

WHAT GOES AROUND COMES AROUND

by **Richard M. Soderstrom, MD, FACOG**

My answering machine brought a chill to my heart when I heard the caller's name. Two years earlier I was an invited guest delivering a lecture to a local medical organization. During the presentation he stood up, gave me "The Finger" with obvious relish and loudly demanded, "Are you still testifying against your fellow physicians?"

His message mentioned a medical case some years ago in which he was the defendant, I was one of several plaintiff medical expert witnesses, and he lost the case. The details aren't important. His attorney had wisely and unsuccessfully advised early settlement. Why was he calling me now? Was I to receive another tongue lashing about physicians who provide case evaluations and testimony to both potential plaintiffs and defendants?

After two days postponing the inevitable I finally called him. "Do you remember me?" he asked. I answered with a hesitant yes and then he said, "I need your help. I've lost my daughter and it didn't have to happen." He then told how his daughter's death resulted from a fellow physician's negligence.

His daughter was 31 years old, happily married and free of complaints on birth control pills, but upon discontinuing contraception to start a family she began having dyspareunia and dysmenorrhea. A year later she had not conceived. Her gynecologist diagnosed chronic pelvic pain and primary infertility secondary to endometriosis without additional evaluation or treatment. A diagnostic laparoscopy was scheduled. She didn't discuss her medical problems with her father because she felt he was too critical of other physicians, and anyway this was a personal matter and her decision.

The surgeon impaled the right internal iliac artery through-and-through with the primary laparoscopic trochar, resultant profuse hemorrhage was not controlled and the daughter exsanguinated. According to the medical records and autopsy report she was mesomorphic and there was no evidence of anatomical anomalies of the pelvis or abdomen. Her husband was later found to be sterile. Her gynecologist testified that the trochar shield was defective and the manufacturer was at fault. His medical expert witness opined that such injuries were reported in the medical literature and therefore a recognized and acceptable risk of laparoscopy.

I asked my caller to send the medical records. After reviewing them I agreed to participate as a medical expert witness in the estate's suit against the defendant gynecologist. The plaintiff's attorney later told me of my caller's personal dilemma. By some bizarre twist of fate he was forced to seek the help of the man whom he previously despised and publicly castigated, and only now realized our first meeting had been precipitated by his failure to meet the minimum acceptable standard of medical care and its subsequent injury to one of his patients.

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THE PRESIDENTIAL BOX

Ray Cestero, President

Hello again from "The Box". While most of you have been enjoying summer vacations your President has been very busy lining up presentations for the upcoming Y2K ACOG Annual Clinical Meeting in San Francisco. As of this writing we are waiting to confirm the availability of two superb speakers, both experts in medical matters, to address subjects of practical importance at the Society's annual meeting Sunday evening and at a Luncheon Conference. We will keep you posted in future newsletters.

After a lot of thought and discussion the Board of Directors recently agreed to implement a modest dues increase in order to meet the financial demands imposed by the production of our *Newsletter*. We appreciate the membership voting overwhelmingly to support this decision while realizing ours are the lowest, most reasonable professional society dues in our specialty and the *Newsletter* alone is worth the cost of annual membership.

A couple of final observations. Other medicolegal newsletters are reporting an increasing number of civil cases in which courts have held HMOs liable in spite of their federal protection under the ERISA preemption. The common denominator has been allegations of injuries caused by substandard care due to the health plans' disincentive policies intended to discourage more expensive, appropriate and complete care by physicians. I believe we will become involved in more and more of these cases in the months to come.

The other issue is also of some concern. These same newsletters now publish "book reviews" of current medical textbooks identifying those containing "medicine a trial lawyer can use", information written in terms attorneys and jurors can understand without basic scientific training. The best ones in the reviewers' opinions are usually those containing "cookbook" treatment regimens, simple diagrams and drawings increasing the chance they will be recognized as "authoritative" by jurors and medical expert witnesses. It behooves us to be aware of this strategy when preparing for testimony and familiar with the trial attorneys' "best-seller" lists. Warmest regards to all. Until the next time,

Ray

THE WITNESS BOX

Doug Daniel, Editor

"While medicine is undoubtedly a science, it is a science in which the scientist is dealing with people and not things."

