THE IMPAIRED PHYSICIAN: DAMAGE CONTROL

by Doug Daniel

Abstract: In spite of government, professional and employer regulatory and investigatory activities, the actual number of impaired physicians practicing clinical medicine is unknown as is the cost of their impairment defined by substandard care and/or medical malpractice settlements and awards. Preventive programs to identify and educate those prone to impairment are practically nonexistent as are effective screening programs to identify those already early or minimally impaired.

One of the most critical emergencies in the United States Navy is fire onboard a ship or boat at sea. The potential for disaster in this situation is obvious considering the coexistence of large numbers of personnel plus incredible amounts of hazardous and highly flammable materials such as paints, solvents, diesel fuel, bunker oil, kerosene, high octane avgas, jet propellant, and missile fuel not to mention weapons both conventional and nuclear. And don't forget nuclear reactor fuel and radioactive waste. The possible injuries plus loss of life and property are staggering, not to mention loss of mission effectiveness in time of war. Consequently tremendous resources in time, money, equipment, training, research and personnel are committed to fire prevention, detection and control.

We face a similar situation today in medicine, though perhaps not of the same magnitude. The impaired physician is literally a loose cannon careening around the deck of the good ship Healthcare just waiting for a chance to explode. The big difference is nobody apparently cares. That's not altogether true because some of us care very much, but most won't even acknowledge there's a problem. Ah, there's the rub.

In spite of the Drug Enforcement Administration’s regulatory and investigatory activities, all 50 states’ boards of medical licensure and pharmacy, all their medical associations' impaired physician programs and countless hospital credential committees, we really have no idea how many impaired physicians practice clinical medicine daily, most of the time or some of the time. We constantly read about increasing numbers of physicians having their licenses restricted or revoked due to various types of impairment, but I suggest they are only the tip of the iceberg.

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THE PRESIDENTIAL BOX

Ray Cestero, President

Hello again, friends. I have survived my first quarter as your President thanks to Doug Daniel's support and guidance. He is truly the cement that keeps us all together. We are getting ready for the Society's annual membership meeting during ACOG's Annual Clinical Meeting in Philadelphia this May. Last year's meeting was superb, chock-full of valuable information and advice. We expect more of the same or even better this year.

I recently ran across an article containing valuable practical advice I thought I would share with you. My medmal insurer, Cooperative of American Physicians, Inc., publishes a quarterly newsletter entitled *CAPsules*. The first quarter 1999's issue (Vol. 18, No. 1) has an article by one of their attorneys, Jamee Tomlinson, entitled "Physicians as Expert Witnesses". Most physicians are naturally reluctant to testify as a medical expert witness, but let's not forget that our members can provide the valuable expertise needed to allow determination by an attorney or jury of whether or not a physician has met the accepted standard of care. And remember that objective evaluation of a case, even if unfavorable to the defendant, may encourage all parties to reach a mutually satisfactory and often less expensive resolution of the claim earlier.

We must remain objective and not encourage the perception of favoring our colleagues. One's credibility before juries will survive cross-examination more easily if he honestly states that he reviews both defense and plaintiff cases. We must be willing to review plaintiff cases if we wish to avoid the taint of bias, which brings up several caveats.

First you must always ask who is the defendant. Testifying against a physician in your own medical community or against a hospital owned by the same corporate parent as yours can have a disastrous negative impact upon your professional relationships and even your economic survival. Evaluating a case in which you are personally acquainted with any of the parties automatically makes a fair and unbiased opinion practically impossible.

You must also know the identities of the opposing attorneys. I've heard of medical expert witnesses accepting a case for review only to discover the opposing attorney has defended them in a previous malpractice, civil or criminal suit. This makes for an unusually difficult deposition or cross-examination.

Finally you must avoid situations which question your objectivity and/or credibility. For example, testifying against a competing physician will be perceived as vindictive, greedy, and/or envious. Your would also be perceived as less than objective if you testified to the merits of a product whose manufacturer funds your research. Objective, honest and scientifically based opinions presented intelligently in an easily understood manner should always be our aim.

Make plans to attend the Society's meeting on Sunday, May 16th 6:00 PM in Rooms 411 and 412 of the Marriott's Convention Center. And don't forget to congratulate our Past President Ben Harer on his nomination as President-Elect. He has for years worked incessantly for both the College and the Society, unquestionably deserving our congratulations and support. See you all in Philly!

THE WITNESS BOX

Doug Daniel, Editor

"The key role of an editor in chief is to secure the integrity of the publication by any means necessary."

George Lundberg, MD

Editor of the *Journal of the American Medical Association* for seventeen years until fired January 1999 for publishing a study on how college-age Americans define "having sex".

This month's installment in the continuing saga of the impaired physician is the last, and I took the editorial prerogative of writing the final installment. Though certainly not a qualified expert on substance abuse or its treatment, I have seen too many colleagues and friends stumble as impaired physicians, some even falling over the edge and committing suicide. But by the same token I am neither unaware of nor immune to the pressures and temptations presented by our unique profession, having personally experienced many of the problems that lead to physician impairment. It is only by the grace of God that I have not followed their well-traveled path. So for those of you who have been concerned about when the emphasis on physician impairment will finally end, it never will. But at least the articles will not be as frequent.

Ray Cestero's column this month may be hard to swallow, but it's right on the mark. He addresses the dilemma facing those medical expert witnesses who as a matter of principle refuse to evaluate cases or testify for plaintiff attorneys. The short course? Working only one side of the street strains your credibility.

Jerry Weinberg does a superb job with this month's Suggestion Box by looking at the problematic relationship between pharmaceutical manufacturers and physicians who prescribe their products, focusing on possible conflicts of interest.

Deep Pockets is currently on a top secret clandestine assignment under deepest cover and even your and his editor could not reach him regarding his contribution to this issue. Assuming he survives this most dangerous duty, I trust his communiqués will continue in the next issue of the *Newsletter*.

Sid Wilchins ably fills the Book Box this month with a review of Galileo's Revenge, a book by Peter Huber bemoaning the fact that unsubstantiated and unscientific testimony has been allowed to poison the well of expert witness testimony both medical and other. By now Sid needs no introduction, but if you don't recognize the name check out Vol. VII, No. 1, January 1999's *Newsletter*. Prominent in the book is an in-depth investigation and explanation of Daubert v. Merrell-Dow, better known as the case which eventually resulted in Bendectin® being voluntarily removed from the U.S. market. For more see the information below on Dave Priver's piece in this issue. This month's Litter Box was precipitated by my continuing heartburn over increasingly expensive and inadequate efforts to assess physicians' clinical competence by professional societies, consumer advocates and government. Certainly the profession and our patients are entitled to some method of accurately insuring physician competency. So far we have seen accredited medical school diplomas, licensure, speciality board certification, mandatory speciality board recertification and mandatory continuing education utilized while physician profiling looms on the horizon. I am of the opinion that the last two have been and will be miserable failures. The ABOG's "open book" recertification test is the last straw.

There's also a view from the other side of the fence written by Andrew W. Watry, Executive Director of the North Carolina Medical Board. Mr. Watry very effectively presents the case that although not perfect, our current system of medical licensure and discipline actually works quite well and anything more than some fine-tuning would only create greater problems. Feel free to write with your opinion.

Dave Priver's piece this month on peer review of medical expert witnesses complements the January 1999 musings of Sid Wilchins ("The Medical Expert Witness: A New Mandate", *The Medicolegal OB/GYN Newsletter* Vol. VII, No. 1, January 1999, page 26), giving us some insight into the AMA's position and how they reached it. Dave is a 1970 graduate of Wayne State University School of Medicine, completing his

residency in obstetrics and gynecology at Sinai Hospital of Detroit in 1974 and practicing briefly in Michigan before moving to the left coast. Since arriving in San Diego he has been Chief of the Gynecology Section and Chair of the Surgery Department at his hospitals plus holding multiple offices in the San Diego County Medical Society and California Medical Association. He has also provided medical services in Lithuania for International Relief Teams.

There's a short personal statement on abortion included in this issue. It's self-explanatory. I'd like to know your feelings on the topic, name withheld for publication if you prefer.

And finally there's another excellent article from *Physician's Practice Digest* reprinted in the back, this one by Jef Feeley on the medmal risk of poor communication skills.

