

THE IMPAIRED PHYSICIAN: EDUCATION

by

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ABSTRACT: Studies have shown that approximately 20% of all healthcare workers with access to controlled substances have been, are or will become drug impaired. If our education process functioned properly, none should become drug abusers.

As we write this the thrill of college football fills the crisp air of autumnal weekends. After three decades of teaching at the Medical College of Georgia (MCG) School of Dentistry, one of the authors (TRD) still delights in welcoming each Fall's crop of bright-eyed and eager new recruits to the dental profession. But there is always a downside, not necessarily referring to the Krebs cycle.

Studies have shown that approximately 20% of all healthcare workers with access to controlled substances have been, are or will become drug impaired ("The Georgia Statement", Vol. I, No. 1, JULY 1998, Georgia Merit System, Atlanta). They risk loss of family, profession and even their lives. We supposedly have taught them the dangers of these potent and governmentally controlled pharmaceuticals as well as their therapeutic benefits, and yet for 20% our warnings apparently have failed to register.

If our education process functioned properly, none of our students would become drug abusers and those who already were would quickly become clean and sober. This obviously is not the case. Two questions then remain: How should we cope with the problem and what changes should we make in health sciences education in order to spare our graduates this personal and professional disaster? We offer for your consideration the Medical College of Georgia School of Dentistry's unique drug education program. "Oh, that's just great," you might say, "all those kids need is more classroom lectures." But give us a moment to explain.

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THE PRESIDENTIAL BOX

Ray Cestero, President

A VERY HAPPY NEW YEAR TO ALL! I start this column, my first as your President, with some trepidation. Dan Avery is one tough act to follow. We all join in thanking Dan and Doug for their hard work and hope both will continue to serve the Society for many years. I sincerely believe this will be a great year for our organization, although we will remind you occasionally that your help is always invaluable and even essential to meeting our goals.

Let me begin by offering warmest congratulations on behalf of the membership to Past President Ben Harer, nominated to lead us into the 21st century as ACOG President in 2000-2001. He has worked incessantly for ACOG and the Society. Congratulations Ben, you certainly deserve it!

This could prove to be a very interesting year in other ways. Legislation is pending in Congress to guarantee patients' right to select and access the physician of their choice. It will also insure optimal, appropriate treatment in accordance with patients' best interests, not their health plan's bottom line.

Litigation meanwhile produces huge judgments with punitive damages against managed care organizations who refuse to cover care recommended by their physicians. Chinks continue to appear almost daily in ERISA's armor. I predict our membership will become more involved in these cases, hopefully as medical expert witnesses and not as defendants.

I would however recommend caution. During my tenure as President you will discover that I sorely resent managed care's damage to our profession and our patients' care. But as medical expert witnesses we must remain objective and analyze each case impartially, only establishing the nature and extent of any breach of minimal accepted standards of care while allowing the attorneys to deal with legalities. We must resist prejudice against managed care defendants. Any hint of bias will irreparably damage our credibility and eventually render us ineffective.

I also wish to remind all our members that we are constantly in need of new members. Sharing Newsletters with colleagues is a great way to tell them who and what we are. Dues are currently among the lowest of any professional medical organization, and the Newsletter alone is worth the annual membership fee. Please write to us. Send your articles and comments, even if only to take exception to the President's obviously biased view of managed care.

And don't forget our presentation at the ACOG Annual Clinical Meeting in Philadelphia next May, listed as an Ancillary Meeting in both the Preliminary and Final Programs. It will be on Sunday afternoon, May 16th, at 6:00 p.m. in the Philadelphia Marriot's Conference Center, rooms 411 and 412. Last year's program was superb and we will try to do even better this year. Once again, I'm honored to serve as your President.

THE WITNESS BOX

Doug Daniel, Editor

"I don't believe the American people want a gelding in the White House."

Grover Cleveland, (1837-1908),
22nd and 24th President of the United States, upon learning of
charges he had fathered an illegitimate child.

If everything went according to plan, realizing it seldom does, this is the first issue of the *Newsletter* to be produced on our new Sharp SF 7855 copier. It should be a marked improvement in quality of reproduction and less labor-intensive for the production staff, going back to the future by returning to the format of the first issue I was responsible for three years ago.

A currently pressing issue is what to do with our incompetent printer. I've decided this guy should run for Official Idiot of the Village of Buckhannon; he'd certainly be the most qualified candidate, a real shoo-in. For those of you wondering what the hell's going on, an unknown number of the October *Newsletters* were printed and mailed without page 24. No great loss if that page were *The Litter Box* but it happened to be one of our best articles to date, addressing clinical issues in diagnosis and follow-up of breast malignancies. At this point the easiest thing to do is republish the article and sincerely apologize to Bill Hindle, both of which have been done in this issue. The membership also gets a reprint of Bill's article to give to the prospective member they gave their extra copy of the October *Newsletter* to. (What's that? You say you didn't pass on that extra copy I mailed? Then consider this a not-so-gentle reminder.) So for those of you who a la Yogi Bera experience *deja vu* all over again when you read Bill's article this month, do not despair. Someone else is reading it for the first time. The printer may be incompetent but he works cheap.

The 1999 Membership List is enclosed and based upon the above comments regarding our printer, I urge a close reading of your entry and notification of the office for any corrections or additions you wish to make.

As you know the membership was recently polled regarding a proposed dues increase to \$100.00/year beginning in 2000, justified by plans to increase publication of the *Newsletter* to bimonthly and eventually monthly. The results are in and only four members will resign if dues increase while 65 will continue their membership. One will probably resign whether dues increase or not. Another is undecided. Two had not responded as of deadline. The most common response was that our dues were much less than other professional organizations, and some said very nice things about the *Newsletter* and our ACM meetings. The bad news is that 24 members have yet to pay their dues although a final flurry of checks is expected after the beginning of the new tax year.

Others complained about the emphasis on impaired physicians, seemingly insulted by *Newsletter* articles which some felt implied they themselves were impaired. The series was originally conceived as one or two articles, precipitated by the concern of some medical expert witnesses that a sizable number of legitimate medical litigations were primarily due to physicians' impairment by alcohol, drugs, fatigue, illness either mental or physical, ignorance, inexperience or inexperience. The intent was never to accuse anyone of impairment, only to educate readers to its signs in others and themselves plus how to address it. There has been a subsequent commitment to support those in recovery, and this will probably culminate in a proposed recovery adjunct based on outdoor recreation. At this time a six day experience including whitewater rafting, hiking, camping, and fourteen hours of twelve step programs is being developed to be sponsored by but financially independent of the Society. The first one could be as early as late Spring or early Summer of 1999. Those interested in participating should be members in good

standing of Caduceus or a similar organization. If you want to go or know someone who might, call the office.

We are still trying to garner business for our members, so far with little success. The latest attempt was contacting managed care companies in California to offer services in performing independent review of patient appeals for denied services. The questions of dues and more frequent *Newsletters* will be presented to the Board at its next meeting and strategies to increase membership plus soliciting work for members will be discussed.

In his first at bat in the President's Box, Ray Cestero hits a home run. In case you miss his subtle inferences, Ray enjoys practicing under the new managed care system about as much as having a root canal. On his comments regarding our need for increased membership, he gets a hearty Amen from this corner.

The Suggestion Box this month contains my personal opinion on L'Affaire Clinton with rejoinders both pro and con from a wide range of commentators. Although perhaps old hat by now, it speaks volumes about our modern society and its moral compass or lack of same. The Litter Box contains a sampler of quotations by and about the U.S. Presidency and those duly elected to its office. You might be surprised.

Fortunately our mole deeply entrenched within the upper echelons of the federal government, Deep Pockets, has to this point evaded discovery and successfully dispatched another clandestine communication via the Drop Box. Never one to take sides on political issues, Deep this month gazes objectively into his crystal ball and at great personal risk prognosticates the outcomes of the more important physician-related issues to be considered in the 106th Congress.

This month's installment in the continuing saga of the impaired physician is by two of our dental colleagues, Tom Dirkson and Jerry Gropper. They discuss the initiation, early development and subsequent progress of what to my knowledge is the first required medical or dental school curriculum specifically designed to deter students' future impairment while preparing them to identify impairment in their colleagues and patients. Since the article was written an additional presentation has been added and for the first time this October, Jerry brought several Talbot staff and recovering dentists to Augusta where they addressed the whole freshman class and answered questions from the floor. Reports are it was a resounding success for both the home team and the visitors.

Tom came to the Medial College of Georgia my senior year to start the School of Dentistry as Dean. He is retiring at the end of this school year. Tempus fugits. And yes, Uncle Everett was Tom's father's twin brother. Jerry is COO and Executive Director of Outpatient Services at the Talbot Recovery Campus in Atlanta.

On the same topic, another of Dan's articles (Vol. 5, No. 4, October 1997) was picked up by the North Carolina Medical Board for republication in its newsletter, *The Forum*, (No. 3, 1998). This is the one about inpatient treatment facilities. Apparently North Carolina's board is only one of several becoming more high-profile on physician impairment, and personal communication indicates that programs are being developed to address intellectual and technical impairment as well. I'd like to think the Society had something to do with this, but the train of events was probably already leaving the station and we just got on board.

The College has now confirmed our participation in the Philly Luncheon Conferences. Dan is scheduled to discuss identification and rehabilitation of impaired physicians on Tuesday, May 18th, followed by mandatory random physician drug testing in the workplace on Wednesday, May 19th. Both promise to be interesting.

Tim McGuinness has almost completed arrangements for the program at our Sunday night meeting during the Philly ACM (see President's Box). A presentation entitled "Bearing Effective Witness" will feature Phillip C. Ginsberg, DO, JD, and Marcella Schell, Esq. Phil is a practicing urologist in Penn Valley, Pennsylvania, and

Marcie is a member of Philadelphia's premier medical defense firm. As of our deadline Tim was still trying to secure a plaintiff attorney to roundout the card.

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 plaintiff 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.

Sid Wilchins has an excellent article this month on maintaining quality, accountability and accuracy in medical expert witness opinions. As always his sound counsel is right on target, but that's not surprising. He's a Past President of the Society, delivered the lecture at our first membership meeting during the 1994 Orlando ACM, and is a Fellow of the American College of Surgeons in addition to ACOG. Currently Clinical Assistant Professor in the Department of Obstetrics and Gynecology of the New Jersey Medical School in Newark, Sid is a graduate of the Georgetown University School of Medicine in Washington, DC, and completed his internship and residency at Saint Michael's Hospital in Newark followed by five years in the US Naval Reserve Medical Corps and subsequent private practice. Although not a graduate of a recognized law school, he is sometimes referred to as a jailhouse lawyer.

