How high-risk pregnancies have become even more complicated

Watch the AMA's daily COVID-19 update, with insights from AMA leaders and experts about the pandemic.

Featured topic and speakers

AMA Chief Experience Officer Todd Unger talks to health experts about how women's health issues, especially high-risk pregnancies, have become more complicated due to COVID-19. This episode is part of a special series throughout September focused on women physicians and patients in honor of the AMA's Women in Medicine Month.

Learn more at the AMA COVID-19 resource center.

Speakers

- Louito Edje, MD, associate professor, GME, University of Cincinnati
- Nicole Lee Plenty, MD, MPH, maternal-fetal medicine physician
- Dana Block-Abraham, DO, maternal-fetal medicine and fetal intervention specialist

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update. Today we're discussing how the care of women, including pregnant women, has been impacted by COVID-19. This is part of a special series focused on women physicians and patients throughout September in honor of the AMA's Women in Medicine Month. I'm joined today by Dr. Nicole Lee Plenty, a maternal-fetal medicine physician and an AMA Women Physicians Section governing council member in Houston, Texas. Dr. Dana Block-Abraham, a specialist in maternal-fetal medicine and fetal intervention in Fairfax, Virginia. Dr. Block-Abraham is also a delegate to the AMA House of Delegates and to the AMA Young Physician Section for the American College of Obstetrics and Gynecology.
And Dr. Louito Edje, associate dean of Graduate Medical Education at the University of Cincinnati College and a family medicine physician in Cincinnati, Ohio. She also represents the Ohio State Medical Association in the AMA House of Delegates. I'm Todd Unger, AMA's chief experience officer in Chicago. Welcome everyone. Dr. Plenty, I'm going to start with you. I know you see your share of high-risk pregnancies as part of your normal practice. How have high-risk pregnancies become even more complicated by COVID-19?

Dr. Plenty: Todd, thanks for having us. First of all, I'm especially excited to be with everybody on the panel. We knew from the beginning that pregnancy would probably be a high-risk category, right? The flu in pregnant women can cause devastating complications. Before we weren't really sure because the studies weren't reflecting what exactly happens in pregnancy and what happens to the fetus. Now we know that the CDC has listed pregnant women in the high-risk category, and we know that pregnant women can in fact get COVID-19, and when they do, they can become very, very compromised from a respiratory standpoint. And there's been some studies, some conflicting, that says, "Now, hey, the fetus can be exposed to COVID-19 potentially." In this past couple of months things are complicated and constantly being developed. We are constantly learning new things, we're constantly developing new protocols for people in pregnancy which wasn't there in April or May.

Unger: Dr. Block-Abraham, yes, go ahead. Sorry.

Dr. Block-Abraham: No, that's okay. Yeah, I think exactly what Dr. Plenty is saying. It's been really interesting to watch this evolve as a physician because we've only known about this for about 10 months now and the speed with which information travels these days is unreal. It's like one day you hear this, the next day you hear that. You're telling a patient this based on this and then the next day you feel like you just told them something you shouldn't have said. I think it's been a bit challenging because of that. It's great because it's prompted a lot of, I think collaboration even overseas, and we're trying to learn from the experience of the Italians and other places that saw this before we did, but still we're trying to figure out how to best work that into our day-to-day and into our counseling of patients.

And the fact that the information keeps changing like Dr. Plenty just mentioned, the studies are coming out and it's like one week ago they say actually pregnant women get sicker, they probably don't have a higher chance of catching it, necessarily, but if they catch it they can become really sick if they do. And then when we're talking with the patients about it, there's already an underlying level of anxiety from COVID itself, and then when we can't answer the questions that they're asking it makes it a little bit harder, I think, even a little bit more anxiety-provoking for them.
Unger: I do remember, and it's been quite a long time, that pregnancy was a time of a lot of joy but at the same time, very, very scary. And so I imagine that for women being pregnant in a pandemic has got to be super scary right now. How do you adjust your practice? How do you relieve that stress about both of these things going on at the same time? Dr. Plenty?

Dr. Plenty: In terms of adjusting the practice my group has tried to alleviate some of the pressure on our general OB-GYNs. And that is one, to make sure we're doing things in collaboration with them more, perhaps if we have a high-risk pregnant patient that has hypertension or diabetes. If they need testing, we will then do the things that they would ordinarily do in their prenatal visits so that they will not have to then go to their OB-GYN office as well. So anything we can do to alleviate the patient having to be seen twice in the same week sometimes or the same two weeks, we'll do to try to assist them more.