For those of you with internet access, check-out the ACOG web site. Each issue of the *Newsletter* is now being submitted for consideration to be posted either excerpted or possibly in toto. The main reason is to raise our profile and increase our Q factor, thereby increasing our dues-paying membership. There should be a credit giving the Society's address and telephone number. If you see it and approve, call or write Mark Graves at the College's offices and tell him what a great job he's doing.

The ACM Luncheon Conferences in Philly are still on. If you attend and don't have plans for lunch on Tuesday or Wednesday, ask if there are any available tickets for Dan Avery's presentations on impaired physicians, T2 and W1. You may already know most of what will be discussed but you'll get to meet Dan, ask questions and make comments.

The membership meeting is Sunday evening in the Marriott's Conference Center Rooms 411 and 412 at 6:00 p.m., and the Caduceus meeting in the same rooms at 8:00 p.m. is also still on. The membership program will be "Bearing Effective Witness" featuring Phillip C. Ginsberg, DO, JD, and Marcella Schell, Esq., discussing the provision of effective and proper testimony during medical malpractice litigation by defendant physicians and medical expert witnesses for both plaintiff and defense. Dr. Ginsberg is a practicing urologist in Penn Valley, Pennsylvania, and Ms Schell is a member of Philadelphia's premier medmal defense firm.

As usual we encourage submission of letters to the editor, articles and guest editorials for publication consideration. Letters and editorials are subject to editing only for space requirements with articles and editorials typewritten and double-spaced. Free reprints of individual past *Newsletter* articles are available to members at no cost upon submission of a SASE, back issues for $10.00 each or $20.00 per volume of four issues. A 44 page monograph entitled "The Impaired Physician" and containing the complete series of articles previously published in the *Newsletter* is available for $20.00 including tax, shipping and handling.

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

4 JANUARY 1999

Dear Doug

As physicians we have all had a multitude of experiences in our professional careers, particularly in our specialty of obstetrics and gynecology. As a member of the Board of Professional Medical Conduct for the State of New York, I have had a somewhat unique experience dealing with professional negligence and incompetence. On the other side of the fence, I am a member of the Board of Trustees of the Medical Society of the State of New York and have for almost fifteen years been a strong opponent of frivolous lawsuits against our subdivision of medicine as well as others. I have also just been elected Vice Chairman Elect of ACOG District II.

Eighty percent of board certified obstetrician/gynecologists have had at least one lawsuit filed against them! These result in major part not from malpractice but from the expectation of perfection against which society often judges us. It also points to the extreme failure of our civil justice system whereby injury or loss often seems to be all that juries need to bring in large damage awards. The fact that no negligence or malpractice was involved apparently does not deter juries from making huge awards.

I have written legislation on the neurologically impaired infant and tried to create an administrative board that would care for New York's 1000 cerebral palsy infants instead of wildly overcompensating only the 50 such babies who win lawsuits and who, along with their lawyers, receive over $200,000,000 each year in New York State alone. This leaves 950 babies with no help at all. But the trial bar fights this furiously and continues to prevail. Taking on the trial lawyers is the most difficult task I have ever experienced.

In 1997 there was a verdict in New York State in favor of an infant for $89,000,000. When this verdict was appealed, it was upheld for $25,000,000. There was no negligence but society decided seventeen years later that this premature birth at 27 weeks deserved to be compensated. Candidly, our civil justice system still does not know how to adjudicate a medical malpractice case. Was there injury here? Yes. Was it caused by malpractice? Definitely not.

What should we as a profession and speciality do? How should society handle the truly incompetent physician? We cannot misguidedly ignore the grossly impaired, incompetent or negligent physician. I believe we must set our standards high and enforce them ourselves. Then, and perhaps only then, can we expect the inequities and unfairness of the tort system to be remedied. In other words, we cannot just oppose the failed civil justice system. Our approach must be two-pronged. We must also take the offensive and demonstrate that a vigorous professional conduct system is the best protection a patient can have.

When will we finally be able to return to the doctor-patient relationship which was the basis of our promise to society? I guess in the end it is up to us! Let us stand together for the highest possible professional standards. And, at the same time, let us proudly stand together to fundamentally reform a civil justice system that no longer serves any fair or valid purpose.

Albert M. Ellman, MD

9 JANUARY 1999

Dear Al,

Thanks for the letter. The readers of the *Newsletter* probably don't know that we serve together on the College's Committee on Professional Liability nor that I solicited your letter following one of our after-hours conversations. But of course you're right, a no-fault compensation fund for neurologically damaged infants is an ideal solution to an unsolvable problem. Virginia has had such a fund for several years and I have heard varying reports on its success. Some have said the requirements for cases to access the fund's benefits are so stringent that almost none qualify. Others have told me the fund has taken a tremendous load off the

state's medical liability insurance system. Defendant physicians have benefited either way since, as you say, litigation involving these infant plaintiffs is one of the most difficult we face as medical expert witnesses for either defense or plaintiff.

You also allude to the problem of identifying impaired physicians before they cause unnecessary harm or injury to patients and, I assume, rehabilitating them whenever possible. Stricter surveillance of practicing physicians is on the horizon, probably by the states' medical licensing boards initially. Almost all boards currently require passing speciality board recertification examinations or a general medicine examination called SPEX before granting initial licensure or even reciprocal licensure by endorsement. The plan is to eventually require one or the other for renewal of existing licenses.

I don't think this will really make any difference. There's never been an effective and reliable written or oral examination, including speciality boards, which will identify impaired physicians. These tests only evaluate recall of facts and confirm knowledge of mainstream medicine. They don't evaluate technical expertise in the operating or delivery room, adherence to professional ethics, aberrant behavior or possible substance abuse. I guess they're better than nothing but it's obvious to me that the best one to evaluate all aspects of a physician's competence and performance is his fellow physician, working side-by-side with him daily. This assumes the universal acceptance and implementation of random drug screening in the healthcare workplace.

Since we are only human and biased for or against almost everyone we know, it may be that the ultimately effective physician evaluation can only be performed by an independent medical expert witness personally reviewing the subject's charts, interviewing his patients and observing his technical performance. Having done this in the past I can assure you it's not only possible but the results are reliable. It is also relatively expensive and labor intensive. I guess we'll just have to wait and see.

Doug

23 FEBRUARY 1999

Dear Doug,

I have just now looked at the very beginning of Case No. 95-02288-I and the strip 6 MARCH, 2200 (*The Medicolegal Ob/Gyn Newsletter*, Vol. VI, No. 3, page 1 of Supplement). Long and short term variability are lacking. If the baby is lacking reserve there will be no impressive decelerations.

"Atta Boy" for your article "The Time Machine" (*Newsletter* Vol. VII, No. 1, January 1999). Sadly I agree too much.

Josephine Hall

28 FEBRUARY 1999

Dear Jo,

Thanks for the letter. You're absolutely right, and Frank Boehm of Vanderbilt said it in *Contemporary OB/GYN*, Vol. 9, MAY 1977, page 57-65. The presence of normal beat-to-beat-variability (BTBV) is still the most reliable EFM indicator of fetal well-being and adequate fetoplacental reserve during the metabolic stress of labor caused by the decreased placental blood flow which normally occurs with labor contractions. Its absence may indicate the fetal effects of maternal drugs both prescribed and obtained on the street such as barbiturates, alcohol, narcotics, diazepam, atropine, scopolamine, propiomazine, promethizine or mag sulfate. I've always assumed any CNS depressant could produce this effect and therefore include

cannabis. Unless resolved it should be assumed to represent early hypoxia and fetal acidosis, requiring intervention and return of normal BTBV.

Of course its a matter of degree, since we are all familiar with the "flat line" tracing, totally devoid of any variability, which suggests severe fetal hypoxia and acidosis. But when ignored the early changes of decreased BTBV will eventually progress to either a flat line or sudden severe prolonged late decelerations unless delivery first intervenes.

The problem comes when serving as a medical expert witness. Few could reliably testify that recognized minimal acceptable standards of care require immediate delivery of the fetus demonstrating decreased BTBV. Appropriate response during labor is to review the previous EFM record and try to find BTBV or subtle decelerations in an earlier portion of the strip, review recent maternal drug use and administration, expect resolution of a possible fetal sleep cycle within 30-40 minutes, and stimulate the fetus with manual or sonic stimuli or best of all digital stimulation of the fetal scalp if the membranes are ruptured. Any of these stimuli should produce a fetal heart rate acceleration of at least 10 BPM x 10 seconds.

