man on a MISSION

A conversation with Dr. Clarel Antoine, who is determined to eradicate a common complication of C-sections

By Rechy Frankfurter

I had vaguely heard about Dr. Clarel Antoine. Wasn't he the doctor that many *heimishe* women went to for high-risk pregnancies? But I had no idea how popular and revered he was by people in our community. So when I received a text from a reader suggesting that we interview him, I filed it away as a maybe. Then I received an email from a young mother in Lakewood, a sometime contributor to *Ami*, with the same suggestion. Not only do many women in the tri-state area use him, she informed me, but people come to him from all over the world. "I really think you should interview him," she wrote.

I was intrigued, and decided to meet the good doctor. A short time later, we had the honor of his presence in *Ami's* offices. With his old-fashioned bowtie and soft Haitian lilt, he gives the impression of a 19th-century gentleman. But looks are deceiving, as he is actually one of the most highly trained OB/GYNs in the world, well versed in the latest 21th-century medical procedures and breakthroughs.

I asked Dr. Antoine to tell me a little bit about his background.

"I was born in Haiti, and attended seminary to become a priest from the age of nine to 14. I was always studying, so my mother encouraged me to follow in the footsteps of my grandfather, who was a doctor. He was actually a pediatrician as well as an attorney. After I came to the United States in 1966, I attended City College and then Columbia University College of Physicians and Surgeons for medical school. I did my training—both residency and chief residency—at Columbia Presbyterian Medical Center, and from there I went to New York University Medical Center, where I was a fellow in maternal-fetal medicine specializing in high-risk pregnancies. I've been affiliated with NYU ever since and opened my own practice in 1981. After Hurricane Sandy, in 2012, the medical center closed down for a few months, so I moved my practice to a brownstone a block away.

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"Although I enjoyed all aspects of medicine and surgery in medical school, I wanted to focus on something more cheerful than the illnesses people tend to get as they grow older, so I decided to go into obstetrics and gynecology. Most of my patients have medical problems like diabetes and hypertension or are carrying multiples, but I take care of regular deliveries as well."

Dr. Antoine's entrance didn't go unnoticed by several of our female employees. As soon as he walked in, our bookkeeper immediately came over to thank him. "You probably don't remember me," she said, "but a couple of years ago I had an emergency and I tried to reach you. It was a weekend, and even though I wasn't your patient you called me back, calmed me down and gave me the help I needed. You even checked up on me a few days later. I am so happy to be able to thank you in person!" Dr. Antoine was touched, but it was obvious that such expressions of gratitude are a common occurrence.

Then a young man whose wife is Dr. Antoine's patient shared this:

"The first time I met Dr. Antoine was around 20 years ago, when my wife was having complications in her pregnancy. It was Labor Day weekend, and Dr. Antoine could have easily told

me that his office was closed, especially since he wasn't even my wife's doctor. But that's not who he is. He told us to go to the hospital and he would meet us there. As I was waiting for the elevator, Dr. Antoine walked in from the parking lot. He had never seen me before, but he figured everything out in a second. He walked over to me and said, 'Don't worry, Hashem is with you. Everything is going to be fine.' He's a very spiritual man."

Another woman who is currently Dr. Antoine's patient related the following:

"I also met Dr. Antoine over a three-day weekend. I was having a problem on Shabbos, so I called my OB/GYN. He said that there was nothing they could do about it anyway, and told me to wait until Tuesday for my regular appointment. I was frantic, so I called my sister and she instructed me to call Dr. Antoine right away. I was embarrassed because I wasn't his patient, but she urged me to get in touch with him. Dr. Antoine opened his office especially for me, did an ultrasound and said, 'Everything is fine. Hashem is with you. Don't worry.'

"The outside world doesn't respect the fact that having large families is important to us, but Dr. Antoine treats us differently. Most doctors are very cavalier about it and even condescending, telling their patients to be happy with the children they have and not jump through hoops to have more. But Dr. Antoine uses all of his knowledge and skills to benefit the members of our community.

"Two years ago, Dr. Antoine told me right before I gave birth that he had a very important operation scheduled that day. From the way he said, it seemed as if this person was in danger of losing her life. Dr. Antoine canceled all of his appointments for this woman, and he delivered my baby shortly after he was finished with her. I ended up meeting her in the convalescent home. She was recuperating very nicely even though it was her fifth or sixth cesarean section."