I'm not doing as much virtual work, but I know some of my MFM colleagues are doing a lot of virtual work, and that is a patient comes in for an ultrasound, there may be one doctor that's seeing two different clinics remotely so that you don't have a provider, all your providers working at the same time. Just in case a provider gets sick, you won't have to close down that entire clinic. We've tried to stagger our schedule to make sure that we have time to social distance ourselves so that we won't get sick.

Dr. Block-Abraham: Yeah, I feel like it's difficult more so with the high-risk pregnant patients because they're needing to come for their visits and there are a lot of times patients that we are not wanting to necessarily delay care for, so a lot of the primary OB groups are women with lower-risk pregnancies. Their visits that were usually every two weeks had been spaced out to every three weeks, or there've been some other adjustments to the schedule as far as frequency of the patients coming back. And so I think we've done our best to help guide that and similarly to Dr. Plenty's group, we're trying to help step in and provide some of the basic prenatal care and answer some of those basic questions as well.

Our schedule really hasn't lightened up much though, I don't know if it has for you guys. But women are pregnant, and they're still getting pregnant and so they still need care. And whereas maybe some other well women visits and those kinds of things aren't happening as frequently, the prenatal care is still ongoing, and so it hasn't changed a lot as far as volume. The flow of patients in our office and in our units has changed. We're doing our best to set aside socially-distanced waiting areas and to try to minimize travel through the units for all of the patients so that they just have to be in a couple of places rather than potentially be exposed by walking through the whole thing. And we have been going to them to review ultrasound results rather than them coming into our offices. Those are just some of the basic flow of things that we've changed.
Unger: Well, Dr. Edje, can you talk a little bit about what kind of gender-based issues you're seeing in your practice during COVID-19?

Dr. Edje: Thank you, Todd, and I'm honored to be with this crew of fabulous women. Our practice basically is built around preventative care. As a family physician that's really important and women have always been very good at coming in for their preventive care. I have not really seen that change except for the fact that those who are of childbearing age have had some issues with trying to find childcare while they come into the office because they have been less likely to want to bring their little ones in, so that has been a little bit of a challenge.

The other thing is making sure that their kids, now that school has started and they're doing some homeschooling and some hybrid models there, trying to make sure that they're still keeping their kids in school and doing the homeschooling but able to come in for their care as well. There have been some compromises that moms have made but I think they've been good ones.

Unger: Dr. Edje--sorry go ahead.

Dr. Edje: The other thing that we have seen and I think as soon as we had a shutdown early in Ohio where we had to stay at home order, I immediately became concerned about the women who have domestic violence as a concern. And we saw increases of, actually a 30% increase in domestic violence calls here in the greater Cincinnati area, but paradoxically as soon as the shutdown actually happened the calls went down 10%. And we assumed that was because the folks were in their homes and not able to make calls from a hotline in the space of their abusers. We did also, however, see a huge surge in the pent-up need after the shutdown was lifted and so definitely there were abuses that were going on. Sad situation.

Unger: Yeah. Dr. Edje, you have a whole other side of your work which is with female residents and fellows. How has COVID-19 impacted them?

Dr. Edje: Yes, I have the privilege that 70% of my work is being an associate dean for Graduate Medical Education. I have about 700 residents and fellows who are in my charge, and I'm to advocate for them. Very early on, again with the shutdown, a lot of the day cares got shut down and so residents who have an 80-hour work week all of a sudden were trying to figure out, "How do I care for somebody who's my little special one and also do really well as a resident or a fellow?"

And so we were very fortunate to be able to connect directly. We have a call every 4:30 since the beginning of COVID, everyday 4:30. And I was able to go ahead and work with a team to get some day care set aside at the YMCA so all of our residents and fellows had an opportunity to go ahead from birth all the way on through to age six, they were getting child care right next to our space. Additionally, we were also able to go ahead and make sure that they had shelter-in-place options because we had some very young moms who did not want to come straight from the ER doing a shift.
and then go home and potentially take COVID to their little ones. We were able to partner with some apartments and go ahead get reduced cost housing for them and so on.

**Unger:** Thank you. I'm going to talk a little bit about health disparities which we know have really been exacerbated by the COVID-19 pandemic. I'd like to talk about, how do health disparities add to the challenge and complications of what we're seeing in caring for women during the pandemic? Dr. Block-Abraham, why don't you start?

**Dr. Block-Abraham:** Sure. I think that really it's just coming to light more, I'm not convinced that it's that much different than it's always been. I feel like there's a lot of systemic bias and racism that exists and I feel like that places people already at higher risk for chronic conditions which then translates into higher risk for pregnancies, higher risk for catching COVID or for becoming incredibly ill from COVID. And so it's not an all of a sudden thing, it's just bringing to light stuff that has been going on for a really long time.

