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Cancer Education: A Catalyst for Dialogue and Action

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"Nobody talks about cancer. People are afraid. It is time to talk. I'm not going to stop talking,"

Words of wisdom shared by a
cancer education course participant

A comprehensive curriculum, "*Cancer Education for Community Health Aides in Alaska*," was inspired by the desires of Alaska's unique primary care providers, Community Health Aides and Community Health Practitioners, to learn more about cancer in order to provide better care for the people in their communities. Community Health Aides and Community Health Practitioners (CHA/Ps) are the village-based primary providers of basic, emergency, and preventive health care in Alaska's 178 small, rural villages. CHA/Ps receive only two hours of cancer education during their 15 week basic training curriculum.

Cancer is now the leading cause of death among Alaska Native people, although it was considered a rare disease as recently as the 1950s. Cancer rates for Alaska Native people are among the highest of any ethnic group in the US, and rates are increasing. Cancer death rates for Alaska Native people (1998 - 2002) are 30% higher than the US White population, and cancer survival rates are 17% lower than for US White people. Data from the Alaska Native Tumor Registry, in existence since 1969, confirm an increase in all cancers. The curriculum was developed with funds from the National Cancer Institute and other cancer organizations.

This project invited CHA/Ps to share their ideas as part of a self-assessment cancer education survey in 2002 and again in 2005. The two-page, paper and pencil needs assessment was developed in collaboration with CHAP Directors and

Instructors, and the CHA/Ps themselves. A total of 402 responses were received from 477 CHA/Ps, for an 84% return rate. The results from this survey were published as "Cancer Education for Community Health Aides/Practitioners (CHA/Ps) in Alaska" in the *Journal of Cancer Education* (2005) 20 (2) 85-88. The survey addressed how comfortable CHA/Ps were with their knowledge of cancer-related words and talking with their patients about various aspects of cancer. For many CHA/Ps, their experience was that everyone diagnosed with cancer dies from their disease. Fear, embarrassment, stigma, pain, grief, lack of knowledge, and poor understanding of medical terms affected CHA/Ps' comfort with talking about cancer. As shown in Table 1, there was considerable variability in comfort with discussing cancer topics on the 2002 survey. Less than half of survey respondents indicated they were comfortable with four of the eight topics.

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Table 1. How comfortable are you talking with patients, family, and others about:

| Topics | 2002 Survey | 2005 Survey |
|---|-------------|-------------|
| Cancer Risk factors | 68.3 % | 77 % |
| Cancer Screening | 69.6 | 74.6 |
| Cancer Diagnosis | 38.7 | 44.2 |
| Cancer Treatment/Side Effects | 48.4 | 55.4 |
| Cancer Pain | 35.5 | 49.8 |
| Loss and Grief | 34.8 | 44.7 |
| Surviving Cancer | 57.5 | 69.7 |
| Providing Care and Support for People with Cancer | 61.6 | 70.9 |

A second survey was conducted in 2005 with a 65% (293/454) response rate. The survey included the same questions as the 2002 survey plus additional items to understand CHA/P learning preferences. CHA/Ps shared the importance of stories, laughter, and the arts as helpful ways to facilitate their learning. Three manuscripts communicate the richness of CHA/Ps' words, adding new dimensions of understanding: "Healing Hearts: Laughter and Learning" *Journal of Cancer Education* (2006)21(2):104-107; "Engaging Adult Learners through the Arts: InterACTIVE Cancer Education" *International Forum of Teaching and Studies* (2007)3(2):17-22; and "Story: The Heartbeat of Learning" *Convergence* (2007)39(4):81-88.

Providing a basic cancer education course

Materials developed for the course included a resource manual "Path to Understanding Cancer," videos/DVDs, CD-ROMS, booklets, and a theatre script. The manual consists of multiple independent modules: 1) Cancer Basics and Cancer Among Alaska Native People; 2) Cancer Diagnosis; 3) Cancer Treatment; 4) Pain Assessment and Management; 5) Cancer Risk Factors; 5a) Cancer and Genetics; 6) Cancer Screening Exams and Early Detection; 7) Loss, Grief, and End-of-Life Comfort Care; and 8) Self Care, Stress, and Burnout issues related to cancer care. Additional sections include a glossary of cancer terms and helpful resources. A variety of interactive, culturally respectful learning activities including games and crafts were developed to facilitate learning.

During the five-year project, the week-long, face-to-face course, also called "Path to Understanding Cancer," was provided 21 times for 168 CHA/Ps from 94 different Alaska communities. Written evaluations were completed by 93% (157/168) of participants, with 100% recommending the course for all community health care providers as well as other interested people. In addition to an increase in cancer knowledge and understanding, participants identified positive ways the course would impact their behavior: 89% (139/157) wrote about healthy ways they intended to take better care of themselves; 90% (142/157) wrote about ways they now felt different about cancer; and 97% (153/157) wrote about how

this course would help them improve care of their patients. Select questions from the written end-of-course evaluation and comments are shared below.

Has this course caused you to change your behavior? N=157

| Yes | No | Maybe | Blank |
|-----------|---------|--------|--------|
| 89% (139) | 8% (13) | 1% (2) | 2% (3) |

- Eat more fruits/vegetables and drink more water. Practice more moments of peacefulness.
- Eat healthier for myself and my kids.
- Do family exercising together.
- It has really made me think about quitting smoking; my sister who is pregnant wants to quit; I think I may ask her to try quitting together.
- I actually cut way back on smoking! And for me that is a big improvement.
- I scheduled a colonoscopy. I've been putting it off.

Do you feel differently about cancer after taking this course? N=157

| Yes | No | Blank |
|-----------|---------|--------|
| 90% (142) | 8% (13) | 2% (2) |

- Demystify cancer and Treatment.
- It's not contagious; it's not a death sentence.
- As a cancer survivor, I did not know how much resources and support were out there.
- I'm more comfortable saying the word cancer.
- I thought that having cancer was a death sentence right from the start; now I know better.
- It's still scary, but not the end of the world.
- Hearing how other CHA/Ps get more comfortable with their cancer patients and how I can get comfortable myself with our cancer patients.
- I have a much more positive outlook on cancer therapy and clinical trial information.

How will this affect the way you do your job? N=157

| | |
|----------------------------|---------------------------------|
| 97% (153) wrote a response | 3% (4) left this question blank |
|----------------------------|---------------------------------|

- Able to look at them as patients instead of people [who have] cancer.
- Let me learn how to talk to cancer patients and how we as care providers can help the patients more.
- I understand what it is, won't feel uncomfortable around people who have cancer.
- Can talk about it now. I feel less afraid of cancer,

- knowing the different types.
- When I read lab reports I know what they are talking about.
- I have more information to pass on to patients and helps me to deal with my stresses.
- I'll now encourage patients to have their screenings done and explain why they are so important.
- More encouragement to patients who don't want to keep their appointments.
- More confidence about the talks that I have with my patients. Do more patient education.
- Be able to find more resources for patients, get patients in for screenings.

Approximately six months after the course, telephone outreach efforts were initiated for a total of 144 participants who had attended cancer education courses (November 2001 - July 2004). This evaluation component provided an opportunity for project team members to understand the impact of the course over time, after participants had returned to their communities and jobs. Of these 144 course participants, 103 (71.5%) completed a telephone interview. The following summarizes responses to select questions asked during the telephone interviews.

How would you rate your comfort with your knowledge of cancer since taking the course? N=103

| Uncomfortable | Ok | Comfortable | Very Comfortable | Not Specified |
|---------------|-----------|-------------|------------------|---------------|
| 0 | 7.2 % (8) | 61.2 % (63) | 25.2 % (26) | 5.8 % (6) |

Since taking the course do you do anything differently in the way you take care of patients? N=103

| Yes | No | N/A: Not Seeing Patients | Not Specified | Not Asked |
|---------|-----------|--------------------------|---------------|-----------|
| 68 (70) | 14.6 (15) | 9.7% (10) | 6.8 % (7) | 1 % (1) |

Seventy respondents indicated they had made one or more changes in patient care practices. The most frequently cited changes included one or both of the following:

- increased patient education (47%)
- increased cancer screening for all aspects of patient encounters (history, exam, consultation, and referral for cancer screening) (37.1%)

Four of the 15 respondents who said "No" to having made post-course changes in patient care practices and who were providing patient care services at the time of interview indicated that prior to the course they had been and continued to provide cancer prevention, cancer risk reduction, and other

cancer patient education and/or cancer screening services within the scope of their practice.