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But Dr. Antoine hasn't come here today to listen to praise; he is a man on a mission, and wants to discuss a topic about which he is passionate: an obstetric condition called placenta accreta, formerly known as morbidly adherent placenta. In typical pregnancies, the placenta detaches from the uterine wall after childbirth. With placenta accreta, the placenta grows too deeply into the uterine wall, so part or all of it remains attached. This can cause severe blood loss after delivery and can be life-threatening.

Placenta accreta is thought to be related to abnormalities in the lining of the uterus. Although it is possible for it to occur in women without a history of uterine surgery, it usually happens because of previous scarring after a C-section. Dr. Antoine wants to bring attention to what he says is an avoidable fallout from cesareans, insisting that it doesn't have to happen if the cesareans are performed properly.

As he explained to us, sometime during the 1970s and '80s, advances in technology led to a reduction in the cost of the procedure. It also decreased the time it took to operate, reduced the amount of blood that was lost, and enabled women to leave the hospital sooner. In the ensuing years, the training that doctors received in medical school was changed, and many of the younger ones were only taught the newer technique, which was speedier and cheaper. Unfortunately, the long-term effects of this were never taken into account.

Back in the 1960s, before the speedier procedure was introduced, the incidence of placenta accreta was one in 30,000 births. In the 1980s, it was one in 2,500. According to the National Accreta Foundation, it currently affects a whopping one in every 272 births.

Is that because of the increased speed with which the surgery is performed?

We don't know, but it's getting worse and worse, and 95% of the placenta accreta cases these days are related to previous cesarean sections. The major New York hospitals—Cornell, Columbia and NYU—are probably treating an average of three to six cases a month.

And you believe that the increase is connected to the new procedure?

Most doctors will tell women who experience placenta accreta following a cesarean section that it's just an unfortunate part of

having multiple cesareans. But in my 40 years of practice, I've had women with seven, eight or nine consecutive cesarean sections, and I've never seen the accreta consequences that are currently described when patients have C-sections.

Tell me about the research study on placenta accreta you've been involved in.

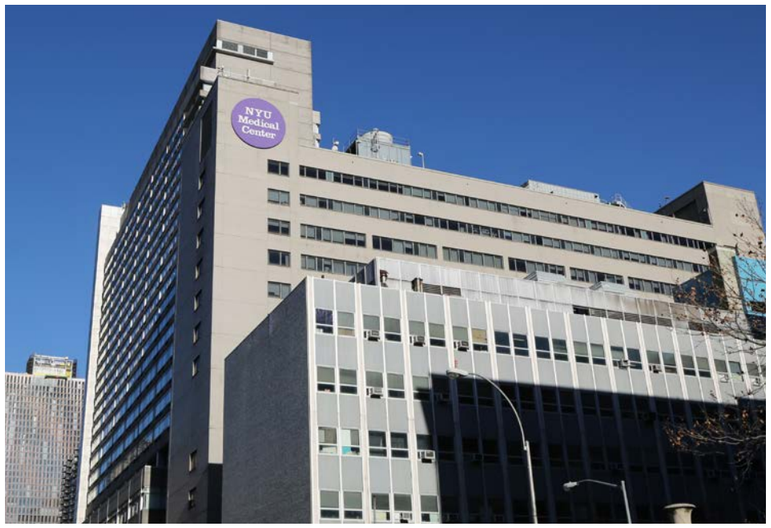
The literature is full of cases and there are numerous publications about this condition. But what we are doing now is a huge undertaking that is going to change the way cesarean sections are done both in the United States and around the world. I'm the lead author and the only surgeon in the study, which is based on participants in my practice. It covers a period of 30 years and includes 5,000 deliveries, of which 727 were C-sections. Almost half of those 727 had between two and nine cesarean sections. There were hundreds of women who had between two and six successive cesareans with me, and the data in the literature clearly show the increasing risk for placenta accreta after each one. But I have never had even a single case, which defies the expectations.

The logical question is, what do you do differently from other doctors?

The suturing after the cesarean is done differently, and it takes time.

What can women who aren't your patients do about this? Can they tell their doctor to make sure to do the suturing according to your method?

That's a very good question, and one that I've been struggling with myself. For the last several decades it has been commonly accepted practice for an obstetrician to do whatever he or she wants for a cesarean section. There are no standards for how to do it. When comparing the various techniques, the literature will tell you that whatever you do has no influence on the short-term outcomes, but it isn't known how it affects the long term. We always knew that most women with placenta accreta experienced it because of a prior



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C-section, but no one ever examined exactly what was done during those prior procedures that may have led to the condition. This is the first time technique has been raised as a very strong possibility to be related to the underlying cause.

