

THE IMPAIRED PHYSICIAN: ALL IN THE FAMILY

by Daniel M. Avery, MD

ABSTRACT: The effects of alcoholism or addiction on families are devastating. Patients so impaired usually deny family problems even exist.

A young physician I know was recently admitted to a residential program for treatment of his alcoholism. When told his wife was to be interviewed by a family counselor he asked: "Why? This is my problem. It certainly hasn't affected my family." His seventeen-year-old daughter ran away from home at the height of his impairment. His sixteen-year-old son was a very angry young man with an attitude, doing poorly in school. His thirteen-year-old daughter didn't know if she would pass to the next grade in school and wasn't sleeping well for worry that her parents might divorce. But no, his addiction to alcohol was having no effect whatsoever on his family.

The family knows something is wrong long before their alcoholic or addict ever realizes a potentially fatal disease is ravaging both their personal and the family's health, work, social life and finances. Denial is such that the consequences to the family are always overlooked. Alcoholics think their family doesn't know, but they almost always do. Spouses, parents, significant others, and even the youngest children know something is wrong, they just don't know what.

Treatment programs consider families a major priority. Some of the greatest rewards in treating substance abusers are the families. Many addicts enter treatment under the threat of impending divorce or being driven from their home. Later they discover that family therapy can save a good marriage gone bad and revitalize shattered family relationships. Most residential treatment programs include a family week when spouses, children, significant others, parents and siblings participate in therapeutic and educational programs. This is a time for processing anger, disturbing thoughts and problems, but most of all a time for healing. It's also often a launching pad for saving marriages and families.

Continued on Page 19

(CONTINUED ON PAGE 19)

THE PRESIDENTIAL BOX

Dan Avery, President

Covering other physicians' patients when on call always places us under serious additional liability, and the following case only confirms this. I have however some hopefully helpful suggestions for those of you in similar circumstances.

A brand new obstetrician freshly graduated from his residency began practice at a large metropolitan private hospital. No one had checked out to him when he came to L&D for his first evening's call. He immediately found himself solely responsible for an actively laboring 400 pound patient he had never met and knew nothing about. She had multiple medical conditions complicating her pregnancy plus a probably macrosomic infant. Her physician, who during prenatal care had agreed to deliver her baby, was not available.

The physician had presented herself to her patient as an obstetrician/gynecologist although she had only completed two years of an accredited residency training program. She was working part-time in a large multispecialty clinic's obstetrics department providing prenatal outpatient services. She had no inpatient obstetrical privileges at any hospital and was only a "shadow doctor" since patients were actually assigned to the department's chairman for billing purposes. He would attend their labors and deliveries, telling them he was on call for their doctor. This arrangement was usually satisfactory to the patients and they never really questioned it, even though the partially trained physician never took call, never delivered babies. Our young obstetrician was covering for the chairman but totally ignorant of his practice arrangement or the patient's prenatal course.

The young man politely introduced himself and immediately encountered the patient's anger over her physician's absence, however they both agreed to his managing the case. The labor was long, the infant was macrosomic, there was severe shoulder dystocia resulting in a humeral fracture and Erb's palsy. The whole family was angry about this unknown obstetrician managing the labor, his method of delivery, and the infant's birth injuries plus subsequent disability. The young obstetrician was angry because he felt someone should have advised him of the patient's condition and treatment plan before he assumed responsibility for her care.

Covering other physicians' patients can be either an advantage or a disaster. When I was a resident one of the older attendings told me I should always try to take even better care of other physicians' patients than I did my own since they were borrowed. Over the years I have developed a routine for taking care of these borrowed patients which mostly involves improved communication.

A sign is prominently displayed in our L&D Nurses Station. Its message is important though obvious, prompting this column.

THE FOLLOWING SHOULD BE DISCUSSED WITH THE ONCOMING NURSE ASSUMING CARE OF YOUR PATIENT AT SHIFT CHANGE:

1. Patient's name and room number
2. Attending obstetrician
3. Obstetrician on call
4. Anesthetist on call
5. Diagnoses and condition
6. Age, Gravidity, Parity and EDC
7. Examiner and time of last vaginal examination
8. EFM interpretation summary
9. Vital sign and I&O summary
10. Physician orders, pending and completed
11. Diagnostic studies, pending and completed
12. Medication and fluid administration summary.

I have found some others helpful to my care of patients and reassuring to the patients themselves when assuming and transferring call responsibility.

Know who is on call each night.

Give a report on each of your patients to the physician on call.

When on call, contact those physicians who haven't reported to you.

Give 125% to the care of others' patients.

Introduce yourself to covered patients if not introduced by their physicians.

Accept patient inquiries as to your abilities and experience gracefully.

Be clear about who has ultimate patient responsibility, i.e. is the attending physician to be called in certain circumstances?

Round on all patients you are accepting responsibility for, most especially those in labor or seriously ill.

Review diagnostic studies, physician progress notes and nurse progress notes on these patients plus write your own note summarizing each case and assuming responsibility for care.

If called to see a patient, write a clear and concise progress note.

Reassure the patient and her family regarding the quality of her care.

Your views, comments, experiences and additional recommendations are solicited.

THE WITNESS BOX

Doug Daniel, Editor

"I heard over and over again of their desperate efforts at bringing themselves 'around' - drinking various herb-teas, taking drops of turpentine on sugar, steaming over a chamber of boiling coffee or of turpentine water, rolling down stairs, and finally inserting slippery-elm sticks, or knitting needles, or shoe hooks into the uterus."

Margaret Sanger, RN (1879-1966)

In *Family Limitation* (1920), about her experiences working as a nurse in the Lower East Side slums of New York City - She was the first to use the term "birth control", openly providing contraceptive information (1914) in violation of the repressive federal Comstock Law (1844-1915) which banned use of the United States Postal Service for disseminating such information or devices. Ultimately she was a founder in 1942 of the Planned Parenthood Federation of America. She advised women to "look the whole world in the face with a go-to-hell look in the eyes."

YOUR 1999 DUES NOTICE IS ENCLOSED WITH A STAMPED, SELF-ADDRESSED ENVELOPE IN THIS NEWSLETTER. THERE WILL BE NO SEPARATE BILLS OR INVOICES!

This month Dan Avery's latest installment in the continuing saga of the impaired physician addresses family issues. Impaired physicians usually are convinced they actually can handle whatever others have perceived as an impairment factor. And anyway, it's nobody's business but their own since it's not effecting anyone else. For more details on that well-known Egyptian riverine system, check-out Dan's piece.

And oh, by the way. Dan's article on twelve step recovery programs (Vol. 6, No. 2, April 1998) was picked up by the North Carolina Medical Board for republication in its newsletter, *The Forum*, (No. 2, 1998). They think the series is good enough to republish some of the other articles. The College has also contacted us about providing Luncheon Conference leaders for the Philly ACM. We submitted several possible topics including impaired physician issues, continuous obstetrician L&D presence and the potential Fen-Phen liability problem discussed in this issue. Both these opportunities should be seen as compliments to the Society, its programs and the *Newsletter*.

Speaking of Philly, Tim McGuinness is working on a program for our membership meeting there, if we have one. The chances are looking better but won't be for sure until the program is dead solid perfect. More to come.

Related to our Impaired Physicians program, I was recently asked to do a guest editorial on physician sexual impropriety for *Ob.Gyn.News*. Research for the piece led me to Richard E. Anderson, a California medical oncologist who is Chairman of the Board of Directors of The Doctors Company. In case some of you don't recognize the name, it is one of the premier medmal insurers in California and several other states west of the Mississippi, recognized for its efforts in physician education, rehabilitation and risk management. The company publishes a series entitled *Professional Conduct* which is provided gratis to its insureds. The issue on sexual misconduct claims was published in 1994 and updated in 1996. I thought it was especially well-done and requested permission for reprinting in the *Newsletter*. Richard assented to the request and as a result you will find it reproduced in this issue on pages 37 through 41. Any questions or comments addressed to him at the Society's office will be promptly forwarded.

Bill Harrison more than adequately fills the Suggestion Box this issue with his editorial essay on the dilemma facing those who are philosophically prochoice on the abortion issue but aren't willing to risk the potentially adverse consequences of standing up for their convictions. While the *Newsletter's* purpose is to promote discussion of medical malpractice issues and their resolutions in the civil court system, I believe Bill's piece dealing with constitutional law, contemporary politics and our possible neglect, for essentially selfish considerations, of our

patients' right to healthcare will be of interest to you the reader. As usual, I could be wrong.

Bill is an enlisted veteran of the United States Navy, Pacific Fleet, afterward graduating from the University of Arkansas and University of Arkansas Medical School. He completed his residency at University Hospital, Little Rock and has a solo private practice in Fayetteville, Arkansas. Bill has been a prominent voice defending the constitutionally recognized and guaranteed right of pregnant women to chose between elective abortion or pregnancy and delivery both in his community, state and across the nation since 1984 via multiple presentations, debates, lectures, interviews and articles in various publications including *Vogue Magazine* (January 1998). His home and public appearances have been picketed. His office has been picketed, blockaded and invaded by protesters on multiple occasions in addition to being vandalized twice and firebombed. He has received so many death threats that he no longer keeps count. Bill has been a member of the National Abortion Federation since 1997.

We're also introducing a new feature this month called "The Drop Box". The name refers to the system used by government intelligence agencies which provides their clandestine agents concealed and almost undiscoverable places to transfer secret messages and stolen documents. If you've read any spy novels, you are intimately familiar with the concept. More to the point, we have secured the secret agent services of our own informant who lives and works inside the beltway, privy to the most intimate comings and goings of our governmental nabobs. For obvious reasons he has chosen to be known by the code name "Deep Pockets", or simply Deep to his close associates, and we look forward to reading his dispatches.

This month Andy Harris contributes an especially "timely" article on the timing of and anesthesia for postpartum sterilizations. He's a graduate of Johns Hopkins Medical School where he completed his internship and anesthesia residency. Currently he is an Associate Professor of Anesthesiology and Critical Care Medicine there with a joint appointment at the same level in the Department of Obstetrics and Gynecology. He also holds a Masters Degree in Health Finance and Management and works as a medical expert witness.