There's also a little piece I wrote about the liability impact of discharging hospital patients sooner and sicker than you think wise, just because whoever pays their medical bills thinks they've had all the care they need or the program can afford.

Another piece draws your attention to a revision of the College's position on VBACs. Mostly its an update, with the exception that now VBACs are not encouraged for the small hospital with limited facilities. In the past the party line was that VBACs were safe for any hospital already providing obstetrical services and no capabilities were necessary beyond the accepted minimum. Although not specifically stating such, it appears that now VBACs are advisable only in Level Three perinatal centers and Level Two hospitals with an obstetrician credentialed to perform Cesarean section plus the necessary OR and anesthesia personnel constantly and immediately available.

There's a piece on the College's recent update of a prior policy statement regarding standards for training family practitioners in obstetrics and gynecology. I'm not the only one getting heartburn over this but few are willing to publicly express their concerns. In order to encourage a more balanced argument, Tom Purdon kindly agreed to present the other side. He was co-chair with Patrick B. Harr, MD, of the AAFP/ACOG Task Force which developed the College's two Statements of Policy. Tom is a graduate of the University of Iowa School of Medicine, completing a rotating internship at Wayne County General Hospital, Detroit, Michigan, and residency at the University of Iowa, Iowa City, Iowa. His career has encompassed clinical practice, medical management, academia and leadership roles in national medical organizations including: Medical Director and Vice President of CIGNA Healthplan of Arizona (Tucson); current Vice Chair of the Department of Obstetrics and Gynecology, University of Arizona Health Sciences Center; Chair, Steering Committee, University Health System Consortium; current Vice President of the American College of Obstetricians and Gynecologists. Wow! Are we bringing you heavy hitters or what?

Hugh Martz and I submit for your approval the third in a series of articles about how the litigation system works, addressing the trial phase of a suit. The first was about the complaint and requirements for filing suit, the second about depositions and other discovery procedures. 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.

Reproduced in the back this month is another excellent article from *Physician's Practice Digest* entitled "House of Cards" by Christine Kilgore, appearing in the November/December 1998 issue. It gives a frank though disturbing overview of some of the problems now developing between physicians who used to own their practices and their new employers to whom the practices were sold. The bottom line is nothing new: physicians work best when they work for themselves.

As usual we encourage submission of letters to the editor, articles and guest editorials for publication consideration. Letters 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

16 NOVEMBER 1998

Dear Doug,

I wish to respond to the article you published on sexual misconduct claims (Vol. VI, No. 4, OCTOBER 1998, p. 36). What I find to be most interesting was in the discussion in which it was stated, "At the very least,...a nurse should be present whenever a pelvic examination is performed." It seems that this so-called "expert" panel (which included only one obstetrician/gynecologist) concluded this, contrary to the evidence (reviewed cases) that they collected.

Contemporary medicine teaches us to use an evidence-based practice, something apparently not practiced by this panel. Given that most of the cases that were reviewed had a nurse in attendance during the examination, and that the majority of the claims seemed to involve possible clinician sexual misconduct, it does not logically follow that having a chaperone present during the examination would necessarily have avoided these claims. After reading the descriptions of these cases, I would have instead concluded that: 1) *some* providers have problems which may interfere with their clinical performance (for which they need professional help); and 2) if a patient wishes to harass a clinician, he/she will find a way to do so. This latter conclusion suggests that nothing can prevent many of these claims.

I also find interesting the panel's conclusion that the *rectal examination* (an often routine and indicated part of the physical examination) is particularly special, requiring the presence of a nurse to be in attendance during that examination. Perhaps, the psychiatrists that sat on the panel had an undue influence on this recommendation!

In my practice, all patients are offered to have the nurse present for the pelvic examination, however 99% of my patients do not want this and in fact consider such to be an unnecessary intrusion into the doctor-patient relationship.

It is clear that given the current liability issues that exist, physicians should do their best in communicating with their patients the nature of the examinations that they perform. It is equally clear that many claims are unavoidable and simply represent the cost of doing medical business today.

Elliot M. Levine, MD

20 NOVEMBER 1998

Dear Elliot,

Thanks for your letter. I sent it on to Richard Anderson for the reply below. You and I will probably have to agree to disagree on this one (see the *Newsletter* issue Vol. IV, No. 1, JANUARY 1996, p. 1 for "Ms. Lovelace, Sen. Packwood, and Dr. Hill" plus guidelines adopted by the Ohio State Medical Board and Kentucky Board of Medical Licensure; complimentary copy of *OB-GYN Malpractice Prevention*, SEPTEMBER 1996, and reprints of prior issues enclosed with *Newsletter* issue Vol. IV, No. 4, OCTOBER 1996).

There is apparently one point on which we wholeheartedly agree, the necessity of routine rectovaginal examination as part of the pelvic examination, and I've sent you a copy of a piece I wrote way back in the *Newsletter* issue Vol. III, No. 2, NOVEMBER 1995. I still think you're taking an unnecessary risk, but if there have been no complaints from any of your patients and they keep coming back year after year, you shouldn't have any problems. I would urge you to exercise extreme caution with patients new to your practice since their previous experience with other physicians will probably have been more along the lines of Richard's recommendations.

Doug

30 NOVEMBER 1998

Dear Doug:

I understand and sympathize with Elliot's sentiments, but not his conclusions. It is unfortunate that contemporary practice must focus so much on defensive medicine. It is a rare physician, however, who, faced with the reality of an unjustified lawsuit, can really dismiss it as "just the cost of doing medical business today." The Doctors' Company panel recommendations are based on the beliefs and practices of our experts. These findings are not proven to prevent malpractice claims, because nothing is *proven* to prevent unwarranted lawsuits. Nonetheless, following these guidelines should accomplish three important goals:

Minimize the possibility of a patient misinterpreting appropriate physician behavior.

Provide a witness who can verify the physician's account of the interaction so the lawsuit is not merely a credibility contest.

Remind the patient, and the doctor for that matter, of the professional nature of the encounter.

Richard E. Anderson, MD

22 NOVEMBER 1998

Dear Doug,

Obstetrical patients with prior Cesarean-sections are defined as high-risk due to potential separation or rupture of their uterine scar.¹ Close observation of these patients, throughout pregnancy and especially during labor, is directed at recognizing and responding to the signs of impending uterine rupture. Most studies report 60%-80% of uterine incisions remain intact after vaginal delivery.² Uterine rupture is a catastrophic obstetric emergency with a reported maternal mortality of 50%-70%, fetal mortality of nearly 100% and considerable morbidity risk for all survivors^{1,2}.

The American College of Obstetricians and Gynecologists (ACOG) advocates Vaginal Birth After Cesarean (VBAC). Repeat cesarean births should not be done routinely, but rather for a specific obstetrical indication.² ACOG, recognizing that there are maternal, fetal and facility contraindication to attempt VBAC, has published Practice Patterns and Committee Opinions addressing VBAC, identifying maternal and fetal contraindications^{2,3}.

Obstetricians are attempting VBAC's more frequently in an attempt to comply with managed care demands for reduced costs, as well as patient demands for more natural childbirth options. Often the recommended protocols are disregarded, thereby causing serious maternal and fetal injuries, deaths and indefensible malpractice claims³.

In the January 25, 1998 issue of the Los Angeles Times, a front page article, entitled *County C-Section Rule Took Heavy Human Toll*, describes how an official policy by the county's public healthcare system directed "a trial of labor for the vast majority of women admitted to the county hospital." Examples were cited of inappropriate VBAC trials resulting in predictable deaths and birth injuries.

Richard H. Paul, M.D., FACOG, Chairman of the Department of Obstetrics and Gynecology at County-USC Medical Center explained as follows in an interview, quoted by the article:

"During that particular time, we had a huge crisis with too many patients, so there were things that happened because of a lack of ability to care for all these patients....We were told, during the crisis years by county counsel, that we could say that everybody gets a trial of labor - without giving the patient an option."

The pre-ordained management plan resulted in the deaths of two mothers and three infants plus multiple cases of cerebral palsy, Erb's palsy and post-partum hysterectomies. This patient care decision was motivated by social and financial concerns without regard for patient protection⁵.

How could this happen? Where were the obstetricians when these policies were initially proposed? The adverse outcomes were predictable based on experience with VBAC's known complications. This cost-conscious approach to maternity care was a preventable disaster, an embarrassment to the specialty, and set back progress made in perinatal morbidity and mortality, fifty years. The real tragedy is that the injured and bereaved will suffer unnecessary and incalculable loss for the rest of their lives.

The following case report demonstrates how deviation from recognized cesarean-section indications can result in uterine rupture and a medical malpractice claim.

Case History:

A 37 year-old gravida III, para I whose LMP was 7/1/92 and her EDC was 5/8/93 was admitted on 5/18/93 at 41-4/7 wks. for induction of labor. She had a previous cesarean-section for "failure to progress, PIH and fetal distress." The first baby weighed 8 lbs. 7 oz.

The aim of admission was for induction and attempted vaginal birth, because the patient "strongly desired" a trial of labor. The obstetrician noted that the patient was informed and understood the risk of uterine rupture.

Initial cervical assessment, on admission, revealed the cervix to be long, closed and posterior with an estimated fetal weight of 8 lbs. 3 oz and vertex unengaged at -2 to -3 station. The Prostaglandin gel was inserted the night before and she was transferred to labor and delivery the following day.

On admission to labor and delivery, the patient was found to be 1 cm, 30% effaced and "high vertex" at -3 station. The patient developed uterine contractions and spontaneously ruptured membranes at 12:00 hrs. and the risks of uterine rupture were again discussed and documented via medical record entries by both the obstetrician and nurse.

At 17:45 hrs., the cervix was "stretched" to 3 cm, 50% effaced and vertex at -3 station. The patient was noted to be excited over her possible vaginal delivery. An intravenous Pitocin infusion was begun of 20 units in 1000 cc Ringer's Lactate. At 19:45 hrs. the cervix was found to be 4-5 cm dilated and 60% effaced with the vertex at -1 to 0 station. At 20:00 hrs. the obstetrician was called and, without examining the patient, ordered epidural analgesia. It was never begun due to subsequent events.

At 20:05 hrs., the patient was more uncomfortable and breathing with contractions but fetal monitor utilizing an external tocodynameter. A poor labor pattern indicated uterine hyperstimulation with poor resting phase and tachysystole. At 20:15 hrs., she became uncooperative, pushing the tocodynamometer from her abdomen and complaining of pain in her left lower quadrant. Her obstetrician was not in attendance.

