

## **THE IMPAIRED PHYSICIAN: TWELVE-STEP RECOVERY PROGRAMS**

by Daniel M. Avery, MD

**ABSTRACT:** "Twelve-step" recovery programs are based on mutual help and encouragement, addressing a wide variety of addiction and self-destructive behaviors.

Alcoholics Anonymous (A.A.) was founded in 1935 by Bill Wilson (Bill W.), a New York stockbroker, and Bob Smith (Dr. Bob), an alcoholic surgeon. Many alcoholics worldwide have achieved and maintained sobriety through A.A. since then. An excellent discussion of twelve-step recovery programs is presented in a recently published book entitled Drug Impaired Professionals by Robert H. Coombs. This article summarizes Dr. Coomb's chapter on "Self-Help Recovery".<sup>1</sup>

Many other twelve-step programs have appeared since A.A. was founded, most based upon the same basic principles established by Wilson and Smith in 1935. These include Narcotics Anonymous, Cocaine Anonymous, Co-dependence Anonymous, Al-Anon, Alateen, Adult Children of Alcoholics, Emotions Anonymous, Gamblers Anonymous and Overweight Anonymous. These organizations and others like them have become so much an integral part of our culture that they are even occasionally used for comedic effect, as in a recent television reference to "Potato Chips Anonymous".

All twelve-step programs are based upon mutual help and encouragement. A.A. meetings for example consist of successfully recovering alcoholics sharing personal experiences, strength, and hope with others recently recovering or nonrecovering. The cornerstone of sobriety through A.A. is "The Big Book", an average-sized book of 575 pages officially entitled Alcoholics Anonymous. It has been published by Alcoholics Anonymous World Services, Incorporated, throughout the world in practically every literate language. Over the years additions have been made to the original true anecdotal stories of recovering alcoholics but the principles, called "Twelve Steps to Recovery" and "The Twelve Traditions" have remained essentially unchanged. Over 2,000,000 have stopped drinking through A.A., making it the most effective means for alcoholics to achieve sobriety.

### **THE PRESIDENTIAL BOX**

**Dan Avery, President**

Remember back when you were an intern on call and had ten admissions after midnight? Remember those calls at County General and Receiving when an intern and his third-year medical student did 21 deliveries a night including four Caesarean

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sections, three midforceps rotations and one shoulder dystocia? Remember how you longed for private practice when anesthesia would manage everybody's epidural so the nurses, obstetricians and patients would all be comfortable? Remember when the call schedule determined which nights you would spend in the hospital? Remember dreaming about private practice allowing you to take call at home, only going to the hospital when a patient was in active labor?

Those days may not have been so bad after all. You were already in-house and didn't have to drive across town when an obstetric emergency came in. You were never detained at a sister hospital and such unavoidable or unpredictable things as wrecks on the Interstate or inclement weather due to snow, sleet and ice never delayed your arrival.

More and more obstetric departments are considering staffing labor and delivery with an obstetrician around the clock. I previously had privileges in a large private hospital with seven other active obstetricians. We worked very well together, occasionally covering for each other. There was one group of four, one group of three and one solo practitioner. If the roads were covered with snow or ice, whoever was in-house covered for everyone (That's a frequent problem here in Alabama where everybody forgets how to drive from Thanksgiving Day until after Easter Morning.) It was great! Most of the patients were delighted to have any obstetrician even remotely known to them present during a snowstorm labor to manage pain and attend delivery.

Several times we discussed rotating the call with one of us staying on labor and delivery each night to attend everyone's patients; during days we could each manage our own patients. We continued to cover each other during emergencies, but routine pooled call never happened for a number of reasons. I suppose reimbursement concerns and the anxiety about being responsible for patients we had never met were high on the list.

These concerns could have been easily addressed by general agreement among ourselves. All the patients could have met each of us at least once during their pregnancy or more if they wished. I've found that most patients will accept any call system if it's explained in advance. The most commonly asked question is, "Do I get to meet the other obstetricians?", and this is not an unreasonable request.

Over the years I moved from Birmingham to a rural regional medical center. We have four active obstetricians on staff and we all share call. There is ample opportunity for each patient to meet every obstetrician except the one who only practices part-time. A board certified obstetrician is immediately available in labor and delivery each night. Weeknights are rotated and weekends are rotated as one call with backup available.

Our experience with rotated 24 hour in-house call is like being a resident except you occasionally go home to eat, shower, shave, etc. if absolutely nothing's going on. A large obstetrical group in a nearby metropolitan area has had the same experience. They have over twenty physicians and keep two or three in-house every night. Call is one in five or six and by no means burdensome. Each works a half day after a night on call, afterward going home to rest and sleep if necessary.

I am convinced this has greatly improved our quality of care plus I sleep better in L&D than I did at home on call. I have experienced none of the former big city problems of traveling in traffic and weather. Nurses in private hospitals without residents, interns or medical students seem more comfortable with an attending obstetrician close at hand, and I surprisingly get fewer calls and pages in-house than I did at home depending on the duty nurse.

I must commend our hospital though for actually making in-house call pleasant by providing amenable call facilities with comfortable sleeping quarters, private toilets, a lounge, and dining facility. I've heard some hospitals are so glad to have an obstetrician immediately available they provide free meals, beverages and snacks..

It seems the busier a service is the more it demands a physician be immediately available on the premises. Almost all teaching institutions now require in-house attending coverage. Busy private obstetrical services may in the future require the same. I am now convinced it ensures the best possible quality of care for every patient around the clock, and they deserve no less.

Comfortable call facilities are obviously a necessity. My hospital used to have only one small, noisy call room beside the nurses' station where sleep was almost impossible. The new hospital's call room is on the obstetric floor but isolated from noisy work areas.