In other words, a woman can present with placenta accreta a number of years after having a cesarean section, and no one ever connects the dots?

That's correct. No one ever connects the dots. Up until our study, the published data associated the phenomenon with the increased rate of cesareans, as well as the ability to do multiple repeat cesareans. Our study goes into what is it about the C-section itself that would lead to it. Of course, there are other factors involved, including the location of the placenta.

And you believe that wouldn't happen with your technique.

My paper showed that it hasn't happened.

What are the actual ramifications of placenta accreta?

It is probably the most catastrophic obstetric event in modern times. It is life-threatening and can lead to death. It requires the care of a specialized team for the best outcome.

How is it discovered?

Most of the time there aren't any symptoms, although there can be bleeding during the third trimester. The diagnosis is usually made via ultrasound.

And you believe that the reason your method fell out of favor is that it's just too time-consuming?

Our study doesn't address that. All I can tell you is that I get copies of patients' previous operating reports, and there is one that I keep on my desk from a doctor who performed a cesarean section in 16 minutes. I'd love to meet him one day and find out exactly what he did. But I can't say that 16 minutes is too short, because I don't know the details. The only reason I know about it is that the patient came to me.

How much of your practice is made up of Orthodox Jews?

For obstetrics, about 70%.

How did you get involved with the community?

I don't really remember how it started but it's been a very long time. I did my fellowship at NYU and published several research papers with my colleagues, notably Dr. Bruce Young. When I went into private practice, they referred patients to me.

Where are most of your patients from?
They come from all over. The Orthodox clientele comes from Lakewood, Williamsburg, Boro Park, Monsey, Monroe, Israel and Russia.

What kind of people are coming from overseas?
I have no clue. They just call and say that they were referred by family or friends.

You've been practicing since 1981, so we're talking about generations.
Absolutely.

Are the young woman of today different from those of 40 years ago?
It's very mixed, in that I see some 19- and 20-year-olds who are very mature and others who aren't. I'm sure that not much has changed because of the age women get married in this community. But the support system is what's so important, particularly from parents.

Even in more secular communities there's a trend towards "helicopter parenting." Have you always found that to be the case among Orthodox Jews?
I would say that it's more common in your community than elsewhere because of the younger age at which people get married.

I know that most doctors won't speak to parents without the explicit permission of the daughter. Are you less restrictive about that?
I'm not allowed to be, but I try to get everyone on the phone at the same time.

Do you find that most daughters want their mothers involved?
Yes, and I want that too. I want to be transparent, and the support of the mother is usually very important both for me and the patient.

Do most of your patients still feel the same way when they're in their 30s?
No. The first birth is when parental support is really crucial. It's not as important for subsequent births unless there are issues.

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Do you find that today's women are more educated than they were 40 years ago?
There's no question about it.

How does that help you?
Forty years ago I had to take more charge of my patients' health, but these days they ask a lot more questions and are more involved. And let's not forget the rabbis! But I really don't speak to them that much anymore because they usually say, "If Dr. Antoine tells you to do something, you should do it!"

I also find that husbands are a lot more involved than in the past. They may be behind the curtain in the literal sense, but they know exactly what's going on. I welcome that, because if you're honest about what you're doing you should be able to tell people why you're doing it. In any case, I don't do unnecessary C-sections, so by the time I tell someone she needs a cesarean the husband will have enough information to call his rabbi and get clearance.

What about your patients' mental health? Is that also within your purview?
I am on Governor Cuomo's task force to look into maternal mortality and what we call other disparate maternal outcomes related to race. We are now pushing for the establishment to pay more attention to postpartum care, although I must say that I have never encountered stronger support than in your community. There is such strong support for young mothers that I have rarely seen a case of undiagnosed postpartum depression.

Dr. Naomi Greenblatt, the wife of Jason Greenblatt, is a psychiatrist who practices in New Jersey. She told me that she sees many cases of PPD, and believes that the problem is more chemical than related to a lack of support.
While there is a chemical element and some people do need treatment, for the most part, the more support you have, the easier it is to combat postpartum depression. If you have one baby and you go to a convalescent home or your mother's house as soon as you give birth, you're going to recover quickly. If you have six children and your parents have 20 other grandchildren and don't have time for you, there's a greater chance of becoming depressed if you have issues and don't have a good support system.