Bill Hindle's article on screening mammography is relevant to anyone's clinical practice; failure to diagnose and treat breast cancer has been number one on the medical malpractice attorneys' gyn hit parade for many years. Bill's a graduate of the Yale Medical School, serving his internship at LA County General Hospital and residency at UCLA Medical Center, Harbor General Hospital, and City of Hope Medical Center. Afterwards he served on Okinawa as a US Army Medical Officer and upon discharge practiced in Hawaii. Currently Professor of Clinical Obstetrics and Gynecology at USC-Los Angeles plus Director of the Breast Diagnostic Center, he is a recognized expert on breast diseases plus author and contributor to numerous textbooks and peer-reviewed journal articles. He has additionally served as Course Leader for eight ACOG Postgraduate Courses on Diseases of the Breast. He is also a Past President of the Hawaii Medical Association but his current status as a world-class surfer is unknown.

Phil Rosenfeld expresses some well-considered opinions on resident education in obstetrics and gynecology, including the overwhelming demands for increasing knowledge and technical expertise we place upon them as graduates and practitioners. He is currently Associate Director of the Department of Obstetrics and Gynecology at Good Samaritan Regional Medical Center in Phoenix, Arizona, and Clinical Professor of Obstetrics and Gynecology at the University of Arizona, Phoenix. A graduate of the Medical College of Virginia, he trained in the late 1950's at Sinai Hospital in Baltimore, Maryland, and has served on the faculties of the University of New Mexico School of Medicine and Hahnemann University School of Medicine. Previously he ran the obstetrics and gynecology residency training program at Monmouth Medical Center in Monmouth, New Jersey, and was a member of the New Jersey State Department of Medical Examiners' Committee on Resident Conditions. Phil is also a frequent presenter at medical meetings, seminars, conferences and symposia including ACOG-sponsored events. He is or has been a consultant to Pfizer Laser Systems, Wyeth-Ayerst Laboratories and Berlex Laboratories. His articles have been published by the peer-reviewed and popular medical press. I'd say he easily qualifies as an expert in the field of obstetric and gynecology resident education.

Hugh Martz and I have been collaborating on a series of articles about how the litigation system works, and this month the second article in the series addresses the discovery phase of a suit. The first was about the complaint and requirements for filing suit; the final one will be about the trial. If you've been sued before it may give you some pointers on how to do better next time. If you've not been sued yet it will give you a fairly simple explanation of what goes on and how best to function in that environment.

You may be interested in some thoughts I had regarding our liability related to future treatment of patients who took Pondimin® and/or Redux®, the prescription weightloss drugs known as "Fen-Phen" that were withdrawn from the market due to questions of increased risk of mitral and aortic valvular disease. Almost nobody's talking about this one now, but there is bound to be litigation coming over subsequent valvular complications due to inappropriate or lack of recommended SBE prophylaxis. Forewarned is forearmed.

And now for something completely different. I have good news and great news, and they're both the same. Communication access to the Society office has taken a dramatic leap forward into the 21st century, albeit 20 years too late. We now have a Toll Free phone number available 24 hours-a-day, seven days-a-week. It's the same as the previous Fridays-only number, 1-800-304-4728. We also finally have a fax machine which was generously donated by Brice Karsh, one of our honorary members. There is no dedicated fax line so you have to call the office first and let us activate the machine. We don't have internet capability yet, but these improvements should be much more convenient for the membership.

Some of you will on occasion receive future *Newsletters* in an obviously previously used envelope. Don't be insulted. In an effort to economize and do our part for the environment, the ever increasing pile of used manila envelopes here in the offices will be recycled for member mailings. We already save discarded document copies for nonessential copying on the other side, finally sending discarded two-sided copies to the recycler. Are we green or what?

On a final note, your Board of Directors elected Paul Sinkhorn Vice President/President Elect at its last meeting. Unfortunately the same action also rotated Ben Harer off the Board after serving three years (I know that sounds like a prison term, but being on the Board really is a pain). None except those who served during the same years know the extent of Ben's interest in and commitment to the Society, and he will be sorely missed. On the other hand, if nominated and elected President Elect of the College he will be busier than a one-legged man in a field goal kicking contest for the next several years. After that we hope to get him back. The Board also amended the bylaws, providing the membership a mechanism for directly amending them.

As usual we encourage submission of letters to the editor, articles and 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.

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.

THE MAIL BOX

Dear Dr. Daniel:

I write concerning the JULY issue of *The Medicolegal Ob/Gyn Newsletter*. On pages 10-11 of this issue, you reprinted two items that ran in *Ob.Gyn.News*: a column entitled "You'll See Them in Court" (*Ob.Gyn.News*; Feb. 1, 1998; p.13), and "Back and Forth," a letter to the editor (*Ob.Gyn.News*; April 1, 1998; p. 13).

While I am pleased that you are following our publications, please be advised that all articles, letters, columns, and other features that appear in *Ob.Gyn.News* are protected by copyright. If you wish to reprint or photocopy an article for distribution, you must first request permission from us in writing. If permission is granted, you will receive a letter stating the reprint fee, which is set at \$300.00 per article, and citation information, which must be published with the article.

In the future, if you would like to reprint one of our articles, please seek permission first...If you have any questions or would like to discuss this matter further, please contact me.

Kathy Scarbeck, Editor
Ob.Gyn.News

6 AUGUST 1998

Dear Ms. Scarbeck:

Thank you for your letter of 3 AUGUST 1998. Our correspondence of 7 APRIL 1998 was intended to request permission to photographically reproduce the two editorials in question, thereby giving your publication more prominent exposure and decreasing the editorial workload for ours.

Following denial of gratis permission to do so and after conferring with counsel, it was our position that as a noncommercial, informational and educational medical publication with no inherent financial value, gain, interest or worth, current US copyright law did not prohibit quoting previously published material with proper attribution, even *in toto*.

Since we cannot afford your \$300.00 per item permission and your position is apparently not likely to change, be assured there will be no further requests for permission to photographically reproduce and publish items. We will, however, most likely continue to cite, quote, discuss and critique items published in *Ob.Gyn.News* simply because they are controversial, relevant, accurate and unusually timely.

I sincerely hope your invitation to discuss this matter further was motivated by a desire to explore a mutually beneficial and more cooperative relationship between our publications, but I must assume it was only to expedite the \$300.00 checks. If I am wrong, please contact me at your convenience.

William D. Daniel, MD, FACOG
Editor
The Medicolegal Ob/Gyn Newsletter

15 AUGUST 1998

Dear Doug:

A common misconception in the review of medical malpractice cases is that poor outcome is almost always caused by obstetrical mismanagement. Blame is placed on factors such as delay in performance of cesarean-section, rather than seeking the proximate cause of injury, which more often occurs as an antepartum event. Unfortunately, a compromised fetus may not be evident until after onset of labor or delivery. Delivery of an unanticipated severely depressed newborn confounds the obstetrician who has followed standard guidelines of electronic monitoring, supposedly assuring fetal well-being.

It is the developmentally compromised fetus which presents the greatest challenge in proving pre-existing injury. Obstetrical management has little effect, if any, on preventing neurologic deficits in the developmentally compromised fetus. Babies born with delayed neurologic deficits secondary to idiopathic cerebral palsy are a good example. The baby subjected to partial prenatal hypoxic compromise, however, often has placental evidence that may be of critical importance in identifying and defending cases of neurologic damage that has occurred antepartum.

A 1985 report by the National Institutes of Health studied 55,000 pregnant patients and concluded that antepartum intrauterine factors caused neurologic deficits in the great majority of babies born with cerebral palsy. A smaller percentage were affected by acute asphyxia.

The American College of Obstetricians and Gynecologists (ACOG) has not endorsed routine placental examination. This decision is based upon cost and "insufficient clinical justification." However, placental examination, in our experience, has proven useful in defending certain medical malpractice claims. Justification for increased expense can be rationalized in that "...savings from one large liability case can pay for a lot of placental examinations."

At St. Joseph Hospital in Houston, Texas, a close working relationship with our pathologists enables us to correlate clinical events with placental pathology. This exercise provides an accurate explanation as to how and when birth injury occurred. We have developed a protocol that limits placental examination to specific clinical complications. We have noted an impact on medical malpractice claims when, placental pathology supports clinical, laboratory and imaging findings of fetal morbidity, pre-dating the onset of labor.

Certain maternal complications are associated with perinatal morbidity. The placental examination may be valuable in linking these stresses to fetal outcome. These complications are, by no means, inclusive but represent the more common high-risk conditions confronting most obstetricians.

1. Multiple pregnancy: There are potentially severe fetal complications, when a single monochorionic/monoamniotic placenta is present. The placenta may be helpful when discordant growth exists.
2. Pregnancy-Induced Hypertension (PIH) or pre-eclampsia: It is important to recognize that maternal hypertension is associated with decreased uteroplacental blood flow and associated pathologic changes in the placenta, such as infarction, accelerated placental maturation and decreased placental weight and size. These changes can occur well before maternal hypertension is clinically evident. As a result, a fetus can be damaged by placental insufficiency before manifesting classic clinical signs of PIH.
3. Post-maturity syndrome: Prolonged gestations are associated with fetal dysmaturity, placental insufficiency and infarction and heavily meconium-stained membranes.
4. Alcohol, tobacco and drug abuse: Practically all chemical substance abuse is associated with generalized maternal vasoconstriction, placental infarction, smaller than normal infants and placentas and shorter gestations.
5. Infections: Chorioamnionitis, cytomegalovirus, toxoplasmosis and syphilis produce specific microscopic placental lesions with positive appropriate cultures.
6. RH isoimmunization: Maternal Rh incompatibility is associated with abnormally large placentas, meconium-stained amniotic fluid and fetal hydrops with hemolysis and anemia.
7. Diabetes Mellitus Classes C, D and E: Severe diabetes is associated with placental vascular insufficiency resulting in smaller than normal placentas.
8. Anemia: Maternal anemia is associated with decreased placental perfusion.

Providing contemporary prenatal care is an exercise in risk management and prevention. The obstetricians responsibility is to identify high-risk patients and obtain the necessary clinical and laboratory tests, along with an appropriate therapeutic plan which will, hopefully, avoid an adverse clinical outcome. However, prevention of fetal damage is not guaranteed, even with optimum prenatal and intrapartum care.

Describing specific pathologic lesions associated with increased perinatal morbidity is beyond the scope of this letter. Experienced pathologists, knowledgeable in clinical obstetrics and placental pathology, can and do provide invaluable information through detailed tissue examination. Injuries due to unpredictable developmental anomalies should thus, never reach the claims stage.

The following case history demonstrates the importance of placental pathology in relating antepartum injury to a neurologically depressed newborn.