When no explanation can be found oxytoxics should be discontinued if in use, a 500 cc bolus of maternal IV fluids containing 5% Dextrose begun, maternal left lateral decubitus position initiated and maternal supplemental oxygen begun. The role of amnioinfusion has been discussed both pro and con, but to my knowledge there has been no solid evidence that it helps. These interventions almost always resolve the problem. If not a decision must then be made whether to perform emergency delivery, via Caesarean section if necessary, recording the decision and its considerations in the medical record.

I personally have never seen decreased BTBV in labor without repetitive prolonged late decelerations which couldn't be resolved by these interventions. Admittedly in some of those cases with persistent decreased BTBV the decelerations were less than "impressive", but they were always there if you looked for them. In those cases with both unresponsive decreased BTBV and unresponsive repetitive prolonged mild or worse late decelerations, I deliver as soon as possible within the College's thirty minute rule.

Sometimes I feel like Richard Kiley playing the lead in "Man of La Mancha". Seems I've been listening to my copy of the original Broadway cast recording a lot lately, sort of like Rep. Hyde. At last it can go back on the shelf.

Doug

THE SUGGESTION BOX

by Jerry Weinberg

A PENNY FOR YOUR PRESCRIPTIONS

How much money do drug manufacturers lavish on physicians each year, millions or billions? Is it appropriate for healthcare providers to be targets of advertising programs as if they were lay consumers? Our choice of appropriate medication for our patients should not be influenced by free dinners or gifts. And how about the drug manufacturers' new gimmick of advertising prescription drugs directly to the patient public? These "Ask your doctor if you could benefit from _______" print and TV advertisements are just the latest twist in drug companies'

established sales strategy of encouraging patients to request or even demand specific medications by brand name.

I have attended “scientific” or “CME” lectures by well-known company-paid speakers who, discussing drugs by brand name and recommending the one sold by their sponsor while defaming the competition, occasionally brought to mind the snake oil salesmen and medicine shows of the past. We physicians have become so comfortable with drug manufacturers and their agents infiltrating our professional societies, social functions, educational programs, mail boxes and fax machines that we have forgotten their only agenda is to convince us to prescribe their products and thereby increase their profits. Even the prestigious American Medical Association contracted to receive large sums of money for endorsing Sunbeam consumer health products, but since then the contract has been reneged on and some AMA senior executive staff replaced while Sunbeam sues for breach of contract. Maybe those discharged from the AMA have been able to find work at Sunbeam.

The ultimate in this scenario has physicians so enamored of healthcare or related companies that they become wedded to them through financial investments, foregoing the reading of recent medical literature to follow stock prices and annual reports. These issues should be of concern to all physicians because even if they’re legal, they just don’t feel right.

Jerry’s concerns are certainly well-founded. Anyone with professional ethics has at one time or another asked themselves these same questions, but answers have been all over the ballpark. It finally comes down to one’s integrity and independence. I’ve always said that a druggist could tell which detail man had last been in town by physicians’ prescriptions. It seems some of us simply prescribe the drug du jour.

Others read textbooks, peer-reviewed journals, the Physician’s Desk Reference, package inserts, companies’ prescribing literature, CDC recommendations, ACOG practice resources, and/or seek their colleagues’ experience before adding a new drug to their armamentarium.

The secret is to independently form your own considered opinions regarding prescribing and stick to drugs you know. Having said this, for-profit companies are definitely a driving force in healthcare. If you don’t agree you must not have attended an Annual Clinical Meeting recently. The money spent on (and College profit from) exhibit construction, space, personnel, and freebies must be staggering. There’s also direct contributions from manufacturers and advertising in College publications. A reliable source has told me that less than 20% of the College’s budget comes from member dues, and although there are certainly other sources of income besides obstetrics and gynecology healthcare businesses, that’s got to account for a lot of it. On the other hand, diversity of income and sound financial management are two reasons why over the past several years we have seen expanded services from the College without a dues increase.

Drug companies have given me some very nice gifts over the years, beginning with Eli Lilly’s inexpensive doctor’s bag, reflex hammer, tuning fork, tape measure, and stethoscope when I was a sophomore medical student and ending with Abbott’s dinner cruise on a local lake for our last component medical society meeting. Along the way there have been drug and product samples, a cash prize for a paper presented at an ACOG District Meeting, support socks, duffel bags, soft cases, T-shirts, textbooks, gestational calculators, calendars, lithographs, photographs, plus innumerable meals, hospitality suites, pens, notepads, etc. None of these ever influenced my prescribing decisions but few of us can resist the temptations presented by financial conflicts of interest, and that’s why federal and state regulations prohibit most of them.

Several things always influence that decision: cost, reputation for quality manufacturing, commitment to new drug research, and responsibility to consumers. The first is the most difficult consideration, the next two define most of the major pharmaceutical companies, and the best example of the last is American Home Products’ response to the Tylenol scare several years ago.

What's my answer? We must beware Greeks bearing gifts, but that doesn't preclude getting to know some of them better and perhaps eating the occasional olive or watching "Zorba the Greek" again.

Doug Daniel

THE BOOK BOX

by Sid Wilchins

JUNKYARD DOGS

Galileo's Revenge: Junk Science in the Courtroom
Peter W. Huber, Esq.
Unillustrated. 274 Pages. New York: 1991
Basic Books.
Hardback, $23.00

Charles Darwin's two most significant conclusions regarding all known life, survival of the fittest and the overriding drive for self-preservation, were first published in his The Origin of Species in 1859. Today our own species' survival and self-preservation involves not only physical prowess and intellectual ability but also social, financial and psychological factors, and we tend to use whatever it takes to obtain our goals. Virtually nothing has worked as well to ensure survival in the courtroom as unscientific expert witness testimony, commonly referred to as junk science.

According to his book's jacket, Huber is "...a M.I.T.-trained engineer and one of the country's leading experts on liability law who offers a scathing indictment of how legions of case-hardened lawyers have successfully shifted the law from the rule of fact, using professional "expert" witnesses to press unsubstantiated claims on the basis of what nobody but a lawyer would call science." He is also described as a former law clerk to Supreme Court Justice Sandra Day O'Conner, a Senior Fellow of the Manhattan Institute, a regular columnist for *Forbes* and the author of Liability: The Legal Revolution and Its Consequences. The assumption is he graduated from an accredited law school but it's not confirmed.

Huber exposes the pervasive, premeditated neglect and disregard for scientific standards in expert testimony which permit judges to easily clear their court calendars, attorneys for both plaintiff and defense to realize exorbitant incomes, expert witnesses to make very comfortable livings, juries to go home early and insurance carriers to continually raise premiums. And the best part is no one gets hurt, so what could be better for all concerned?

But for every winner there's always at least one loser, in this case the litigation loser plus science's hard-earned reputation for truth and progress. One of the common junk opinions we see in obstetric cases is the plaintiff medical expert witness opining without corroborating scientific evidence that if the defendant had performed a Caesarean section sooner than or instead of awaiting vaginal delivery, the plaintiff would not be permanently disabled/neurologically damaged/dead/etc. Only since the U.S. Supreme Court's 1993 decision in Daubert v. Merrell-Dow has a standard of scientific truth been imposed upon expert witness testimony, and the old "anything goes" system was so popular that even these new more stringent standards may eventually be subverted.

Read the book. You will feel better for knowing that while you may be smart but poor, these guys are rich but dumb. Since junk science not only survived but thrived for as long as it did, there must be a good reason why. Call me when you figure it out. I'm in the phonebook.

THE LITTER BOX

Doug Daniel, Editor

CHANGING THE ANSWERS

The January/February 1999 issue of *ACOG Clinical Review* confirmed something I was told my first year in medical school. You remember what it was like: unmanageable floods of arcane information to be at least temporarily memorized if not understood while fending off the constant threat of failure posed by never-ending evaluations (tests).

One of my fraternity brothers was in his last year and probably at least ten years older than the rest of us, in addition to being married with children. With the benefit of his extra years of life experience and a modicum of alcohol-induced wisdom, one evening he revealed the closely guarded secret to successfully completing medical school. "Don't worry about the tests. They ask the same questions every year and we have an extensive test file here at the fraternity house. The problem is the damn professors keep changing the answers every year."