At 20:28 hrs., her mother came to the nurses' station and said, "The nurse is having difficulty finding fetal heart tones." The obstetrician was called at 20:30 hrs. and performed an abdominal ultrasound examination at 20:35 hrs. At 20:40 hrs, the patient was taken to the operating suite and emergency cesarean-section began at 20:43 hrs. under local field block. Anesthesia personnel refused to provide services without evaluating the patient first or connecting all monitors, since no pre-anesthetic evaluation had been performed.

At 20:46 hrs., an 8 lb. 9 oz. male infant was delivered from a vertex presentation via low transverse cervical cesarean-section with Apgars of 2 @ 1 min., 3 @ 5 min. and 4 @ 10 min. Cord blood gas was reported as pH 6.89, pCO₂ 80 mm/Hg, pO₂ 11 mm/Hg, O₂ saturation 4.4% and a base excess of -22 mEq/l. Kleinbauer-Betke was positive. The baby has had spastic quadraplegia since birth.

The case was settled after mediation with the hospital paying the major amount.

Risk Management: Lessons to be learned.

A prenatal consultation is an essential part of VBAC management. Not only is it important to discuss the risk/benefit of VBAC, but also to obtain the patients understanding and consent to allow termination of labor by cesarean-section, when in the obstetricians judgement, the risk of an adverse outcome exceeds the benefit of allowing labor to continue. These risk/benefit options are often undocumented in the prenatal record. In this manner, patient autonomy can be respected, but at the same time, the physician must be able to make appropriate obstetrical decisions, taking into account the patient's choice².

The understanding regarding the decision time for cesarean-section should occur in the office and not after the patient is in labor. Once the patient is admitted, neither party can walk away from a disagreeable confrontation. Just as patients have the right to participate in treatment decisions, physicians also have the right and, moreso, the responsibility to practice their speciality. They do this by providing the patient with the benefits of their obstetrical training and experience in knowing what the consequences may be with a delayed intervention.

Relevant obstetrical history from previous delivery is often omitted⁴. Often, this history provides information that can influence the ultimate decision for or against a trial of labor. Absolute contraindication to VBAC is a classical cesarean-section. "Relative" risk factors, such as, a history of two or more sections, previous dystocia or macrosomia, contracted pelvis, extension of uterine incisions, placenta previa, bicornuate uterus, should be recognized, documented and discussed openly with the patient prior to hospitalization.

A post-dates pregnancy, poor Bishop's score, desultory labor requiring Pitocin augmentation, and a previous cesarean-section done for "failure to progress" (with previous delivery of 8 lb. 7 oz. baby) were additional risk factors added to the primary diagnosis of previous cesarean-section.

When arrest occurred in the active phase of labor, despite adequate oxytocin augmentation, labor should have been terminated and proceed with cesarean-section⁴. In view of the poor prognosis for vaginal delivery, the patients progress in labor should have been closely supervised by the obstetrician.

There was also a delay in not recognizing an impending uterine rupture (most women will have severe, sudden, sharp pain even with epidural anesthesia⁴). There was inappropriate preparation for urgent cesarean-section, in not having an

anesthesiologist evaluate the patient during labor. The potential for uterine rupture should be considered with each previous section, even if the patient has had a prior VBAC. Appropriate personnel (anesthesiologist) and facilities should have been alerted and available to respond to the uterine rupture.

In the 1960's, the cesarean-section rate at Margaret Hague Hospital in Jersey City, New Jersey averaged between 6-7%⁷. At that time, this hospital was among the top ten in the nation in total number of deliveries/year. The number of deliveries exceeded 9,000/year.

In that institution, the service was divided into two-thirds private patients and one-third clinic patients, serving a city/county area of over one million people. The policy, at that hospital concerning previous cesarean section, was to allow most patients a trial of labor. The only absolute contraindication to labor was the patient who had a previous classical cesarean-section.

In order to avoid delivering a premature baby, because of miscalculated dates, patients with previous cesarean-sections were allowed, in most cases, to initiate labor. It was also considered beneficial to allow labor in order to develop the lower uterine segment to reduce excess bleeding and allow a transverse uterine incision. The uterine contractions of early labor also help reduce transient tachypnea of the newborn.

Following admission, abdominal and pelvic evaluations were done to determine if obstetrical conditions were favorable to allow a trial of labor. Obstetrical factors such as a poor Bishops score, malpresentation, cephalopelvic disproportion, premature rupture of the membranes or fetal compromise were indications that cesarean-section provided the least risk of traumatic delivery

Among the indications we used for proceeding directly to repeat cesarean-section rather than allowing trial of labor were: 1) History of previous classical cesarean-section, 2) Malpresentation (breech or transverse lie) and 3) Macrosomic baby (>4500 g). The rationale for this type of management was the principal of not compounding risk factors. Previous cesarean-section, of itself, is a risk factor and in order to reduce the likelihood of an adverse outcome, the addition of another obstetrical risk factor, would be avoided.

Medical records were requested, and in most cases available prior to admission. The indication and type of cesarean-section was documented. If the patient had a *recurrent* indication for cesarean-section, such as prior dystocia, careful pelvic assessment was done to determine if the findings were consistent with a diagnosis of recurring dystocia. For example: If the baby's head was unengaged with an unfavorable cervix and premature rupture of the membranes, proceeding directly to cesarean-section would be considered the safest modality of delivery.

A trial of labor and delivery should occur in a hospital setting that has the professional resources to respond to acute intrapartum obstetric emergencies. A physician who is capable of evaluating labor and performing a cesarean-section should be readily available. Although we disagree with actions or policies that coerce patients to undergo either a trial of labor or repeat cesarean-section as this interferes with patient autonomy. The mode of delivery ultimately should be based on the favorable clinical condition for vaginal delivery and with the patients choice considered⁶.

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Anthony P. Lucci, MD

11 DECEMBER 1998

Dear Tony:

Thanks for the letter. We always need medmal case presentations since we benefit from the mistakes of others without having to make the same ones ourselves.

The problem with the Los Angeles VBAC protocol has been very disturbing. I researched the original articles from the *Times* before you sent your letter, forming the conclusion that Dick Paul was essentially a victim of circumstances and a convenient scapegoat for overzealous cost-slashing government bureaucrats. I've known Dick since the early 1970's when he used to come to Bethesda as a medical officer in the Naval Reserve, spending Friday and Saturday with the residents in conferences, case presentations and rounds. I've attended his ACOG-sponsored seminars on obstetrical emergencies and maternal/fetal care. His book on EFM, first published years ago by Corometrics and still in print, taught me strip interpretation and labor management. More importantly these skills were passed on to residents and L&D nurses in presentations and strip conferences. Most importantly his explanations of the physiology behind FHR irregularities and their consequences if unaddressed or unresolved allowed me to successfully ride-out some labors which otherwise would have been sectioned unnecessarily, while at the same time terminating some labors early enough to deliver minimally or undamaged babies which others might have allowed to continue to the possible detriment of the infants.

I have few heroes, but Dick Paul is one of them. Having found myself in similar situations where higher-ups made me responsible for more than the system could safely provide, the dilemma he faced as department chair is understandable. The same is true of the inability to constantly and personally monitor everyone working in one's department. The only criticism I have is the failure to give patients their informed choice of VBAC or repeat Caesarean section. The role of VBAC always has been, continues to be, and probably always will be too controversial for either method of delivery to be universally accepted and automatically imposed upon patients. Informed consent and patients' choice in their treatment modalities is obviously more than a mere inconvenience to medical researchers and busy charity clinicians, but it is also a vital part of modern medicine despite what managed care gurus or lawyers may say.

The College has even backed off a bit on VBACs (see "VBAC: Are the Benefits Worth the Risks?" later in this issue), possibly due to the problems in L.A. and cumulative litigation experience. It's safe to say that if Dick could do it all over again, things would be much different the second time around.

THE SUGGESTION BOX

THE THREE LITTLE PILLS

by Doug Daniel

When as a child I would finally reach an obviously foregone conclusion, Dad would always say, "Well, I guess you've had the third little pill." That makes absolutely no sense whatsoever unless you've also heard one of his favorite stories, about the two little country boys playing in the yard. The smaller takes a matchbox from his pocket, rattles the contents, slides open the cover, shakes the box while counting to himself, closes it up and sticks it back in his jeans pocket without saying a word. The other says, "Whacha got?" "Nothin'", the first replies. "Yeah, you got somthin' there awrite. I seen 'at box in yo' pocket." "Whut box?"

This interrogation of questions and denials goes on for a while until the first little boy says, "Well, if you just gotta know, they's wise pills." "Whacha mean? I ain't never heard a no wise pills", the other replies. "Yeah, they's wise pills awrite. My granddaddy give 'um to me. He says if you take 'um they makes you wise."

"I don't believe it", the second says. "You don't have to", the first says. "Gimme 'at box." "No. Granddaddy said not to let anybody else have any." "I said gimme 'at box or I'll give you such a licking that when you finally get home even yo' mama won't know who you are."

The box is grudgingly pulled from deep in the pocket and reluctantly handed over. The inquisitor takes out one of several little round, green pills about the size of a Rice Krispie, pops it in his mouth, chews it up and swallows. "You foolin' me, ain'tcha? I don't feel no wiser." "Well, granddaddy says some folks is so stupid it takes more'n one." "I ain't stupid", rejoins the other as he fishes a second little pill from the matchbox and chews thoughtfully. "Nope, cain't tell no differns." "Try another'n", his friend helpfully suggests. "You know, these kinda look like rabbit pills", the young seeker of wisdom observes as he munches the third little pill. "I told you some folks took more'n just one. Now you's gettin' wise", the other little boy shouted over his shoulder as he ran home just as fast as he could. (For the benefit of you city boys, rabbit droppings are composed of little round, green pills about the size of a Rice Krispie.)

But enough folksy humor. I think I have finally had the third little pill as regards ethical and moral behavior versus sexual impropriety in those with positions of responsibility and trust. I'm specifically thinking about we physicians and the duly elected chief executive of our country. It's late October now and the House has voted, after considerable *sturm und drang*, to finally consider whether or not to send presidential articles of impeachment to the Senate for their investigation and action.

A small portion of the pundits, politicians and proletarians remain vocally and violently split at opposing extremes of the opinion spectrum while most remain in the soft center willing to be blown in either direction by each day's prevailing winds. The point is, if Bill Clinton were licensed to practice any of the healing arts in any one of the 50 states, districts, protectorates, territories or possessions of the United States of America, he would be out of a job until he completed, at his own considerable expense, a rigorous and prolonged inpatient psychiatric evaluation and rehabilitation program; after which his practice of his profession would be strictly limited in its contact with females and monitored for recurrent sexually inappropriate behavior. But such is not practical in his case. Maybe impeachment is humane by comparison.