Obviously a solo practitioner or two person group taking in-house call is impractical, but shared call is very reasonable for any obstetric department maintaining an adequate number of deliveries. I would appreciate the membership's opinions and experience.

Dan Avery

## THE WITNESS BOX

Doug Daniel, Editor

*A woman goes to a gynecologist. The doctor says, "You're crazy." The woman says, "I want a second opinion!" "O.K., you're ugly, too."*

*In memorium: Henny Youngman, 1907-1998*

Plans for the Society's meetings at the New Orleans ACM are complete. We will be sponsoring a combined AA/Caduceus meeting after our 5:30 PM Special Interest Group meeting on Sunday, 10 MAY 1998, in the Oak Alley Room of the New Orleans Hilton Hotel. Ben Harer has informed me he will be unable to attend the membership meeting, but Joe Pastorek (the Society's agent in New Orleans) has arranged an excellent program with practically no notice, putting together a no-holds-barred contest between dueling attorneys Gregory J. Avery, Esq., and C. William Bradley, Esq. Mr. Avery is a knowledgeable and experienced plaintiff attorney who specializes in personal injury (including medical malpractice) and physician actions against adverse determinations of medical organizations and agencies. Mr. Bradley is a knowledgeable and experienced attorney who confines his practice to medical malpractice defense. I can promise you it will be a dynamite presentation. Ya'll come.

Dan Avery's installment this month on impaired physicians addresses the self-help movement, or twelve step groups. It's reference source is an excellent book recently published by Harvard University Press on impaired physicians and other professionals, soon to be reviewed in The Book Box. In case you're interested, A.A. is listed in every phone book I've ever seen. If you can't find their number, call me. Anyone trying to contact other self-help recovery groups without success, ditto.

As part of the Newsletter staff's never-ending effort to provide you the very best in medicolegal thinking we premier this month a new department, *The Suggestion Box*, best described as a guest editorial. Although neither the Newsletter, the Society, nor their staff and membership will necessarily always agree with all the opinions presented in *The Suggestion Box*, we will publish any responsible opinion thought relevant to our profession. We couldn't have asked for a better piece to inaugurate this new column than Hugh Martz's on the differences in the practice and ethics of medicine and law. I'm sure we'll receive plenty of letters on this one.

Hugh is a Society member, on the Newsletter's Editorial Board and a former law professor, practicing general law in Valparaiso, Indiana. He co-authored with me this month's *Med Mal 101*, first in a three-part series on how the legal system works in medical malpractice litigation. He last wrote for us in JULY 1997 (Vol. 5, No. 3).

The last two items this month are by me, the first about the College's financial support of IDEX, a for-profit defense advocate litigation research and private investigation firm. To my way of thinking this support violates or at least belies the AMA and ACOG ethics statements regarding impartiality in medical expert witness activities. There's nothing wrong or illegal about that, but some are concerned that the College is using members' dues to financially support a medical malpractice defense advocate. Decide for yourself. The second is based upon a JAMA article last year about how physicians' lack of or poor communication skills is a major factor in whether or not their patients sue them.

The good news is we apparently lost only three members this year. Two were dissatisfied with the quality of the Newsletter and felt the Society was doing

nothing for them. The other retired from clinical practice to take a full-time job with a major medical malpractice carrier and felt his membership could present a conflict of interest. All three will be sorely missed.

Oh by the way, in case you haven't heard there's been quite a tempest in a teapot brewing at the College offices in DC recently (Don't you just love juicy gossip?). It seems the powers that be decided to save some of our hard-earned dues money by discontinuing complimentary publication and distribution of the Tech Bulletins, Committee Opinions and Criteria Sets on heavy print stock punched for three ring binders and mailed to the membership. Alternatively, all would be published in the Green Journal beginning with the March issue and anyone wishing the old style documents could subscribe to them separately, at \$150.10/year in my case.

Apparently some of the membership's reaction could best be described as less than enthusiastic, and as of our printer's deadline quite a few of the staff were reported to be busily scurrying about the College offices trying to find a satisfactory solution. If you've already expressed displeasure toward the worshipful masters in the East, rest assured that your concerns are being seriously considered. If you feel inclined to fire off a scathing epistle in the same direction, I suggest you contact the Resource Center first at 1-800-673-8444, Extension 2518, to see what the final outcome will be. Then if you still feel full of piss and vinegar about the whole affair, there's an extensive list of responsible staff members in the back of your Directory of Fellows with toll-free telephone numbers, fax numbers, E-mail addresses, and of course snail mail addresses. And don't be shy. After all, it's your money.

This issue also marks the debut of our official disclaimer as follows:

"All opinions expressed in The Medicolegal OB/GYN Newsletter are strictly those of the bylined authors and do not necessarily represent policies, opinions or recommendations of the American Society of Forensic Obstetricians and Gynecologists, its members, Board of Directors, Editorial Board, etc."

Don't even ask.

As usual we encourage submission of letters to the editor, articles, and now guest editorials for publication consideration. Letters and editorials are subject to editing only for space requirements with articles and editorials typewritten and double-spaced. Free reprints of individual past Newsletter articles are available to members at no cost upon submission of a SASE, back issues for \$10.00 each or \$20.00 per volume of four issues.

***LAISSEZ LE BON TEMP ROULEZ!***

## THE SUGGESTION BOX

I've been thinking recently about how the medical and legal professions differ. First of all physicians are sued for malpractice more often than lawyers. The pat answer is that lawyers screw up just as much or more than physicians, but they run the store when it comes to the legal system. There is some validity here, but there is truth beyond.

