months in all of the women. Patients and investigators were blinded to the test results.

CA 125 levels exceeded twice the up-

per limit of normal in 527 patients, who were then randomized to either immediate treatment or to delayed therapy in which they continued to have blinded CA 125 measurements but did not begin treatment until they had clinical or symptomatic recurrences. Patients in both arms were treated according to standard local practice. The other 915 patients have not been randomized because they had no CA 125 rise and no relapse (48%); they relapsed with or without CA 125 (30%); they died (6%); or they withdrew from the study (14%); 2% were not randomized for other reasons.

Patients in the early treatment arm of the study started their regimens 0.8 months after randomization, compared with 5.6 months in the women whose treatment was delayed until they were symptomatic. In the early treatment arm, 68% of women went on to third-line chemotherapy, compared with 56% of women in the delayed-treatment arm. Those in the early treatment arm had relapses, on average, 4.6 months earlier than did the women in the delayed-treatment arm, an indication that early treatment does not offer longer remissions.

Also, study participants completed quality of life surveys every 3 months. Those in the early treatment arm had

earlier declines in quality of life by 3 months. Early chemotherapy not only failed to improve quality of life, it made quality of life worse.

The data were frozen at 56.9 months of follow-up with “absolutely no difference in survival,” Dr. Rustin said. The trial lasted as long as it did because of overall good survival. The study was designed to detect a 10% improvement in



**Women can defer testing until they have symptoms, as long as they know they must return at the first sign of symptoms.**

DR. RUSTIN

2-year overall survival in the immediate-treatment arm with at least 85% power and at a 5% significance level.

These findings mean that women can be offered informed choices about CA 125 monitoring after first-line chemotherapy, Dr. Rustin said. They can opt to defer testing until they develop symptoms, as long as they recognize the importance of returning at the first sign of symptoms, and feel assured that they will have the same outcomes as women who continue CA 125 monitoring.

In the United Kingdom, CA 125 tests are available “in the local chemist shop,

and women are almost addicted to getting them,” he said during an interview. Many say they feel as though they are living from one test to the next. Now they need not have the anxiety that accompanies each routine monitoring test and can rely on clinical symptoms. As a result, these women will have far fewer courses of toxic chemotherapy and the same chance of survival.

Dr. Karlan said the findings will have a major impact on the cost of health care by decreasing the use of resources not shown to improve overall survival and quality of life. There will be less frequent assays, fewer follow-up tests, and improved quality of life.

It will take some time for patients to feel comfortable with this change in approach, she acknowledged, but the message to not worry about the next CA 125 value should be a positive one for them. “So many live from one CA 125 measure to the next, and any small bumps in their levels can cause them great anxiety and distress.”

Dr. Karlan commented that the study, although very well done, also has some weaknesses. There was a lack of prescribed secondary- or tertiary-line chemotherapy, and the type of surgery was not considered—optimal versus sub-optimal and secondary cytoreduction. New drugs have come along.

The investigators said they had no relevant conflicts of interest in regard to this study. ■

## Laborists Ease Call Burden

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traditional models that rely on lower revenue from delivery fees. Dr. Swain estimates that the program is revenue neutral in hospitals that have at least 1,800 deliveries a year, provided the hospital is billing and coding efficiently.

In Taunton, Mass., the executives at Morton Hospital and Medical Center sought to hire laborists to ease the call burden on their obstetrical service. They hired two to rotate working weekend shifts from Friday night to Monday morning. Though the program is costly for the small community hospital with about 600 deliveries a year, it was the only way they could keep their obstetrics program open, said Jeanne Tierney, director of physician services at Morton Hospital.

The program has been in place for about 2 years and so far it is working well, she said. The two laborists have provided stability to the program and allowed the obstetrical service to increase.

These are but two laborist models; there are many others. In fact, some laborists are known as “nocturnists” because they work only night shifts. The nocturnist model is a good modification of the traditional laborist approach, said Dr. Louis Weinstein, who developed the laborist model and is chair of the department of obstetrics and gynecology at Jefferson Medical College in Philadelphia.

But some of the newer models do little to improve safety, he said. Under the original laborist model outlined by Dr. Weinstein in 2003, four laborists would work a maximum of 42 hours each week, with

two working 14-hour shifts, and two others working 10- and 12-hour shifts (Am. J. Obstet. Gynecol. 2003;188:310-12).

But today, the most common model appears to be laborists who work 24-hour shifts covering the entire hospital. This type of arrangement leads to fatigue and eliminates the ability for the ob.gyn. to act as part of a rapid response team, he said.

Dr. Weinstein said his best guess is that the field will only increase in popularity over time. Young physicians and dual-career couples are drawn to it because of the controlled schedule, he said. “Our sense is that it’s rapidly growing,” he said. “But it’s growing from infancy. If you doubled it overnight, it would still only be a small number of hospitals.” There is no national clearinghouse of information about laborists or laborist programs.

There are many factors pushing the rise of laborist programs, said Janet Meyers, assistant vice president of women’s and children’s clinical services at HCA (Hospital Corporation of America) in Nashville, Tenn., which has laborist programs in about 10% of its more than 100 hospitals. Declining reimbursement is driving physicians to see a higher volume of patients in the office, while at the same time there are a higher number of uninsured patients who are coming to the hospital with obstetric needs. These factors, coupled with the decreasing willingness of ob.gyns. to take frequent call and the increasing risk of malpractice suits, are all propelling the field forward. ■

## Pondering the Public Plan

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conservative Democrats saying they cannot support a public plan.

The physician community is also wrestling with this issue.

The idea of a public plan was debated extensively at the recent policy-making meeting of the American Medical Association, and delegates there ended up passing policy that supports “health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.”

The AMA leadership has shied away from coming out for or against the public plan option. But the organization has stated publicly that it does not support any plan that would force physicians to participate in a public plan or that would pay physicians based on Medicare rates.

The AMA has said, however, that it will consider some of the variations on a public plan that are being discussed in Congress now, such as a federally chartered co-op health plan.

Part of the problem with evaluating the public plan option is that there isn’t just one.

There are a number of health reform proposals circulating in both the House and the Senate, some of which include a government-run or quasi-government-run option to compete with private insurance.

The purest form of a so-called public plan would be one that is something

like Medicare, where federal dollars, not just premiums, are used to support it, said Kathleen Stoll, health policy director at Families USA, which supports the general idea of a public plan but hasn’t thrown its support to a particular proposal.

But many lawmakers and analysts have said this design would give the public plan an advantage over private insurance products and cause private payers to leave the market.

A proposal being put forward by leaders in the House would create a public plan on the same footing as other insurance plans.

For example, public and private plans alike would have to adhere to the same benefit requirements and insurance market reforms and would have to be financially self-sustaining based on premiums.

This proposal would not require participation by physicians but initially would use payment rates similar to those of Medicare. Rates would be unlinked from Medicare rates over time as other payment mechanisms were developed.

In the Senate, an approach getting a lot of attention is to create not a public plan but rather a federally chartered, nonprofit cooperative plan, Ms. Stoll said.

This proposal is seen by many as a compromise between a government-run plan and no public plan at all, she noted. ■