I think the House will, after both parties milk it for all it's politically worth, send the aforementioned articles to the Senate. The Senate will dance, prance and pontificate awhile and the final vote will be determined by a combination of the preceding day's polls and party affiliation. But if the motion to remove Mr. Clinton from office doesn't pass, assuming the vote is prior to the next inauguration and he hasn't already resigned, we need to rethink the way we define and discipline sexual impropriety in our colleagues.

If our patients as residents and citizens of these United States accept, condone, approve and/or ignore such behavior in their President, then their physicians should be treated no differently. In all candor, I think the constitutional provisions of equal protection under the law require medical licensure boards to get out of the sex business, leaving the investigation, judgment and punishment of accused offenders to the criminal justice system under existing laws addressing sexual assault and harassment. This is the situation, i.e. no harm - no foul, for most of the rest of the world, especially the sexually mature and cosmopolitan Europeans. It would also be more equitable since everybody knows physicians also don't lose their medical licenses for lying under oath during a judicial proceeding.

In case you haven't noticed, my tongue is firmly thrust into my cheek. Bill Clinton should no longer serve in his fiduciary position as President. Physicians and executives found guilty of work-related sexual impropriety should be considered impaired in the performance of their duties and either rehabilitated or relieved. Everyone should be held equally accountable for their actions.

Should President William Jefferson Clinton be impeached for his extramarital sexual relationship with Monica Lewinsky in the White House, his subsequent lies, and/or his alleged obstruction of Judge Starr's investigation? Absolutely not! Impeachment is meant to be the penalty for elected or appointed government officials' serious breaches of their public duties, not their personal indiscretions. Presidential impeachment is designed to protect the public from dishonest and incompetent chief executives' official acts, not to punish their private behavior which becomes public. There are political, moral and legal issues involved here, but I will limit this commentary to legal issues as only they are relevant to impeachment.

A sitting President cannot lie while discharging the duties of his public trust without suffering the consequences. Thus President Nixon could not be allowed to lie about burglaries and cover-ups pertinent to his remaining in office. Clinton is not our first President to practice deception; even Honest Abe may have shaded the truth a bit to conceal Union troop movements and battle plans. Who would condemn a President who lied to save his soldiers' lives? Perhaps the lie's content, context, purpose, motive and consequences are important.

Clinton is also not the first President to engage in extramarital sex within the White House. JFK regularly made time for such diversions and a long past President was discovered by his wife in a White House closet having sex with an underage girl. No one considered impeaching either of them. Many Presidents have probably had discrete extramarital sexual relationships within the White House. It should be expected of those with the personality traits necessary to seek and obtain power, especially considering the endlessly available opportunities.

There is new information including DNA analysis to support long-standing rumors of children born from extramarital affairs of both George Washington and Thomas Jefferson, yet their impeachment was and still is unthinkable. The Presidency of the United States is arguably the highest elected office in the world, but it must be occupied by human beings with human frailties. There is certainly an Olympian aura about the White House, but its residents are burdened with the daily functions and necessities of human physiology. Even divinely appointed monarchs suffer the same trials and tribulations as the rest of humanity!

Context is everything in this argument. Clinton is accused of lying about his sexual relationship with Lewinsky, but guys lying about sex is nothing new. In high school they start lying by bragging about fabricated sexual conquests. When young and single they tell each of their multiple partners she is their one and only. After marriage only a fool would not lie when confronted with his extramarital affairs. Men in our society commonly lie about their sexual encounters, and if President Clinton is impeached for it he will be removed from office for actions unrelated to his public duties.

Lying is generally not a crime unless committed while under oath. Perjury is defined as making a sworn statement known to be false, but as with every crime there must be intent to lie as opposed to merely the giving of an unintended false statement.

One can argue that the Lewinsky matter is more serious since it occurred in the White House on government property while the President was or should have been performing his public duties. I agree this is of greater concern than the same off premises, but the President is not required to punch a time clock. While obviously impractical, time off work for marital activities, vacations and recreation should be provided if the issue is going to be utilization of time in the workplace.

The United States Supreme Court erred when it allowed Jones v. Clinton to proceed during the President's term in office. A judicial precedent precluding pursuing civil suits against a sitting President was reversed. While sympathetic toward plaintiffs whose actions against Presidents in office might be deferred, the importance of public duties precludes such litigation. The legal actions brought against Citizen Clinton have seriously impeded the fulfillment of President William

Jefferson Clinton's public duties. Depositions given in the Jones case have been used by Special Prosecutor Kenneth Starr to investigate sexual matters disclosed therein, snowballing into apparently serious consideration of possible presidential impeachment, consuming significant government resources, and detracting from important national and international issues.

Consensual sex between two consenting adults neither is nor should be an impeachable offense, and Presidential sex with a White House intern is not the equivalent of physician or attorney sex with a patient or client. While Clinton was at the time our highest government official and Lewinsky only a volunteer or entry level employee, they were still coworkers. There was no fiduciary relationship between them as she was neither patient nor client. There has been no evidence she was forced, coerced or harassed into the relationship. Neither her salary, benefits, advancement nor future employment were conditioned upon provision of sexual favors. She has never alleged nor is she expected to claim infliction of emotional or physical harm.

The patient/client seeking a fiduciary relationship with their physician or lawyer needs medical or legal services and counsel while often physically and/or emotionally vulnerable. The law recognizes this potential vulnerability and therefore imposes upon practitioners of these and similar professions high standards of professional conduct with stringent penalties for violations, but Clinton was under no such restraints in his relationship with Lewinsky.

The only remaining question is whether Clinton should be impeached for his misstatements and alleged misconduct regarding the relationship, i.e. lying and allegedly obstructing justice by interfering with Judge Starr's investigation. Context again prevails. Perhaps he should be charged, tried, and if convicted then punished for minor criminal offenses, but no breach of public duties has occurred that justifies impeachment.

Litigation of civil and minor criminal offenses of a personal nature committed by a sitting President should be deferred until completion of the elected term of office. That includes perjury and obstruction of justice related to sexual activities plus all civil litigation. Only criminal matters directly related to the devolution of Presidential duties should be pursued during office or used as grounds for impeachment. If a President lies under oath or obstructs justice in government matters he should be impeached.

In summary, context is vital to the argument. It allows us to separate political, moral, religious and other considerations from the substantive legal issues. If the recently held off-year elections are a reliable barometer of public opinion, the majority of voters share my viewpoint. Most exit polls indicated that Congress should drop the Clinton/Lewinsky matter and move on to other more pressing issues. Senators and Congresspersons who have not gotten their fill of titillating and graphically detailed sex stories should spend evenings reading the record for their own enjoyment and devote days to earning their salaries by addressing the real issues affecting constituents.

The Congressional investigation of Clinton's personal life is much ado about nothing. If we were foundering in the depths of an economic depression, losing hundreds of thousands to a plague epidemic or tottering on the brink of a nuclear war, we would have neither the luxury of nor interest in the media fires of impeachment being stoked and fanned by fat political cats lounging on the banks of the Potomac.

Hugh Martz

Constitutional scholar? No way, but I know our Republic is currently facing a serious threat. A threat posed by the commission of "...Treason, Bribery, or other high Crimes and misdemeanors (Article II, Section 4, Constitution of the United

States)". William Jefferson Clinton, current Chief Executive Officer of the United States and Steward of the Republic, has twice taken a sworn oath that he will "...faithfully execute the Office of President of the United States, and will to the best of my Ability, preserve, protect and defend the Constitution of the United States (Article II, Section 1).". He also has twice been charged to "...take Care that the laws be faithfully executed (Article II, Section 3)".

The legally constituted Judiciary Committee of the U.S. House of Representatives possesses "...sole Power of Impeachment" (Article I, Section 2), and has been presented credible evidence to support four articles of presidential impeachment. Its members consequently are constitutionally obligated to determine in their best collective judgment whether or not certain acts and omissions of this President constitute grounds for his impeachment.

A strong case can be made for presidential impeachment by the House on charges of obstruction of justice, lying under oath, and possibly perjury with subsequent referral to the Senate for trial. Each and all of these confounds the rule of law and its Constitutional foundation. The grounds for these charges have nothing to do with sex. They also have nothing to do with inappropriate use of the Republic's executive offices, time, and finances for sexual dalliances in its workplace.

If the charges are found to be true then the Republic's best interests require removal of its Chief Executive Officer and Commander in Chief of its Armed Forces from office. If the charges are found to be true then the duly elected leader of the most powerful nation on earth is unworthy of trust or credibility, both by foreign powers' leaders and his fellow citizens.

If the House passes articles of presidential impeachment by simple majority vote, trial in the Senate with the Chief Justice of the United States as presiding judge will follow. If there be sufficient proof of such high Crimes and misdemeanors to produce a guilty verdict by a two-thirds majority of the Senate's members present for a vote, presidential conviction will result. If there be insufficient proof for conviction the Senate may adjourn the trial with or without acquittal.

"Judgment in Cases of Impeachment shall not extend further than to removal from Office, and disqualification to hold and enjoy any Office of honor, Trust or Profit under the United States: but the Party convicted shall nevertheless be liable and subject to Indictment, Trial, Judgment and Punishment, according to Law (Article I, Section 3)."

Herb Underwood

THE DROP BOX

Deep Pockets

When You're Wrong, Admit It

No, this column is not about our President's problems. In my initial dispatch I said patient safety would not be a big issue in the 106th Congress. I was wrong. President Clinton's State of the Union address this month will focus on education and patient safety, considered key issues in regaining control of Capitol Hill and maintaining control of 1600 Pennsylvania Avenue. Democrats and some Republicans see these as populist issues for their own reelection campaigns.

Essentially three patient safety bills were considered by the 105th Congress. Not surprisingly the Democratic Bill was the most liberal, the Republican Senate Bill the most conservative and the Republican Congress's Bill somewhere in-between. Early predictions are they will be reintroduced in the 106th Congress and something will pass both houses as early as August. More astute readers may ask, "That's early? Whatever does our Congress do with its time?"

The House's new Speaker, Rep. Robert L. Livingston (Rep. Louisiana), is widely known as "institutional", meaning he is expected to run the Congressional Railroad on time. Debates and votes will occur as scheduled. The budget will pass when promised. Congress will be more cordial and there will be less open confrontation between Members. Although Speaker Livingston is no stranger to confrontation, he is more reasonable than the last guy.

Politics will become even more important as we approach the 2000 primaries. "How can that be?", you may ask. There are a number of reasons. The Republican House only has a five vote majority so it's either compromise or deadlock. Compromise presupposes lots of posturing. While hesitating to experience *deja vu* again, I predict we will quickly sicken of the 106th House. Remember its Democratic leader is a Presidential candidate as are a number of Senators.