CB is a 16 year-old Gravida I, Para 0, Abortus 0 whose last menstrual period began July 4, 1992 with an estimated date of confinement of April 11, 1993. First prenatal visit was at 13 weeks gestation with initial weight of 147 lbs. Weight at delivery was 203 lbs. reflecting a weight gain of 56 lbs. She was a known asthmatic with prior acute exacerbations requiring hospitalization, IV aminophylline and steroids. She was admitted in labor April 11, 1993 at 21:50 hrs. with the cervix 5 cm dilated, 100% effaced and a vertex presentation at -3 station. She remained afebrile throughout her labor and delivery.

Amniotomy was performed at 23:30 hrs. with light meconium-stained fluid noted and decreased beat-to-beat variability on continuous electronic fetal monitoring. Within fifteen minutes, mild variable decelerations associated with contractions began, demonstrating early onset and rapid resolution. By 03:00, the pattern had progressed to moderate variable decelerations with prolonged (20 seconds) resolution to baseline.

A vacuum extractor was used for easy delivery of a markedly hypotonic 5 lb. 14 oz. infant at 03:47 hrs. from a +2 station. The one minute Apgar score was 3, and the 5 minute Apgar was 5. Arterial umbilical blood gas analysis revealed a pH of 6.79 with a base excess of -18.9 mEq/l. Tone and blood gasses improved rapidly, approximately two hours after admission to the neonatal intensive care unit. The rapid recovery of the newborn, in conjunction with the absence of maternal and/or fetal hypoxic complications intrapartum, strongly supports the clinical conclusion that there was no acute fetal hypoxic damage (hypoxic ischemic encephalopathy) or injury during labor.

Gross tissue examination found the placenta to weigh 280 gm with expected term weight 450 gms. Cord length was 26 cm, with normal at term, greater than 40 cm. Acute chorioamnionitis, acute funisitis and scattered edematous chorionic villi were found on microscopic tissue examination.

The baby developed spastic quadraplegia at 6 months of age and diagnosed with cerebral palsy. Magnetic resonance imaging was consistent with brain damage secondary to partial intermittent hypoxic encephalopathy.

The claim was settled for a nominal but unspecified amount, based on a small for gestational age baby, markedly underweight placenta, short umbilical cord and microscopic findings of chorioamnionitis, funisitis and villous edema. Without these placental findings, the mechanism of injury would likely have been argued as being caused by an acute intrapartum hypoxic event. Little defense evidence would have supported a pre-existing injury secondary to placental insufficiency.

Well-controlled bronchial asthma during pregnancy is ordinarily not associated with increased maternal or fetal morbidity. The dilemma in treating pregnant asthmatics centers on the selection of medications which will effectively relieve maternal bronchospasm but not adversely effect the fetus. Theophylline and epinephrine have been shown to cross the placenta, and a risk of epinephrine its vasoconstrictive effect may decrease uteroplacental blood flow and/or cause fetal cerebral ischemic injuries.

Uncontrolled, severe asthma is associated with intrauterine growth retardation due to chronic placental hypoperfusion. In one study, 75% of cesarean-sections in asthmatic women, were done for acute fetal distress. *The prevalence of fetal distress, in laboring asthmatic patients, suggests occult decreased fetoplacental reserve and mild fetal hypoxia. The compromised fetus becomes more distressed after the superimposed transient hypoxia produced with labor.*

Competent placental examination allows the obstetrician, the patient and their families to better understand the pathophysiologic mechanisms causing neonatal deaths, neurologically damaged infants and stillborns. It must be stressed that the placenta must be used with other clinical and laboratory evidence that supports a diagnosis of intrauterine asphyxia. After all, the placenta is fetal tissue and may be the only objective information documenting intrauterine disease.

Anthony Lucci

20 AUGUST 1998

Dear Anthony:

Thanks for the letter. Your point is well taken and I wish more people agreed with us, including the College. But the plain fact is that nobody (well, almost nobody) is going to push for better placental pathology until the College recommends it. Virginia Baldwin, one of our Charter Members and a world-renowned expert on forensic placental pathology, has agreed to write an article for the *Newsletter* which we hope to publish by the first of next year. Meanwhile, the more people who advocate your position, the better the chance of the College coming up to speed on this issue.

Doug

THE SUGGESTION BOX

I've been a full-time practitioner of obstetrics and gynecology since 1972, providing elective abortions since 1974 and practicing only gynecology since 1991. I'm stoking the fires under an already boiling abortion pot because unless there is a major shift in public and professional opinion regarding elective abortion very soon, we face an ever increasing number of tragic cases like those which produced *Roe v Wade* in the 1960's and halted the destructive effects of the 1880's criminalization of abortion.

By the 1950s some physicians began to recognize the hypocrisy of refusing to perform elective abortions for some patients while declaring others in identical circumstances worthy of "therapeutic interruptions of pregnancy", regularly violating both the letter and spirit of antiabortion laws. Most of us breathed a collective sigh of relief after *Roe v Wade* but the hypocrisy and moral cowardice have continued.

States began to liberalize their abortion laws in 1967 and until 1981 there was a steady increase in the availability of abortion services, especially after *Roe v Wade*. But since the second year of the Reagan Presidency there has been a continuing decline in the number of physicians, clinics and hospitals willing to risk their professional reputations, economic fortunes and personal safety to provide a still desperately needed service, i.e. safe, readily available and affordable elective abortion.

In October 1983 there were at least thirteen physicians, eight of us obstetrician-gynecologists, within twenty miles of my office providing unrestricted access to either office or hospital elective abortion. By August 1984 I was the only one left. That is not to say I am the only physician in the area who does abortions, but the few others do only one or two a year for "special" patients under "special" circumstances such as the pregnant patient who is scheduled for tubal ligation or hysterectomy, the close friend's daughter who finds herself pregnant and desires a "private" abortion, or the obstetrical patient found to have a fetal anomaly. They also perform "partial birth abortion" under certain circumstances, but last summer were not willing to go to court as plaintiffs or medical expert witnesses in an effort to overturn our law banning the procedure. Words such as hypocrisy and cowardice come easily to mind.

I don't know how many practicing physicians provided abortions nationwide in 1981, but today there are only about two thousand in full-time practice who openly provide elective abortions either exclusively or in a medical practice. Less than one thousand of these are obstetrician-gynecologists and far fewer offer a full range of services in their practice. The lack of our colleagues' support and

involvement in the controversy serves to isolate those of us who feel a strong moral obligation to provide safe and legal abortion along with our regular care. Too many of us are solo practitioners because there are increasingly few Pro-Choice residents willing to face the withering verbal and physical attacks upon themselves, their families and their practices by Pro-Life zealots, plus they wish to avoid the indifference and discrimination of their peers.

I recently read that the average abortion provider is now 64 years old, and I'm sure a large percentage will be retiring or otherwise leaving clinical practice over the next few years. Of the five in Arkansas one is nearly seventy, I'm sixty-five and two others have very serious health problems. During the past ten years there have been about fifty facilities a year permanently closing their doors to elective abortion patients according to the antiabortion group Operation Rescue (OR).

Why do we continue to openly provide elective abortions in the current climate of hate and fear? Why do we write for local, regional and national publications in both the lay and professional press? Speaking only for myself and those whom I know personally, most of us came to our commitment in much the same way. Our experiences as medical students and residents before *Roe v Wade* showed what society's restriction of access to legal abortion really means for women.

Every resident training in obstetrics and gynecology prior to Jan 22, 1973, saw part of an endless stream of thousands of women ravaged by the criminalization of elective abortion and its consequences. We saw them in emergency rooms, operating suites, wards, labor rooms and sometimes morgues following attempted clandestine abortions which had failed or become complicated by infection or hemorrhage. By every criterion of compassionate medicine, a safe and reliable abortion would have been performed for these women had it not been a felony to do so. I never had to watch a patient die with complications of a back-alley abortion, but others did. We all remember the horrors of gynecology before *Roe v Wade*, and as long as we have breath we do not intend to go back there.

Roe v Wade did not dispel moral cowardice. Upon entering private practice in 1972 I didn't provide abortions even though Arkansas's abortion law had been significantly liberalized in 1969. I had performed dozens in residency but there were already three well-trained and respected gynecologists in Fayetteville offering elective abortion. I was the new kid on the block and the word abortion had an unsavory ring to it then as now, plus I was afraid I might be called an abortionist.

In 1974 a close friend and his daughter asked me to abort her unwanted pregnancy. I refused and offered to refer her to one of the local gynecologists providing abortions. On being told I would not abort his daughter and knowing I was strongly in favor of safe, legal abortion, my friend sadly said, "Well, you're just a coward then, aren't you?"

I didn't sleep very well that night. The next morning I called my friend and agreed to perform the abortion if he still trusted me with his daughter's care. Since then I have provided abortion to all who meet the parameters of my practice.

By November 1983 there had been hundreds of serious non-violent and violent antiabortion demonstrations by religious fundamentalists across the nation shouting they had "both God and the President of the United States" on their side. Many were in Arkansas and some were even in Fayetteville. By then there were ever more vigorous and violent efforts to outlaw abortion across the country. Our hospital and another physician's office were picketed regularly. A local anesthesiologist colleague even wrote personal letters to the abortion providers stating he was going to do everything in his power to "stop abortion in my town". I wrote back that he could do as he pleased but I would continue to practice medicine in what I considered an ethical and proper way.

The other physicians soon abandoned their patients seeking abortion. That year Arkansas went from perhaps thirty or more physicians and facilities providing elective abortion to a mere handful. Given Ronald Reagan's public comments during the 1984 presidential campaign, even more severe restrictions on elective abortion and family planning services seemed imminent.

In his January 1984 State of the Union Address he became the first US President to publicly mention abortion. On Jan. 22, 1984, he addressed by telephone those gathered in opposition to safe and legal abortion at a Pro-Life "March On Washington", and intimated he would consider a Presidential pardon for anyone convicted of violence against abortion providers or facilities. Across the country Pro-Life activists monitored these inflammatory remarks via radio and television.

Nationwide there had been only twelve acts of major violence against abortion facilities between 1973 and 1983, but following Reagan's remarks there were over fifty bombings and arsons in 1984 and 1985. One was the arson of my office by a fourteen-year-old boy after being shown *The Silent Scream* at a local church. Since then there have been hundreds of acts of major violence toward physicians, employees and facilities associated with legal abortion.

In the election year of 1984 I felt that my training, experience, professional ethics and abortion politics obligated involvement in the fight to preserve safe and legal abortion. My conscience and upbringing would not allow dodging the issue any longer. I began writing, debating and lecturing in newspapers, magazines, schools, churches, Sunday Schools, colleges, medical schools and any other available venue in Arkansas. Since the first abortion-related murder in 1994 in Florida I have assumed an even more prominent and public role in the abortion debate.