The physician's duty to his patient may well be held higher in the law than the lawyer's to his client since the consequences of the lawyer's errors or negligence are seldom as severe as those of the physician's. There are a limited number of crimes for which the death penalty is required or provided, but a physician's practice daily involves his patients' loss of life or its quality. The worst that can happen in a contract dispute, divorce or real estate transaction is the loss of property interests.

Secondly, the practice of law involves greater client/patient participation than the practice of medicine. Clients usually know more law than patients know medicine. Clients come into my office and relate facts which I sift through, afterward advising them of the applicable law and asking how they wish to proceed. I often send them away to gather more facts in the form of documents, names and addresses of witnesses, etc. at their convenience, all the while sharing with them legal memos, court pleadings and such. You on the other hand must sometimes very rapidly gather historical and clinical facts, evaluate and treat. Your patients are almost always given their choice of recommended treatments but otherwise participate far less in the decision-making process than my clients.

Add to this the fact that everyone thinks you are highly compensated for your services with more than adequate assets to satisfy any judgments against you, and the fields are ripe unto the harvest. I therefore suggest important distinctions exist beyond the superficial as to why physicians have been and ever shall be subjected to malpractice litigation beyond all other professionals.

Physicians sued for medical malpractice are often perplexed and occasionally appalled at the unpleasantness of being dragged kicking and screaming into the legal process. Sometimes they encounter plaintiff lawyers who appear hungrily on the prowl for deep pockets. Understanding the differences between the practices of law and medicine may help.

Both have rules but each operates differently. Medicine is an applied scientific art calling for strict technological precision, often under very pressing and stressing time constraints. Law on the other hand is one of the humanities, governing human relationships and interactions. It remains relevant and viable only by flexibly accommodating to new and changing theories, facts and circumstances.

Medicine rules-out possible diagnoses until only the one most likely correct remains, then quickly begins appropriate treatment. Law on the other hand slowly gathers and considers evidence plus the credibility of the involved parties and witnesses, eventually reaching a carefully deliberated decision based upon the weight of the evidence but always subject to appeal, reconsideration, amendment or reversal. This can be disconcerting to the physician, trained and experienced as he is in dealing with obvious black and white issues, when he realizes his and his family's future will be decided by barely over half the weight of the alleged evidence presented to twelve or fewer of his fellow citizens.

When law enters the Temple of Aesculapius it usually rules with an iron fist concealed within calfskin Isotoners. Both disciplines must however interact cooperatively when medicine enters the courtroom, but their rules cannot be interchanged. Medical expert witness and defendant testimony is based upon medical considerations, rendered during litigation in accordance with the rules of law and

the court. The flexibility of the law can allow abuses by skilled advocates, but when you understand the basic rules of the legal system you can make it work for you and assume you had your fair day in court. Remember the judge, not plaintiff's counsel, runs the court. Between your proper preparation, commitment to the purpose at hand, the expertise of your defense counsel, and the judge's enforcement of your constitutionally protected rights, you can make your way through a difficult legal quagmire and exit the other side with the best possible result.

Hugh Martz

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## THE LITTER BOX

Doug Daniel, Editor

This month's Litter Box focuses on Vol. 33, Nos. 5 and 6 (March 1 and 15, 1998) of OB.GYN.NEWS. I was impressed by how many of the articles were relevant to my practice, and hopefully yours. This is more a newspaper than a peer-reviewed journal, so the opinions are that and nothing more; but stories are current and some cover peer-reviewed journal articles. If you still have this issue, it's worth digging out. If not, send me a SASE and I'll return copies as requested. Subscriptions are \$96.00/year, but if you call 800-445-6975 and ask for circulation you might get on their complimentary subscription list. Mailing address is:

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1 MARCH 1998

Project Aims to Cut Failed Inductions - Page 1: Covers an effort by Boston's nonprofit Institute for Healthcare Improvement (IHI) to decrease Caesarean section rates by decreasing failed inductions of labor by delaying "unnecessary" inductions and awaiting spontaneous onset of labor. IHI is "A consortium of hospitals, clinics, and managed care organizations engaged in a nationwide effort to reduce the number of failed labor inductions through more judicious use of induction techniques and better patient selection." The chairman of the project, Bruce L. Flamm, FACOG, is associated with Kaiser Permanente Medical Center in Riverside, California. No surprise there.

Telephone interview with Ms. Nivedita Misra, Coordinator of IHI's National Cesarean Section Collaborative Project, revealed that the Institute is about ten years old, initially founded with a private grant from The Hartford Foundation (Wait a minute. Ain't the insurance industry heavily based in Hartford, Connecticut?), now self-supporting via tuition for its quality improvement seminars. Objectives of the Institute are "to improve outcomes, efficiency and quality of healthcare while decreasing costs." Hmm. Now where have I heard that before?

FDA Panel Gives AutoPap the Nod for Primary Screening - Page 1: Two proprietary systems of automated Pap smear reading are currently being evaluated by large-scale clinical investigation. One (AutoPap) appears sufficiently accurate to be approved for primary independent reading and diagnosis, while the other (PAPNET) appears only good enough to be used as a quality control via rescreening after manual reading by a cytotechnologist. My broker advises buy AutoPap.

Workforce Increases May Mean Job Losses by 2010 - Page 1: Fewer and fewer jobs for more and more obstetricians and gynecologists. Ralph Hale from the College says, "...we may be training young men and women who will not have job opportunities in the near future." To quote PFC Gomer Pyle, USMC, "Surprise, surprise!"

53% of Residency Directors Back Primary Care Training - Page 2: More importantly, this means 47% don't support the College's position that we should be providing general medical care as primary care providers. See above, Ralph Hale.