On more than one occasion I have heard the Immediate Past Speaker of the House Gingrich say that after 40 years as the minority party, the Republicans have forgotten how to govern. One of the reasons is Republicans lack legitimate experts in some areas. Truly informed experts know their subject backward and forward, therefore they always know where they're going. Mr. Gingrich used to say that Pete Stark and Henry Waxman knew every morning when they got out of bed exactly where they were going that day.

Another reason is the wide philosophical split within the Republican caucus, which an institutional compromiser like Speaker Livingston may be able to overcome. But today's Congressional Republicans resemble their Democratic forebears of twenty

years ago, when the liberal far left was fighting for control of that party. Republican infighting must stop for their precariously slim majority to prevail.

Most of the less controversial patient safety reforms will be passed and sent to the President for signature including ability to choose one's physician, external and internal appeal of adverse managed care decisions, designation of more primary care providers, improved access to emergency care and elimination of physician gag rules. Business lobbies will keep the ERISA preemption intact. Professional liability reform will be taken up by the Republicans.

1999 promises to be politically entertaining. Expect at least a bare bones patients' rights bill with bipartisan House and Senate support encouraged by White House approval. But be prepared for lots of posturing, lots of fingerpointing, and little real legislation.

THE BALLOT BOX

And now for a *Newsletter* update: Ben Harer is the official nominee of the College's Committee on Nominations for ACOG President-Elect! By the time you read this the election will probably be a done deal and we here at the Society's office hope you all voted for Ben. Assuming there was no successful write-in candidate, all ASFOG members are encouraged to congratulate Ben either in person at the Philly ACM or by your preferred communication technology.

THE LITTER BOX

Doug Daniel, Editor

While writing this month's piece on Slick Willie's sexual improprieties, I tried to find a quote about Presidents not being above the law, kings or better than ordinary citizens, possibly attributed to George Washington. He probably said something along those lines but I couldn't find it in our college library's research section. But I did find a whole bookful of political quotes with lots and lots about Presidents. Hope you enjoy them as much as I did.

"If a king goes astray the common people pay for the sin."

English Proverb
1393

"The first man put at the helm will be a good one. Nobody knows what sort may come afterward."

Benjamin Franklin (1706-1790)
Member, Constitutional Convention
In reference to George Washington
1787

"Shall any man be above justice? Above all shall that man be above it who can commit the most extensive injustice?"

George Mason (1725-1792)
Member, Constitutional Convention
1787

"No man will ever bring out of the Presidency the reputation which carries him into it."

Thomas Jefferson (1743-1826)
3rd President of the United States
1796

"That the President of the United States may be subpoenaed, and examined as a witness, and required to produce any paper in his possession, is not controverted."

John Marshall (1755-1835)
U.S. Supreme Court Chief Justice
1807

"To dance in these rooms would be undignified, and it would be respectful neither to the house nor to the office."

Sarah Childress Polk (1803-1891)
11th First Lady of the United States

"This is not my house. It's the people's house."

Franklin Pierce (1804-1869)
14th President of the United States

"I must in candor say I do not think myself fit for the Presidency."

Abraham Lincoln (1809-1865)
16th President of the United States
1859

"Our nation has no right to expect that it will always have wise and humane rulers, sincerely attached to the principles of the Constitution. Wicked men, ambitious of power, with hatred of liberty and law, may fill the place once occupied by Washington and Jefferson."

David Davis (1815-1886)
U.S. Supreme Court Justice
1866

"The Executive is as independent of either House of Congress as either House of Congress is independent of him, and they cannot call for the records of his actions, or the action of his officers against his consent, any more than he can call for any of the journals or records of the House or Senate."

U.S. House of Representatives
Judiciary Committee Report 141
1879

"I am not fit for this office and never should have been here."

Warren G. Harding (1865-1923)
29th President of the United States

"When I was a boy I was told that anybody could become President; I'm beginning to believe it."

Clarence S. Darrow (1857-1937)
American lawyer

"You can't hardly find a law school in this country that don't, through some inherent weakness in the school, turn out a Senator or Congressman from time to time - or if their rating is real low, even a President."

Will Rogers (1879-1935)
American humorist

"The Congress has sometimes been a sore trial to Presidents."

Calvin Coolidge (1872-1933)
30th President of the United States
1929

"In times of crisis, the American citizen tends to back up his President."

Clark P. Clifford (1906-1998)
Special Counsel to Presidents
1948

"A President immunized from political consideration is a President who need not listen to the people."

Ibid.
1972

"In America anyone can become President. It's one of the risks we take."

Adlai E. Stevenson (1900-1965)
Democratic Presidential Nominee

"So you want this fucking job?"

John F. Kennedy (1917-1963)
35th President of the United States
To Senator Barry M. Goldwater
During the Bay of Pigs Invasion

"With all the power that a President has, the most important thing to bear in mind is this: You must not give power to a man unless, above everything else, he has character. Character is the most important qualification the President of the United States can have."

Richard M. Nixon (1913-1994)
37th President of the United States
1964

"The Presidency has many problems, but boredom is not one of them."

Ibid.
1973

"When the President does it, that means it is not illegal."

Ibid.
1988

"A President's hardest task is not to do what is right, but to know what is right."

Lyndon B. Johnson (1908-1973)
36th President of the United States
1965

"Being President is like being a jackass in a hailstorm. There's nothing to do but stand there and take it."

Ibid.

"The caliber of talent attracted to the public service will depend in substantial measure upon the excitement that can be conveyed by presidential leadership."

Stephen K. Bailey (1916-1982)
Dean, Maxwell School of Business
Syracuse University
1968

"There is nothing in the Constitution that authorizes or makes it the official duty of a President to have anything to do with criminal activities."

Samuel J. Ervin, Jr. (1896-1985)
Chairman, Senate Select Committee on Watergate
1973

"Unlike a monarch, the President is not the Sovereign."

Archibald Cox (1912-)
Watergate Special Prosecutor
1973

"Richard M. Nixon has acted in a manner contrary to his trust as President and subversive of constitutional government, to the great prejudice of law and justice and to the manifest injury of the people of the U.S."

U.S. House of Representatives
Judiciary Committee
Articles of Impeachment
27 JULY 1974

"I think a President has to be able to think like the people think."

Betty Ford (1918-)
38th First Lady of the United States
1975

"The genius of impeachment lay in the fact that it could punish the man without punishing the office."

Arthur M. Schlesinger, Jr. (1917-)
Presidential Advisor
1979

"We do many things at the federal level that would be considered dishonest and illegal if done in the private sector."

Donald T. Regan (1918-)
White House Chief of Staff
1986

"Three weeks is a lifetime in presidential politics. The conventional wisdom changes so suddenly."

Albert A. Gore, Jr. (1948-)
U.S. Senator
Democratic Presidential Candidate
20 October 1988

"The President has a constitutional right to behave like a spoiled child."

Barney Frank (1940-)
U.S. Senator
1989

"Presidents are Presidents. They're not kings."

David R. Obey (1938-)
U.S. Representative
1990

"When I first came to this town, I didn't think Presidents lied."

Benjamin C. Bradlee (1921-)
Editor, *The Washington Post*
1991

THE IMPAIRED PHYSICIAN, Continued From Page 1

The program's concept has evolved over the past ten years, beginning with a request from the Georgia Board of Dental Examiners for an MCG-sponsored hands-on continuing education program for recovering dentists whose licenses had been revoked or restricted for drug impairment. The Board spoke so highly of the program's skills assessment portion that word reached the Talbot Recovery Campus (TRC) in Atlanta, Georgia. Subsequently a request was made to MCG and a similar program developed to specifically test recovering dentists' hand/eye coordination and diagnostic skills. Based upon these two existing programs, it was a simple matter to combine working with recovering dentists in treatment and educating dental students on the risks and processes of impairment.

Initially the educational experience was offered as an elective field trip for our students, but as of this year all third year MCG dental students will spend three days at TRC in rotating groups of four. They will follow the same schedule as the recovering patients by living, eating and socializing with them in the TRC dormitory residence plus attending structured learning sessions presented by the TRC staff. Students will also attend regular morning staff meetings followed by group therapy sessions and staff-presented lectures on the disease of addiction.

This experience provides students an altered forum for drug impairment education, prevention and information exchange oriented specifically toward dentistry. The program's objectives are:

Help students understand the relationships between dentistry and addiction

Teach students to identify the signs and symptoms of chemical dependency and subsequent impairment in themselves and colleagues

Allow students to identify sources of stress within their own lives and help them develop strategies to cope with stress more effectively

Familiarize students with how to access the resources of the Georgia Dental Association's Well-Being Committee

Identify students with risk-prone behaviors and antecedents to addiction

Provide the State of Georgia with dentists better prepared to care for their addicted dental patients.

A preliminary program last year involved four groups of four senior dental students each with one of the authors (TRD) accompanying the first group. Written evaluations were used to refine the future curriculum. Students were unanimous in praising the TRC visit; all thought every student should be so challenged while each admitted initial trepidation about visiting TRC as evidenced by comments such as "What would they think of us?" and "How would we be received?"

Fortunately such worries were for naught since they were rapidly befriended by both patients and staff, ultimately being nicknamed "Earth People" as an indication of their acceptance. Time and again the patients told the students, "I'm so glad you came. I just wish we had had this opportunity when I was in school." Students

heard patients describe themselves as high IQ, superachiever, perfectionist, compulsive and workaholic, all familiar terms to those in the health professions.

Time will determine the benefits of this new educational approach, but in the meantime it will be expensive to accommodate 56 students a year (data available upon request). On the other hand, we feel the program is cost effective even if it only prevents one dentist per decade from collecting their disability and/or life insurance.

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.

THE MEDICAL EXPERT WITNESS: A NEW MANDATE

by Sidney A. Wilchins, MD

A new standard for medical expert witness testimony is demanded by the U.S. Supreme Court's decisions in Daubert v. Merrell Dow (1993) and GE v. Joiner (1997). The expert witness's first and only allegiance has always in theory been to the court, regardless of which adversary paid his fee. The precedents established by the above decisions now additionally require his testimony be based on four specific criteria, i.e. acceptability, testability, peer review and error rate. Physicians are more accustomed to the terms reproducibility and statistical significance instead of testability and error rate. In order to now qualify as admissible testimony in court:

The knowledge base for the expert's conjectures, concepts and professional medical opinions has already been accepted by the mainstream scientific community (acceptability).

Repeated and continuing scientific investigation has confirmed and sustained the accuracy of the knowledge base acceptability (testability).

Medical peer review has and continues to affirm the knowledge base utilized in court testimony.

Statistical evaluation of possible error has and continues to find the knowledge base mathematically acceptable.