Since taking the course, do you do anything differently in the way you take care of yourself? N=103

| Yes | No | Not Specified | Not Asked |
|-----------|-------------|---------------|-----------|
| 67 % (69) | 29.1 % (30) | 3.9 % (4) | 0 |

For the 69 respondents who indicated they had made changes in post-course self-health practices, the most frequently reported changes included one or more of the following:

- dietary changes; e.g., eating increased amounts of fruits and vegetables, cooking with less saturated fat, and dietary changes resulting in weight loss (30.4%)
- regular exercise, such as walking daily (14.5%)
- increased cancer screening, including self-exams as well as clinical screening exams and procedures, such as mammogram and colorectal screening (26.1%)

Notably, 12 (17.4%) respondents had successfully quit using tobacco after participating in the course. Four other respondents had cut down on smoking; three others reported they wanted to quit; and two respondents who had quit after the course reported at time of interview that they were using tobacco, but were now planning to quit again.

Of the 30 respondents who responded "No" to post-course changes in self-care practices, seven stated that prior to the course they already engaged in healthy lifestyle practices, including one or more of the following: healthy nutrition, exercise, no tobacco use, and regular cancer screening, and were maintaining those practices.

Since taking the course, do you do anything differently in the way you take care of family? N=103

| Yes | No | N/A: No other family members | Not Specified | Not Asked |
|-------------|-------------|------------------------------|---------------|-----------|
| 65.1 % (67) | 28.2 % (29) | 1 % (1) | 1 % (5) | 1 % (1) |

Of 67 respondents who reported post-course changes in family health care practices, the most frequently cited changes included one or more of these categories:

- cancer education for family members (49.1%)
- healthy dietary changes (47.8%)
- regular exercise (6 %)
- family member had cancer screening (15%)
- family member stopped using tobacco (12%)

Movies to support cancer understanding

In collaboration with CHA/Ps and the people in their

communities, four 30-minute cancer education movies were developed to share cancer knowledge and understanding and decrease cancer related fear. The movies are available through Native CIRCLE, a cancer resource center for American Indian and Alaska Native peoples (nativecircle@mayo.edu or (877) 372-1617). Additionally, the movies can be viewed via video streaming at the Arctic Health website <http://www.artichealth.org/anthcvideos.php>.

“*The Story Basket: Weaving Breast Health into Our Lives*” describes three important choices women can make to find breast cancer early, when it can be best treated. We see a clinical breast exam, a mammogram, and a self-breast exam demonstrating the vertical breast exam pattern. A breast health booklet extends learning.

- It had a natural feel that included all generations. The movie embraces Alaska Native people’s cultural values of community, family, spirituality, storytelling, humor, and living traditions.
- Made mammograms less scary.
- Wow, by seeing a real person doing a breast exam it made it a lot easier to do my own exam. I can’t wait to share this with my sister.

“*Understanding: Stepping into the Light*” is a call to action. It is an invitation to come together to engage in meaningful conversations to illuminate possibilities and choice. Cancer among Alaska Native peoples is often not talked about. The play, which was adapted for television to reach rural, Alaska Native communities, enters the silence, making audible the experience of cancer. An all-Alaska Native cast explores many challenging and sensitive cancer-related themes, including emotions associated with a diagnosis, treatment, pain, and the end of life. Healthy lifestyle choices and recommended cancer screening exams are voiced. We hear Alaska Native people’s stories of hope and resilience.

- Great for all ages.
- Offers one thing we do not think about with a cancer diagnosis: hope.
- Speaks to all of us. Touches universal themes that are not culture specific.
- The personal stories connect you.
- The movie gives courage and support to people with cancer and their families. It also expands that it is OK to be afraid.
- The terrible part of not talking about it because of fear, shame; take every opportunity to talk about cancer in a normal way.

“*Awakening Choices: Colon Health, Our Stories*” shares the stories of Alaska Native people talking about colorectal cancer and healthy lifestyle choices. Early detection through colorectal screening is highlighted. Stories of wellness and the

gift of life are brought out through the beauty of Alaska Native people’s songs, dances, and culture. An activity guide and colon health booklet accompany the movie to assist with community cancer education.

- Inspired, motivated, comfortable, relieved, encouraged, hopeful.
- I felt a part of the people in the movie — same fears, same relief.
- I want to go and get colon screening now.

“*Staying Strong, Staying Healthy: Alaska Native Men Speak Out About Cancer*” was developed in response to the many requests for a movie specifically for Alaska Native men. Alaska Native men whose lives have been affected by prostate, colorectal, and testicular cancer tell their inspiring stories. Men speak out about ways to prevent cancer, ways to decrease cancer risk, and ways to find and treat cancer early. Part two of the movie shows a clinical testicular exam and a young man doing a self-testicular exam.

- This should be seen by all men.
- It felt good to see our Native men speak out and act. It helps all of us to understand.
- I felt encouraged and braver to get checked.

Sharing Stories through Theatre

“*Understanding*,” a 45-minute theatre script, weaves people’s stories, experiences, common questions, and concerns related to cancer into the lives of five characters. Between March 2002 and November 2005, “*Understanding*” was performed and evaluated 25 times as a staged performance or a Readers’ Theatre. The script was read as part of cancer education courses both face-to-face and over the telephone as well as at community gatherings, school presentations, and a radio show. Approximately 82% (606/738) of people, including both audience and readers, completed a written evaluation. Of those people who completed an evaluation, 95% of people felt more comfortable talking about cancer, 72% of people shared a variety of information about what they learned, and 71% of American Indian and Alaska Native people wrote healthy ways they intended to take better care of their health after seeing the play. Most commonly cited healthy choices included eating more fruits and vegetables, exercising more, quitting tobacco use, and having recommended screening exams. “Using Theatre to Promote Cancer Education in Alaska” was published in the *Journal of Cancer Education* (2005)20(1):45-48.

- Now I have more of an understanding of what the patient endures. Now I can better communicate with patients and their families.
- I learned that we are not alone and we have support when we need it. I have changed how I feel about cancer now.

-
- My sister died of denial of cancer. I wish she could have seen this 10 years ago.
 - I learned I'm afraid! I still have to live. I don't want to get my mass diagnosed. Thanks for letting me know everyone is afraid. I still haven't faced it. After seeing this play, I want to keep going to the doctor. Quit putting it off.
 - I can see how this play can break down barriers to discussion around cancer. My favorite part was the individual stories. Interweaving common experiences through single word/short phrase segments.
 - I learned the power of the spoken word.

This project worked with Community Health Aides and

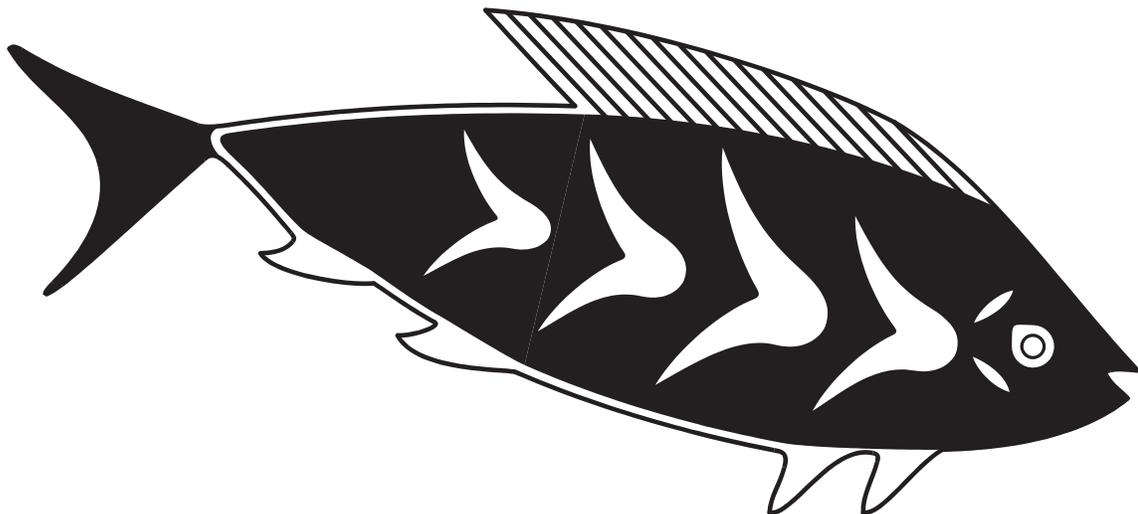
Community Health Practitioners in Alaska to design, develop, and provide culturally respectful cancer education courses and materials. Alaska Native Peoples' core values of story, humor, and respect for life's interconnections through spirituality, family, community, and elder wisdom provided the foundation for cancer education.