I was reminded of this advice because the *Review* was dedicated to the ABOG Recertification Examination and covered the articles selected as the knowledge base for its questions. The questions and correct answers were then given with a brief explanation but the remaining incorrect answers were not. Since recertification is voluntary for me and I never bother to do anything unpleasant which I don't have to, I decided to look the answers over just for fun. This little exercise quickly came to a halt when I encountered the following:

Question 4: A sexually active 18-year-old develops her first episode of dysuria. Which laboratory test is usually unnecessary?

Answer: b) Urine culture. Dysuria may occur as a result of acute urethritis from a *Trichomonas, Neisseria gonorrhoae*, or *Chlamydia* infection, as well as cystitis. The presence of microscopic pyuria, positive leukocyte esterase, or nitrate is considered presumptive evidence without necessitating a culture.

I've always thought that unnecessary exposure to antibiotics was not good medical practice, and recent articles in both the lay and medical press have presented reliable evidence that we are now reaping the wind as regards years and years of indiscriminate prescribing of antibiotics. More and more previously susceptible organisms are becoming increasingly resistant to the commonly used antibiotics, especially gram negative bacilli (E. coli and Enterobacter species) in culture-proven female acute cystitis.

Cystitis in females is one of the most frequently overdiagnosed conditions I see in locum tenens clinical practice and reviewing charts. There're just too many other gynecologic conditions which can produce dysuria. When you consider the fact that almost 100% of obstetrician/gynecologists' UTI diagnoses are based upon a "clean catch" urine specimen with or without culture, the situation becomes even more ridiculous.

Although mid-stream "clean catch" collections are theoretically possible in females and research studies have found little difference in analysis of strictly controlled clean-catch vs. catheterized specimens from females, the everyday reality is that few patients bother or know how to obtain a reliable clean catch urine specimen even when instructed by office staff. Such collections are almost always contaminated by vulvar and vaginal flora plus normal vaginal leukorrhea, and even if there is a legitimate cystitis chances are the usual and customary antibiotics will

now be ineffective. Ergo the unnecessary or inappropriate prescribing of antibiotics with its attendant risk of contributing to resistant organisms and adverse drug reactions. (Ever seen a case of toxic epidermal necrolysis? If memory serves correctly it has about a 50% mortality rate and though rare, is one of the recognized risks associated with all the sulfa drugs and their derivatives.)

So I called up my friendly urologist, who has always demonstrated an impressive currency of medical knowledge for someone in clinical and not academic practice. I read him the clinical presentation of a young girl with dysuria. "Arnold, would you get a urine culture?" I asked. "Of course," he replied, adding that he routinely obtained a catheterized urinalysis on all females suspected of having cystitis. If the urinalysis confirmed cystitis, a culture was submitted before instituting antibiotic therapy.

I've asked many urologists this same question over the years as our speciality down-played the necessity of catheterized urinalysis and culture in diagnosis and treatment of female cystitis, and their answer has been consistently the same. I suspect it's the same situation as routine rectovaginal examination, i.e. some of us perceive that our patients won't like us if we do unpleasant though necessary things to them when they come to see us. I personally choose my physicians based upon their attention to detail and thoroughness, not whether they do embarrassing or uncomfortable things to me in the pursuit of an accurate diagnosis and safe, effective treatment.

But the gist here is the difficulty of accurately assessing competence, whether in freshmen medical students or practicing board certified specialists. I'm more convinced than ever that the use of written tests is one of the least accurate methods of assessment for a number of reasons, not the least of which are variations in acceptable practice and medical knowledge literally changing at the speed of light now that we have the internet. Certainly such tests never will be as reliable as an oral examination or detailed chart review by presumably qualified examiners such as we have with the ABOG oral examinations.

Currently state medical boards are requiring the SPEX (Special Purpose EXamination) before granting licensure by endorsement. This written test of general medical knowledge is promoted by the Federation of State Medical Boards of the United States, Incorporated, and it is expected that soon they will require passing the SPEX at regular intervals for license renewals.

There are certainly easily defined standards of minimal acceptable care in medicine, but it is ludicrous to attempt to micromanage practice parameters for purely economic reasons down to the level of whether or not to perform rectovaginal examinations or obtain catheterized urines for analysis and culture. The standard of care for such should be based upon maximum benefit to the patient, preferentially establishing the minimum standard and still allowing or even encouraging practice above that minimum.

THE IMPAIRED PHYSICIAN, Continued From Page 1

What leads me to this conclusion? Our lack of the Navy's commitment to prevention and detection. Don't get me wrong. We have excellent means of treatment and rehabilitation similar to the Navy's damage control systems, fire fighting personnel and equipment, and ship repair facilities. Dan Avery's piece on interventions previously discussed these in detail (The Impaired Physician: Intervention, *The Medicolegal Ob/Gyn Newsletter*, Vol. V, No. 1, January 1997). But most physicians are unfamiliar with available resources and we're sorely lacking in prevention and detection.

First of all we don't acknowledge the potential extent of and consequently the danger posed by the undetermined number of impaired physicians in clinical practice. Nobody we know has a problem, least of all ourselves. The reality is that all physicians, for the very same reasons we decided on a career in medicine and made it through our training, are at risk of addiction. Not only that but we have the keys to the candy store. Additionally there are physicians performing procedures and managing clinical situations who are inadequately educated, trained, and/or experienced plus those physically impaired by other diseases or age. Some learn early to deal with it, some late, some never.

To the best of my knowledge there are currently no truly effective educational efforts addressing physician impairment which reach all clinicians. Many organizations and agencies make laudable efforts, but there is neither understanding of the problem's extent nor the motivation to define it.

What we need first is awareness, just like onboard ship. All officer and enlisted personnel at sea are intimately aware of the dangers posed by hazardous materials (HAZMATS) and fire to them, their shipmates and their mission. Untold hours are spent in educating sailors about these dangers. It is inconceivable that a ship's captain would refuse to provide this information for thinking there would never be an accident or fire on his ship, or perhaps for fearing his crew might not want to hear about these dangers. But some will argue that if we promote and support accurate and reasonable media presentations and discussions of physician impairment everybody will think we're all a bunch of drunks and druggies. I don't think so.

Look at the gains made since AIDS became an acceptable topic for print, television and cinema. Remember those who said in the early '80s there was no reason to be alarmed because only a few people were effected, they deserved their misery, we would be better off without them, it'll never happen to us or ours, and such topics aren't suitable for discussion in polite company anyway? I've never seen the danger in providing accurate and fair information on any topic, but realistic portrayals of compassionate treatment and rehabilitation of impaired physicians by "E.R.", "Chicago Hope" or Robin Cook are rare if not unheard of.

Instead we see occasional portrayals of physicians and nurses ravaged by emotional conflict or drug use who self-destruct, sober up at the last minute to save the world, or perhaps like the denizens of the 4077th MASH guzzle bathtub gin and copulate like randy minks. There was and probably still is the occasional cocktail or sexual escapade to be sampled in the military medical establishment, but in my experience abuse and impairment were no more prevalent there than in civilian medicine. Unfortunately many patients form their perceptions of us based upon "M*A*S*H", "General Hospital", <u>Coma</u> or God forbid "Marcus Welby, MD". I submit it's time to wake-up and smell the coffee regarding impaired physicians, the quality of care they deliver, and its subsequent cost in patient loss and injury. Keep this in mind the next time you're watching Thomas Mitchell's excellent portrayal of the frontier doctor/drunk in John Ford's "Stagecoach".

Next we need a good prevention program to identify those most at risk and encourage them to change dangerous habits or at least be very careful if they continue to work in a hazardous environment. The Navy does this with clear labeling or signing of HAZMATS and dangerous situations in addition to enforced compliance with stringent requirements regarding job performance, obviously after extensive

education and training. So far we have mostly neglected education as a preventative for physician impairment and I'm not aware of any practice or performance monitors currently in wide use to specifically identify potential addicts.

On the other hand, if a sailor is discovered smoking in an unauthorized area or carelessly handling HAZMATS improperly, he is immediately corrected and reported to the chain of command for remedial and/or disciplinary action. We however tend to cover for our colleagues and make excuses for them instead of holding them responsible for their behavior.