Anal Ca May Be a Sexually Transmitted Disease - Page 8: It's obvious that in today's culture, either heterosexual or homosexual anal penile intercourse places both receptive males and females at increased risk for epidermoid carcinoma of the rectum. The interesting thing is that even women who aren't anal receptive also have an increased risk if they harbor cervical Human PapillomaVirus (HPV).

Does Nature Know Best? - Page 10: One of our new members, Jerold Weinberg, FACOG, writes an editorial column for each issue. This one is especially relevant as it opines that the rush to natural childbirth and nonintervention obstetrical practice is being modulated by increased interest in active management of labor and operative procedures for vaginal delivery. The more things change, the more they stay the same.

HIV-1 Shedding Tied to OCs, Lack of Vitamin A - Page 18: Another reason to encourage HIV screening. Seropositive women are apparently more infectious if on BCPs, DepoProvera®, or vitamin A deficient. On this one my broker advises buy Trojan.

When to Use C-Section in Amniotic Fluid Embolism - Page 27: There's no improvement in maternal survival regardless of treatment. Immediate Cesarean section (within fifteen minutes of maternal cardiac arrest) markedly increases neonatal survival with half of survivors neurologically intact. "A cesarean section could, however, worsen the chance of survival in women with cardiac arrest who are hemodynamically unstable." Au contraire, mes amis. Research has shown for years that in maternal cardiac arrest beyond 30 to 32 weeks gestation, cardiopulmonary resuscitation is ineffective until the uterus is emptied.

Even Second VBAC Deserves Special Attention - Page 28: Sixteen uterine ruptures during attempted VBAC were analyzed with almost half previously delivered by successful VBAC. No mention of maternal or fetal/neonatal deaths, but "Severe variable fetal heart rate decelerations appeared in 14 cases and triggered the intervention (Cesarean section). Nonreassuring fetal heart rate patterns persisted for 42 minutes on average before the decision was made to intervene. An average of 17 minutes elapsed from that decision to incision, he (Michael Katz, FACOG, of USC San Francisco) noted."

Sexual Misconduct Charges Plague Ob.Gyns - Page 32: Speaks for itself.

Boston Residents Want the Right to Unionize - Page 32: Ditto. Looks like they might get collective bargaining status and it could quickly spread.

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Subtle Clues to Domestic Abuse in Office Visits - Page 25: A partner insisting upon accompanying the patient into the office and examination room, standing watch over the patient, monitoring all interactions or answering questions for the patient should be considered an indicator for possible spouse abuse. Also overly solicitous behavior by either patient or partner should raise suspicion.

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THE IMPAIRED PHYSICIAN, Continued from page 1

The Big Book lists twelve steps to recovery. They are:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.<sup>1</sup>

The Big Book also lists "The Twelve Traditions". They are:

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all of our Traditions, ever reminding us to place principles before personalities.<sup>2</sup>

Today A.A. meetings are held around the clock in 134 countries and most U.S. cities. Each starts with "The Serenity Prayer": *God grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference.*<sup>2</sup> New members normally attend ninety meetings in their first ninety days of recovery, then at least three meetings a week or as many as they need. Each is assigned a same-sex sponsor with at least two years sobriety, willing to sponsor another member and be available 24-hours-a-day if called.

A.A. is based upon recovering members helping others achieve sobriety, and meetings are available at all hours of the day or night. There are also programs for families and spouses. More alcoholics have gained and maintained sobriety through A.A. than all other means combined including inpatient hospitalization, halfway houses, counseling and individual therapy.

Some alcoholics however feel that A.A. is not for them, the most common complaint being the emphasis on spirituality and a higher power. Rational Recovery was formed in 1986 as an alternative to A.A., deleting the concept of spirituality. A basic premise of R.R. is that sobriety can be achieved with complete cure in six to twelve months. A.A. on the other hand teaches that one has the disease forever.

Secular Organizations for Sobriety (SOS) was established in 1987. It is self-described as a secular approach to recovery, separating sobriety from religion or spirituality. Like A.A. it regards addiction as a chronic, progressively fatal disease and recognizes total abstinence as the primary treatment goal.

Women for Sobriety was founded in 1975. It addresses issues specific to women alcoholics and is reported to have 250 to 300 groups in the U.S. with about 5000 members. Moderation Management was begun in 1993. It utilizes 30 days abstinence from alcohol followed by drinking in moderation. It is not recommended for chronic alcoholics.<sup>1</sup>

A number of professional groups have been founded involving physicians, dentists, pharmacists, nurses, lawyers and other professionals. International Doctors of Alcoholics Anonymous (IDAA) was established in 1949 as a support group for recovering alcoholic physicians and their membership is constantly growing. They address the specific needs of recovering physicians. In the early 1980's Dr. Doug Talbot, cofounder of the Talbot-Marsh Recovery Campus in Atlanta, started the Caduceus program for recovering healthcare professionals. Today Caduceus is active in every major U.S. city and many foreign countries addressing the special recovery needs of healthcare professionals.

Birds of a Feather International was created in 1976 by and for recovering pilots, advocating two to three A.A. meetings each day. The AirLine Pilot's Association (ALPA) subsequently established its Human Intervention and Motivation Study (HIMS) to rehabilitate commercial pilots impaired by alcohol, safely returning over 90% to the cockpit. Prior to HIMS a violation of federal or company alcohol regulations permanently canceled a pilot's commercial license and ended his career.