Thank you to the many people who shared their knowledge, understanding, and experiences as we journeyed together to make a difference in the story of cancer among Alaska Native people. For further information contact Melany Cueva by telephone at (907) 729-2441; e-mail mcueva@anmc.org; or write to ANTHC-CHAP, 4000 Ambassador Drive, Anchorage, Alaska 99508.

The 13th Annual Elders Issue

The May 2008 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the thirteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and

their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.



Frequently Asked Questions about Infant Feeding Choice

Stephanie Klepacki, CRS Project Manager/Lead Analyst, Albuquerque, New Mexico

Background Information

Why collect these data? Because they are used in the clinical performance measure called Breastfeeding Rates that is reported in the RPMS Clinical Reporting System (CRS). While this measure is currently not a GPRA measure (one reported to Congress and OMB) it is used in support of the GPRA measure Childhood Weight Control with the goal of lowering the incidence of childhood obesity in the IHS patient population. Additionally, facilities can use these data to track infant feeding patterns and breastfeeding rates within their own patient population.

Research indicates that children who were breastfed have lower incidences of overweight or obesity. For additional information, please see the review the article in the March 2007 issue of *The IHS Primary Care Provider* at <http://www.ihs.gov/PublicInfo/Publications/HealthProvider/issues/PROV0307.pdf>.

How are these data used? They are used in the CRS Breastfeeding Rates topic in several measures that report:

1. How many patients approximately two months through one year of age were ever screened for infant feeding choice.
2. How many patients were screened at the approximate ages of 2 months, 6 months, 9 months, and 1 year.
3. How many patients who were screened were either exclusively or mostly breastfed at those age ranges.

Users may run the CRS Selected Measures (Local) Reports to view all of the breastfeeding performance measures. The report also provides the option to include a list of patients and identifies the dates and ages they were screened and their infant feeding choice values. Click the following link to learn how to run this report in CRS, starting on page 206 (as numbered in the document itself, not in Adobe): http://www.ihs.gov/misc/links_gateway/download.cfm?doc_id=10716&app_dir_id=4&doc_file=bgp_070u.pdf.

Are Infant Feeding Choice data the same as the data included in the Birth Measurements section of the EHR and with the PIF (Infant Feeding Patient Data) mnemonic in PCC? No, they are different. The information collected in these sections are intended for one-time collection of birth weight,

birth order, age when formula was started, age when breastfeeding was stopped, and age when solid foods were started, all linking to the mother/guardian. Shown below is a screen shot of this section from EHR. While this information is important, *none of it is used in the logic for the CRS Breastfeeding Rates measure; only the Infant Feeding Choice data are used.*

Update Birth Measurements

To enter Birth Weight in lbs and ozs, enter two values separated by a space. Also you can enter K after the value for kilograms (kg), and likewise for grams enter G after the value.

Examples: 7 2 for 7 lbs 2 ozs
3.2K for 3.2 kilograms
3200G for 3200 grams

Birth Weight (lbs oz)

Birth Order

Feeding Choices must contain a number and then either a D for Days, W for Weeks, M for Months or Y for years.

Formula Started

Breast Feeding Stopped

Solids Started

Mother or Guardian ...

OK

Cancel

What are the definitions for the Infant Feeding Choices? The definitions are shown below and are the same definitions used in both EHR and PCC.

- *Exclusive Breastfeeding:* Formula supplementing less than three times per week (<3x per week)
- *Mostly Breastfeeding:* Formula supplementing three or more times per week (≥3x per week) but otherwise mostly breastfeeding
- *½ Breastfeeding, ½ Formula Feeding:* Half the time breastfeeding, half the time formula feeding
- *Mostly Formula:* The baby is mostly formula fed, but breastfeeds at least once a week
- *Formula Only:* Baby receives only formula

Who should be collecting this information and how often? It depends on how your facility is set up, but any provider can collect this information. At a minimum, all providers in Well Child and Pediatric clinics should be collecting this

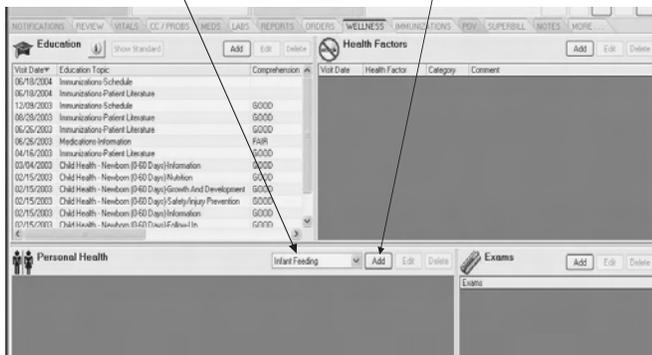
information for patients 45 - 394 days old at all visits occurring during that age range. Public Health Nurses should also be collecting this information. These data can be entered in EHR or PCC/PCC+, as described below.

Entering Infant Feeding Choice Data In EHR

In which version of EHR is Infant Feeding Choice data able to be entered? EHR Version 1.1, which was deployed nationally on October 3, 2007.

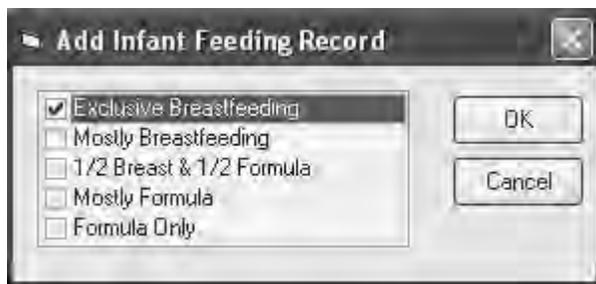
How do I enter Infant Feeding Choice in EHR?

1. After you have selected the patient and the visit, go to the Personal Health section. For some EHR sites, this may be included on the Wellness tab.
2. From the Personal Health dropdown list, select Infant Feeding, then click the Add button.

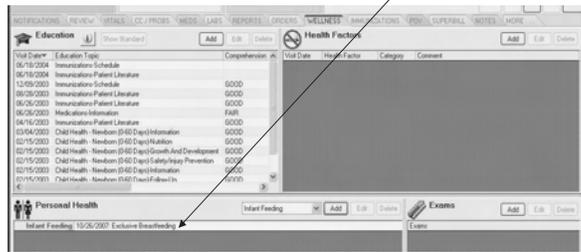


Note: The age of the patient must be five years or less to be able to select Infant Feeding; otherwise, Infant Feeding will not be listed in the dropdown list.

3. At the Add Infant Feeding Record window, click the appropriate checkbox to select the type of infant feeding, and then click the OK button to save the value.



4. The patient's value for Infant Feeding Choice for this visit is now displayed in the Personal Health section, as shown below.

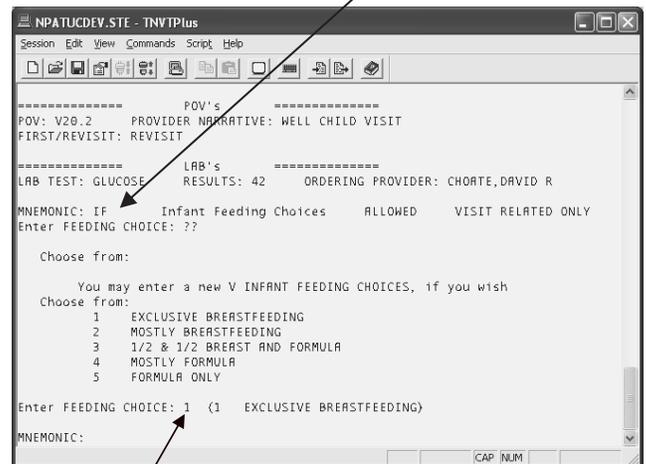


Entering Infant Feeding Choice Data In PCC/PCC+

Which data entry patch do I need? You will need to have data entry patch 8 (apcd0200.08k) installed, which was released on October 19, 2005.