It is necessary that medical expert witness testimony be based upon these four criteria, but it is not necessary that the expert witness personally perform the applicable research or author the relevant publications. Physicians and scientists stand on the shoulders of those who have preceded them. The witness should, however, be able to reference and cite the sources used in forming his opinions.

There is an excellent argument that medical expert witnesses should no longer offer "opinions", instead bearing witness to matters of scientific fact applicable to the case at hand. This would unquestionably establish the medical expert witness as unbiased and neutral toward the adversarial parties. Those concerned about a possible loss of income secondary to fewer consulting opportunities should remember that in every adversarial process one of the sides will always find the unbiased witness favorable to their cause. The others will recognize the deficiencies and errors in their case demonstrated by the unbiased consultant.

Our court system is currently choked by its inefficiencies and backlogs. There have been proposals that expert witnesses be retained by the courts in order to ensure fair and unbiased opinions meeting the requirements noted above, but so far this has seldom been done. The same fair and unbiased opinions can be obtained from ethical witnesses hired by the adversarial attorneys. Since they should usually agree, relatively few trials would subsequently be needed to determine liability.

Non-meritorious suits would be dismissed and all others would be submitted for arbitration or mediation to determine plaintiff compensation. Trial by jury would be infrequently needed to determine contested damages. Trial and litigation costs would be greatly reduced with savings to the judicial branch of the government and ultimately the taxpayer. Worthy plaintiffs would more quickly receive increased recovery.

Third party payor curtailment of physician cash flow has given rise to a new breed of medical expert witness. He supplements his limited clinical income by denying the validity of recognized medical knowledge and recommended standards of practice such as those provided by the American College of Obstetricians and Gynecologists through its Committee Opinions, Practice Guidelines, Guidelines for Perinatal and Women's Healthcare, and Practice Bulletins. The so-called expert doesn't demonstrate why this knowledge and its subsequent standards are wrong. He also doesn't produce statistically substantiated and peer-reviewed alternatives.

Today's medical expert witness should remember Koch's Postulates which require rigorous experimental evidence to prove an etiologic relationship between a given cause and a specific effect. Self-declared, unsustainable or unsubstantiated opinion is no longer admissible in court. Few medical expert witnesses are aware of these new requirements and the status quo will continue for many years due to the inertia of the system and its participants' fear of financial loss. Your comments are solicited.

WHO'S IN CHARGE HERE?

by Doug Daniel

I've written before about the College's *ACOG Clinical Review*, and the more I see of it the more I like it. The only regret is that even though defensive positions are well-taken, their counterattacks appear less than spirited. This of course has been the age-old response of the frontline soldier to what he sees as the generals' and diplomats' inadequate, though perhaps politically correct, military strategies. Recent history is rife with examples: Patton's drive to the Rhine only to be reined-in short of German soil, Viet Nam, even Desert Storm. I can't remember a specific instance, but probably even Julius Caesar made at least one of these apparently boneheaded political/military decisions. History is supposed to confirm their advisability or folly but it never does; there are just too many variables and "what ifs".

Volume 3, Issue 5, September/October of the *Review* is the case in point. The lead article addresses the controversy over postpartum length of stay (PLOS), reporting the results of a College survey of approximately 500 members (personal communication from ACOG Department of Research). The survey was essentially an opinion poll asking, "What do you think are the most important factors determining optimal postpartum length of stay following uncomplicated vaginal delivery and how do you define adequate versus inadequate PLOS?" It also reviewed four recent articles from *JAMA* and *Pediatrics*.

The Top Ten List of maternal clinical considerations was:

Vital signs

Prenatal complications

Home care availability

Urinary retention

Third or fourth degree perineal repair

Prolonged labor

Chronic medical illnesses

Anemia

HIV infection

Number of children at home

The majority of respondents thought more than a 32 hour PLOS was adequate while less was inadequate.

After I was born in 1944 my primiparous mother was required to lie flat in a hospital bed for a full week, occasionally dangling her feet over the side toward the end. When I was a junior medical student working on the charity obstetrical service at University Hospital in 1968 - 1969 there were apocryphal stories about the recently disbanded "Stork Club", which routinely sent mothers and babies home twelve hours or less after delivery. When I was an intern and resident between 1970 and 1974 uncomplicated postpartum primiparas were ambulated within four hours or less after delivery and remained in hospital until at least PostPartum Day (PPD) 4, Caesarean sections until PPD 7. Today we've had to fight managed care's welfare and insurance third party payors tooth and nail, finally securing a federal mandate guaranteeing a minimum 48 hour PLOS even for patients with significant complications.

In the days before preadmission certification, maximum lengths of stay, and utilization review, private-pay fee-for-service obstetrics allowed patients and physicians to reach agreement on timing of discharge without the interference of uncaring and miserly tightwads representing financial institutions known as "third party payors". Patients were entitled to as much care as they could afford, and those who were charity cases received the humane minimum as recognized by accepted medical practice. Over the years some of this accepted medical practice has proven unwise but at least attending physicians were making those decisions in concert with their patients, always keeping the best interests of the patients foremost.

Today we are expected to discharge patients with repairs of perineal lacerations disrupting the anal sphincter before their first postpartum bowel movement. We are expected to discharge patients with indwelling Foley catheters and leg bags who haven't regained normal bladder function within 48 hours postpartum. We are expected to discharge patients severely anemic due to obstetric hemorrhage before the risk of continued or recurrent bleeding has passed (We used to just give them two units of packed cells and send them home with precautions about postpartum hemorrhage but the AIDS crisis changed all that). We are expected to discharge preeclamptic patients before their postpartum diuresis is complete and their blood pressure stable.

The operative phrase here is "we are expected to". Only you, the attending physician, can make the decision to discharge a patient and assume the subsequent liability. The only responsibility of the welfare or insurance carrier's physician reviewer is to make a decision regarding the financial advisability of paying for continued inpatient treatment. He makes financial, not medical, decisions. His decisions are based upon contractual relationships between the carrier and the state, employer or patient, not upon fiduciary relationships such as those between you and your patients. (If you don't recognize the term fiduciary relationship and its coincident liability implications, see "MedMal 101: Theory", Vol. 6, No. 2, April 1998, page 12.) Furthermore he takes no personal liability responsibility for his decisions, with his employer only responsible for the costs of the sought-after care if his denials of payment are causation of subsequent losses or injuries to their clients.

There is an alternative however. If you really and truly think it's not in your patient's best interest, refuse to discharge her. Explain to the patient your reasons and concerns, possible complications of premature discharge and their long-term consequences. Remaining in hospital a day or two longer may not prevent these complications but it will certainly greatly decrease the chances of their occurrence, plus their early signs can be recognized by the healthcare team allowing sooner and better treatment. Also explain that the hospital may bill them directly for the costs of unapproved care.

The reality of the situation is that most of the time when I do this my patient decides she can't afford the risk of having to pay for some of her hospitalization, in which case I explain I can't afford the risk of being sued for preventable complications. I then explain the process of Discharge Against Medical Advice, which places the responsibility for the discharge decision squarely upon the patient. Most patients grasp the concept with surprising ease and appreciate both your concern for them and reluctance to be responsible for a decision you think poorly advised.

I've always thought hospitals would be smart not to press for discharge against the attending physician's better judgment, instead accepting his decision as the best alternative and aggressively contesting the carrier's decision not to pay. In those cases where the final appeal is unsuccessful, it would be good public relations and good medicine for both the physician and hospital to write-off their charges incurred after the approved length of stay.

In the best of all possible worlds there would be no third party payors. Hospitals would see their mission as providing the best possible care to their patients, not providing maximum financial return on investment. All physicians would be responsible for their decisions and their decisions only. We don't live in the best of all possible worlds and probably never will, but until then you don't have to incur liability responsibility for less than the best care you are capable of providing your patients.

TO VBAC OR NOT TO VBAC,

THAT IS THE QUESTION.

by Doug Daniel

I've also written before about the vital necessity for the College to establish and maintain a minimally acceptable standard of care benchmark for our speciality, and the revamping of their publications will hopefully come closer to meeting this need. Case in point, ACOG Practice Bulletins. The series actually began in August 1995 as ACOG Practice Patterns, publishing two monographs before changing to the newer moniker. The latest is entitled "Vaginal Birth After Previous Cesarean Section, Number 2, October 1998", presenting the most recent and reliable scientific evidence plus unsubstantiated but recognized opinions.

At its conclusion it makes several simple, direct, easy-to-understand recommendations classified by their foundation in good and consistent scientific evidence (Level A), limited or inconsistent scientific evidence (Level B), or consensus and expert opinion (Level C). In case you weren't paying attention, some things have definitely changed. Since we're all big boys and girls here, you can read the following excerpts and make your own judgments. And after you do, be advised that there is litigation underway in Florida over a court-ordered forced repeat cesarean section in a patient demanding trial of labor for attempted VBAC. More to come.

"Despite more than 800 citations in the literature, there are no randomized trials to prove that maternal and neonatal outcomes are better with VBAC than with repeat cesarean delivery...most studies of VBAC have been conducted in university or tertiary-level centers with in-house staff coverage and anesthesia. The safety of trial of labor is less well documented in smaller community hospitals or facilities where resources may be more limited."

"Women who have had two previous low-transverse cesarean deliveries also may be considered for a trial of labor, but the risk of uterine rupture increases with the number of previous uterine incisions. Following are selection criteria useful in identifying candidates for VBAC:

- One or two prior low transverse cesarean deliveries
- Clinically adequate pelvis
- No other uterine scars or previous rupture
- Physician readily available throughout labor capable of monitoring labor and performing an emergency cesarean delivery
- Availability of anesthesia and personnel for emergency cesarean delivery.

"There has been a tendency to expand the list of obstetric circumstances under which VBAC may be appropriate. These include multiple previous cesarean deliveries, unknown uterine scar, breech presentation, twin gestation, postterm pregnancy, and suspected macrosomia. Whether trial of labor should be **encouraged** (author's emphasis) for patients with these obstetric circumstances and a low-vertical uterine incision is controversial. Although success has been reported in some series, continuing analysis of the risk of adverse outcome is necessary before VBAC is routinely adopted in these circumstances.

"It often is stated that the cost of VBAC is less than that of repeat cesarean delivery. However, for a true analysis of all the costs one has to include the costs to the hospital, the method of reimbursement, and medical malpractice payments. Higher costs may be incurred by a hospital if a woman has a prolonged labor or has significant complications, or if the newborn is admitted to a neonatal intensive care unit. Furthermore, 20-40% of women will fail the trial of labor, which will incur surgical costs. Increased time or attendance for a woman undergoing a trial of labor results in increased cost to the physician. The difficulty in assessing the cost-benefit of VBAC is that the costs are not all incurred by one entity.