The Other Bar was founded in 1971 by and for alcoholic attorneys with most of its chapters in California, Oregon and Washington while organizational efforts have been less than successful in the southern U.S. A similar group was formed in 1975 as International Lawyers of Alcoholics Anonymous (ILAA). Dentists Concerned for Dentists was organized for impaired dentists.<sup>1</sup>

Coombs describes about 750 self-help and mutual support groups in the U.S. with an estimated 15,000,000 members. Self-help groups are probably the most important aspect of all recovery programs, and he provides an excellent description of them. Whether impaired, recovering, or neither, everyone should read Drug Impaired Professionals cover-to-cover. There is a lot to be learned.

#### REFERENCES

1. Coombs, RH. Drug Impaired Professionals. Cambridge: Harvard University Press, 1997.
2. Alcoholics Anonymous. New York: Alcoholics Anonymous World Services, 1976.

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## MEDMAL 101: THEORY

by Hugo Martz and Doug Daniel

Most would agree that as regards medical malpractice, there are three basic categories of clinical obstetricians and gynecologists:

1. Those who have been sued,
2. Those who will be sued, and
3. Those who will be sued again.

While this may seem bleak, it's fairly accurate. Being sued however isn't the real problem. There are many things which can be done to decrease both the chances of being sued and the overall number of suits. The Newsletter has been alerting you to the causes of suits, i.e. high-risk practice patterns, plus some of the ways the specialty's quality of care can be improved. Addressing these issues should decrease the number of preventable injuries/losses and the number of suits subsequently filed. Obviously both physicians and patients benefit, a win-win situation.

The real problem is potential defendant physicians often don't understand the mechanics of how or why they get sued, how the judicial system operates to resolve disputes while protecting both the accuser and accused, or how lawyers try to best represent their clients' interests. A salty old Chief Petty Officer once told a young and inexperienced medical officer shortly after his arrival at Naval Regional Medical Center Guam many years ago: "You can't change the system. And if you don't understand how the system works, you'll never make the system work for you." So here's how the system works.

First one must understand the legal theory of medical malpractice. Although we talk about the therapeutic contract between physician and patient, medical malpractice is based very little in contract law (ex contractu) and primarily in tort law (ex delicto). Society has a completely different set of rules for settling disputes arising out of the alleged failure of one party to meet contractual obligations to another. Contractual disputes are often easier to settle. The issues are objective - literally in black and white within the written and previously agreed upon terms contained within the four corners of the contract. In medical malpractice the two issues are liability (Did the physician breach his duty of care which proximately caused the claimed injury?) and damages (What losses if any did the claimant suffer?). Both are often subjective, open-ended questions involving difficult to define standards of medical care and vague legal principles regarding how losses are valued.

Everett C. Hughes writes in Ethical Issues in Professional Life that when exchanging goods the commercial marketplace recognizes the ethic of caveat emptor (Let the buyer beware). In English that means No Exchange, No Refund, No Return, No Guarantee, As Is, Buy It And It's Yours, etc. The comparable ethic in the medical marketplace is credat emptor (Let the buyer trust). This best describes the legal difference between our relationship with patients and Walmart's relationship with customers.

Tort law respecting physicians is defined by fiduciary responsibility (a high duty) dealing more in shades of gray by subjectively determining injury, loss, pain, suffering, and damages both compensatory (actual dollar value of loss) and sometimes punitive (dollar value necessary to adequately punish the tortfeasor or responsible party and deter future similar actions of gross negligence and irresponsibility). Whether you like it or not, the physician-patient relationship is legally defined as a unilateral fiduciary responsibility on the physician's part. Unilateral means that short of purposefully or negligently failing to follow clear medical advice, she has no responsibility whatever to you except payment, and even that seldom applies in this age of third party payors.

Fiduciary may sound like a banker's word but it comes from fiduciarius, Latin for trust. It applies to advisors, practitioners and counselors in finance, law and medicine. The idea is that if you can't trust your banker, lawyer, doctor, business agent, accountant, etc., who can you trust? Such professionals are expected to possess unusual expertise and knowledge in arcane and complicated areas, always using this expertise and knowledge in their client/patient's best interest. To do otherwise violates the trust placed in them.

If this betrayed trust results in a tort (loss or injury) the injured party must be compensated, the injuring party punished and future similar actions deterred. Most issues in tort law are unfortunately a matter of opinion and the opinions vary depending on whom you ask. Some commentators have made the obvious point that physicians would be better off if their profession were subject to contract law instead of tort law's fiduciary requirements. On the other hand, can you think of any relationship more fiduciary than that between physicians and their patients?

Every high duty in the law carries heavy responsibility. Just stop and think about that for a moment. We really shouldn't want it any other way. Physicians since Hippocrates have been entrusted with the priceless training, expertise, and experience of their forefathers in treating and occasionally curing disease and illness, all the while attempting to relieve pain and suffering. This requires the freedom to utilize a wide variety of diagnostic and therapeutic methods. Practitioners of the healing arts should not be shackled when providing healthcare, but this broad latitude also carries a high duty.

The plaintiff attorney representing your patient who is suing you for medical malpractice must convince a trier of fact (either a judge or jury) that four allegations are indeed factually proven. This burden of proof is not "beyond a reasonable doubt" as in criminal trials but simply "in all (medical) probability", or better than a 50% weight of the evidence making it more likely than not. Remember how O.J. was found innocent of criminal charges but later lost the Goldmans' multimillion dollar civil case against him? The civil burden of proof is always less than the criminal.

These four allegations can be thought of as the four legs of a table and are crafted in the same order as discussed below. Each must be intact and tested before the next can be added. If any one is missing or faulty, the table will literally collapse upon the slightest pressure or challenge like a house of cards. If all four are well-designed and built of strong materials, the table can withstand the fiercest onslaught and remain intact. The same four allegations are also the framework of the Complaint or Declaration which is filed with the Court Clerk and delivered to you along with a Summons from the Court demanding your Answer within a specified period of time, commencing with receipt. In some jurisdictions this Complaint will include specific dollar amounts requested for various damages and in others simply refer to damages "as allowed by law".