How do I enter Infant Feeding Choice in PCC?

1. Create a new visit or select an existing visit to append.
2. At the Mnemonic prompt, type "IF" (Infant Feeding Choices) and press Enter.



3. Type the number corresponding to the type of feeding and press Enter. If you do not know the number, type "??" and press Enter to see a list of choices.
4. You are returned to the Mnemonic prompt. Continue with data entry of other items.

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 6, No. 1, January 2008) available on the Internet at <http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm>. We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner

Digest

Abstract of the Month

What happens if your patient hears her results as Negative? Positive? Normal? Abnormal?

We tested whether adding interpretive labels (e.g., "negative test") to prenatal genetic screening test results changes perceived risk and preferences for amniocentesis.

Study Design. Women (N = 1688) completed a hypothetical pregnancy scenario on the Internet. We randomly assigned participants into two groups: high risk of fetal chromosomal problems (12.5/1000) or low risk (2/1000). After prenatal screening, estimated risk was identical (5/1000) for all participants, but results were provided either alone or with interpretive labels.

Results. When receiving test results without labels, all participants react similarly. With labels, the participants who received "positive" or "abnormal" results reported a higher perceived risk (P < .001), greater worry (P < .001), and greater interest in amniocentesis (57% vs 37%; P < .001) than did the participants who received "negative" or "normal" results.

Conclusion. Interpretive labels for test results can induce larger changes to a woman's risk perception and behavioral intention than can numeric results alone, which create decision momentum. This finding has broad clinical implications for patient-provider communication.

Zikmund-Fisher BJ et al. Does labeling prenatal screening test results as negative or positive affect a woman's responses? *Am J Obstet Gynecol.* 2007 Nov;197(5):528.

Editorial comment

Barry Weiss MD, Tucson

Do you understand everything the networking folks in your IT Department say about your own facility's server?

If you understood everything they said the first time you heard it, then you can probably stop reading right here. On the other hand, have you ever been called on the phone by a friend or relative, who asked you to explain to them something they were told by their doctor but which they didn't understand?

You then explain things to your friend or relative in a simple, easy-to-understand way. Did you ever ask yourself why their physician didn't use an easy-to-understand explanation in the first place? Did you ever wonder why we don't all use those simple explanations with our patients every day?

Data from the recent National Assessment of Adult Literacy (NAAL) show that about 1/3 of all American adults have limited health literacy. Such individuals do not understand what you've told them, nor what they are supposed to do in response to advice you have given them. NAAL data show that the rate is even higher -- approaching 50% -- among American Indians and Alaska Natives. So, whether you know it or not, you are seeing patients -- many patients -- every day who have difficulty understanding what you've told them.

Two of the most important things you can do to address this problem are first, explain things to patients using easily understood words, as you might explain them to your grandmother. The other is to use the "teach-back" technique, in which you ask patients to explain back to you what you have just told them. This helps verify that they have understood what they need to know. Zikmund-Fisher et al, above, illustrate a simple point that interpretive labels for test results can induce larger changes to a woman's risk perception and behavioral intention than can numeric results alone, which creates decision momentum.

Clinicians routinely underestimate the prevalence of limited health literacy among their patients and frequently overestimate the ability of individual patients to understand the information they provide. For more information and a helpful perspective, go to *Assessing Health Literacy in Clinical Practice*, Barry D. Weiss, MD at <http://www.medscape.com/viewarticle/566053>. Other recent Health Literacy resources: Online

From Your Colleagues

David Gahn, Tahlequah, Oklahoma

You can make a big difference in women's and children's lives

Here are some unique opportunities that are available for Indian health staff

The Office of Global Health Affairs (OGHA), within the Department of Health and Human Services (HHS), has invested in improving the level of care at Rabia Balkhi Hospital (RBH), one of four maternity hospitals in Kabul, Afghanistan. HHS/OGHA has also contracted with a few non-governmental organizations (NGOs) to provide expertise in certain aspects of the program, run with the permission of and under the supervision of the Afghanistan Ministry of Public Health (MoPH). HHS partners include the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Agency for Health-Care Research and Quality (AHRQ) and the Indian Health Service (IHS).

RBH provides care to women, mostly in obstetrics. There is also a small component of general surgeons, internists, and dermatologists. Some 40 to 60 women a day deliver at RBH. One of the other four hospitals in Kabul, Malalai, is also this busy. Because of the US presence at RBH, it has become the main referral hospital in Kabul, and receives the sickest women for delivery. RBH also houses a residency program in obstetrics and gynecology, with about 50 residents and 14 faculty.

The current focus of the HHS project is a Cesarean section quality-assurance (QA) program. The project is starting at RBH, but will branch out to collaborate with the other hospitals in Kabul. Over the last several years, HHS/CDC has developed a system within the MoPH for collecting data on maternal and child health in Kabul. The current data show an increase in the Cesarean section rate from 4% to 10%, which the Ministry and our partners thought would decrease maternal and perinatal morbidity and mortality. However, the data also show a concurrent *increase* in mortality.

HHS/OGHA is looking for obstetricians/gynecologists and pediatricians to go to RBH to work as advisors to the local physicians, to improve their skills, and to work on the QA programs as well the Cesarean section quality-assurance collaborative. The primary role for HHS/IHS staff would be to serve as advisors, by working at the bedside with the Afghan doctors and residents to improve the level of care.

The role of IHS CNMs has not been completely clarified, but deployment in 2008 is highly likely. I encourage CNMs who are interested to contact me.

The length of the tour would be 1 - 3 months, and could start as early as January 6, 2008. This is a TDY assignment. Candidates must be Federal employees (civil service or Commissioned Corps). HHS/OGHA will pay travel and per diem and will also reimburse service units for the salary. The interagency agreement between HHS/IHS and HHS/OGHA is under negotiation, and should be complete in the next two weeks.

Security in Afghanistan is always an issue. HHS personnel in Kabul will stay on the U.S Embassy

compound. Trained security personnel in armored SUVs will accompany HHS staff to RBH. Leisurely travel about town is absolutely forbidden, but HHS staff may go to the army base, the International Security Assistance Force (ISAF) base, and the MoPH.

The US Embassy itself is self-sufficient, and has two post exchanges (PXs), two dining halls, a gym, a swimming pool, etc. The rooms in which HHS staff will stay are converted shipping containers called "hooches." The rooms are relatively small, but include all the amenities: fridge, microwave, TV with cable, DVD player, bed and linens, desk, Internet access, phone, shower, toilet, sink, and hot-water heater.

My role in all of this is to coordinate recruitment and scheduling within HHS/IHS, and to participate in the operational aspects of the project. I will be going to Kabul in January with a pediatrician, a pharmacist, and a scrub tech. If you are interested in going to Kabul, please send me a CV, and we can discuss things over the phone. Afghanistan is an exciting place, and I can promise you a life-changing experience, as well as provide an opportunity to improve some of the highest maternal-mortality rates ever recorded. This is also a chance to contribute meaningfully to international efforts to stabilize Afghanistan.

Hot Topics

Obstetrics

Cesarean delivery on request not recommended if desiring several children

Abstract. Cesarean delivery on maternal request is defined as a primary cesarean delivery at maternal request in the absence of any medical or obstetric indication. A potential benefit of cesarean delivery on maternal request is a decreased risk of hemorrhage for the mother. Potential risks of cesarean delivery on maternal request include a longer maternal hospital stay, an increased risk of respiratory problems for the baby, and greater complications in subsequent pregnancies, including uterine rupture and placental implantation problems. Cesarean delivery on maternal request should not be performed before a gestational age of 39 weeks has been accurately determined, unless there is documentation of lung maturity. Cesarean delivery on maternal request should not be motivated by the unavailability of effective pain management. Cesarean delivery on maternal request is not recommended for women desiring several children, given that the risks of placenta previa, placenta accreta, and the need for gravid hysterectomy increase with each cesarean delivery.

Cesarean Delivery on Maternal Request. ACOG Committee Opinion no. 394. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2007;110:1501-4.