Back in the days, people were much stricter about convalescing for six weeks. Nowadays, mothers are already going to the *bris* and they also return to

work much sooner, especially when they can work remotely from home. Is this a bad thing, or has childbirth become easier in modern times and women don't need the same amount of rest?

Childbirth is probably the most all-consuming time in a woman's life, so I encourage everyone to get as much rest as possible. I talk to my patients about resting during the day while the baby is resting, because I'm a firm believer that one of the contributing factors to postpartum depression is exhaustion. Physical exhaustion then drives emotional exhaustion, which is why a support system is so important.

Do you get involved in the emotional state of your patients, or is that something you can't really do?

I can, but I'll only do it indirectly. At the beginning of each pregnancy I'll ask general questions about what's happening in their lives. I also have a different relationship with my patients than most doctors because I'm a solo practitioner. If someone has a problem, she's usually very open and willing to discuss it with me. If a woman has emotional problems, I'll refer her for therapy or put her on medication. Thank G-d, most of my patients are happy to be pregnant. But if a patient does have a problem, I feel blessed when she confides in me and asks for help. And if there's an issue my patients aren't aware of, I'll help them take care of it.

What advice would you give women in terms of being proactive about their health?

I want the message to be that people need to understand that cesarean sections have unintended consequences. Short-term recovery isn't an indicator of the long-term impact. I don't want to scare people, but there *are* far-reaching consequences, and it troubles me that they aren't spoken about. Had you ever heard of placenta accreta before today?

Truthfully, I have not. Would you encourage women who have had C-sections to get themselves checked for scarring?

There are tests that can be done to determine the presence or absence of scarring. But not everyone who has scarring will have placenta accreta.

So the message is more that if a woman knows that she is going to have a cesarean, she should do research about the doctor to make sure the procedure is going to be done right.

My message is to be clear with the doctor that the cesarean should be done in the best possible way to avoid scarring.

And she should ask her doctor what he or she is going to do to avoid it.

That's correct.

But not everyone knows she's going to end up with a caesarean.

That's true.

So the idea is to at least discuss the possibility of a cesarean and whether there's a plan to avoid scarring if a C-section becomes necessary.

I'm approaching it on a different level, an educational level. The doctors themselves have to know that a technique exists that can limit scarring. It's going to require a revamping of the way doctors are trained because all this is new to them. The first thing that is needed—and I'm going to be speaking to the governor and the commissioner of health for New York State about it—is a registry about the incidence of placenta accreta, so that everyone can know the extent of the problem.

Where are you getting the numbers you have now?

Those are national numbers, but we have no idea what's happening on the state level. It's very telling that people in the community

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don't know about the incidence of placenta accreta. When something happens, people are very private about it. People don't even want others to know they had a cesarean, which makes it even harder to talk to them about future risks and possibilities. I heard through a friend that there's a support group for women in Monroe who have had placenta accreta. The problem is that it's kept very quiet.

To what do you attribute the increase in cesareans? Is it unnecessary?

It's a multifactorial thing. One factor is that there is no standard for practicing obstetricians to perform a cesarean. There is also the fear of malpractice, which is certainly influencing doctors. There is no question about it.

Is it possible that it's also because doctors are more educated in preventive medicine these days?

No. I think the main factor is fear, because malpractice is a very easy thing to claim.

If you've never had a case of placenta accreta yourself, why are you so passionate about raising awareness?

I'm passionate because the literature claims that this is just something to be expected. It should not be so.

When I was in training at Columbia Presbyterian, we were instructed to respect the layers of the uterine lining and not incorporate one that doesn't belong with the other. When I started my practice, I needed to teach the residents exactly where to place the needle when stitching. I had to point out the junction between the muscle of the uterine wall and the lining inside. I taught that to approximately 200 residents. Some of them still do it that way, but not all of them. But it's not part of the current teaching nationally. It still has to evolve.

I have two missions. One is to bring to providers' attention that technique matters. We may need to do a larger multi-physician study. But because the incidence of placenta accreta is rising so rapidly, we don't have the luxury of time to do nothing about it.

The second mission is to educate and advocate for women to have safe births.

Although Dr. Antoine is a soft-spoken man, the fact that he is passionate about women becoming educated about placenta accreta and helping them avoid this catastrophic condition comes through loud and clear. We are honored to help him spread the word. ●