If those of us who remember what it was like before *Roe V Wade* and are now responsible for the care of women's medical, gynecological and obstetrical problems on a daily basis don't speak up and take an active role in protecting their right to chose between safe abortion and childbearing, who will? Who is better qualified or more responsible to lead this public debate than we who have already seen the disastrous effects restriction of safe elective abortion will have on women?

I fear for those women who in the future find themselves burdened with an unwanted pregnancy and are compelled to seek abortion. Who will take our place? Will it be well-trained and competent young physicians or ever more marginal and incompetent cynics who practice abortion only because there is no other employment for them in medicine?

Pro-Choice obstetrician-gynecologists can effect positive changes in public and professional opinions and policies which will insure continued availability of safe elective abortion after the current abortion providers are gone. What role will you play? Will you stand idly by on the sidelines and watch as access to safe abortion is once again restricted to the "special" few or will you endeavor to join the fight to keep elective abortion safe, available, affordable and legal for all patients?

There is no middle ground. Either all who are Pro-Choice must add their voices to what is now a tiny chorus or other voices including those of our Pro-Life colleagues will cry out in the streets, State Houses and Congress that there should by law be no legal abortions, decreeing all abortions to be a crime and making them as dirty, painful and dangerous as conceivably possible.

Let there be no misunderstanding. The Pro-Life activists fully intend to force society back to the pre-*Roe v Wade* Dark Ages. Their goal is to eliminate all abortion without exception. If their only option is increasingly inflammatory rhetoric inspiring unstable individuals to commit terrorist acts such as intimidation, harassment, arson, bombing, mayhem and murder instead of securing legislation criminalizing abortion, that's OK with them. You should decide whether it's OK with you.

Bill Harrison

THE DROP BOX

Deep Pockets

Thank God It's Over (Or Is It?)

Usually by this time in the election cycle the Congress of the United States has adjourned *sine die*. This early adjournment allows them to get to their real jobs, being reelected for another two years in the case of Representatives or another six years for a third of the Senators. While they are in their home districts on the stump, Washington campaign fund raising continues at a fast pace.

Over the past year just about every healthcare-related publication you read was filled with articles about what Congress was going to do to, for or against HMO's. Although the House passed the Patient Protection Act of 1998, the final answer was nothing.

The whole debate confused me. Republicans sounded like Democrats and Democrats sounded like Republicans. Traditional friends and foes changed sides. The AMA sided with the plaintiff's bar on eliminating the ERISA preemption and an Illinois Republican Member of Congress called the AMA "Toadies of the Democrats". Everyone sounded like a patient advocate.

Someone actually was, to an extent. President Clinton pressured Congress to act. On February 20, 1998, by Executive Order he extended many "patient protections" to all federal workers. On August 29th he mandated an internal appeals process for all private employer-based healthcare plans. At the urging of its rank and file members, the House passed HR 4250 as the Patient Protection Act of 1998.

Republican members of Congress wanted to pass a patient protection bill on the theory that they needed it back home to be reelected, but their leadership wanted to deny the President a political victory. The Democrats wanted a bill to show they were champions of patient rights and hand their President a win. In July, the Democrats had a very good chance of regaining the House majority and possibly taking one or two Senate seats. OOPS!

Since the "oops", the urgency to pass such legislation has gone the way of Howdy Doody. Republicans don't need another Bill to help them get reelected and they are unconcerned about possible charges of insensitivity to the healthcare needs of their constituents. In reality they are no longer vulnerable on most issues, but will all talk about how hard they worked to protect patients' rights.

Substantively, HR 4250 was a pretty good piece of legislation; it applied reforms to healthcare plans and issuers while the Senate Republican bill covered only group healthcare plans, not issuers. The AMA-endorsed Democratic Senate bill applied to healthcare plans, group healthcare plans and insured group healthcare plans.

A lightning rod issue for consumers has always been access to emergency care. The House bill applied only to screening, and the standard to be applied was that of a "prudent layperson". Pediatricians were designated primary care physicians as were obstetrician/gynecologists. There was no provision for transitional care in the House bill, but it expanded choices for "out-of-network" coverage. Every bill disallowed all restrictions on patient-physician communication. The House-passed and Senate bills also addressed information disclosure, grievance procedures, appeal time for urgent decisions and the ERISA preemption.

A pretty quick overview perhaps, but the real battlefield was the ERISA preemption. Physicians generally have the opinion that if HMOs are making treatment decisions they should be held to the same standards as a healthcare professional and subject to litigation. The ERISA preemption says employee healthcare plans may not be sued for administrative decisions or treatment decisions made as part of their administration. This obviously denies the plaintiff's bar another source of potential recovery, hence the unholy alliance between the AMA and the ATLA.

The objection we healthcare liability reform supporters have is that the AMA could have advocated the elimination of the ERISA preemption while adding that Congress should include comprehensive medical malpractice tort reform. It is incongruous that healthcare providers would advocate expanded liability and not also advocate liability reform. For one thing, this would make the plaintiff's trial bar get back into their own bed. It is my opinion that the ERISA preemption will continue to be eroded by state courts and legislatures, sparing the Congress from action.

You may have noticed I wrote in the past tense. I did this for two reasons. First, the 105th Congress is over and the issue died with adjournment, to be reintroduced in the 106th Congress. Second, I do not think it will be seriously considered by the 106th Congress. Republicans do not need it as a campaign issue and Democrats are going to be too weakened to make an issue of *anything*. Healthcare liability reform will begin anew in the 106th Congress with prospects a little brighter, although nothing definitive will occur until there is a person in the White House who is not the plaintiff bar's Buddy.

States will continue to address patients' rights, and I think everyone should just sit back and watch while the AMA and ATLA expand liability. At the same time we need to focus on the patients, whose rights are ultimately best served by sound medical practice, respect for the individual and unrestrained communication. "First do no harm."

THE BOOK BOX

Doug Daniel, Editor

THE WAY THEY WERE

On the Shoulders of Giants: Eponyms and Names in Obstetrics and Gynaecology

Thomas F. Baskett

Illustrated. 270 Pages. London: 1996

RCOG Press.

Hardback, \$64.00

Paperback, \$32.00 (Reduced Size)

About twenty years ago I had a good friend whose two children were in elementary school. One evening our families were together for a barbecue at his house, and afterwards we gravitated to the living room while our kids played outside and our wives talked in the kitchen. "Want to watch television?" I asked. "No," Greg said, "I've got a better idea."

He had only recently bought a set of The World Book Encyclopedia for his girls, and his "better idea" was to sit on the living room floor and read the encyclopedia. He was in the process of reading the whole set literally from A to Z, and that night we each chose a volume. When we came across something especially interesting, we read it aloud to the other. It was one of the most fascinating evenings I have ever spent; familiar company, familiar topics, and interesting though previously unknown facts.

Dr. Baskett's book is much the same. Like an encyclopedia it goes from A to Z; from Apgar to Zipper, Aschheim to Zondek. It is also a detailed and historically accurate biographical study of those individuals directly and indirectly responsible since the first century AD for the way we practice obstetrics and gynecology today. But there's still more. It's a veritable *Bartlett's Familiar Quotations* of pithy and relevant insights and comments by these same forefathers and foremothers, not to mention the 530 entries in its excellent bibliography. Most of the biographies have an accompanying portrait represented by either a photograph, woodcut, painting, drawing or etching. Obviously it's a reference work.

Ah, but there's more. It also reads like a family history through the ages since the names are mostly familiar, sometimes obscure, and usually we don't know very much about them. But wait, there's even more! You get tales of intrigue, conflict, and danger; stories about tightly-held secrets and the spies working to discover them, life on the American frontier, disappointing failures and unrecognized successes. You even get some medical-surgical *Star Trek* adventures about innovators, investigators and explorers who first "went where no man had gone before". So it's also an historical adventure novel. Think Certs®, the breath mint that's also a candy mint.

The author is a Professor, Department of Obstetrics and Gynaecology, Dalousie University, Halifax, Nova Scotia. He is a native of Belfast, Northern Ireland, born in the midst of the Second World War. Premedical and medical education was in Belfast, and he later practiced general medicine before spending six years postgraduate training in surgery, obstetrics and gynaecology in Belfast. He emigrated to Winnipeg, Canada, in 1970 and served as a Medical Consultant to the Central Canadian Arctic with regular on-site visits. He moved to Halifax in 1980 and has served as President of the Canadian Gynaecological Society, an Examiner in obstetrics and gynaecology for the Royal College of Physicians and Surgeons of Canada, and Editor of the Journal of the Society of Obstetricians and Gynaecologists of Canada. He is a Fellow of the Royal College of Obstetricians and Gynaecologists and the American College of Obstetricians and Gynecologists. I heard him speak at

the 1998 ACM in New Orleans. He both looks and sounds like Frank McCourt, one of my favorite authors and also from Belfast.

Mostly the book is just fun to read. Like Greg and I lying on the living room floor with the *World Book*, you will be amazed at the interesting facts found in *Giants*. For those of you who occasionally put on your writer's hat, the vast store of quotations and anecdotes alone is worth the purchase price. Every medical library and especially every residency training program in obstetrics and gynecology should have a copy. If you can't find a copy locally, order direct Par Avion from:

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27 Sussex Place
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I'll bet you find yourself staying up later than you intended if you buy or borrow a copy, because once you start reading you won't be able to put it down.

THE LITTER BOX

Doug Daniel, Editor

Since I'm apparently the only gadfly in the College's ointment, first to bitch and first to bark, it seems only fitting to also be the first to compliment an improvement in one of their programs. This time its a new format for standard of care recommendations called "ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists", debuting JUNE 1998. The usual disclaimer is prominently displayed on the front page, now in a bordered frame with larger type, and reads:

"...The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice."

There was no disclaimer when the Tech Bulletins were first published back in '56, only being added in JULY 1972 as:

"This Technical Bulletin...describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of The American College of Obstetricians and Gynecologists. Its publication should not be construed as excluding other acceptable methods of handling similar problems."

Over the years the exact wording was frequently changed, probably reflecting the Executive Board's dilemma in trying to establish a minimal acceptable standard of care for the specialty while simultaneously appeasing members who practiced below said standards and were subsequently sued for medical malpractice.