Gynecology

Early feeding within the first 24 hours after major abdominal gynecologic surgery is safe

Selection Criteria: Randomized controlled trials that compared the effect of early versus delayed initiation of oral intake of food and fluids after major abdominal gynecologic surgery were considered. Early feeding was defined as having oral intake of fluids or food within the first 24 hours after surgery regardless of the presence or absence of the signs that indicate the return of bowel function, and delayed feeding was defined as after the first 24 hours following surgery and only after clinical signs of resolution of postoperative ileus.

Conclusions: Early feeding after major abdominal gynecologic surgery is safe and is associated with the increased risk of nausea and a reduced length of hospital stay. Whether to adopt the early feeding approach should be individualised. Further studies should focus on the cost-effectiveness, patient's satisfaction, and other physiological changes.

Charoenkwan K, et al. Early versus delayed (traditional) oral fluids and food for reducing complications after major abdominal gynecologic surgery. *Cochrane Database Syst Rev.* 2007 Oct 17;(4):CD004508.

Child Health

Rapid response team: Implications of findings on mortality rates for children are dramatic

Implementation of an RRT (rapid-response team) in our free-standing, quaternary care academic children's hospital was associated with statistically significant reductions in hospital-wide mortality rates and code rates outside the ICU (intensive care unit) setting.

The authors found that

- A significant decrease in the hospital-wide mortality rate of 18% occurred after RRT implementation. Mean monthly mortality rates preintervention and postintervention were 1.01 and 0.83 deaths per 100 discharges, respectively.
- The rate of codes outside the ICU per 1,000 eligible patient-days decreased by 71.2% after RRT implementation, with preintervention and postintervention rates of 0.52 and 0.15, respectively.
- The rate of codes outside the ICU per 1,000 eligible admissions decreased by 71.7%, with preintervention and postintervention rates of 2.45 and 0.69, respectively.
- The estimated code rate per 1,000 admissions for the postintervention group was 0.28 times that for the preintervention group.

The potential implications of these findings on national mortality rates for children could be dramatic.

Sharek PJ, Parast LM, Leong K, et al. Effect of a rapid response team on hospital-wide mortality and code rates

outside the ICU in a children's hospital. *JAMA.* 2007;298(19):2267-2274.

Chronic disease and Illness

Reconsider use of rosiglitazone

A 2004 meta-analysis concluded that both thiazolidinediones have similar effects on glycemic control and body weight. Both drugs appear to have a beneficial effect on serum lipids. In a meta-analysis comparing the effect of thiazolidinediones on cardiovascular risk factors, pioglitazone produced a more favorable lipid profile. The Proactive study measurement of macrovascular events included all cause mortality and non-fatal stroke with combined endpoints. It was noted the study narrowly achieved statistical significance. Both drugs increased HDL, rosiglitazone increased LDL and had a neutral effect on TG, whereas pioglitazone had a neutral effect on LDL and lowered TG. Rosiglitazone was shown in June and September 2007 issues of JAMA to increase macrovascular events. The first study demonstrated increase risk of MI with rosiglitazone, and the second study displayed increased risk of MI but not death. No head-to-head trials have been conducted to date. In regards to adverse effects, both drugs may cause fluid retention, which may exacerbate or lead to heart failure. Thiazolidinediones are not recommended for patients with NYHA Class 3 and 4 cardiac status. Some clinicians choose to avoid this class of drugs in NYHA Class 2 as well. Edema was more pronounced as a side effect with both drugs: rosiglitazone 4.8% and pioglitazone 4.8% versus placebo 1.3% and 1.2%, respectively. LFT monitoring is recommended for both drugs. Post-marketing experience with rosiglitazone reported some cases of angioedema and urticaria. Rifampin decreased rosiglitazone AUC by 66%, and the clinical significance of this is unknown. Look-alike, sound-alike: Avandia and either Coumadin or Prandin; Actos and Actonel noted by the Institute for Safe Medication Practices. Use of rosiglitazone has changed from 2005 to 2007, from 170 to 119 patients, respectively. Use of pioglitazone has increased from 2005 to 2007, from 66 to 128 patients. Clinical trials have shown similar decreases in A₁C between pioglitazone 15 and 30mg. Based on safety, pioglitazone has been shown to have a better safety profile than rosiglitazone. Dialogue regarding the Accord trial pointed out that the study is still in progress, and results are inconclusive for cardiovascular events. Pioglitazone has a significantly lower risk of death. Today, rosiglitazone is not as cost effective as it was back in 2005. The current data describe a potential increase in cardiovascular events associated with rosiglitazone that has not been seen with pioglitazone.

Conclusion: Reconsider use of rosiglitazone. Patients who are taking rosiglitazone 2 or 4 mg can be switched to pioglitazone 15mg and those taking rosiglitazone 8mg can be switched to 45mg of pioglitazone.

Charbonnel B. Glitazones in the treatment of diabetes

mellitus: clinical outcomes in large scale clinical trials. *Fndam Clin Pharmacol.* 2007 Nov;21 Suppl 2:19-20.

Features

ACOG, American College of Obstetricians and Gynecologists

Human Immunodeficiency Virus

Abstract: Because human immunodeficiency virus (HIV) infection often is detected through prenatal and sexually transmitted disease testing, an obstetrician-gynecologist may be the first health professional to provide care for a woman infected with HIV. Universal testing with patient notification and right of refusal (“opt-out” testing) is recommended by most national organizations and federal agencies. Although opt-out and opt-in testing (but not mandatory testing) are both ethically acceptable, the former approach may identify more women who are eligible for therapy and may have public health advantages. It is unethical for an obstetrician-gynecologist to refuse to accept a patient or to refuse to continue providing health care for a patient solely because she is, or is thought to be, seropositive for HIV. Health care professionals who are infected with HIV should adhere to the fundamental professional obligation to avoid harm to patients. Physicians who believe that they have been at significant risk of being infected should be tested voluntarily for HIV.

Human immunodeficiency virus. ACOG Committee Opinion no. 389. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2007;110:1473-8.

Ask a Librarian Diane Cooper, MSLS, NIH Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity

In February 2004, the American Medical Association convened a second expert committee to guide the development of three articles that would explore current evidence-based science and form the basis of new recommendations on the assessment, prevention, and treatment of child and adolescent overweight and obesity. Representatives from 15 national organizations formed the second expert committee. The committee used a multidisciplinary model and integrated approaches across disciplines. The conceptual framework is the chronic care model with the goal of achieving family/self-management of childhood obesity.

The product was four articles, one on each of the aforementioned overview areas of the management of obesity and one overarching support document. The articles were written by national experts in the field of childhood obesity who were nominated jointly by the members of the expert and steering committees.

Barlow SE and the Expert Committee. Recommendations regarding the prevention, assessment, and treatment of child

and adolescent overweight and obesity: Summary report. *Pediatrics.* December 2007;120(Supplement 4):S164 - S192.

Krebs NF et al. Assessment of child and adolescent overweight and obesity. *Pediatrics.* December 2007;120(Supplement 4):S193 - S228.

Davis MM. Recommendations for prevention of childhood obesity. *Pediatrics.* December 2007;120(Supplement 4):S229 - S253.

Spear BA et al. Recommendations for treatment of child and adolescent overweight and obesity. *Pediatrics.* December 2007;120(Supplement 4):S254 - S288.

http://pediatrics.aappublications.org/content/vol120/Supplement_4/index.shtml or www.pediatrics.org.

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

Teens, Depression, Black Box Warnings, and Suicide

After a substantial period of gradually decreasing rates of suicide in adolescents, including AI/AN adolescents, recent 2004 data documenting increased suicide rates for adolescents suggest more attention will be coming to adolescent mood problems. The increase in suicides was most dramatic in female populations, with rates rising dramatically in younger female populations ages 10 - 14 (75.9%) and significantly so in older adolescent females ages 15 - 19 (32.3%) and males ages 15 - 19 (9%). The increases coincide with the FDA's black box requirement for many antidepressants that is likely responsible for an overall reduction in the prescription of antidepressants for teenagers. Does this mean decreased antidepressant prescription was causally related to the increase in suicides? We don't know, but the temporal association is suggestive.

Our adolescents are, unfortunately, at the forefront of the suicide curve. Indian country has received significant attention recently due to increasing concern about suicide clusters in adolescent populations and more generally in young adults. Theories abound as to why this is occurring, and, given the low base rates of the event and the high frequency of conditions and behaviors associated with increased risk, real understanding is still some time away.