I remember back in 1975 or '76 when Joe Pursch came through Guam with his traveling medicine show. He was a Captain in the U.S. Navy Medical Corps plus founder and director of the Dry Dock program at Naval Hospital Long Beach in California, later expanded worldwide. Everyone knew all the military services had long-standing problems with alcoholics, especially among career "lifers". But nothing had ever been done except to discharge those who could no longer be ignored or tolerated. Joe changed all that.

He convinced the admirals to authorize and fund an alcohol rehabilitation program at Long Beach, naming it Dry Dock. He certainly knew how to turn a phrase. Any officer or enlisted could volunteer for treatment or be ordered into the program if involved in a disciplinary action for an alcohol-related offense. Dry Dock was the first alcohol treatment program I ever heard about that wasn't just a place to hide and dry out. Instead there was emphasis on detoxification, counseling, behavior modification, aftercare, monitoring and drug treatment including Antabuse. The first trip to Dry Dock was essentially a free pass; no adverse recommendations in your service record. The second trip when necessary was less forgiving. If you fell off the wagon again you were discharged. Three strikes and you were literally out.

So Joe Pursch came to Guam as a stop on his globe-circling tour of naval bases and brought three of his alumni alcoholics, a line Captain and two petty officers. All the medical officers on island were required to attend one of several presentations offered. I didn't realize it at the time but this was probably the same as an open Alcoholics Anonymous meeting, only by order and not invitation. We heard the three's stories in typical A.A. fashion, and they were truly frightening. Then Joe talked for about thirty minutes on the medical aspects of alcoholism and its special problems in military personnel. At that time interesting, but I thought irrelevant. He made two intriguing comments though.

First he said you should ignore the alcohol (and by inference any impairing factor) in considering how to address a person's unacceptable actions. For instance, a sailor who destroyed a bar while in a drunken rage should be held accountable for all damages and disciplined accordingly instead of the behavior being lightly dismissed as only due to inadvertent overindulgence of alcohol. You shouldn't let people use alcohol as an explanation or excuse for their behavior and its consequences. Made no sense to me then but now it's the basis for the concept of not "enabling" addicts to continue their destructive behaviors.

He also made the comment that you couldn't drink and safely practice medicine. I thought I'd misunderstood him because while chief resident at Bethesda I routinely went to the golf course pro shop's snack bar every Wednesday for a lunch of two chili dogs and a beer, then returned to work. Quite a few of us would stop by one of Guam's many Officers Clubs every day on the way home from work. And you never went to a social function, public or private, where everyone wasn't apparently imbibing freely whether on call or not. One of my colleagues even kept a fifth of excellent scotch in his desk drawer and we not infrequently had a taste after work before heading out for the "O Club". But I knew of no alcohol-related problems among our staff.

I questioned him after the presentation. He hadn't stuttered and meant every word. At the time I thought he didn't know what he was talking about; his position seemed unreasonable and extreme. With more than twenty years experience under my belt I now know he was dead right.

The Federal Aviation Administration (FAA) requires licensed commercial pilots to be without alcohol consumption for at least eight hours before assuming control of an aircraft, euphemistically called "bottle to throttle". The airline companies require twelve to twenty-four hours. I advocate the same for licensed physicians before assuming patient care. Licensed commercial pilots are subject to random urine and Breathalyzer® screening when on flight status. I advocate the same for licensed physicians on call, in the office or in the hospital. There is a "zero tolerance" policy by the FAA and the companies for illegal drug use or blood alcohol concentration greater than 0.04%, meaning that commercial pilots immediately lose their license, are removed from the cockpit, and go directly into rehabilitation if they want any chance of reinstating their commercial pilot's license and keeping their lucrative job. I advocate the same for licensed physicians.

In extending all this to the impaired physician issue, we should do the following:

1. Stop covering unexplained absences or rationalizing therapeutic misadventures while ignoring the potential cause, i.e. chemical, mental, physical, intellectual, and/or technical impairment
2. Take such indicators seriously and always consider the possibility of impairment
3. Be responsible for our own actions and not allow others to avoid responsibility for theirs, i.e. no more cover-ups or advocating the defense of unquestionably substandard medical care
4. Submit voluntarily to random screening for chemical abuse or addiction, additionally supporting required screening for colleagues.

By now you may be thinking, "Yeah, yeah. That's all well and good. But how can you tell if someone's impaired or not?" Glad you asked. First of all assume anyone might be and support random screening. In spite of what you perhaps like to think about your constitutionally protected right to privacy or Big Brother's unwanted surveillance of your private affairs, a recent Associated Press article quoted a January 1996 survey by the American Management Association which found that 81% of major U.S. companies test employees for drugs. This is the highest testing rate since the annual survey began in 1987. Federal law requires random drug screening for 8 million trucking, railway, maritime, airline, pipeline and other transportation workers. Everyone would probably agree that effective self-imposed screening, identification, intervention and rehabilitation along the lines of the ALPA's HIMS program as described previously by Dan Avery (The Impaired Physician: Workplace Drug Testing of Physicians, *The Medicolegal Ob/Gyn Newsletter*, Vol. 6, No. 1, January 1998) is preferable to government-mandated screening.

Next take a realistic look in the mirror. If you think you might even possibly have some type of impairment, seek an evaluation by an addictionologist. This is an excellent example of the old adage that a doctor who treats himself has a fool for a patient. Get professional help. There's also some warning signs but not every case has them.

When I was an intern at Bethesda rotating on medicine I was responsible for the Officer General Medical Ward. One day a Medical Corps Captain, the head of Clinical Pathology, was admitted for evaluation of a peripheral neuropathy in his legs. On physical examination he indeed had multiple sensory deficits involving the lower sacral dermatomes, and he wasn't even aware of some of them. He was well-known and popular among the interns, residents and staff, and everyone hoped for an easily treatable early diabetic neuropathy but feared the worst possible case of a CNS tumor or degenerative disease.

About the third hospital day he became increasingly nervous, agitated, and finally began hallucinating. The neurologist was called to see him again and diagnosed alcohol withdrawal with DTs even though admission medical history had revealed no abnormal alcohol consumption. It was then obvious his presenting complaint was caused by alcoholic neuropathy.

In retrospect it all made sense. He had been hailed as having a "hollow leg" because daily lunches at the Officers Club Captains' Table always included several martinis, possibly doubles, and he would leave looking as sober as when he came in. A search of his office revealed a fifth of top shelf vodka, and an empty pint was found in his hospital room hidden in his luggage.

Everyone was stunned. We saw him every day, worked and talked with him, attended his presentations and lectures, and nobody ever suspicioned he was an alcoholic. We were uneducated about addiction and there were no screens or monitors in place to identify addicts. Admittedly he was not directly involved in patient care, but his decisions effected it. And without successful rehabilitation his career, not to mention his earthly existence, would have ended prematurely. It just goes to show you that the most impaired can be the one you least expect.

But there is a profile for the impaired physician and the danger signs include:

1. Missed days of work or chronic tardiness, especially on Mondays or Tuesdays after Monday holidays
2. Failures of or delays in arrival, or outright refusal, when summoned to attend a patient
3. Presence of alcohol breath when reporting for work or on call
4. Bizarre, volatile, paranoid or argumentative behavior
5. Unexplained prolonged surgical procedures
6. Missed diagnoses, especially on reading histopathology, cytology, EFM, EKG or diagnostic imaging studies
7. Unusually frequent intraoperative complications or readmissions/reoperations for postoperative complications
8. Hospital rounds at unusual hours
9. Nonphysicians such as office or labor and delivery personnel being overused in patient management
10. "Nodding off" during deliveries, surgeries or office visits.

The Committee for Physicians' Health of the Medical Society of the State of New York also adds the following:

11. Unkempt appearance or poor personal hygiene
12. Tremors or slurred speech
13. Bloodshot or bleary sclera
14. Unusual number or character of patient and nursing complaints
15. Irritability, depression or unusual mood swings
16. Irresponsibility, poor memory or evidence of impaired concentration
17. Unexplained accidents or self-inflicted injuries
18. Neglect of family and friends
19. Record of DWI arrest or DUI violation
20. Financial and/or legal difficulties
21. Failure to answer phone or return calls
22. Decreasing practice

23. Missed appointments and unexplained absences
24. Loss of interest in professional, social or community activities
25. Neglect of patients, recordkeeping or medical staff obligations
26. Inappropriate medical treatment or dangerous orders
27. Excessive prescribing of scheduled drugs
28. Unusually high doses or wastages of scheduled drugs in narcotic logs
29. Obvious dependency upon alcohol and/or drugs to relieve stress and facilitate sleep
30. Obvious intoxication at social or recreational events
31. All, most, some or none of the above.