The disclaimer moved from the back to the front in August 1996 when the name changed from Technical Bulletins to Educational Bulletins. The disclaimer previously had read:

"...This Technical Bulletin does not define a standard of care, nor is it intended to dictate an exclusive course of management. It presents recognized methods and techniques of clinical practice for consideration by obstetrician-gynecologists for incorporation into their practices. Variations of practice taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice may be appropriate."

After August '96 it read:

"...This document is not to be construed as establishing a standard of practice or dictating an exclusive course of treatment. Rather, it is intended as an educational tool that presents current information on obstetric-gynecologic issues."

These obviously well-meaning efforts at appropriate wording of the disclaimer have over the years unfortunately allowed rationalization and perpetuation of obsolete and unacceptable methods of practice such as delays of up to four hours in beginning emergency Caesarean section due to lack of immediately available anesthesia services in small rural hospitals still offering obstetrical services when a full-service level II hospital is less than an hour away. The good news is that each of the new Bulletins concludes with several clear, concise clinical management recommendations identified as based on good and consistent scientific evidence, limited or inconsistent scientific evidence, or consensus and expert opinion. Perhaps I'm making too much of this, but it seems a step forward in our specialty organization's meeting its responsibility of defining the nationally applicable minimal acceptable standard of care. Your replies and/or rebuttals are solicited.

THE IMPAIRED PHYSICIAN, Continued From Page 1

Addiction is a dreadful disease for everyone involved and not all marriages are salvageable, but surprisingly most are. The commitment to seek treatment and try to work through family problems together is at least a beginning. Family members can expect to be involved in group counseling, individual family and marital counseling, and of course individual personal counseling.

Education is foremost in any treatment program and addiction medicine is no different. Most family members come to the treatment center thinking this is all their fault, not realizing they are being affected by and not the cause of their loved one's serious disease. The best analogy is uncontrolled diabetes mellitus. Most understand and accept this disease concept of addiction but some don't. Some others never will.

His family will eventually realize their alcoholic/addict will never be cured of his disease, but in treatment they will also realize he has a relatively good prognosis. If they must cope with a member's life-threatening illness, this is the one to have. My friend, with support from his family, can control his disease by not drinking, reading the "Big Book" and going to meetings. These are infinitely easier than treatment of malignancies or severe diseases of the liver, heart or kidneys.

We all know there are no guarantees with medical or surgical treatment, but treatment of alcoholism and other addictions does have a guarantee: as long as you don't drink or use, you won't get drunk or stoned. Substance abuse is just another aspect of life - it's all about the choices you make.

Monthly individual counseling sessions for the couple in addition to family week allow an opportunity to resolve past and current problems. Individual counseling for some family members may be necessary and can often be arranged closer to home.

One of the biggest problems with residential treatment is that the patient receives counseling everyday in a round-the-clock therapeutic milieu while family members receive only intermittent counseling. Therefore he logically should be therapeutically well ahead of his family, and when he returns home they commonly expect him to be completely back to normal. Such is almost never the case. Addicts leave the residential treatment program with the tools to start solving life's problems, but the vast majority of those problems have been addressed only minimally if at all.

Sobriety in and of itself does not eradicate all the other problems. The family may expect a brand new "fixed" spouse or parent, but the first month at home is when the work really begins. The character defects in AA's Fourth and Fifth Steps are still lurking in the background, and anger, denial and isolation can quickly reemerge. Imagine a wife expecting her alcoholic husband to be cured, only to find he still gets angry and screams at the children. Immediately things seem no better and perhaps even worse than before.

Most treatment programs require 90 AA or NA meetings within the first 90 days back at home, and this may seem onerous to the family. Daddy's been away in treatment for a long time, so how come he still has to go to these meetings every day? It's absurd to even consider going to three AA meetings within 24 hours, but meetings are one of the tools vital to alcoholic recovery. Actually there are some twenty points in a good recovery program, a few of which are:

- Meetings
- Meditation
- Time with family
- Therapy
- Marriage counseling
- Medical care
- Adequate rest
- Reading the "Big Book"
- Talking to others in recovery
- Pursuing a spiritual life
- Placing reasonable limits on work
- Avoiding hunger, anger, loneliness and fatigue
- Working a twelve step recovery program.

Spouses often are disturbed by meetings or therapy groups which interfere with family activities, failing to realize that sometimes it is necessary to place recovery above everything else lest everything else be lost. Marital and family therapy almost always must be continued upon returning home, sometimes with additional individual therapy. Reason and proper planning can prevent many conflicts. Most large treatment programs provide quarterly visits allowing families to return for more focused therapy. Yearly retreats are also an opportunity for revitalization.

Financial support is another common family problem. How is the family to survive while its breadwinner goes off to treatment and is out of work? Are there adequate savings? Can the remaining parent's salary alone forestall an impending mortgage foreclosure? Children commonly fear financially losing their home. Most centers offer plans for financing the cost of treatment when full insurance coverage is not available, but everyday living expenses such as groceries, utilities, clothing, insurance, etc. can be intimidating.

There are many ways to get by and all include some form of help from others. Employers are far more likely today than in the past to allow time off for substance abuse treatment and rehabilitation rather than terminate one's employment. Many times loans from family members are necessary to financially survive treatment. But where there's a will there's a way, and far more make it than don't.

The effects of alcoholism or addiction on families are devastating. Patients so impaired usually deny family problems even exist, and this is the hallmark of their disease's denial. Proper treatment and family therapy can fortunately save many marriages and their families.

TIMING AND ANESTHETIC MANAGEMENT OF POSTPARTUM TUBAL LIGATIONS

by Andrew P. Harris, MD

ABSTRACT: Elective permanent sterilization by immediate PostPartum Bilateral Tubal Ligation (PPBTL) is more convenient for both patient and surgeon, and also cheaper. Unnecessary and avoidable complications can be prevented by insuring an empty stomach by strict NPO maintenance or delaying surgery.

There has been increasing pressure recently to schedule elective sterilizations via immediate PPBTL for several reasons. First, it is more convenient for the patient and this certainly should be considered in the medical decision-making process. Second, it is more convenient and efficient for the surgeon to eliminate an extra trip to the hospital, especially since there is no additional compensation for the extra time required by delaying the sterilization. Finally, third party payers demand discharge as soon as possible following delivery, and delaying the sterilization may result in hospitalization exceeding the approved Length Of Stay (LOS). Here in Maryland "drive-thru" delivery policies requiring discharge within twelve hours postpartum have been thwarted by our legislature, but there is no provision for extended LOS when sterilization is delayed 24 hours or more after delivery. The primary consideration should of course always be that it is an elective, never an emergency, procedure.

PPBTL can be performed immediately following or within 48 hours of delivery, but sterilization can also be performed as an interval procedure six weeks or more postpartum as an outpatient laparoscopy or mini-laparotomy. Each has its advantages. PPBTL is generally recognized as having a slightly higher failure rate than the same operation performed as an interval procedure, but is certainly cheaper than another hospitalization. Complications such as concomitant postpartum hemorrhage or endomyometritis are avoided with interim procedures. Unreliable or irresponsible patients may become pregnant again before interim sterilization can be performed. The ultimate decision should be a consensus between patient, anesthesiologist and surgeon based upon anesthetic safety.

Anesthetic safety concerns relate to the theoretical risk of aspiration pneumonia associated with blocked airway reflexes and incomplete gastric emptying. The Center for Disease Control and Prevention(CDCP) reported 29 deaths related to tubal sterilization between 1977 and 1981, four of these due to anesthetic complications of PPBTL and all four using inhalation general anesthesia by mask.¹

A review of gastric physiology prepartum, intrapartum and postpartum is necessary in order to resolve the safety questions concerning PPBTL. Normal nongravid subjects empty their stomach of liquids within one and solids within four hours of ingestion. Factors such as obesity, diabetes mellitus, narcotics and nicotine delay gastric emptying. Stress may or may not delay emptying. There is no delay of emptying in pregnancy except during labor^{2,3,4}, but this is not necessarily relevant to scheduling immediate PPBTLs since all prospective cases will have experienced labor directly prior to the surgery. Strict NPO status prior to the onset of labor usually ensures an empty stomach during labor, and if no oral intake occurs during labor the stomach should be empty immediately postpartum.

Gastric emptying following delivery is another matter entirely. O'Sullivan et al found slower emptying in the first hour postpartum than in nonpregnant controls, but this was true only if narcotics were administered during labor.⁵ Whitehead et al found slower emptying of liquids two hours postpartum than during 18 - 48 hours postpartum or in nonpregnant subjects, but narcotic administration was not a considered variable.³ A more recent study found emptying of liquids to be prolonged

if epidural fentanyl dosage during labor exceeded 100 mcg.⁶ Gin et al found no difference in emptying of liquids on the first postpartum day, the third postpartum day or six weeks postpartum.⁷ Sandhar et al found normal emptying of liquids two to three days postpartum.⁸ Apparently there is a poorly defined but increased risk of prolonged gastric emptying and subsequent retained contents immediately postpartum.

The most significant study investigated the presence of intragastric solid material postpartum and the time required for emptying. Jayaram et al performed abdominal ultrasound scans immediately postpartum, locating food in eleven of 28 subjects although some had last eaten fourteen hours earlier or more. Some had even foregone narcotics during labor. They also fed subjects five hours postpartum and scanned their stomachs four hours later, with nineteen of twenty showing residual gastric solids.⁹ This suggests that the immediate postpartum period indeed has an increased risk of aspiration pneumonia during general anesthesia despite preanesthetic NPO status, and maintaining eight hours of preanesthetic NPO status following a postpartum meal is probably ineffective in preventing these complications.

Anesthetic options for PPBTL include general inhalation, epidural, spinal or local anesthesia. All have advantages and disadvantages. General anesthesia probably has the greatest risk of aspiration, although epidemiologic evidence indicates no greater risk when endotracheal intubation is utilized than that of regional anesthesia. General provides quick induction, dependable maintenance and is less technique dependent, especially when using rapid and short-acting agents such as propofol and mivacurium.

The epidural analgesia frequently used in labor can easily be extended and deepened to abdominal anesthetic levels for PPBTL or initiated independently postpartum. Many anesthesiologists will agree to proceed directly to sterilization immediately postpartum, but there is a recognized risk of anesthetic failure even with an apparently properly functioning epidural catheter. The anesthesiologist should preoperatively discuss alternative anesthetics to be used in case of epidural failure with both patient and surgeon.

Spinal anesthesia is a reasonable alternative, especially techniques utilizing low doses of local agents and narcotics administered via small bore Whitacre needles. I personally prefer 30 to 40 mgs. of hyperbaric lidocaine combined with 25 mcg. of fentanyl.