Never take this initial notification of suit lightly, but immediately contact your insurance carrier and personal attorney. Yes, we said "your personal attorney". If you don't think you need a personal attorney in addition to the carrier-employed attorney, go back and reread Vol. 5, No. 3, JULY 1997 of the Newsletter before proceeding further.

Failure to provide timely notification to your carrier can void the insurance policy and terminate its protection. The carrier will appoint a defense attorney to answer the Complaint but he will need your complete cooperation and assistance. If the Complaint is not answered within the specified period of time, the judge will assume you do not contest the plaintiff's allegations and demands for compensation. He then by default gives them pretty much whatever they want.

On the other hand your attorney may try to have the suit dismissed on technical grounds such as the statute of limitations having expired. This is the plaintiff's window of opportunity to file suit and varies state-to-state by statute from two years to forever depending on such things as age of the injured party, when the injury became known to the plaintiff and whether the defendant denied the plaintiff knowledge of the injury. For example, if a physician through negligence renders a patient sterile but doesn't disclose this to her, the statute is generally tolled (does not start to run) until she discovers the loss and that he caused it.

The first allegation is that you and the plaintiff actually had a physician-patient relationship in the fiduciary sense. This isn't so hard to prove. You must admit to being licensed to practice medicine in the applicable jurisdiction or confess to the felony criminal offense of practicing medicine without a license. Just about all jurisdictions recognize the relationship to be established by the time you see the patient in the therapeutic setting of your office or the hospital. "Good Samaritan" laws protect healthcare professionals from allegations of medical malpractice when they render medical assistance or treatment under emergency conditions outside the bounds of the office or hospital. The trick to remember here is that this protection vanishes later if you and the same patient enter the hospital or office setting, thereby establishing the fiduciary doctor-patient relationship.

Some jurisdictions recognize the fiduciary relationship as established when you, through your receptionist, agree to grant the patient an initial visit appointment regardless of whether or not she keeps the appointment. The relationship can be terminated at any time for any reason by the patient with no obligation or notification to you. You however can legally terminate the relationship only upon written notification of the patient giving her a reasonable length of time (usually ten working days) to secure equivalent medical care plus directions as to where that care is available.

You can't legally terminate the relationship because she won't pay her bill, no-shows her appointments, refuses to follow your advice, won't take her medicine, and/or upsets your whole office staff and the rest of your waiting room every time she comes in. Assuming you have notified her by certified mail with return receipt of your intentions as noted above, giving her a perfectly reasonable explanation for your action, the relationship still is not legally terminated until she chooses to establish another doctor-patient relationship. There was an instance several years ago in California, Oakland perhaps, in which an obstetrician/gynecologist was unable to discharge a patient from his practice over several years simply because she refused to seek other care. If this doesn't seem fair, it's because it isn't and was never intended to be. Ergo, the first leg is almost never a problem.

The second leg is that your care of the patient did not meet recognized minimum standards of care for your profession in your geographic area. Even if the care was without question below this standard, you haven't committed medical malpractice yet. This is where attorneys and medical expert witnesses really begin to earn their keep.

You might think that substandard medical care is obvious, but just try to define it. After viewing an allegedly obscene movie, United States Supreme Court Justice Potter Stewart wrote in his 1964 opinion regarding one of the early pornography cases, "I can't define obscenity, but I know it when I see it." It's obviously a matter of opinion and medical opinions are like anal orifices, i.e. everybody's got one and they're all different. Unfortunately there is no template which can be placed over a medical chart to see if it passes or fails, so it is inevitable that medical expert witnesses must evaluate each case and decide if it meets recognized minimum standards of care. Regrettably some defense experts will pass every case and some plaintiff experts will fail every case. Medical expert witnesses usually are involved only in attacking or supporting the allegations of substandard care and causation. The exception is psychiatrists and orthopedic surgeons who sometimes give opinions regarding the existence and/or extent of an injury.

The situation is only complicated by national professional medical organizations which resist or refuse to even attempt definition of a minimum level of acceptable medical care. But a simply worded and definitive standard of care for each medical specialty is a platonic ideal. Remember Charlton Heston in The Ten Commandments? God dictated and Moses obediently wrote in stone brief, simple King James English directions, standards, rules, "guidelines" or whatever to be applied to our Judeo-Christian lives. Ever since then rabbis, priests, Jews, Christians and lawyers have spent untold eons of billable and unbillable hours trying to apply these ten simple rules to our civilization. So even if we had concise, simple definitions of minimal acceptable levels of medical care there would still be lawyers and medical expert witnesses arguing about how they should be interpreted and applied. But at least there would be an established basis from which to begin.

ACOG's decision to change from publishing "Standards" to publishing "Guidelines" (see The MedicoLegal OB/GYN Newsletter, Vol. 4, No. 2, March 1996) has done nothing to resolve the confusion over defining minimal acceptable standard of care, and if anything has only muddied the waters of an already perplexing issue. Many hold the position that establishing and publishing recognized minimum standards of care would result in more nuisance suits, but it probably would actually decrease such suits and provide an effective defense for qualified and conscientious physicians. It goes without saying that such a well-defined minimum standard of care would also force providers of substandard care to either upgrade or close shop. Either way the patients get better care.