"Those patients who fail a trial of labor are at increased risk for infection and morbidity. Infants born by repeat cesarean delivery after a failed trial of labor also have increased rates of infection. In contrast to previous reports, the most recent series showed that major maternal complications such as uterine rupture, hysterectomy, and operative injury were more likely for women who underwent a trial of labor than for those who elected repeat cesarean delivery."

"A trial of labor is not recommended in patients at high risk for uterine rupture. Circumstances under which a trial of labor should not be attempted are as follows:

- Prior classical or T-shaped incision or other transfundal uterine surgery
- Contracted pelvis

- Medical or obstetric complication that precludes vaginal delivery
- Inability to perform immediate emergency cesarean delivery because of unavailable surgeon, anesthesia, sufficient staff, or facility

"A combination of factors, which singly may not be compelling for cesarean delivery in a patient without a uterine scar, may influence the decision to forego VBAC and recommend repeat cesarean delivery."

"If the site of the ruptured scar is confined to the lower segment, the rate of repeat rupture or dehiscence in labor is 6%. If the scar includes the upper segment of the uterus, the repeat rupture rate is 32%. Therefore, women who have had a prior uterine rupture should undergo repeat cesarean delivery as soon as the fetus is mature.

SUMMARY

LEVEL A

"Most women with one previous cesarean delivery with a low-transverse incision are candidates for VBAC and should be counseled about VBAC and offered a trial of labor."

LEVEL B

"Women with two previous low-transverse cesarean deliveries and no contraindications who wish to attempt VBAC may be allowed a trial of labor. They should be advised that the risk of uterine rupture increases as the number of cesarean deliveries increases.

"Use of oxytocin or prostaglandin gel for VBAC requires close patient monitoring.

"Women with a vertical incision within the lower uterine segment that does not extend into the fundus are candidates for VBAC.

LEVEL C

"Because uterine rupture may be catastrophic, VBAC should be attempted in institutions equipped to respond to emergencies with physicians readily available to provide emergency care.

"After thorough counseling that weighs the individual benefits and risks of VBAC, the ultimate decision to attempt this procedure or undergo a repeat cesarean delivery should be made by the patient and her physician."

THE TIME MACHINE

by Doug Daniel

I feel like I just woke-up in front of the TV after sleeping through the middle half of a "Movie of the Week". Maybe a completely different movie than the one I went to sleep in. Like Rip Van Winkle I'm very confused and none of what I'm seeing makes much sense.

Let me be more specific. I just received the ACOG Statements of Policy entitled "AAFP (American Academy of Family Physicians) - ACOG Joint Statement on Cooperative Practice and Hospital Privileges" and "Maternity and Gynecologic Care" dated March 1998, accompanied by a nice letter from Stanley Zinberg, MD, ACOG Vice President of Practice Activities. These replace previous publications of the same name issued in July 1980. I don't remember the prior documents but apparently these all represent an agreement between the two physicians' organizations regarding appropriate minimal requirements for teaching obstetrics and gynecology in family practice training programs plus recommended minimal requirements for those programs which purport to train family practitioners for the independent practice of obstetrics and gynecology.

The caveat is given that these documents should in no way be the basis for hospital credentialing or granting of privileges, including the statement that "The assignment of hospital privileges is a local responsibility and is based on training, experience and current competence." The reality based on previous personal experience is that's exactly what they will be used for. There is also a related statement that:

"The standard of training should allow any physician who receives training in a cognitive or surgical skill to meet the criteria for privileges in that area of practice. Provisional privileges in primary care, obstetric care and cesarean delivery should be granted regardless of specialty as long as training criteria and experience are documented. All physicians should be subject to a proctorship period to allow demonstration of ability and current competence. These principles should apply to all health care systems."

Sixteen years ago when I was being recruited to come to a small town in rural West Virginia as the first fully-trained and Boarded obstetrician/gynecologist within a travel time of 45 minutes in two directions and two hours in the others, there were three old GP's and two young "Family Physicians" still delivering babies in town. Two of the old guys and one of the young ones said if I would come to town they would accept no more obstetrical patients, realizing there was no way in hell they could get anyone to come otherwise. The other old GP said he really enjoyed obstetrics and would like to keep practicing at a limited level for a while longer if I would serve as his obstetric consultant. The remaining young FP told me to my face before a group tasked with the recruiting chore that he could take better care of pregnant patients than I could.

He may have been right and maybe I should have taken him seriously, but I came anyway. Over the years there has been a steady parade of board eligible and certified obstetrician/gynecologists through our area including a small hospital about fifteen minutes away, but few have stayed longer than two or three years. The old GP who loved obstetrics has retired, the no-longer-young FP still does an occasional delivery, and new FP recruits have been in and out of the baby business at various times, mostly because the medmal carriers have literally forced them out of the market with escalating premiums.

When I first started doing locum tenens work I didn't object to covering family practitioners' practices who did obstetrics and I didn't object to working in obstetric practices which included family practitioners. But based on multiple terrible experiences, I soon quit. If someone now wants me to cover a family

practitioner's practice who delivers babies, I pass. If someone wants me to cover an obstetric practice which includes family practitioners, I say I'll be happy to assume care of all labor patients and act as the family practitioners' prenatal consultant. Some say OK and others say no way.

Over the years I've also espoused the opinion that there should be a physician credentialed to perform Caesarean section continuously present in the labor and delivery suite whenever a patient is in labor, and Dan Avery recently agreed in this publication. I sort of thought that since almost nobody in their right mind would today credential a family practitioner to independently perform Caesarean sections, at least one fully-trained obstetrician would be continuously available to any patient in labor.

You've also recently read and will continue to read in the *Newsletter* well-considered and clearly presented opinions opposing the trend to train and classify obstetrician/gynecologists as "primary care physicians", thereby blurring the distinction between the practice of general or family medicine and what used to be the specialty of obstetrics and gynecology. These new Statements of Policy simply make that distinction more difficult, I fear to the detriment of patients.

The recommendations for basic curriculum in family practice training programs include many items which trained nurse practitioners and midwives already do, but under varying degrees of obstetrician/gynecologist supervision depending on the particular state. These include colposcopy, endometrial biopsy and benign cryocautery. But they also include items which, in my considered opinion, are better referred to the obstetrician/gynecologist such as sexual assault examination of females, management of malignant neoplasms of the female reproductive system, culdocentesis (the only indication for which I am aware is suspected ectopic pregnancy), Bartholin cyst drainage or marsupialization (a frequently recurrent condition if not properly treated surgically), and especially VBACs since their management may include emergency Caesarean section with some of the worst intraoperative complications known. In fact, ACOG Practice Bulletin Number 2, October 1998, entitled "Vaginal Birth After Previous Cesarean Delivery" recommends: "Because uterine rupture may be catastrophic, VBAC should be attempted in institutions equipped to respond to emergencies *with physicians readily available to provide emergency care* (author's emphasis)."

The recommendations for advanced skills curriculum, defined as applying to "...family practice residents who are planning to practice in communities without readily available obstetric-gynecologic consultation and who need to provide a more complete level of obstetric-gynecologic services for the proper care of patients...", include ultrasound-guided amniocentesis; management of preterm labor, severe pre-eclampsia, multiple gestations, breech delivery and "complications of vaginal birth after previous cesarean delivery"; external cephalic version; amnioinfusion; Caesarean delivery; tubal ligation, postpartum and with Caesarean delivery; and conduction anesthesia/analgesia, assumed to be intrapartum use of spinal, caudal and epidural anesthesia. The last one is especially bothersome since the College years ago took the position that simultaneous management of conduction anesthesia and labor/delivery by the obstetrician posed an unacceptable risk to patients. I used to be damned good at saddle blocks and could provide remarkably effective, extremely low cost, and instantaneous pain relief to my obstetrical patients with no more serious complications than the occasional postspinal headache, but haven't done one since because my speciality organization said in so many words that to do so was beneath the recognized acceptable standard of care and if I eventually got a serious complication I was on my own.

I can't understand all this. I spent six years of my life trying to qualify as a specialist in the diagnosis and treatment of diseases and conditions specific to women as opposed to or in addition to a practitioner of general medicine, and now I'm being told that for all practical purposes it only takes a family practice resident three months to do the same. It seems like after 20 years of trying to limit any but the most routine obstetrical cases to specialist care and get the undertrained and underqualified physicians out of obstetrics, we're going back in time and nullifying all our advances in patient care including those which have markedly decreased maternal morbidity and almost eliminated maternal mortality. Perhaps I simply lack the perspective one gets from the top of the mountain.

The recent updating of the joint policy for core educational guidelines and practice activity by the AAFP and ACOG task forces can serve as a very strong model for the appropriate education of family physicians who wish to provide obstetrical and gynecological services. The 1980 joint statement was obviously outdated. Therefore, the activity provided an opportunity for physicians from both organizations to come together in a spirit of collaboration to advance appropriate healthcare for women.

In many parts of the country there has been a lack of communication and even outright hostility between OB/GYNs and Family Physicians to no good purpose; particularly, it has done nothing to improve women's accessibility to appropriate healthcare. In fact, a woman could find herself in a dangerous situation if such services were not available by well-trained individuals who understand what is necessary to provide proper coordination of care.

While the main body of the document is designed to reaffirm the elements that are essential for education of physicians, the establishment of the joint committee has other positive ramifications. It is possible for hospitals to have joint committees made up of representatives from OB/GYN and family practice who meet on a regular basis, reviewing the in-house teaching and training activities as well as providing a coordinating council for any quality issues that may arise. In many areas of the country, successful collaboration has resulted in improved relations between family practitioners and obstetricians and gynecologists.

It is the hope and intent of the ad hoc task force that all physicians will realize we have an ethical obligation to provide the highest quality of care possible for our patients. This includes family physicians requesting only those privileges for which they are properly trained and experienced, as well as an appreciation for timely referral of patients that have various high-risk or other warning factors identified. Conversely, obstetrician/gynecologists have an obligation to respond to family physicians who request consultation and should do so with the idea that collaboration can only improve quality of care. Lack of this effort could result in situations unwanted by both disciplines, leading to undesired and unnecessary legal consequences.