Which I think is a good thing because we need to identify this and we need to work on ways to fix it from the get go rather than be reactive to something that is again, getting a little bit more attention. Great, wonderful, let's do something about it because it's time that we do that. It's just showing or highlighting that certain populations in our country still get sub optimal care for a variety of societal reasons, and they're sicker, and they catch it more often and die more often from it.

**Dr. Plenty:** I would add that from a pregnancy standpoint, COVID has definitely complicated the care of health disparities. If you have somebody that is in DKA and they have COVID, I mean, that's a big deal. And so it's definitely complicated that. And then if somebody gets COVID, they're more likely to get exacerbation of other things, right? If they have chronic hypertension, we know that people that have chronic hypertension are more likely to get preeclampsia. If you get COVID that by itself can increase your risk of preeclampsia and if you already have chronic hypertension, well, that can make treating it so much worse.

And so we're seeing things like that in terms of pregnant women being at home. Now there are people that have COVID in their households, we know that Black and Brown communities, they can basically be codependent on one another, meaning if you have multiple generations in the same household and one person gets COVID then everybody gets COVID. And so if you have a pregnant woman that's also in that household that's trying to care for small children and they're pregnant and their spouse has COVID or their mother or mother-in-law has COVID, it makes things very, very complex.

In my clinic if you screen positive for COVID or if you just screen positive on the questionnaire for an exposure to COVID or if you have a fever, then you're not seen. Then we have to be creative with how we're exactly seeing you. Initially it was, okay, we'll just delay them for the two weeks until they're negative or they're asymptomatic or until their mother-in-law gets treated and they're negative. But now that this thing is going on for quite some time and will probably continue for quite some time, we've created a specific COVID clinic. So if you're positive or you have an exposure and symptoms
and you could be positive then you're seen in this other clinic. That's the thing that we're trying to do to make things a little bit better to treat it, but yes, the disparities on top of COVID have created a lot of complexity.

**Unger:** Well, the last question. I know as leaders in the AMA that each of you have your own policy and advocacy issues that you're really passionate about. Where should we be focusing our efforts right now? Dr. Edje, will you lead off?

**Dr. Edje:** Sure. One of the biggest concerns I have as an educator is making sure that our residents, male and female, both are able to get the best educational experiences. And unfortunately, with some of the travel bans that has just really been very, very difficult. We've had to be creative and use multiple modalities to try and get residents and fellows educated and to try and shore up opportunities for them that are multidimensional. That's my biggest thing, making sure that their educational content remains rich.

**Unger:** Dr. Plenty in terms of advocacy and policy issues, where do you think we should be focusing our efforts right now?

**Dr. Plenty:** I think that, actually, the AMA is doing a really good job in advocacy and policy issues. They are definitely talking about health disparities and ways we can combat that. We are talking about ways that we can uplift them, promote women. We're doing that through the WPS or the Women Physician Section, and we're creating policies that promote women. We are personally promoting women and celebrating women this month as a whole, and of course we celebrate women every single day. I think that the AMA do a really good job with diversity in medicine, promotion of women, promotion of people of color and making sure that there are paths for people of color and women to become leaders within medicine and within their communities.

**Unger:** Dr. Block-Abraham, your final thought on policy and advocacy?

**Dr. Block-Abraham:** Sure. I agree with Dr. Plenty and Dr. Edje. I think the AMA is already doing a fantastic job on a lot of these fronts. I think that we need to continue advocating for equal pay for telemedicine visits that we would get for in-person visits because in the day and age where we're using more of that because we're forced to, I think people are starting to, the general public and hopefully CMS and those people are starting to recognize the utility of it, how useful it can be. And maybe it will be more open to ensuring that we get paid for the time that we spend because it takes the same amount of time whether we see them, telehealth remotely or in-person. And maternal mortality is a big thing for maternal fetal medicine specialists and across the board, and so having strong policy and supporting advocacy on those efforts as well as what Dr. Plenty already had mentioned, for just general equality and reducing disparities and things.

**Unger:** Well, thank you so much, Dr. Plenty, Dr. Block-Abraham and Dr. Edje for being here today, sharing your perspectives and being an important part of celebrating Women in Medicine Month.
That's it for today's COVID-19 update, we'll be back soon with another segment. For updated resources on COVID-19 visit ama-assn.org/COVID-19. Thanks for joining us and please take care.

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