There is a general consensus, however, that part of the solution lies in identifying and treating depression in primary care. The American Academy of Pediatrics recently released GLAD-PC (Guidelines for Adolescent Depression in Primary Care) I and II which include excellent resources for developing primary care based approaches to management. The full documents can be found at www.glad-pc.org and include screening and assessment instruments as well as treatment tracking tools.

The recent publication of further results from the TADS (Treatment of Adolescent Depression Study) is also encouraging, as it suggests that risks related to antidepressant treatment can be mitigated with appropriate therapy and management.

Combined depression regimen appears to reduce suicidality. *Psychiatr News*. Mar 2007;42:28-35.

Some basic recommendations for tackling adolescent depression:

1. Screen using a systematic assessment (screening tool). For those of you familiar with the PHQ-9 there is a slightly modified instrument for adolescents available on www.glad-pc.org. Other instruments with established psychometric properties are also available for use and several are free.
2. Develop relationships with your local BH system. You can treat and manage many patients successfully with fairly limited consultative support.
3. Take adequate time – pediatric and primary care schedules are often crazy and packed – this is for better or for worse one of those occasions where time up front reduces emergencies and time later. If you have the opportunity to integrate BH care into your primary care services, your schedule interruptions can be minimized.
4. Treatment works – and while there may be issues with the relative strength of psychotherapy vs. medications, both have demonstrated efficacy over placebo or treatment as usual approaches. Keys to successful treatment include having a plan, reassessing progress frequently, particularly in the early stages of treatment, and getting help if there is no improvement or if improvement plateaus before full resolution.
5. Access to lethal means restriction counseling may reduce risk of self-injury.
6. (see http://www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf).
7. The “Medical Home” is an encompassing model that, if applied properly in conjunction with developmentally appropriate preventive counseling, provides maximum opportunity to identify, intervene, and mitigate at least some of the risk for self-destructive behaviors in adolescence – whether that behavior be self-injury, smoking, unprotected sex, or drug and alcohol use.

If you decide to use medications, keep in mind the following:

1. Medications should be used to treat full MH disorders and generally avoided in sub-syndromic states in children and adolescents.
2. Fluoxetine remains the best option to start with for adolescents – it has the best risk profile and is indicated for treatment of adolescent depression.

3. Educate the patient and parents/guardians/family members about use of the medication, including the possible development of agitation, restlessness, and anxiety. These symptoms may portend the development of medication-induced suicidal thinking. The FDA and AACAP guidelines suggest initial weekly face-to-face visits. While this is desirable, it is often not feasible or practical, but the pearl here is to plan regular weekly contact whether in person, by phone, or through other means, with the patient and family, and identify this in your documentation. Follow-up may actually need to be more frequent if there is any significant suicidal ideation or self-harm concerns.
4. Screen for history of bipolar symptoms both in the patient and through the family history. Be very cautious using medications without consultation where there is a history of mania-like symptoms or family bipolar disorder.
5. Stop medications gradually. Risk periods for increased suicidal thinking appear to be both around the time of initiation of antidepressant therapy and after sudden discontinuation.
6. Limit refills. Keep dispensed amounts to only slightly more than necessary to get to the next contact or appointment for the first three months of treatment.

References: Online

Breastfeeding

Suzan Murphy, PIMC

Breastfeeding, it is not just about the baby

According to a 2005 meta-analysis by the Agency for Healthcare Research and Quality (AHRQ), postpartum depression (PPD) is a major depressive disorder that effects between 5 - 25% of women in developed nations. Compared to men, women are twice as likely to experience depression in their lifetime.

Risk factors for PPD include:

- adolescence
- poverty
- family or personal history of depression
- relationship discord
- lack of social support
- unplanned/unwanted pregnancy
- life stress (including child-care issues)
- challenging infant temperament (fussy, colicky)
- low self-esteem

- prenatal anxiety

Symptoms include:

- Loss of interest or enthusiasm for daily activities
- Depressed mood
- Difficulty making decisions or concentrating
- Fatigue
- Appetite disturbance
- Feelings of worthlessness, hopelessness, excessive/inappropriate guilt or shame
- Suicidal ideation
- Somatic complaints such as headaches, GI distress
- Psychomotor disturbance
- Sleep changes

For many reasons, PPD is often undiagnosed. PPD left untreated can be devastating for new mothers and their families. A recent study by Mancini, et al (cited below) described using the Postpartum Depression Screening Scale (PDSS) developed by Beck, et al to screen women in large midwifery and obstetric practice in Albuquerque, New Mexico. The practice saw approximately 2000 deliveries per year, 40% enrolled in the Medicaid program. The goals of the study were to look at prevalence of positive PDSS screen at 6 weeks, determine the benefits and challenges of using the PDSS screening tool, and find demographic and clinical characteristics that were related to positive screens.

In a 12 month period, 755 women were screened, 740 with complete data sets. Data were collected on PDSS score, age, parity, race/ethnicity, education, marital status, infant feeding, type of delivery, and history of depression. The prevalence of a positive screen at six weeks was 16% for major PPD and 20% for symptoms suggesting potential PPD risk. The PDSS was ultimately integrated into the patient care routine, with positive feedback by the staff and patients. A total of 75% of the providers participated, 6 of 11 obstetricians and all of 9 CNMs. They reported a sense of providing more comprehensive care and the opportunity to gently educate about mental illness. Patients reported appreciating the chance to talk about mental wellness issues.

The study found that women who had a positive screen at six weeks postpartum were more likely to not have completed high school, not be partnered, be exclusively bottle feeding, and have a history of depression. The two characteristics that were statistically significant as predictors of a positive PDSS screen were history of depression (risk ratio, 4.8; 95% CI, 4.4-5.2) and exclusive bottle feeding (risk ratio, 2.0; CI, 1.6-2.4). The possible reasons suggested for breastfeeding reducing risk of PPD included decreased maternal stress sensitivity, and enhanced response/action of the parasympathetic nervous system.

Like many other articles about PPD, the authors reiterated the need for more research and attention to timely screening

and early intervention.

A side note: Other possible reasons for reduced PPD risk with breastfeeding mothers include increased levels of prolactin and oxytocin, shortened duration of post partum bleeding with enhanced involution, possible delayed return to menses, and so less risk of PMS symptoms, possible weight loss, reduced stress due to less infant illness, and likely increase in maternal self-esteem.

Reference: Online

Featured Website

David Gahn, IHS MCH Portal Web Site Content Coordinator

Preconception Counseling for Women with Diabetes and Hypertension: New module

This is a new module in the Perinatology Corner Series. This particular topic is coming up a lot more frequently in our patients. What can you treat with and not endanger the fetus? What can't you treat with? This module offers good advice on these and many other issues, plus lots of resources, even if you don't want the free CME. <http://www.ihs.gov/MedicalPrograms/MCH/M/PNC/PreconCouns01.cfm>

Frequently asked questions

Q. How should we manage a patient with a previous abruptio placenta?

A. There are significant risks after two previous abruptions or if fetal death resulted.

Short take: In the vast majority of cases, no change in management is required in subsequent pregnancies. Reversible risk factors can be modified (e.g., avoid cigarette smoking or cocaine use), and women with nonrecurrent risk factors (e.g., trauma) may be reassured. In selected patients, such as those with two or more prior perinatal deaths or one perinatal death with persistent nonmodifiable risk factors for abruptio, offering patients the option of preterm delivery upon documentation of fetal lung maturity is reasonable.

Full answer online at the MCH FAQ site: "How should we manage a patient with a previous abruptio placenta?" <http://www.ihs.gov/MedicalPrograms/MCH/M/documents/AbruptioRec12907.doc>

International Health Update

Claire Wendland, Madison, Wisconsin

Disparities, Inequalities, or Inequities?

Everyone knows that the average health status of people living in poor countries is generally worse than that of people living in wealthier ones. When health outcomes differ among different population groups, are they health disparities or inequalities? Or, in the only term that implies a moral wrong,

are they health inequities? Inequities based on differential access to a society's resources are difficult to detect without some sort of assessment of wealth. Because of technical problems with the measurement of wealth, and perhaps because of a lack of political will, we've had a real dearth of information on inequality within countries – especially poor countries – until recently. Now a new World Bank report focuses on the correlations between economic status and health within fifty-six poor countries in Africa, Asia, the former Soviet Union, and Latin America. The authors made female-male and rural-urban comparisons as well, but their focus is primarily on economics.