Local anesthesia using up to 100 ccs. of 1% chlorprocaine for local infiltration and intraperitoneal instillation concomitant with intravenous sedation has been reported to be successful and tolerated reasonably well by patients.¹⁰

The following protocol is currently used at The Johns Hopkins Hospital:

1. Maintain NPO status during labor for all patients requesting PPBTL
2. Initiate epidural analgesia during labor only upon patient request for pain relief regardless of desire for PPBTL
3. Perform requested sterilization immediately postpartum, preferably under regional anesthesia, if patient's labor was induced and preceded by at least eight hours of NPO status
4. Perform requested sterilization immediately postpartum if an adequately functioning epidural in place at delivery can be incrementally dosed to provide adequate abdominal surgical anesthesia
5. Perform requested sterilization after at least eight hours NPO postpartum if an epidural in place at delivery cannot be incrementally dosed to provide adequate abdominal surgical anesthesia
6. Perform requested PPBTL, preferably with low dose spinal anesthetic, after at least eight hours NPO postpartum if labor was not induced and an epidural was not in place at delivery
7. Regional anesthetics are encouraged for all PPBTLs.

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SCREENING MAMMOGRAPHY

by William H. Hindle, MD

ABSTRACT: As primary care physicians for women, gynecologists are responsible for counseling annual screening mammography, recommended by the American Cancer Society (ACS) to begin at age 40. Physicians responsible for women's healthcare should also include a breast examination, pelvic examination and Pap smear as part of their routine annual office visit. During the decade between ages 40 and 50 it is particularly important that women have annual screening mammography because rapidly growing breast cancers are more common in this group than in women over 50.

For years there has been heated controversy among medical organizations over recommendations regarding frequency of screening mammography for women age 40 to 50, mainly due to a lack of statistically significant data demonstrating cost-effective benefit. Several Swedish clinical trials have recently reported such data, allowing the American Cancer Society (ACS) and the American College of Radiology (ACR) to agree on a recommendation for annual screening mammography beginning at age 40. Baseline screening mammograms before age 40 have been found not cost-effective. But in selected cases such as women whose first degree relative has had breast cancer, annual screening mammography should begin sooner. A mother diagnosed at age 42 with invasive breast cancer justifies annual screening mammography for her daughters beginning at age 32, ten years earlier.

It is imperative that screening mammography orders be written in the medical record. Refusals of recommended mammography and desires to independently schedule studies should be recorded also. Orders for routine testing are sometimes recorded by receptionists, but all such documentation should be available until the medical record is destroyed. This is particularly important since the ever-present risk of breast cancer increases consistently after age 30.

Reports for all screening and diagnostic studies, including mammograms, should be obtained, reviewed and documented in the medical record. Patients should be contacted if screening reports are not received within two months, even though the ACR recommends four to six months. Patients should be contacted by telephone or mail if these studies have not been performed and reminded to have them completed. The same patient contact may be used to explain the benefits of early breast cancer diagnosis and risks of undiagnosed preclinical breast cancer, plus an offer made to arrange an appointment for the study. As previously mentioned, all these elements should be properly documented in the medical record.

It is best to reemphasize the importance of breast cancer screening each time a mammogram is ordered. A patient tracking system should be used to document requests for all diagnostic studies including mammography, routinely updating and monitoring their status until reports are received. Written notifications or brochures stressing the importance of screening mammography and advising annual mammograms should be sent to noncompliant patients certified mail, return receipt requested, and copies filed in the medical record.

Good medical practice requires informing our patients of the results of their diagnostic studies, including mammography. Appropriately trained office staff using an established protocol can do this by phone, letter or in person during the next office visit. A complete medical record must document these communications and instructions regardless of the method used.

Although the federal Mammography Quality Standards Act of 1995 requires radiologists to report mammogram results to their patients, it does not relieve the ordering physician of responsibility. Good medical practice includes personally discussing all results, more especially those abnormal, with your patients either in person or by phone. Again, documentation of this communication is essential.

Physicians should continue to monitor patients' clinical status after consultant referral. They should contact these patients and ascertain their plans when failure to comply with the consultant's recommendations for treatment or follow-up is discovered. This communication should also be recorded in the medical record and the referring physician's subsequent recommendations plus the patient's response documented.

Most early breast cancers have a prolonged, indolent preclinical course and some will be undetectable in these stages even with optimum medical care. Annual screening mammography is currently the most effective means to diagnose nonpalpable breast cancers before lymphovascular invasion has occurred. However, the search for asymptomatic breast cancers places an increased liability upon gynecologists. Each of us should have a reliable patient tracking system that monitors the ordering, performing and informing patients of the results of all diagnostic testing, including mammography. This same system should ensure prompt physician review of all results, appropriate follow-up, and treatment of abnormal studies.

Four Years Ago I Couldn't Even Spell Obstetrician/Gynaecologist, and Now I Are One

by Philip A. Rosenfeld, MD

We obstetrician/gynecologists are responsible for our increasing number of malpractice suits and have no one to blame but ourselves. We inadequately train our residents and do nothing to improve postgraduate education. Corrective actions by our specialty's Board and College are either nonexistent, delayed or confusing. They should admit that the purpose of training, if that is the proper word, obstetrics and gynecology residents in primary care is to allow direct access to patients covered by third party payors instead of through intervening gatekeepers.

We all did limited primary care in the past and referred to a specialist when simple treatment failed. But one of my current residents saw only one gynecology patient last week; the rest were primary care. What kind of specialist training is that?

The federal and most state governments now provide women direct access to their obstetrician/gynecologist. So why do the Board and the College still require dedication of precious resident training time to primary care? I say it is poor medicine and leads to diluted specialty training. Just wait until one of us is sued for failure to diagnose and treat an early myocardial infarction or thyroid storm. Then we'll change our tune.

We expect our graduating residents to be jacks of all trades, and subsequently masters of none, without a correspondingly increased training period. But they cannot be experts in everything. Such diverse, diluted experience results in more judgment errors, more failures to diagnose and treat, and ultimately more litigations.

Plaintiff's attorney always questions the physician defendant's training early in his case. If a patient's incontinence correction procedure fails, he looks for cystometric and urodynamic preoperative evaluations. If a postoperative patient develops a vesico-vaginal fistula, he demands to know why an undertrained "regular

gynecologist" attempted the repair instead of referring her to a urologist. "Just how many of these operations have you done, Doctor?"

Medicine has advanced exponentially in the past decade, but residency training and the Board have yet to realize it. Lawyers, however, continue to realize they can cash in on physician inexperience. We must demand medical governing bodies respond to our wishes and desires, not wait for Moses to bring the commandments down from the mountain. Continuing dilution of residency training and decreasing clinical experience will bear poor patient care and more litigation in the future. I have done more neurosurgical cases, one, than most practicing Junior Fellows have Le Fort procedures. What entitles them to be called specialists?

I believe today's obstetric/gynecology residents are frustrated by our specialty's diluted teaching and intense desire to be accepted as both primary care physicians and superspecialists. I also believe our rapidly increasing technology and scientific knowledge are best managed by reverting to a previously abandoned system, i.e. every gynecological patient, including gynecologic oncology, is attended by a properly trained surgical gynecologist and every obstetrical patient, both uncomplicated and high risk, by a properly trained obstetrician. Residents do reproductive endocrinology and infertility fellowships knowing full well they will never deliver another baby, wasting half of their costly residency. Why should the Board's examinations test future gynecologic oncologists on electronic fetal monitoring strip interpretation? It's silly!

Now to a more practical question: "Does diluted residency training invariably lead to poor patient care and more malpractice suits?" Inexperience certainly increases risk and subsequent loss. Litigation-prone patients see physicians as having deep pockets, will always sue for any reason, and most such cases are dropped, dismissed or won by the defendant. But these cases are still responsible for time lost from one's practice plus unnecessary stress and anxiety on one's family.

A young obstetrician/gynecologist performs a difficult forceps delivery, delivers a damaged baby, and incurs a six million dollar settlement. Would a specially trained obstetrician who always uses forceps have less chance of delivering an injured baby, possibly even convincing a jury that forceps delivery posed the least risk for both patients?

When an obstetrician/gynecologist applies to take his oral board examination, does a case list including only six vaginal hysterectomies constitute enough experience to grant specialty certification? See one, do one, teach one does not apply here; we must require much more experience before we grant certification. Would you accept your mother's, wife's or daughter's gynecologist performing only six vaginal hysterectomies in the past two years, maybe a few more during residency? Those practicing maternal fetal medicine routinely care for patients with severe pregnancy-related medical illnesses and fetal abnormalities, but the average obstetrician sees relatively few and cannot possibly be familiar with the latest diagnostic and therapeutic advances.

If current residents' training and clinical experience in gynecologic oncology does not produce expertise, how can they be expected to perform such surgery? If the unexpected occurs and complications result, how can we expect these physicians to manage them without further complications?

I advocate redesigning residency training programs to produce physicians limited in what they can do but capable of doing it very well. They would then be certified as qualified in a much smaller area of expertise. How can we do this? Residents would have to decide their future early in postgraduate training, maybe after the first year. Then they would finish their training in either obstetrics or gynecology, but not both. Obstetrics would combine maternal fetal medicine and infertility. Gynecology would combine gynecologic oncology, gynecologic endocrinology and urogynecology. Some in the specialty even advocate more than four years of PGY training.

Earlier diagnosis and treatment with fewer complications would be the result, significantly decreasing lawsuits. Patient care would improve because a focused, well-trained physician who was no longer trying to capture the gatekeepers' dollars would be practicing in a limited field where he was a truly qualified specialist. Isn't this our real aim? I challenge the College and the Board to address these proposals.

MEDMAL 102: DISCOVERY

by Doug Daniel and Hugh Martz

Having survived the initial Complaint, the next course served on your plate will be Discovery. No, this doesn't refer to the Discovery Channel on cable television. It's the pretrial process allowing limited time for the defense and plaintiff attorneys to gather and review evidence, each attempting to accentuate the positive and eliminate the negative. During discovery such devices as depositions, interrogatories, requests for admissions of fact, and requests for production of hospital and office records are used. After obtaining and solidifying the facts either side may file motions to dismiss or for summary judgment. These are supported by affidavits and other sworn statements in an attempt to have the case favorably decided without a trial. All devices for gathering facts and evidence are important, but the most important are depositions and production of medical records. Medical records generally tell the tale and depositions fill in the blanks.