The best state medical board impaired physicians operation I've come across is the North Carolina Medical Board's *North Carolina Physician's Health Program*. They list 46 symptoms or markers of physician impairment by alcohol and chemicals, sexual misconduct, psychiatric disorders, behavioral disorders, and multiple diagnoses of any of these. Not only are their educational materials excellent, so are their identification, investigation and rehabilitation programs. If you're interested in more information about any of their resources, contact the Society offices at the masthead address or call 304-472-8594 and we'll get you a copy of their presentation materials.

So now that you're aware let's assume you've detected a possibly impaired colleague. What should you do? First go back and reread Dan's piece on interventions. Then go to your colleague's immediate supervisor and discuss your concerns. If you're the immediate supervisor, talk to your supervisor. At some point the president of the medical staff or his equivalent will become involved and an intervention can be planned if indicated after consulting the hospital attorney regarding due process issues. Realize that some interventions may result in evaluations which find no evidence of impairment. That's not a failure but a validation of the system. If your hospital bylaws or employee policies and procedures don't clearly establish due process procedures in cases of suspected impairment, start lobbying right now for their inclusion.

If you're lucky there will be a random drug screening policy in effect at the discretion of the president of the medical staff or department heads. If not, refer to the previous paragraph. Realize that such screens will not identify those impaired by mental or physiologic illness, nor will they identify clinical ignorance or poor judgment. Those situations require evaluation by an unbiased and uninvolved psychiatrist, occupational medicine specialist, or medical expert/peer reviewer. The key words here are unbiased and uninvolved.

If the drug screen is positive, the individual in question appears obviously intoxicated or seems emotionally unstable at any time, he must be instantly relieved of all clinical responsibility in order to prevent future harm to patients. This means other physicians must be willing to immediately assume care of his patients and any of their complications, possibly without compensation. There's also a confidentiality responsibility to the suspended individual which can best be served with no explanation or discussion other than he had a personal medical emergency and his colleagues helped him. This does not necessarily apply to a private office practice, which can be covered by locum tenens arrangements until his return, but it seems more a matter of professional courtesy to help out until adequate coverage can be arranged. It also prevents allegations of abandonment.

Dan, Blaine, "Marshall", Tom and Jerry have covered the rest of it. The most important point to reemphasize is that the motivation must be caring and compassionate, not punitive or degrading. Realize that the impaired physician has the same right to confidentiality as any other patient. Don't lie for him, but don't discuss his condition either. Despite any personal or professional conflicts with the individual, scrupulously protect his right to due process and fair

treatment. The ultimate consideration should always be what is best for him and his patients.

AN OUNCE OF PREVENTION: THE IMPORTANCE OF EARLY INTERVENTION

by Andrew W. Watry, Executive Director
North Carolina Medical Board

ABSTRACT: National consumer groups are critical of medical boards because there are only about 2,500 to 4,500 serious disciplinary actions taken annually in this country. Using these invalid parameters to determine board performance and then advocating increased regulation ultimately harms physicians and patients by interfering with efficient function of the boards themselves.

The North Carolina Medical Board exists, first and foremost, to protect the citizens of North Carolina through the medical regulatory process. That is done essentially in two ways: (1) pursuing an effective program of vigilance and accessibility to identify substandard medical practices that violate the Medical Practice Act and, where required, apply appropriate sanctions after full due process; and (2) doing what we can to prevent the problems and medical misadventures that precipitate disciplinary actions. The comments that follow concern the second category.

The principal measure of a medical regulatory board's effectiveness tends to be the number of disciplinary actions it takes. Many national consumer groups and federal government critics tend to rate boards based on a "notches in the gunbelt" standard. Those with the most "serious disciplinary actions" such as revocations, suspensions and formal probations are rated as the best. Those with the fewest such actions are rated as ineffective. The use of one number to evaluate the work of a medical board is a bit like rating the criminal justice system based on the number of executions. This is troubling to those of us that make the process work because we know it is far too simplistic. The number of public board sanctions is a useful indicator of medical board productivity, but taking this single measure and projecting consumer safety in a given state is a big stretch with no relevant data to support it.

If you rate medical boards by the definition of "serious disciplinary actions" used by many consumer groups and federal government critics, the North Carolina Medical Board will seldom stand near the top of the list. We do however have a renowned and highly respected medical culture. People from all over the world come to our specialized medical care facilities. There is clearly a lot more to the medical regulatory process and its ability to protect the public than a simplistic counting of "serious disciplinary actions."

To accomplish our mission of providing optimal public protection we should do everything we can to prevent problems that lead to complaints and disciplinary actions. Even an ounce of effective prevention can significantly reduce the need for heavy doses of "serious discipline."

EARLY INTERVENTION

Each disciplinary action taken by the Board involves an element of human tragedy. There is possible tragedy for involved patients. There is certainly tragedy for the licensee. Imagine the devastating consequences of having your name on the Board's published list of disciplined physicians.

There are many interventions that don't result in public postings of Board action or meet the parameters of "serious disciplinary action" counted by consumer groups and government critics, but are still almost as devastating to licensees. Some are anonymous referrals of chemically impaired physicians to the North Carolina Physicians Health Program, and at a recent meeting of the Board 48 physicians were

asked to appear for confidential investigative interviews to explain possible violations of the Medical Practice Act that did not appear to rise to the level of prosecutable cases.. In many instances such interviews are effective mechanisms for redirecting behavior, although many if not most of those so requested probably lose quite a few nights' sleep.

We provide the best service to the citizens of North Carolina by minimizing, to the extent practicable, those problems and events that lead to disciplinary hearings for violation of the Medical Practice Act while ensuring legitimate violations that do occur are handled appropriately.

The following are some of the mechanisms in place or being developed for early intervention.

Assessment/Remediation: The Board is working on a program that, outside the traditional disciplinary/prosecutory process, would identify practitioners' substandard medical skills before they result in public complaints, removal from hospital staffs, etc. These individuals would be offered the opportunity to participate in an assessment/remediation program that, if successful, would help identify substandard skills through a clinical assessment model and then prescribe remediation through one of our state's medical schools. This follows the model of the North Carolina Physicians Health Program by providing incentives for early identification and intervention before patients are exposed to substandard care that results in disciplinary action. Work is being done in the following areas:

* Improving assessment tools, such as using standardized patients in a sound psychometric environment
* Developing standards of practice for personalized assessment and education programs
* Deciding who pays and identifying funding sources
* Developing sound structured educational and remedial training opportunities through partnerships with schools of medicine, medical boards, medical societies, hospital associations, etc.
* Providing incentives for early identification and remediation
* Creating governance mechanisms.

The focus of this effort is prevention. The Board has provided start up funding for development of an effective program in North Carolina.

2. Improving Referral Sources: Certain referral sources are more productive than others. Physicians or nurses who contact the Board about a peer's suspected substandard practice tend to be reliable. The Board is trying to develop such reliable sources by lowering barriers to such reporting through expanding immunity provisions, meeting with medical societies and hospital medical staffs, meeting with hospital nursing staffs, and improving access to the Board through a statewide toll-free telephone number.

3. Improving Coordination and Monitoring of Marker Information: The Board monitors markers such as malpractice settlements, hospital staff changes, etc. The vast majority of these markers **do not** warrant Board action when individually considered but when evaluated with other markers may point to problems. A physician who resigns three hospital staffs at the same time and subsequently establishes an office address in another location does not necessarily show markers of a problem. A physician however who resigns three hospital staffs at different times in

the same community, maintains the same office address and also suffers a couple of malpractice settlements has markers indicating there may be a problem that needs to be investigated further.

Avoiding Problems: A Few Hints

Now, let me offer some helpful hints in the spirit of helping physicians avoid the problems that may land their names on the disciplined physicians list. Though at least 95 percent of the licensed physicians in North Carolina are conducting their medical practices in such a way that they will likely never be called before the Board, there are things that can be done to minimize exposure, including the following.