Why are these data so late to the scene? Economic status was neglected in most of the earlier studies of health disparities because it is very hard to measure. Household income may not be in cash at all, especially where unemployment is high; people may be much more reluctant to estimate family income for analysts than to check a box revealing gender or race; and proxy measures like education or occupation did not prove to be good analogues for wealth. All of these problems were magnified in poor countries. In the late 1990s, researchers realized that various assets (for instance bicycles, radios, piped water, or corrugated iron roofing rather than thatch) could be compiled into an “asset index” that worked very well to rank economic status. It's only been in the last decade, therefore, that researchers were able to correlate economic status and health with reasonable accuracy.

I urge you to check out the report itself. For those of us interested in maternal and child health, it includes detailed tables on child and infant health, basic fertility indicators and STD prevalence, and some maternal health indicators (such as deliveries attended by skilled staff). The results are sobering, though preliminary. Infant and child mortality, fertility, and malnutrition are all much greater among the poor than the rich. Immunization, antenatal care, medical treatment of respiratory infections, oral rehydration for diarrhea and other basic health interventions are all less likely to be used (or available) the poorer the household. Even primary health care offers greater benefits to the better-off than to the poor: 12% of benefits accrue to the poorest 20% of the population, 29% to the richest 20%, although it isn't as skewed in this regard as hospital care, where 10% of benefits go to the poorest quintile and over forty percent to the richest. The only indicator in which the poor do better is breastfeeding: in nearly every country surveyed, the poorest were more likely to breastfeed their infants. (Other studies have shown that the richer are also more likely to get unnecessary operations like excess Cesarean sections, and to suffer the associated morbidity. That particular issue is not addressed in this report.)

Most sobering of all, the authors predict that as new health improvements find their way into poor countries, inequalities are likely to worsen. Whether it is antiretrovirals for HIV or surfactant for prematurity, the rich have means to learn about these improvements and to access them long before the poor

do. Average health status may improve even as inequalities – and inequities – worsen. As the authors conclude, “Much more will be needed if the global health community is to move beyond platitudes about improving the health of the poor to effective action that can do so.”

Gwatkin DR, Rutstein S, Johnson K et al. Socio-economic differences in health, nutrition, and population within developing countries: an overview. Washington DC: World Bank. 2007

MCH Headlines

Judy Thierry, HQE

Oral Health for Head Start Children: Best Practices

This 12-page document provides evidence-based approaches and interventions to improve the oral health of Head Start children and their families. The best practices are divided into three key points of intervention;

- pregnancy,
- birth through two years, and
- two years through five years of age.

Readership should include Head Start administration and staff, and medical, dental, and community health staff who will need to work together to effectively improve the future oral health of American Indian and Alaska Native children. IHS Head Start Program website: www.ihs.gov/nonmedicalprograms/headstart/. You can also find current information and bulletins on oral health as it relates to Head Start at the Head Start Bureau Learning Center at the following website: <http://www.eclkc.ohs.acf.hhs.gov/hslc>.

Medical Mystery Tour

What is the Presenting Part?

You may recall we last presented the case of a 20 year old gravida 4 para 1,0,2,1 at 40 2/7 weeks in active labor.

The patient had had a 39 pound weight gain throughout her otherwise unremarkable prenatal care. The patient's obstetric history was significant for one previous vaginal delivery of a term 9 pound 15 ounce infant. Laboratory testing was essentially unremarkable. On admission the patient's exam was cephalic presentation, 4 cm dilation, -1 station. The cervix was soft and in a mid position. External fetal monitoring was reassuring. Sixty second contractions were noted every five minutes.

At 01:30 the CNM noted that patient had progressed nicely in labor to 7 cm dilated and 100% effaced. The presenting part was still at -1 station. The membranes were intact. The CNM was unable to completely identify the presenting part. The FHR tracing was reassuring. The CNM noted that a suture line and fontanelle were palpable, but other tissue may have been present. The MD on call was asked to perform a bedside ultrasound to confirm the presenting part. The bedside ultrasound confirmed a cephalic presentation

which was slightly oblique. The physician proceeded to perform a digital exam.

What did the physician find on digital exam?

In the interim since the physician had been initially called, the patient's membranes had ruptured and the FHR remained reassuring. The physician noted several long loops of umbilical cord presenting. Otherwise the fetus was in cephalic presentation with complete cervical dilation and effacement. The CNM then elevated the fetus's head out of the pelvis with her hand and the patient was moved to the operative suite in an expeditious manner while in knee-chest position.

As the obstetric team reached the OR table before the anesthesia team was ready and the patient was completely dilated, an attempt was made at funic reduction. This maneuver was only successful for part of the prolapsed cord, but loops remained distal to the fetal skull.

The maternal skin incision was made within 13 minutes of anesthesia's notification and the fetus was delivered within one minute as a Joel-Cohen technique was used. The infant female was delivered from an occiput posterior position and weighed 3450 g with Apgars of 8 and 9. At the time of surgery the cord was felt to be clinically 'long' plus had a true, but loose, knot with no proximal edema. A generous section of umbilical cord was obtained for possible cord gases. The arterial pH was 7.17 with a base excess of -5.4. The venous pH was 7.23 with a base excess of -4.0. Of note, the arterial CO₂ was 70.5 (mmHg) (49.2 to 50.3) so some cord occlusion had begun shortly before delivery.

Examination of the placenta in the pathology department the next day revealed a somewhat eccentric umbilical cord insertion, 4 cm from the placental margin. Even after formalin fixation and not measuring either the portion of the umbilical cord sent for cord blood gases, nor the area remaining on the infant at surgery, the cord was still 53 cm. There was a true knot at 17 cm from the insertion. As you will see below, the most accurate measurement of cord is actually done in the delivery suite, not after formalin fixation and other incisions for cord gases, etc.

Both the patient and her new daughter had unremarkable hospital courses for two days prior to discharge.

So, what was the presentation the CNM had noted?

The patient had a funic presentation prior to SROM. In this case there was so much cord that it essentially filled the pelvic outlet. By the time the physician performed a digital exam after SROM and the ultrasound exam, the patient had been in an unrecognized cord prolapse with reassuring FHRs for approximately 10 - 15 minutes.

Long umbilical cord

Cord length increases with advancing gestational age. The average length at term is 55 cm (22 inches), with a wide

normal range (35 to 80 cm) (14 – 32 inches) (Rayburn). The length should be noted and compared with published standards (Table below). Umbilical cord accidents were most frequent in the presence of a long cord (20 of 32 cases, 62%). In addition, mothers with a history of an excessively long umbilical cords are at increased risk of a second long cord.

The length measurement should include the portion of cord on the infant after cord transection at delivery as well as the part remaining with the placenta; thus it is best determined in the delivery room. Cord length is determined in part by hereditary factors, but also by the tension the fetus places on the cord when it moves. For this reason, short cords are associated with fetal inactivity related to fetal malformations, myopathic and neuropathic diseases, and oligohydramnios. Long cords may be caused by a hyperactive fetus and have been associated with cord accidents, such as entanglement, knotting, and prolapse (Rayburn). Long cords are also associated with placental lesions indicative of intrauterine hypoxia, as well as fetal death, fetal growth restriction, and long term adverse neurologic outcome (Baergen). A very helpful discussion of the risks for and management of prolapse umbilical is available online

Navajo News

Jean Howe, Chinle

Informed Refusal, Leaving Against Medical Advice, and Asking Questions

A recent article in the "Clinical Practice" series of the New England Journal of Medicine addresses the assessment of patients' competence to consent to (and decline) treatment. This series uses a case vignette and discussion to address common clinical problems. In this case, a 75 year old woman with type II diabetes, peripheral vascular disease, and a gangrenous foot ulcer who refuses a recommended amputation is described. The patient states that she "prefers to die with her body intact" and the provider is concerned about apparent increasing confusion and possible depression limiting her ability to provide informed consent. Legally relevant criteria for evaluating decision-making capacity are outlined for the patient's tasks of communicating a choice, understanding the relevant information, appreciating the situation and its consequences, and reasoning about treatment options. Approaches to assessment and the consequences of a finding of incompetence are reviewed. The lack of formal practice guidelines for assessment of competence to consent is highlighted.