Interrogatories are simply written questions requiring written answers under oath, generally used to learn background information and establish facts which will not be contested at trial. They are also used to get defendants to admit potentially arguable allegations. Interrogatories are submitted to the opposition lawyers with a deadline for filing the Answers.

Both Interrogatories and their Answers require timely and detailed attention whether posed by defense or plaintiff, and your input is essential if your lawyer is to represent you properly. The questions may appear inane, irrelevant, personal and nit-picking but you must answer them carefully, accurately and promptly. Never take interrogatories lightly but always give them your immediate attention and insist that your attorney do the same.

The first depositions taken are usually the plaintiff's and yours. Both of you are entitled to attend any depositions and even though inconvenient or perhaps emotionally traumatic, you would be best advised to attend them all. It's much harder for anyone to say bad things about you while sitting directly across a table with you looking them in the eye, and this reluctance may prove crucial at trial. It also gives you some idea of what to expect in trial testimony, i.e. you may decide it's preferable to settle the case and avoid potentially bad publicity or emotional trauma for you and your family. Don't expect to play an active role in the depositions of others. You are there only as an observer, but during breaks you can discuss any discrepancies or errors in private with your attorney.

During depositions it is crucial to realize that even though the setting may seem relaxed and informal, they are just as important as court testimony. Your deposition and trial testimonies must agree. In fact, you may be privileged to have the plaintiff attorney read your deposition testimony back to you during the trial

in an attempt to confuse or discredit you before the jury. All the attorneys present who represent parties to the suit have an opportunity to ask questions of the witness and are even entitled to additional rounds of questioning to clear up any potentially damaging or contradictory testimony.

Generally speaking, the same rules apply at deposition as at trial. The date, time and location of the deposition will be entered into the record by the court reporter. Then he will have you swear to tell the truth. If you have a problem with swearing or acknowledging God's existence, mention such concerns to your lawyer beforehand and the traditional oath can be altered. The opposing attorney will also tell you that he doesn't want you to try and answer any questions you don't fully understand, in spite of the fact that he will do everything within his power to confuse and disorient you. If you don't understand a question, ask that it be repeated. By all means remember the opposing attorney's goals in taking your deposition:

1. To observe what kind of an impression you make
2. To find out how well you stand up under questioning
3. To gather and augment the facts
4. To see if you will make any admissions which can be used against you in settlement negotiations or at trial.

Being intimately familiar with the medical records, depositions, medical literature to be cited and all the information they contain is vital for deposition and trial, as is detailed overall preparation for testimony. Answer only the question asked. Do not elaborate. If you forget something important and you previously discussed it with your lawyer, he can ask you about it during his examination. If you begin to tire, ask for a break. It's your right.

It's also your right to read your deposition and correct any errors prior to filing with the court, but it's very important that you reserve or claim that right at the time of the deposition. Discuss this with your attorney in advance and if he doesn't mention it, remind him on the record. Otherwise it will be assumed that the transcription is 100% accurate as presented. They never are, and seemingly innocent or innocuous errors of punctuation, grammar and even context can become very embarrassing or harmful at trial.

Always conduct yourself in a courteous and professional manner, never making casual conversation off the record or within earshot of anyone but your attorney. "On the record" means the court reporter is recording every word spoken plus gestures. But even when an attorney advises the reporter to "go off the record", anything said could be admissible in court as evidence. The attorneys will frequently make comments such as "strike that" and you may assume the court reporter will delete the prior question or statement, but it remains in the deposition until the judge decides the jury need not hear it. Even so, you can't instruct the reporter to "strike" a comment or response if you answer in haste or lose your temper. Always remember to carefully consider what you're about to say. If you misspeak be sure to correct yourself as soon as possible, or simply stop and start over with an explanatory comment such as "I may be confusing you, so let me try again."

A favorite ploy of attorneys is to wait in a toilet stall or send someone into the toilet during breaks to listen to supposedly confidential conversations between their opposition. These discussions should either be held in a private conference room or in an obviously open area where anyone approaching can be seen. Another trick is to have someone follow you to the restaurant where you and your attorney eat breakfast, lunch or dinner and sit close enough to eavesdrop. All this is perfectly legal and ethical, but forewarned is forearmed. Make sure that all conversations regarding the case are secure and private.

A good attorney will try to get you angry or flustered during your deposition, not just because he's rude and insensitive but because he's good at his job. Once a

defense attorney suddenly rose from his seat during a videotaped deposition and began walking around the room out of camera range while jiggling his pocket change and keys. Though appearing mad as a hatter, he was actually trying to produce a distraction during his opposing colleague's examination.

Then there's the story about Clarence Darrow, a famous trial lawyer who practiced back in the days when smoking and chewing were allowed during court. If old enough you may remember the spittoons, smoking stands and ashtrays which used to be prominently and frequently displayed in all public areas of government buildings. During his opponent's examination of witnesses or arguments to the jury he would light up a big cigar, smoke a bit, and then place it in the ashtray on the table before him without flipping off the ash. Soon there would be an inch of ash hanging off the end of the cigar, and it would get longer and longer while the jury couldn't take their eyes off it for wondering when the ash would fall. No one ever guessed that he would previously insert a small steel wire the length of the cigar to allow the ash to reach impossible lengths. Needless to say, the jury never heard a word his learned opponent said. Be on the lookout for similar ruses.

Sometimes it may appear that the attorneys are about to come to blows during an argument on the record. Ignore it. Usually it's either their egos clashing or they're posturing for the judge when he considers their motions later. It doesn't concern you at all.

Always wait a second or so before you answer the opposing counsel's questions. There are three reasons for this. First it gives your attorney a chance to object to your answering or advise you not to answer. Either one can keep unfavorable testimony from the jury. Secondly it gives you a moment to consider and form your answer, possibly avoiding future embarrassment over your sentence structure, grammar, or hastily and poorly conceived answers. The transcript will not reflect how long you take to answer and if the opposing attorney tries to prod you to answer, ignore him.

Thirdly it ensures that you do not interrupt before he finishes his question. Doing so makes you appear rude, inconsiderate and overbearing, plus there's no way you can properly answer if you don't hear the whole question. Due to the pressure and anxiety common during depositions it is ever so easy to jump the gun and assume you know the rest of the question, trying to shorten an already painful process. If you are aware of this tendency and recognize it, you can avoid it.

On the other hand don't avoid the question itself or be evasive. This makes you appear deceptive and unreliable in the eyes of the jury. Answer all questions honestly and directly after the above noted pause. Most importantly, don't volunteer more in your answer than was asked. You probably won't notice, but volunteering such additional information makes the opposing counsel ecstatic because you look like an idiot and might even unintentionally say something which could harm your cause.

If your answer on the other hand is obviously making good points and effectively attacking the opposing attorney's case, he may try to interrupt you with another question. At other times you may think of an important point after finishing an answer. You can always continue or add to a previous answer by saying, "Well, regarding your question about" or "I may have misled you with that last answer, but ..." or "If I may continue that last answer, ...".

The worst thing that can happen during a deposition or trial is your attorney being surprised or blind-sided. It is imperative that you be totally honest with your lawyer without regard for what he may think of you personally. Ad hominem attacks are efforts by the other side to discredit you based upon personal information unrelated and irrelevant to the case but potentially damaging in the eyes of the jury. Some examples are previous alcoholism, drug rehabilitation or alcohol-related charges if impairment played no part in the alleged tort; prior adverse peer review, licensing board or medical staff decisions; performance of abortions; credit and business history; marital problems or sexual preference. There are few ethical or legal restraints upon what you may be asked during direct or cross examination, but what little protection you enjoy is in the hands of your attorney.

You should however find some solace in the more stringent restrictions applied to admissibility of evidence at trial compared to discovery depositions. In depositions and other discovery devices you can be asked about anything reasonably calculated to lead to discovery of evidence admissible at trial. This is very broad and pretty well opens up your personal and professional life like a can of creamed corn. For more on this see *How to Give an Effectice and Honest Defendant's Deposition in Civil and Criminal Litigations and Investiganions* by William Jefferson Clinton, coming soon to a bookseller or supermarket near you.

But at trial the test is much narrower, addressing whether the evidence is relevant, i.e. does it make an issue of fact in the case more likely than not? It may also be relevant to impeaching your credibility as a witness, but only those matters pertaining to your honesty count. This doesn't include sexual preference, divorce, alcohol related offenses, etc.

And always remember that the SOB sitting across the table may be asking those embarrassing questions just to see how you respond to pressure and to create anxiety about your trial testimony, all the while knowing full well he can never get it past the judge to the jury. Your defense counsel will file a motion in limine to keep out of evidence those matters which have no relevance to the issues or to your credibility, especially if the prejudice of admission far outweighs any probative value of the evidence.

Never try to con a con artist. Attorneys are experienced experts highly trained in the arts of debate and intimidation. Regardless of what they may tell you, good medical malpractice attorneys both plaintiff and defense know as much as you or more about the medical aspects of the case in question. Try to teach your attorney as much medicine as he wants to learn, but don't be deceived by comments from the opposition such as "Now I'm not a doctor, so maybe you could explain that for me." Phrase your answers in terms a layman could understand in order for the jury to appreciate the issues, illustrating your point with analogies to familiar and common situations.

Never allow yourself to think you can deceive or enlighten the opposing attorney. He may not have ever managed a labor or delivered a baby but they all are well-versed in fetal acidosis, EFM interpretation, IUGR, gestational diabetes, etc. Never underestimate the importance of preparation but instead be familiar with and knowledgeable about all the medical records, previous depositions, relevant textbook literature and appropriate medical journals, realizing that relevance is also related to accepted medical knowledge at the time of the occurrence in question.

Don't think you can play mind games with, argue with or outlawyer lawyers. They'll beat you every time. As for the jury, "Everybody likes a little but nobody likes a smart one." It may be a frightening thought, but probably the single most important factor at trial is whether or not the jury likes you.

How should you appear for a deposition? Always be well-groomed and confident but never ostentatious or cocky. Even if you are attending another's deposition, dress professionally with suit, dress shirt/blouse and shoes, and power tie for the guys. An example would be a navy pinstripe suit, white shirt and red tie. The same goes for videotaped depositions, plus remember that the camera adds at least ten pounds. If the deposition is taken in a hospital environment, clean scrub suit and shoes with a clean lab coat is an option but make sure they fit well. And don't forget to check with your attorney first. Flashy jewelry and clothes should be left at home as should the Beemer or Benz.