* Avoid Professional Isolation: Professional isolation is a recurring theme for physicians who have suffered public disciplinary actions. There are several things that can be done to avoid this including insuring appropriate back-up, affiliating with professional associations and participating fully in continuing medical education. The Board will soon be posting continuing medical education requirements. The value of participation in programs that involve association with professional colleagues cannot be overstated.

* Pay Particular Attention to Communication with Patients: We receive over 600 public complaints a year. The most obvious recurring pattern in these complaints is failed communication between physicians and patients. If the physicians who were the subject of these complaints had been more careful about their communication with their patients they would have prevented a large number of these complaints. My friends in the liability insurance business tell me there is little correlation between bad outcomes, medical malpractice suits and settlements. They do however report a strong correlation between poor communication skills and these suits/settlements. That correlation also applies to patient complaints to the Board. I know an obstetrician who made it through his entire career without ever being sued, largely because he had excellent communication skills. Even when a poor medical outcome occurred, which happens to all physicians at some time, he communicated with patients so effectively and sincerely that they had no inclination to complain about or sue him.

* Submit Your Name as a Peer Review Volunteer: Volunteering to work as an expert reviewer for a medical board has a significant secondary benefit: problems encountered by other physicians can generate a "there but for the grace of God go I" reaction - a healthy learning experience. You would of course receive the same benefit from serving as a reviewer for another entity such as a hospital or medical society complaint committee. I have heard from several physicians including some who serve on medical boards that they have improved their levels of medical practice based upon what they learned as expert reviewers.

* Consider Your Medical License an Important Asset That Needs to be Protected: There are patients that would put your license in jeopardy, for example drug-seeking patients that seek to divert controlled substances. Even Stadol® and Ritalin® have street value. You need to strike a delicate balance between being compassionate while medicating patients appropriately and at the same time alert to those patients that attempt to deceive you. I recognize that this is more easily said than done.

* Maintain appropriate medical records: I mentioned previously that 48 physicians were invited to a recent Board meeting to explain certain events in their practices. Those that had good medical records to explain what occurred—faired much better than those

that didn't. In one of its position statements entitled "Medical Record Documentation", the Board defines what it expects in a good medical record and encourages those who are not familiar with the SOAP method of recordkeeping to study it carefully.

Successful Prevention is Real Success

National consumer groups are critical of medical boards because there are "only" about 2,500 to 4,500 so-called "serious disciplinary actions" taken annually in this country. This variation in numbers depends on who is counting and what is defined as serious action. Regardless of the counting mechanism each disciplinary action can represent a tragedy for one or more patients and the physician named. A great deal of pain can be avoided through preventing such actions by identifying unprofessional behavior or other problems as early as possible and intervening before harm is done. Success in that effort is far more important than numbers of actions or rankings.

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THE MEDICAL EXPERT WITNESS: UNDER THE MICROSCOPE

by David M. Priver, MD

The American Medical Association (AMA) has put physicians who serve as medical expert witnesses on notice. False or dishonest testimony promoting "junk science" will no longer be tolerated. Providing medical expert witness services is now considered the practice of medicine, and professional medical opinion testimony is subject to the same peer review as any other aspect of medical practice. Complaints against medical expert witnesses found to be meritorious can result in disciplinary action including possible loss of medical licensure.

This review process has long been needed to protect our profession's credibility and our patients' access to quality healthcare. Prior to December 1997 there was no true peer review of medical expert witness testimony, but the AMA's meeting in Dallas, Texas, changed all that with adoption of a new policy. A small but significant number of these witnesses made the change necessary by unethically acting as advocates of their employing attorneys' positions, espousing increasingly fanciful and scientifically insupportable theories (junk science). Many have been today's equivalent of the Old West's hired guns, selling their services to the highest bidder and doing whatever has been necessary to neutralize the opposition and win the dispute.

A simple example demonstrates why this action is long overdue. A physician who treated a diabetic in ketoacidotic coma with only intravenous glucose would kill his patient. Such action would also quickly trigger the peer review mechanism to either prevent his attending any more diabetics or educate him in today's evidence-based treatment of diabetes. Prior to the AMA action, had the same physician testified that the appropriate treatment of diabetic ketoacidotic coma was intravenous glucose alone, there would have been no mechanism to prevent his future testimony on such matters.

The noble system of trial by a jury of our peers is a cornerstone of American justice. To render a fair and just verdict, these twelve nonmedical laymen must sort through complex and highly technical conflicting testimony to reach the truth. Recent appearances of dueling experts demonstrate the problem well. Subsequently, these "experts" have directly interfered with our patients' access to care. The Dow Corning cases saw plaintiff medical expert witnesses linking silicone breast implants to any of 80 autoimmune diseases in spite of multiple scientific studies showing no connection between the presence of silicone in the human body and autoimmune disease.

Merrell Dow Pharmaceuticals, Incorporated, voluntarily took Bendectin® off the market in 1983 for purely business reasons. Although previously inexpensive and proven effective for treatment of hyperemesis gravidarum over literally millions of patient-years use, the skyrocketing cost of manufacturer product liability insurance priced the drug out of the market. The liability crisis was the direct result of a few plaintiff attorneys' medical liability suits, a handful of compliant plaintiff medical expert witnesses' unsubstantiated testimony, and their subsequent collusion to associate Bendectin® with minor fetal malformations.

Such malformations have always been seen as existing at very low background rates unrelated to known teratogens, but testimony was given to establish Bendectin® as a causative factor. This was not only unsupported by recognized medical literature, it was actually refuted by numerous studies published in reputable peer-reviewed medical journals.

Merrell Dow put on a vigorous defense and won nearly every case, but in the process sustained massive liability insurance and legal costs. Since Bendectin's® disappearance from the formulary, the incidence of hospitalization for hyperemesis gravidarum has more than doubled in the U.S.[1]

Bendectin® is still available on prescription through Duchesnay, Incorporated, a Canadian pharmaceutical manufacturer, under the brand name Diclectin®. Wholesale price is about $50.00 U.S. per bottle of 100, so cost to our patients would be around $75.00 - $100.00 per bottle if not covered by third party payors. Diclectin® is not available in the U.S. but Duchesnay still manufactures and sells enough product to fill an estimated 34,000 prescriptions yearly.[2]

The prestigious *New England Journal of Medicine* recently addressed the Bendectin® controversy very succinctly:

> "One example of the gap between the perception of teratogenic risk and evidence-based proof of safety is the case of Bendectin. During the late 1950s and the 1960s, this drug, a combination of an antihistamine (doxylamine) and pyridoxine, was the most widely used medication in the United States for nausea and vomiting associated with pregnancy. During the 1970s, many lawsuits claiming that Bendectin was teratogenic were filed against the manufacturer in American courts. Therefore, the drug was withdrawn from the market by its manufacturer in 1982 *(Bendectin® was actually withdrawn from the market on 9 JUNE 1983.[3] Ed.)*, which left millions of pregnant women without a drug approved by the Food and Drug Administration (FDA) for the treatment of nausea and vomiting. The rate of hospitalization for severe nausea and vomiting during pregnancy increased by a factor of 2 in both the United States and Canada after Bendectin was withdrawn from the market.
>
> "The drug was withdrawn despite a substantial body of evidence that the rate of major malformations amoung the children of women who had received Bendectin during pregnancy did not differ from the rate in the general population. Withdrawal of the drug from the American market did not decrease the rate of any specific category of malformation, as would be expected for a truly teratogenic drug estimated to have been used by up to 40 percent of pregnant women at one time.
>
> "In Canada, the drug continues to be marketed under the trade name Diclectin. A review committee has advised the Canadian Minister of Health that the drug is safe. A recent study revealed that severe nausea and vomiting of pregnancy often lead women to terminate or consider the termination of otherwise wanted pregnancies. Other formulations of doxylamine in combination with pyridoxine are available in other countries (e.g., South Africa, Spain, and Thailand)."[4]

Committee Opinion No. 12, November 1995, of the Society of Obstetricians and Gynaecologists of Canada entitled "Guidelines for the Management of Nausea and Vomiting in Pregnancy" also addresses the Bendectin® controversy by stating:

> "Doxylamine Succinate 10 mg, in combination with Pyridoxine Hcl 10 mg (Diclectin), were approved for use in the treatment of nausea and vomiting in pregnancy by the Health Protection Branch of Health and Welfare Canada in 1990. To date, this formulation is the only anti-nauseant approved for such use.
>
> "Health practitioners and pregnant women who are concerned that this drug has the same formulation as Bendectin which was withdrawn from the market in 1983 in the USA after several unsuccessful lawsuits against it should know that in spite of the most vigorous testing of any drug in pregnancy, no evidence of teratogenicity has been found. In fact, the Australian obstetrician who originally stated the drug was a teratogen has been found guilty of scientific fraud in his experiments related to the drug.
>
> "Multiple studies have reviewed Bendectin and concluded that the drug is a safe, effective treatment for nausea and vomiting of pregnancy and that there is no evidence that it is a teratogen.
>
> "Doxylamine Succinate 10 mg, in combination with Pyridoxine Hcl 10 mg (Diclectin) is a delayed release tablet. Most women experience their symptoms in the morning. Therefore, it is recommended that they should start with two tablets at night before bed. If symptoms are not

relieved, one tablet in the morning and another in midafternoon can be added. The dosing regime can also be tailored to fit each woman's peak of symptoms."[5]

The physicians who provided the tainted testimony have never been held totally accountable. And the AMA has finally decided enough is enough. The actual peer review process has yet to be finalized, but will probably be initiated by a physician filing a grievance with his local medical society against a fellow physician. A committee would then investigate the complaint and issue a ruling to include disciplinary action, if any.

Several problems are yet to be resolved. As in litigation matters, jurisdiction of the investigating entity is an issue. Also of concern is adverse action against a medical society non-member or out-of-state licensee. Plaintiff medical expert witnesses generally don't testify within their local geographic area or state, so adverse findings could only be forwarded to the appropriate society or board. Effective discipline without both support and involvement of state medical licensing boards will be difficult if not impossible.

The AMA is encouraging all local medical societies to create expert medical witness peer review programs and is expected to provide the leadership necessary to ensure compatibility between societies. It's the right thing to do. Our profession, our patients, and the medical manufacturing industry have suffered long enough. I commend the AMA's effort, and their initiative deserves the support of government, patients and their physicians.

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Fair and unbiased physician peer review is like mom and apple pie, there's no way to effectively argue against it. The key phrase here is "fair and unbiased". This is obviously why our Society advocates outside peer review by qualified physicians, important for protecting the rights of the reviewee.

That's also why I question the AMA's system of essentially local review. My local medical society hasn't the expertise to do such reviews effectively, especially if you consider the possibility of reviewing criminal case testimony. And while we would all agree it's foolish to provide medmal plaintiff testimony locally, it's unlikely a medical society member would file a complaint against one of his fellow members who had served as his defense expert.

For us, the College is best qualified to serve this purpose. First of all it is committed to maintaining availability of a minimum acceptable level of obstetric and gynecologic care to patients, encouraging members to practice at or above this minimum level, and advocating honest and accurate testimony in all litigations without bias toward sound testimony for plaintiff, prosecutor or defendant. Additionally the College has long been a leader in professional liability issues with an administrative department and committee of the membership which is second to none. And finally the College now has an effective method of discipline to include expulsion. There's an excellent book available on unscientific expert testimony entitled Galileo's Revenge: Junk Science in the Courtroom by Peter W. Huber, and Sid's superb review of it appears in this issue's Book Box on page 10.

Doug Daniel

THE GREAT HORNED DILEMMA

by Doug Daniel

A close personal friend recently informed me he was going to run for election to the West Virginia Senate in the 2000 elections. It was more than a bit of a surprise because he did not appear to have any interest in politics, although on reflection I remembered he had once served as an outstanding mayor. He was retiring from a long and illustrious career as an educational administrator but wasn't ready for the rocking chair and lap robe on the front porch of the Home.

If you don't already know it, abortion has been a hot political issue in West Virginia since before I got here over fifteen years ago, and it is even hotter than usual now with the governor and both houses of the legislature committed to a "partial birth abortion" bill they passed to have taken effect last summer. It was temporarily stayed by order of the federal district court upon a challenge immediately before its effective date.

Although the state's citizens are fairly evenly split on abortion issues the antiabortion segment tends to vote as a bloc on this single issue, ergo the legislature's almost unanimous support of the governor's bill, its defense, and revision/reenactment if necessary. My friend's supporters will probably never bring up abortion in public, but his opposition can be counted on to try embarrassing him with it.

So I thought perhaps I could be of help by giving him some ideas to use as background in preparing for such questioning. Without realizing it I ended up with a statement quite succinctly presenting my own views which may or may not be of help in his campaign. It's printed here not to exhort anyone to change their position or way of thinking on abortion, and hopefully doesn't represent an overinflated ego. But if any of you are better able to reach a conclusion on the issue or answer questions about your position, it will have been worth the effort.

A PERSONAL STATEMENT ON ABORTION

I am opposed to abortion. It is one of the most divisive moral or political issues our country has faced in the 20th century, second only to race in its violence, loss of life, and effect on the election and selection of those we task with enacting, enforcing and interpreting our laws. While our involvement in multiple wars across the globe has exacted an inestimably greater cost in human life, none has lasted as long or posed as widespread a terrorist threat to our citizens here at home. The preceding century was dominated by race and saw the two greatest disasters since men white or black first set foot on this soil, one to be ignited in the extinguishing of the other. God willing, race will no longer be an issue in the next century. Abortion inevitably will.

I staunchly support our Constitution's commitment to "...secure the Blessings of Liberty" by guaranteeing to each and every citizen the rights of privacy, freedom from established religion, and freedom from oppressive government intervention. I also steadfastly believe in our millennia-old Judeo-Christian and centuries-old social precepts establishing each and every person's right to choose how to lead his or her life with regard to religious matters while recognizing the temporal authority of civilian government.

Abortion is a most disagreeable solution to a tragic problem, unwanted pregnancy, and yet for many mothers it is their only acceptable solution. In the United States abortion-related maternal deaths declined from greater than 600 per one million births in 1940 to less

than 10 per one million births in 1974 following legalization of elective abortion. A pregnancy may be unwanted for many reasons including current lack of economic resources , fear of social criticism or ostracism, desire to remain independent, conception by incest or sexual assault, fetal anomalies including those incompatible with life after birth, severe maternal illness, inheritable fetal disease and many more. An unwanted pregnancy can destroy anyone's career, marriage, education, social acceptance or even will to live. It can result in every form of child abuse imaginable including sexual assault and torture. It can change a young life full of joy and happiness into a lifelong existence of seemingly unbearable misery.

These are only a few of the reasons why some mothers always have and always will take any risk including that of maternal death or infanticide to resolve their dilemma of unwanted pregnancy. These risks and results are greatly alleviated by offering as many options to unwanted pregnancy as possible, including but not limited to available effective contraception, adoption, government welfare assistance, social and religious organizations' support programs, and elective abortion. But no matter how extensive the list of options offered the most important factor is the mother's right to privately choose what she believes to be the best option for her without fear of humiliation, intimidation, loss of her future life or its quality, or interference by government or anyone else.

Both the Old and New Testaments speak of two conditions when addressing the existence of life, the quick and the dead. Still today a mother's first sensation of movement by her unborn child is referred to as "quickening", medically recognized as occurring around twenty weeks of gestation from the first day of the mother's last normal menstrual period. Under Mosaic law as recorded in Exodus 21 an unborn child was not considered property whose loss required compensation until it had quickened, and any pregnancy loss before that time, even if induced, was of no legal consequence.

Resolution of this dilemma, if possible, will first require resolution of these two apparent conflicts. There is only a small proportion of our society holding hard-core positions at either end of the issue's spectrum. At one extreme are those who advocate total elimination by government action of all abortions with severe criminal penalties for all nonconformists, while at the other extreme are those who advocate elimination by government action of all restrictions on abortion. The majority opinion lies somewhere between with a very soft middle easily swayed toward either side depending on how the argument is presented, where the line is drawn. Until this majority resolves its moral, social and religious interpersonal and intrapersonal conflicts through intensive individual soul-searching inquiry, discovers what it really believes deep in its heart, and finally takes a firm stand in support of these beliefs regardless of either minority's criticisms or attempts at intimidation, we all will remain impaled on the horns of this beast.

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