Refusal of treatment is also the focus of an overview of hospital discharge "against medical advice" in this month's American Journal of Public Health. This database audit of over 3 million discharges from US non-federal acute care hospitals identified a rate of 1 in 70 (1.44%) of "self-discharges." Higher rates were associated with young age, male gender, African American race, and low socio-economic status.

Because this study is a database review only, no information is available on the reasons for AMA discharge. The authors discuss possible reasons, including frustration with administrative delays in the discharge process, pressing domestic or social concerns, and disagreement with their physician's assessment of their health status. They also discuss the public health significance of these discharges and the importance of addressing shortcomings of the health care system that may place underserved patients at higher risk for this event.

Meanwhile, the Agency for HealthCare Research and Quality is launching a campaign called "Questions are the Answer" encouraging patients to ask questions about their health care as a safety measure and in an effort to improve overall health through greater understanding and ownership of health care decisions. Their sample questions for patients and more information about this campaign, including video clips of singing and dancing health care workers are available at the AHRQ website.

I happened to encounter all three of these articles/information on the same day and was struck by the increased attention to patient autonomy and recognition that medical advice may be rejected, ignored, or poorly understood. We, as health care providers, have an ongoing duty to encourage our patients' understanding and ownership of their health and their right to make informed decisions about their care.

Vulnerable groups may benefit from additional attention to their needs, whether for respectful assessment of decision-making capacity or for culturally appropriate hospital care that minimizes the risks of "self-discharge." I'm not sure if the singing health care workers in the AHRQ videos will help, but we must continue our efforts to welcome, encourage, and respect our patients' efforts to make truly informed health care decisions.

Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment, *N Engl J Med.* 2007 Nov 1;357(18):1834-40.

Ibrahim SA, Kwok CK, and Krishnan E. Factors associated with patients who leave acute care hospitals against medical advice. *Am J Public Health.* 2007 97:2204-2208, 10.2105/AJPH.2006.100164.

AHRQ.

<http://www.ahrq.gov/questionsaretheanswer/index.html>.

CCC Editorial Comment

What Are The Elements of Patient Decision Making?

This is a very timely topic as ACOG has just released the three Committee Opinions below that relate to a patient's decision making process. We need to have made all efforts possible to assure that the decision is informed, on the patient's actual educational level, as well as ethical. Please also note this month's Abstract of the Month and Dr. Weiss's comments

on Health Literacy, above.

Health Literacy. ACOG Committee Opinion no. 391. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2007;110:1489-91.

The Limits of Conscientious Refusal in Reproductive Medicine ACOG Committee Opinion no. 385. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2007;110:1203-8.

Ethical Decision Making in Obstetrics and Gynecology*. ACOG Committee Opinion no. 390. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2007;110:1479-87.

Perinatology Picks

George Gilson, MFM, ANMC

Fewer errors with more standardization of corticosteroid regimens

Repeat vs single dose corticosteroids did not differ significantly, except NS cerebral palsy

Conclusions: Children who had been exposed to repeat as compared with single courses of antenatal corticosteroids did not differ significantly in physical or neurocognitive measures. Although the difference was not statistically significant, the higher rate of cerebral palsy among children who had been exposed to repeat doses of corticosteroids is of concern and warrants further study.

Wapner RJ et al. Long-term outcomes after repeat doses of antenatal corticosteroids. *N Engl J Med.* 2007 Sep 20;357(12):1190-8.

Editorial comment: George Gilson, MFM

It would probably be good if we all standardized our use of antenatal corticosteroids for fetal lung maturation. I have seen various regimens being used, but the one below is the one recommended by ACOG on the basis of the available evidence. Steroids are given over a 48 hour interval. Their maximum effect is maintained for seven days, although a lesser, but still significant, effect is seen for a considerably longer interval. Giving the doses at closer intervals will not speed up the fetal lung maturation process, even though you think the baby needs to deliver sooner than later. The regimens are:

Betamethasone 12 mg IM x2 at 24 hour intervals, or
Dexamethasone 6 mg IM x4 at 12 hour intervals

Steroids are appropriate between 24 and 34 weeks gestation (some authorities would restrict their use to 32 weeks or less in women with PPROM). There is no consensus on whether betamethasone or dexamethasone is better, so either regimen is fine. Steroids should ideally only be given once, so you should carefully consider if they are really needed at the time. (One "rescue" dose later, while not recommended, has

not been associated with significant adverse neonatal effects, and is also acceptable on an individualized basis.)

Antenatal corticosteroid therapy for fetal maturation. ACOG Committee Opinion No. 273. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2002;99:871-873.

Women's Health Headlines

Carolyn Aoyama, HQE

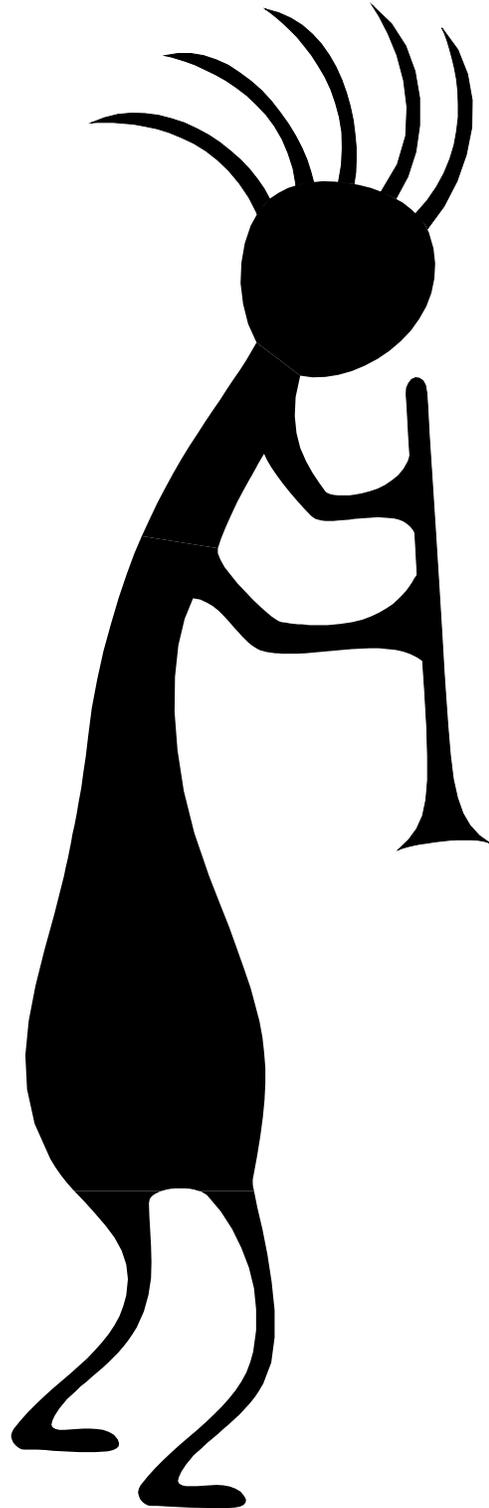
Making a Business Case for Investing in Maternal and Child Health

Health care services for children and pregnant women account for \$1 out of every \$5 large employers spend on health care. A substantial proportion of employee's lost work time can be attributed to children's health problems, and pregnancy is a leading cause of short- and long-term disability and turnover for most companies. Yet most companies don't have a strategy for promoting the health of mothers and children.

In November, the Business Group released a new toolkit aimed at improving employer-sponsored health benefits and programs for children, adolescents, and pregnant women. The core component of this toolkit is the Maternal and Child Health Plan Benefit Model, which outlines 34 evidence-informed health, pharmacy, vision, and dental benefits recommended by the Business Group. A webinar provides an overview of the new toolkit. The speakers also discuss:

- The business case for investing in healthy pregnancies and healthy children.
- Benefit design recommendations.
- Recommended cost-sharing strategies to promote appropriate utilization and incentive for prevention.
- Data on the cost-offsets associated with prevention.
- "Lessons learned" from Marriott on communicating health benefits and engaging beneficiaries in health promotion and disease prevention.

To view Investing in Maternal and Child Health: An Employer's Toolkit, visit: <http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/index.cfm>.





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