Make sure you are well-rested and alert. Don't let the situation develop where you are up for 36 hours straight working L&D before walking into the deposition. Also don't try to squeeze it in over lunch at the office or between cases in the OR. If scheduled for the morning, leave the rest of the day open. You may know what time it will start but you have no idea when it will end. Good advice is to arrange for someone else to take your calls and cover your responsibilities. And please don't ever take an active beeper or cellular phone to a deposition or court. Arrange for someone else to take your calls and slip you notes only if absolutely necessary.

You are entitled to certain considerations when providing testimony. If you're uncomfortable due to a need to attend to bodily functions, ask for a comfort break. If you're hungry or thirsty, ask for a meal break or a drink of water. If you become emotionally distraught or get aggravated and angry, by all means ask for a brief break to settle down. Most people start to tire or fade after about two hours or less of continuous testimony, and a jury will begin to lose interest in about an hour unless something really interesting is going on. Anytime your attorney suggests a break, take it. He may need to talk to you in private.

Be responsible in your role as defendant or medical expert witness. Be prepared on the medical aspects of the case. Know the fundamental rules of case and court behavior, but leave the legal operating to your counsel. Develop a solid, trusting, working relationship with your lawyer, the same as you expect from your patients. It will prove invaluable as your case progresses through what may at times seem an interminable legal system.

Next time we'll talk about going to court and what to expect when you get there.

THE FEN-PHEN PHRENZY

by Doug Daniel

"Vanity, thou name art woman." Someone much wiser than I wrote that a long time ago, maybe in the Old Testament. Today a lot of men answer to that name also. Untold masses of both sexes took the weightloss combination of Pondimin® and Redux®, popularly known as "Fen-Phen", before manufacturers voluntarily removed them from the market due to concerns about their possibly causing cardiac valvular lesions such as Mitral Valve Prolapse (MVP). The problem is that MVP is a common finding in asymptomatic women whether they took Fen-Phen or not, it just seems more common and more severe in those who did.

So now the Fed's *Morbidity and Mortality Weekly Review* (MMWR), Vol. 46, No. 45, November 14, 1997 (Yeah, I know this is almost a year old, but read on anyway because nobody much is talking about this yet. They will.) has published Department of Health and Human Services *interim* recommendations for cardiac work-up and/or Subacute Bacterial Endocarditis (SBE) prophylaxis for these folks. The recommendations were developed in conjunction with CDC, FDA, NIH, ADA, AHA (American Heart Association), and ACC (American College of Cardiology) but evidently not ACOG or AMA. Here's the condensed grocery list of recommendations.

1. Everybody who took either or both drugs, even one dose, should be evaluated with medical history and cardiovascular exam for signs/symptoms of cardiopulmonary disease.
2. Everybody who took either or both drugs, even one dose, should have an echocardiogram if the medical history or physical exam suggests cardiac valvular disease.
3. Physicians should strongly consider performing echocardiography on everybody who took either or both drugs, even one dose, **BEFORE** performing invasive procedures for which AHA recommends SBE prophylaxis. Those with findings meeting AHA guidelines for prophylaxis should be so treated. If echocardiography is not or cannot be performed preoperatively (emergency surgery), all those so exposed to the drugs should be treated with SBE prophylaxis.
4. Mild aortic regurgitation and moderate mitral regurgitation on echo qualify for SBE prophylaxis in these patients.

ACOG *Educational Bulletin No. 237, JUNE 1997* entitled "Antibiotics and Gynecologic Infections" addresses SBE prophylaxis regimens and those patients who have qualifying cardiac valvular disease. Various oral and parenteral regimens providing preoperative or preoperative/postoperative antibiotics including ampicillin, gentamicin, amoxicillin and/or vancomycin are described for qualifying patients undergoing hysterectomy, I&D of abscesses or other infected areas, and urethral catheterization or GU surgery in the presence of UTI. Unless infection is present at the operative site, SBE prophylaxis is not necessary for urethral catheterization, D&C, IUD removal, tubal sterilization or laparoscopy. As for elective abortion, routine prophylactic antibiotics are not directly recommended but they seem to think it's a good idea. Evacuation of incomplete spontaneous abortion is not addressed.

ACOG *Educational Bulletin No. 245, MARCH 1998* entitled "Antimicrobial Therapy for Obstetric Patients" also addresses SBE prophylaxis and those patients who have qualifying cardiac valvular disease. Various oral and parenteral regimens providing preoperative or preoperative/postoperative antibiotics including ampicillin, gentamicin, amoxicillin and/or vancomycin are again described for qualifying patients but not recommended for Caesarean sections or uncomplicated vaginal deliveries "...with the exception of high-risk patients for whom it is optional".

Routine prophylactic antibiotics are not directly recommended for *nonelective* Caesarean sections, but again they seem to think it's a good idea and everyone else seems to agree.

So what's going to happen when patients exposed to FEN-PHEN are found to have cardiac valvular damage possibly due to SBE following surgical procedures for which they did not receive prophylaxis? Unless the *interim* recommendations change, there's going to be a lot of settlements/judgments because nobody I know is following the DHHS protocol. I asked one of the presenters on treatment of gyn infections at the New Orleans ACM if his department was asking preoperative patients about Fen-Phen exposure. He looked surprised and said of course not. After we discussed the DHHS recommendations, he said that was all well and good, but such a protocol would be too expensive and not cost-effective.

And he's not the only one. Nobody I've asked about this is following the protocol and evidently the College isn't interested either. So what should you do?

I can tell you what I'm doing. First of all I reviewed the MMWR. Then I reviewed the College's *Bulletins*. Next I reviewed the AHA recommendations with my cardiologist. Finally I decided to start asking **ALL** patients if they ever took prescription weightloss drugs. If they did, what was it. If they don't know I assume it was Fen-Phen. The situation is then explained in detail and echocardiography recommended if applicable. For those who refuse, there's an entry in the record to document it.

Those preoperative patients for whom recommended cardiac work-up is refused or inconvenient get SBE prophylaxis. Since most of my vaginal deliveries end up with an episiotomy if not a perineal laceration, I'll treat everybody who should have had an echo and didn't, plus all those with positive echos. Same for elective Caesarean sections, D&Cs, hysterectomies not on routine prophylactic antibiotics, I&Ds, elective and incomplete abortions, and urethral catheterizations or GU surgeries. At least until more recent *interim* recommendations come to my attention. Don't forget that SBE prophylaxis should be started one hour before surgery, even on Caesarean sections.

If you find yourself reviewing one of these cases, be aware that these *interim* recommendations are sure to change, probably several times. There's also going to be a considerable lag time before most of us are aware of each *protocol du jour*. Nevertheless, the risk has been identified and publicized. Those who don't have a good reason for not treating appropriate patients with SBE prophylaxis are going to have a problem if they get hit with a suit.

The other thing is I just recently received a copy of CDC's "1998 Guidelines for Treatment of Sexually Transmitted Diseases" as published in MMWR, Vol. 47, No. RR-1, 23 JANUARY 1998. It seems like now they are recommending treating almost everything except syphilis with oral azithromycin, which just happens to be one of the SBE regimens in the Course Syllabus the above lecturer provided at the ACM. I've got to check the PDR to see who the manufacturer is and call my broker.

'TIS A PITY SHE'S A WHORE

by Doug Daniel

When I was in college way back in the sixties there was a young coed on campus who was a superb student, very intelligent, most attractive, great sense of humor, excellent conversationalist, lots of fun to be with and built like my grandmother's brick outhouse. Everything but a 4-H Blue Ribbon winner and makes her own clothes, and she may even have done those for all I know. Definitely Playmate of the Month material. In short, she was a perfect 10 at age 19. Fortunately, or unfortunately as the case might be, she also was heavily into the sexual revolution, free love, be naked and run free, etc. Most students with these interests seemed to gravitate to left coast schools such as UC Berkeley or to Woodstock, New York, so she was a bit of an oddity at a small, rural Georgia teacher's college.

We had a class together my first freshman quarter. I really enjoyed her company and conversation, even dating her several times. Imagine my chagrin when I heard an upperclassman in the student lounge describe her as what Paul Simon has called "The Human Trampoline". Apparently quite a few of the young bucks on campus eagerly shared her hippie interests but didn't want to be seen with her. They didn't talk with her in public, didn't take her to movies or dances, and met her only after dark. You'd think they didn't know her in daylight!

We went to a few more dances, movies, football games, etc. and then she transferred to the University. The way everyone gossiped about her, the other coeds shunned her and her consorts ignored her really bothered me. Just never did sit right. Couldn't understand it. Until a few months ago.

One recent spring morning I got a call from a paralegal with one of our state's premier med mal defense firms. She had a case which her firm wanted me to evaluate. Very flattering but I get relatively few cold calls from attorneys asking me to review cases and almost never from counsel for the defense. "How did you get my name?", I asked. She assured me her attorney had been awestruck by my talent, ability, insight, intelligence, and integrity after reading one of my prior plaintiff cases in a reporter. So with stars in my eyes and joy in my heart I said, "Sure, tell me something about your case."

It sounded justified but possibly defensible, so we agreed she would send the documents with an escrow check. Upon receipt I realized we had neglected to exchange the usual contracts, so I called back and said I would be sending them by FED EX. She said OK, but since I already had their check could I at least start on the case?

Only an idiot would refuse to work for someone who had already paid in advance, right? So I said, "Sure, no problem." A week later I called again to discuss the case. It was possibly defensible but by no means a sure thing, depending upon what was in two or three documents missing from the file. I then inquired about the contracts since they had failed to appear in my mailbox. "Let me put you through to Mr. Barrister," she said. Hmm. Without thinking I reached for my trusty tube of KY Jelly.

After a few minutes' wait B. A. Barrister, Attorney at Law, came on the line and said he was glad we had this opportunity to talk. An ill omen if ever I heard one. He appreciated my assessment of his case but upon reading the contract he had become very concerned that someone might in the future connect the two of us as working on the same case and he didn't feel his spotless reputation could survive being mentioned in the same sentence as a known common plaintiff medical expert witness (read whore) and would I please return the unused portion of his escrow thank you very much.

A few days later I realized what had happened. Mr. Barrister's chaste and virtuous defense medical expert witnesses probably advised settlement instead of risking trial, but his client said no way. So Mr. Barrister said, "OK, howabout I

send it to someone who does primarily plaintiff work. If he tells us the same thing maybe you'll believe him." Then once Mr. Barrister got what he wanted I was dropped off at the corner to walk home since he never planned to take me to the dance (read court) anyway. If some people think of us as whores and even call us whores, why should I be surprised when they treat us like whores?

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