The good news is that most jurisdictions have abandoned the old "locality rule" which held that each and every geographic locality had its own standard of care, established and interpreted only by locally practicing physicians. Most jurisdictions now recognize a nationwide standard of care which implies that if you can't provide necessary services equivalent to the minimum standards of the best hospital in the nation, you should transfer the patient to a facility that can and stop representing yourself to the patient public as a provider of that service.

This may oversimplify the standard of care issue but it's still more or less accurate. The most important fact to remember from this discussion is that failing to deliver medical care equal to or exceeding whatever minimum standard is eventually determined is not, in and of itself, medical malpractice.

The third leg is that the plaintiff, your now hopefully former patient, sustained a tort (loss or injury) as a result of your care during the fiduciary relationship. This injury could involve loss of income via missed work or increased expenses of additional medical care, convalescence, child care, housekeepers, etc. The injury could involve loss or decrease of quality of life via pain, suffering, and/or mental anguish. The claim may also allege permanent impairment which will decrease future earnings and adversely affect quality of life or the ability to pursue happiness. It is hard to put a dollar value on these but there are some well-paid recognized economic expert witnesses who are only too happy to try. The injury often involves the plaintiff unexpectedly undergoing additional painful and expensive surgical procedures that may or may not be successful.

The injury could also involve "loss of consortium", a euphemism for loss of sexual services, association and comfort to your patient's now injured spouse. It's difficult to understand how a dollar value can be placed on sex without branding one a prostitute, but it's done routinely in just about every medical malpractice case. Juries do not usually place a high value on this element of damages, confirming our belief that even though there is much talk about sex few receive from it great value. Obviously the injury could involve loss of limb or normal physiologic function with subsequent disability, the ultimate being loss of life.

Actually it's not necessary for your patient to die. The single most frequent and ultimately costly complaint in medical malpractice suits today is failure or delay in diagnosis of a malignancy, the delay in appropriate treatment allegedly resulting in future unnecessarily premature death or lessened chance of cure and survival. The disability may even be due to psychologic effects of treatment or psychiatric complications, and in many delayed diagnosis and treatment malignancy cases the only injury is the emotional distress of worrying about the arguably lessened chance of survival or length of life. Go figure.

Some of these losses are difficult to prove and others are obvious. Loss of life is probably the most obvious, and at the other end of the spectrum lie emotional damages and loss of consortium. Most fall between these two extremes and here we find the neurologically damaged infants, but even in cases of loss of maternal, fetal or neonatal life the issues can be difficult to resolve.

The final leg of the table is most often the weakest, most difficult to resolve and hardest to prove. Causation is literally where the money is, the final step which has to be proven before the judge lets the jury even consider damages. You may have provided the worst imaginable medical care possible and your patient may have died, but unless the plaintiff attorney can show that the chances are better than 50% that your substandard care directly and proximately caused the plaintiff's loss, there's no medical malpractice. Ergo, there's no financial recovery and the trial attorney partners in the legal firm of Dewey, Cheatham & Howe miss a big payday. Of course the defense attorneys get paid regardless of the trial's outcome because they work by the hour and not on contingency, but the best news is you don't get reported to the National Data Bank and Mike Wallace's office calls to cancel next Thursday afternoon's interview appointment.

Be sure and tune in next time when we'll talk about depositions and other discovery devices.

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## They Shoot Messengers, Don't They?

by Doug Daniel

The January 1998 issue of *ACOG Today* contained a rather interesting item, answering the Dear Abby question "I am concerned about the role of expert witness testimony in medical malpractice cases. Is the College doing anything about this?" I figured I should get this guy's address and send him one of our information packets since he obviously shares the Society's concern with improving the quality of both defense and plaintiff medical expert testimony. Boy, was I ever wrong!

The answer noted that the College had recently become a member of IDEX Expert Witness Research, "...an expert witness research organization that gathers and disseminates trial court and settled case information from all over the US." Dues are \$375.00 the first year and \$185.00 each following year, paid with your College dues monies. Fellows can obtain histories of plaintiff and defense experts' testimony, literature searches to find publications written by an expert or naming an expert, disciplinary actions taken against an expert, copies of experts' depositions, trial testimony, CVs, "other materials", cases similar to members' cases, referrals to experts and "in-depth" background searches.

Well I thought this was just great! Someone else was trying to establish responsibility and credibility among medical expert witnesses through accountability and review of their work. So I called up Mr. Robert Parker, President of IDEX. He turned out to be a cordial and intelligent gentleman who was very helpful until I asked how I could access IDEX's services on a defense medical expert witness. After a quite pregnant pause on the line, Mr. Parker informed me that IDEX served only the defense in criminal and civil litigations.

At any rate I asked for some of their promotional literature and an explanatory letter which I could use as the basis of this article. Here's what I found out, with quotes directly from aforementioned letter and promotional literature.

"I dex was started in 1984 for the purpose of tracking expert witness testimony for the defense...Because much of the information in our database of expert testimony was contributed by our defense firm clients with the understanding that the information would stay within the defense network, we have always felt strongly that we cannot work with the plaintiff bar...

"After our conversation, I reflected on your inquiry and realized that many of the Fellows in your branch of ACOG may be fairly active as experts, with a significant percentage testifying for plaintiffs. I wanted to make note of that simply to reinforce the fact that we have limitations in terms of who we can represent." I think that means that if you accept plaintiff cases as a medical expert witness, your College dues are going to a company which limits its business to investigating plaintiff medical expert witnesses for defense firms and insurance companies.