Thomas F. Purdon, MD

MEDMAL 103: TRIAL

by Hugh Martz and Doug Daniel

The judicial process may sometimes seem interminable, occasionally lasting five or even twenty years, but the judge always sets deadlines for discovery, pretrial motions, settlement conferences, mediation and trial. Rarely will the plaintiff prolong discovery or delay trial, and if he does it usually is an indication that he knows he has a weak case but is hoping for a nuisance settlement if he can keep the case open. It may even indicate that he has not properly researched and investigated the case or cannot find a credible medical expert witness whose testimony is favorable to his case. In many states failure of the plaintiff to find a medical expert witness to support his claim is grounds for summary judgment in favor of the defense, thereby avoiding trial. Most of the time the defense tries to delay the trial's start as long as possible for several reasons:

1. They get paid by the hour
2. New medical knowledge or literature may become favorable to their case
3. Frustration and delay may make the plaintiff more amenable to a lower settlement
4. The plaintiff may drop either the suit or dead
5. Inflation may make a judgment or settlement less costly in real dollars.

Either party may ask for and get an extension, but eventually there is a definite endpoint and a trial date is set.

Don't expect initial trial dates to be reliable, but arrange your schedule anyway to guarantee uninterrupted attendance and attention. It may not be the Caribbean cruise you had planned for vacation this year, but completely remove yourself during trial from all other responsibilities except family. Your absence for even part of the trial or a distracted appearance may be interpreted by the jury as disinterest, a possible reason to dislike you.

The attorneys representing the parties will have numerous meetings with the judge between the end of discovery and trial, during which various motions or pleas may be argued. Some address what evidence the judge will allow the trial jury to hear. Neither side wants jurors exposed to testimony potentially damaging to their case, and oftentimes arguments revolve around the relevance or irrelevance of the evidence in question to the case at hand. Other motions may attempt to gain access to records or information requested by one side but withheld by the other.

Most frequent seems to be the defense's Motion to Dismiss or Motion for Summary Judgment, alleging that with discovery complete the plaintiff has not produced evidence to support his Complaint's allegations. In granting Summary Judgment the court considers the facts most favorable to the plaintiff, and as a matter of law the defendant still prevails. Motion to Nonsuit or Dismiss, on the other hand, is based upon legal technicalities instead of the merits of the case. These motions are usually denied but if granted, everybody goes home and the Data Bank is none the wiser. Denial of such defense motions often requires that the plaintiff's medical expert witness submit to the judge an affidavit or sworn document favorable to the plaintiff. It proposes that medical negligence or malpractice occurred, or is at least arguable in the plaintiff's favor, considering the facts most advantageous to the plaintiff. Depending on whether the motion is granted without or with prejudice the case may or may not be refiled, i.e. dismissal with prejudice prohibits future refileing.

Similar motions called Motion for Directed Verdict or Judgment on the Evidence can be made by either defense or plaintiff at the completion of the opposition's case before submission to the jury for deliberation. These motions argue that either the plaintiff did not meet the requirements of all four of the Complaint's table legs (see below) or the defense did not offer evidence to adequately refute them. Granting such a motion from either defense or plaintiff means the jury never deliberates a verdict regarding the injury in question, the judge instead deciding the verdict issue. If the plaintiff prevails on the issue of liability through the judge's ruling, the jury may still hear evidence on and decide the issue of damages.

For advice on how to conduct yourself during trial refer back to "MedMal 102: Discovery", *The Medicolegal Ob/Gyn Newsletter*, Vol. VI, No. 4, October 1998 and its discussion of depositions. Essentially the same rules apply to both but the jury's emotions toward you are more important at trial, so leave the attitude, ostentatious jewelry, flashy clothes and expensive cars at home. Plus don't forget to get any chips and your pet burro off your shoulders. Concentrate on being pleasant, courteous, non-argumentative, confident, well-spoken, honest and professional. Do not appear either intimidated or intimidating, defensive, nervous, patronizing, inconsiderate, unconcerned, evasive, shifty or stupid.

Usually your attention should be directed toward the lawyer conducting your examination during his questions, but toward the individual jurors during your answers. Eye contact is essential to veracity. Ask your attorney for his advice but most recommend the above.

Keep your focus of attention upon the speaker during all other court proceedings or testimony. By all means do not watch the jury in an attempt to "read" them. Your attorney and his staff will do this much more effectively and less obviously than you. Your emotional reactions to questions, answers or statements others make before the jury are potentially damaging to you and should be restrained. In the same vein resist the temptation to make whispered comments to your attorney during the trial. He needs to focus on the events transpiring. Unless he solicits them from you while court is in session, any enlightening comments are best made by written notes which he can read at his convenience or later during a recess.

Ask your lawyer about the advisability of your spouse and other family members attending the trial. Although emotionally traumatic and draining for them, they may provide a valuable positive impression to the jury. On the other hand they may do more harm than good if they don't follow the above profile. Think Maureen Dean, John's conservatively attractive and dutiful wife.

The same warnings about conversations during depositions apply here in spades, including family members and friends. That fellow in the next stall may be a juror. Jurors and alternates are usually required to wear obvious buttons or badges identifying them as such but under no circumstances should you or your supporters ever engage a juror, alternate or anyone else in conversation about the case, nor even unrelated pleasant conversation. Efforts by anyone to discuss the case with you, your family or your supporters should be viewed as coming from the opposition and potentially damaging. Juries in medical malpractice cases are almost never sequestered and they go to restaurants, movies, bars, churches, etc. just like everyone else. Plus they don't need those stinking badges except around the courthouse.

The warning about overheard conversations especially applies to telephone calls and conversations outside the courthouse. It may not have happened yet, but assume all your cellular phone calls are monitored unless totally digital. Think Speaker Gingrich, Princess Di and Prince Charles.

Also don't forget that the confidentiality of privileged communications during any past physician-patient relationship prevents your discussing your patient plaintiff's medical, personal, or personal-but-medically-related information save during court testimony or with your defense lawyers. Without her legal consent you are held to silence except under these two conditions. This even applies to your malpractice insurer.

Patient plaintiffs however are under no such restraints and may say anything they wish to anyone at anytime regarding your treatment, advice, recommendations, demeanor or personal information revealed during the physician-patient relationship. When testifying to factual evidence as a nondefendant, you may invoke the confidentiality of the physician-patient relationship but usually if the questions are relevant to the case at hand, the judge will order you to answer or be held in contempt of court with possible incarceration until you do answer. Call Susan McDougal if you don't understand contempt of court penalties for refusing to testify.

On the other hand, the concept of burden of proof provides protection to the physician defendant similar to that enjoyed by the criminal defendant. The plaintiff must prove all four basic elements of the complaint to a reasonable degree of medical certainty. Failure to prove any one of these four elements results in a verdict for the defense. For more on the four essential elements of a medical malpractice complaint, see *The Medicolegal OB/GYN Newsletter*, Vol. 6, No. 2, April 1998, page 12, "MedMal 101: Theory".

Civil trials don't usually require a unanimous jury verdict. The number of votes necessary to win varies but always benefits the defendant. Most physician defendants can win because both the system and the jury generally favor them, but if the negligence is obvious or the plaintiff gains the jury's sympathy you might as well make out a check for the requested amount or more. Those cases with a poor chance of successful defense are almost always settled prior to trial, although some carriers reportedly take the attitude of defending every case to the bitter end.

Your consent to settlement is usually unnecessary unless your insurer is a physician-owned company, but their advice to settle may be based upon a business decision that a guaranteed limited settlement is preferable to the chance of a judgment or runaway verdict meeting or exceeding their policy's limits. Either way you end up in the National Data Bank.

Your refusal to accept a recommended settlement offer within the policy's limits of liability usually relieves your carrier of the subsequent judgment or verdict amount in excess of the proposed settlement even if they pay the cost of further defense. That means you can end up losing a lot of your assets which were previously protected by insurance. And of course there's always the chance your insurer may have gone broke or you voided the policy by not meeting the terms of its contract. Yes, Virginia, medical malpractice carriers are forced into receivership or bankruptcy more frequently than we like to admit, leaving their physician policyholders unprotected. A.M. Best rates insurance companies yearly, and checking your carrier's Best rating each year is a good idea. Think PIE Mutual.

Assuming you lose, there are some options for decreasing the judgment amount. If the judge thinks the jury's award is excessive and unjustified, he can unilaterally reduce it (remittitur). On the other hand he can also increase it (additur). Your attorney may argue that others such as fellow physicians, nurses, hospitals, HMOs (joint and several liability), or even the plaintiff (contributory negligence) share some of the liability responsibility. This responsibility can be expressed in percentages with the total judgment (contributory negligence) and/or your portion of it (joint and several liability) proportionately reduced.

The ultimate recourse is appeal of the verdict but appellate courts almost never overturn lower court decisions or remand cases for retrial based upon the evidence presented initially, nor do they consider new evidence or arguments. Appeals are usually based upon technical errors of law committed by the judge. When successful they often result in settlement for a lesser amount and only rarely in a retrial. The mere threat of appeal favors the defense in negotiations toward a lower settlement, but once a plaintiff verdict is a final judgment both the patient and her lawyer will seek payment as soon as possible.

If you the defendant win there is the possibility of suing the plaintiff's attorney for barratry (unjustified or malicious litigation) and recovering your financial losses related to his filing suit. If you lose you can sue your carrier for breach of contract if it didn't fulfill its requirements under the policy to properly defend you. You can also sue the company-appointed defense attorney, or

even your personal defense attorney, for malpractice if either didn't properly represent you. These three alternatives are seldom used, and when attempted usually fail or cost you more than the recovery. Another option is to file a complaint against the offending lawyer with the state bar association or supreme court, but you would be best advised to discuss this with an attorney specializing in actions against fellow attorneys. Needless to say, they are about as common as hen's teeth. Even if you find one there will be no financial gain, but your personal satisfaction may be worth the expense.

The best advice? Give defense of the case your very best shot, trying to cover as much of your assets as you can. If you win, consider yourself lucky to have dodged the bullet and try not to let it happen again. If you lose, hopefully within policy limits and without loss/restriction of your medical license or reduction of hospital privileges, walk away considering yourself lucky it's over and try not to let it happen again. Either way life goes on, believe it or not.

Buy a copy of Exploring Medical-Legal Issues In Obstetrics And Gynecology from the Association of Professors of Gynecology and Obstetrics (APGO) for more on the court system and medical liability. Their phone number is 202-863-2514. It costs \$40.00 (\$30.00 to APGO members) and is an excellent resource. Another is Professional Liability For Residents published by the Council on Resident Education in Obstetrics and Gynecology (CREOG), 202-863-2588. It costs \$15.00. The Department of Professional Liability at the College has produced several series of monographs and other resources (*The Assistant*) plus they are happy to talk to ACOG members anytime about liability issues at 202-863-2581. All the above can be contacted Toll-Free at 1-800-673-8444 or U-Pay at 202-638-5577, via FAX at 202-484-5107, or by snail mail at Post Office Box 96920, Washington, DC 20090-6920. For instructions on E-Mail call the Toll-Free. All are probably available from ACOG Publications, 1-800-762-2264.

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