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Commentary

Calling for Better Maternal Care Requires a Call for More Training

Julia Marcus[1], Samantha Cash[1], Damali Campbell Oparaji[2*]

[1]University of New England College of Osteopathic Medicine, USA

[2]Associate Professor Rutgers, New Jersey Medical School, USA

***Corresponding author:** Damali Campbell Oparaji, Associate Professor Rutgers, New Jersey Medical School, USA

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"Excuse me ma'am, but do you know how I can find a methadone clinic where I can get care around here? I recently moved here from another state and I haven't had my methadone in 4 days." The past two days had been consumed by trying to coordinate care for the pregnant patient we discharged from labor and delivery. She presented to labor and delivery in a northeast state to rule out preterm labor, with a history of six previous preterm deliveries. We learned that she was on methadone maintenance and had not had her dose for 4 days. We gave her methadone, her contractions stopped and she was ruled out for labor. The problem of access to methadone as an outpatient became apparent. Since she was new to the state she had no established care (prenatal or substance use) here and none of the Obstetrician and Gynecologist (OBGYN) staff had experience managing pregnant patients in recovery from opioid use disorder.

We were able to get her into the local methadone clinic expedited by her current pregnancy. She went on to have a term delivery. The question is can we continue to rely on luck? If care for her opiate use disorder was not restarted, she could have easily relapsed to the use of illegally obtained opioids. Relapse is particularly dangerous these days because of synthetic opioids, which increase the risk of respiratory depression, opioid overdose, cardiac arrest and maternal death.

As medical students on our obstetrics rotation, we encountered more pregnant patients on labor and delivery that struggled with substance use disorder (SUD). We saw the short-term management of these pregnant patients and became aware of the enormous unmet need for treatment in this vulnerable population. We wanted to learn more, we wanted to help.

Data shows that one baby is born with Neonatal Abstinence Syndrome (NAS) every 24 minutes. According to the CDC, from 2010 to 2017, the number of women with an opioid related diagnosis documented at delivery has increased 131% [1]. As the opiate crisis worsens nationally and more individuals are using substances, this includes those of reproductive age and those who are pregnant. We need experienced, skilled providers comfortable caring for pregnant people with this dual diagnosis. Women with SUD and particularly those who become pregnant have unique vulnerabilities and needs [2]. While two separate providers can provide care (one obstetrical care and one for the substance use disorders), models where patients can get comprehensive care (prenatal and substance use care) in a comprehensive treatment program have shown to successfully overcome systemic and individual barriers and can produce improved outcomes [3]. These models reduce stigma, transportation barriers and the need for having to go to multiple appointments with different providers.

Generally, obstetricians are the authority on which medications are safe during pregnancy. Providers who do not regularly care for pregnant patients may not feel comfortable prescribing medications to them. This reluctance to prescribe is magnified when it comes to buprenorphine treatment for a pregnant individual, yet some obstetricians may feel that managing these medications is out of their scope of practice. Other clinicians may worry that their malpractice insurance does not cover them if they care for a patient who becomes pregnant, even if they had been prescribing buprenorphine prior to the patient's pregnancy. Even within methadone clinics, where medication treatment has been standard for decades, physiologic changes caused by pregnancy can cause increased metabolism of methadone. Among pregnant people being treated with methadone increased cravings may appear to the untrained eye as a relapse or hurdle in recovery instead of a change brought on by the pregnancy itself. Methadone prescribers need knowledge so that dosage can be increased

or split as clinically indicated for this population. All in all, pregnancy creates a huge gap in care and highlights the increasing need for physicians who are comfortable managing pregnancy and substance use disorders together. Who might those clinicians be? It seems impractical to silo the care of pregnant persons with one specialty.

Pregnant women with substance use disorders may present to family medicine and internists offices, emergency rooms, urgent care centers, prenatal care offices, labor and deliveries, etc. There are many management issues to consider: antepartum management, labor management and postpartum care (which extends up to 1 year). Morbidity and mortality related to SUD in pregnant and postpartum women most often occurs in the late postpartum period 42 days –1 year post delivery. Among reproductive age women with a need for SUD treatment, only 9.3% received treatment. Pregnant and parenting women were less likely to receive treatment compared to not pregnant nor parenting women [4]. We argue that more obstetricians need to be trained in treating SUD in order to reduce the current care gap and the threats it poses.

Access to board certification in addiction medicine has historically been available through two pathways: a fellowship or by providing care as an attending through the Practice Pathway. The practice pathway to certification will close in 2025. Currently there are 95 ACGME-accredited addiction medicine fellowships in 43 states all of which last 12 months. There are only 3 subspecialty fellowships, Boston University, Swedish Health Center and University of Pittsburgh, dedicated to training physicians caring for pregnant patients.

We call the medical community to action: we need to increase the education of various providers in the treatment of women, particularly those pregnant and in the postpartum period with substance use disorder. The current training of OBGYN residents to care for patients is insufficient to fully address this unless specific curricula is placed within residency training. OBGYN residents spend several months on gynecological oncology rotations performing surgeries and ordering chemotherapy that they may never perform again; a rotation in psychiatry, where time could be focused on perinatal mental health disorders and addiction care would be more beneficial to the general population.

Substance use disorder is a major public health crisis and does not spare pregnant patients. Not only are pregnant patients at higher risk, but we must consider the pregnant patient as well as their unborn baby. Given that this practice pathway is now closing in 2025, we are worried that less providers will feel comfortable caring for patients with SUD and there will be less avenues for them to get the education they so desperately need.

To overcome this unmet need, we call for the incorporation of more formal addiction medicine training in OBGYN residences. If all OBGYNs had more expertise and confidence with this patient population, there would be better care coverage and fewer complications. Evidence shows that coordinated care between a patient's providers results in better health outcomes. Patients who have SUD frequently see many providers for various aspects of their health and communication between providers is essential for successful patient treatment. Obstetricians and gynecologists who feel comfortable working with patients who have substance use disorders, allow for those patients to have more comfort and trust in their providers. Beyond pregnant patients, many female patients see no doctors on a regular basis except for their gynecologist. It is essential for a gynecologist to feel comfortable screening, discussing, and/ or referring and treating SUD as it is likely that they will have patients who will present with it, and they may be their only provider.

As medical students considering a career in women's health, we see a need for a wider range of providers to feel confident treating and caring for pregnant and postpartum individuals with SUD. The opioid epidemic does not spare this vulnerable population. Adequate and comprehensive training is essential.

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