I guess I have two problems here. First, it seems to go against the College's own policies as expressed in Committee Opinion No. 56, *Ethical Issues Related to Expert Testimony by Obstetricians and Gynecologists*. i.e. "The American College of Obstetricians and Gynecologists recognizes the duty of obstetricians and gynecologists to testify as expert witnesses on behalf of defendants or plaintiffs." The Opinion also endorses the "Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association-1986" which warns "The medical witness must not become an advocate or a partisan in the legal proceeding." This warning is then repeated again as the opinion of the College. Maybe I'm missing something here, but it seems to me that the College's membership in and financial support of a defense-only research service makes it "an advocate and a partisan in the legal proceeding".

Second, IDEX doesn't confine its activities to legitimate peer review of testimony and opinions. The *ACOG Today* item listed "other materials" and "in-depth background searches", which according to the promotional literature includes: employment, educational and military records on plaintiff medical expert witnesses; corporate and business credit reports on plaintiff medical expert witnesses; newspaper articles mentioning plaintiff medical expert witnesses; medical board disciplinary actions against plaintiff medical expert witnesses, including copies of disciplinary actions "at no additional cost".

The materials also imply that IDEX will find a medical expert witness who has given prior testimony which would be favorable to your case. It's pretty clear to me that we're way beyond "not becoming an advocate or a partisan in the legal proceeding".

Finally there's the statement that "The IDEX Network has always existed for the benefit of the defense bar and its clients. Since day one, our goal has been to facilitate the communication of case information between IDEX members. The documents you supply will always be available for the benefit of other IDEX defense members."

Just so no one misunderstands, permanent revocation of and current status of medical licensure are certainly relevant to one's qualification as a medical expert witness. But I would remind you that any disciplinary action by a state board of medical licensure is now a matter of public record in most if not all states. This includes past temporary suspension or probation for recovering impaired physicians now duly licensed, which has no bearing whatsoever on one's current qualification as an expert medical witness.

As you can probably tell by now I'm not exactly pleased with the way the College chose to spend my dues, and subsequently wrote them of my displeasure. If you feel so inclined I urge you to express your opinions to Ralph Hale, Executive Director of the College and a member of the Society. He might agree.

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## Why We Keep Getting Sued

by Doug Daniel

I recently came across an article in JAMA, February 19, 1997 - Volume 277, No. 7, page 553-58, entitled "Physician-Patient Communication: The Relationship With Malpractice Claims Among Primary Care Physicians and Surgeons". Needless to say that title piques more than a passing interest in any physician. The article is really well-done and should be enlightening for any clinical physician, not just surgeons, family practitioners and internists. Those were the participants in the study which, with everyone's permission, taped ten consecutive patient office visits of 124 Oregon and Colorado physicians. They were divided into "no-claims" and "claims" (two or more lifetime claims) groups after stratification by years of practice and specialty.

Claims were defined as any patient requests for funds, any malpractice suits filed by patients, or any contacts by attorneys representing patients in actions against physicians regardless of their outcome. Patients were over the age of 18 years, English speaking and in no acute distress. Of the participating patients, 85% were Caucasian, 63% had some college education, 45% were male and their median age was 51 years. Of the participating physicians, 94% were male and 92% were Caucasian. Stratification was into mid (graduated medical school 13-20 years ago) and late (graduated more than 20 years ago) career.

The authors found significant differences between the tapes of the two groups of primary care physicians but not the surgeons. I guess you could think of us as either surgeons or primary care physicians, but most of us seem to practice more long-term primary care than short-term surgical care. The exception is of course our subspecialists; the maternal-fetal medicine guys, the gynecologic endocrinologists and oncologists, and the urogynecologists. The rest of us are more or less general practitioners of obstetrics and gynecology, so let's look at why some family docs get sued and others don't.

Several consistent characteristics were noted. No-claims docs spent more time telling their patients what to expect during the office visit. That's no surprise. Hippocrates said more or less the same thing about 2500 years ago when he stressed to his students the importance of accurate prognosis. It just makes sense that a patient would appreciate your telling her what you're going to do and what's going to happen to her. Plus it makes you appear to know what you're talking about when your prognostications later come true. Nothing new here.

The no-claims guys laughed with their patients more and seemed to have a comfortable sense of humor. This may be difficult to utilize in our specialty, what with its sexual implications and undercurrents. I'll leave the jokes to the professional comedians, but it seems reasonable to share patients' humor as long as there is no question of seductive behavior.

They also spent more time asking their patients what they thought, how they felt and whether they had any questions. If you sense a trend here it's that the good guys spent more time with their patients, 3.3 minutes per visit to be exact, and this had an independent effect in predicting claims status.

Several studies were cited, one showing that the quality of care as determined by peer review and chart documentation did not vary significantly between never sued and frequently sued obstetrician-gynecologists. Other data indicated that the quality of care is apparently not the determining factor in a patient's decision to initiate a medical malpractice claim. Most surprisingly only 2% of patients suffering a significant injury due to medical negligence initiated a claim, and the most important consideration seemed to be dissatisfaction, especially when combined with an unfavorable outcome.

Another found that patients of obstetrician-gynecologists with prior medical malpractice claims reported feeling rushed and/or ignored, receiving inadequate explanations or advice, and spending less time during routine visits with their doctor when compared with those of never sued physicians, even to the point of having twice as many complaints about their care.

My sympathies go out to those of you who are employees of managed care companies. Just try telling the guy who signs your paycheck to start scheduling fewer clinic appointments because you're going to be spending more time with your patients so they won't sue you. Better call the state unemployment office first and check on what benefits you're eligible for, if any.

Private practitioners don't fare much better. You certainly can spend more time with your patients, but the third parties aren't going to pay for that extra time unless you convince them you're providing additional clinical services. Think up-coding and Medicare-Medicaid-insurance fraud. Of course there's always the option of trading the wife's new Lincoln in on a used Geo Metro. You know, pathology and radiology are actually quite interesting careers the more you think about it.