Charles Horner Greer Macafee, MD (1898-1978)

Irish obstetrician-gynecologist who first advocated expectant management of placenta previa until as near term as possible.

This issue marks yet another milestone in the *Newsletter's* history: this is the first bimonthly issue with publication now going to six times a year. You should notice a considerable slimming effect which is intended to make the *Newsletter* more reader friendly. It was getting cumbersome and inconvenient in size, ergo a lot of people didn't read it. This should help. It will also allow us to comment on immediately pressing issues more quickly. And in case you haven't noticed, we changed the type font to a more professional look on the advice of a real editor of a real magazine. Your comments are solicited.

Your Executive Board met via telephone conference in June and the major items on the agenda were a dues increase, new memberships and renewals, and election of officers. Dues were increased to \$100.00/year effective 1 JANUARY 2000. Although acceptable to the membership according to last year's poll, this increase is only a bandaid solution to a serious problem, i.e. limited membership. We have known from the start that only a large, stable membership roll (≥ 1000) could support the Society and its programs. While garnering new members each of the last four years we have also been losing about 20% of the membership per year through failure to pay dues. Everyone who finds a new member does the Society and the other members a literally lifesaving service, not to mention mailing your own renewal dues check promptly. Notices for dues will go out in November and those paid by 31 DECEMBER 1999 will be listed in the 2000 membership directory. As to officers, Paul Sinkhorn will be our Y2K President, Dan Avery President-Elect and Ray Cestero Immediate Past President.

Another of Dan Avery's articles on impaired physicians has been picked-up and republished by the North Carolina Medical Board's *Forum*, this one entitled "All in the Family" from the Volume 6, Number 4, October 1998 *Newsletter*. If you've forgotten, it's the one about the effects of physicians' substance abuse and recovery on their families. Those Tarheels must think we're really on to something. Along the same lines, the College has formally assured us of its commitment to educating the membership on impaired physician issues in addition to supporting those in recovery. This was evidenced by a letter from Gerry Holtzman, Vice President for Education, outlining the Society's participation for the San Francisco ACM. First of all, the College wants us to continue Caduceus meetings during the ACM even though past attendance has been abysmal at best. They will provide the meeting venue and help with other costs incurred.

Secondly, we have been requested to present a Clinical Seminar on impaired physicians as part of the Scientific Program. This will probably involve Dan picking a specific topic, producing a syllabus and expounding professorially for about an hour with Q&A to follow. We have also been asked to again present Luncheon Conferences on impaired physician topics as at the Philly ACM.

We hit the jackpot when we called Dick Soderstrom recently with an invitation to write a single article for the *Newsletter* on medmal issues. What we got was a pulled triple to the deep right field corner. This month's lead article is the first, relating an unusual though satisfying personal experience. Dick is a graduate of Northwestern University Medical School in Chicago and completed his residency in Seattle at the Swedish Hospital Medical Center. He was Chief of Obstetrics and Gynecology at Fairchild Air Force Base Hospital in Spokane, Washington, during his tour of military service. He has also served as the Medical Chairman of Planned Parenthood-Federation of America in addition to founding and serving as president of the American Association of Gynecologic Laparoscopists. He currently is Clinical Professor of Obstetrics and Gynecology at the University of Washington School of Medicine in Seattle in addition to being a widely published author on topics medical, legal and literary. If you like this one, there's more to come.

This issue's Book Box is by Ben Harer and reviews a guide to surviving the managed care environment by Neil Baum, MD, a widely published author on several topics. It's fair to say Ben's opinion of the book is relatively favorable, and it will be especially valuable to those finishing their residency or just starting practice. There's also a reprint in the back of a recent article from *Physician's Practice Digest* by the same Neil Baum. It's the ultra-short course on managed care; for more buy the book.

Ben also fills this issue's Suggestion Box with his experiences attending the Society of Obstetricians and Gynecologists of Canada's annual meeting last June in Ottawa. One of the conferences he was invited to attend addressed Canada's medmal

problems, so Ben compares their resolution of alleged medical torts and ours. As always, all that glitters is not gold. Our colleagues to the north certainly enjoy some advantages although both judicial systems are founded on English common law. On the other hand, plaintiffs have some advantages not found here. The biggest shock is their drastically lower premium rates and award costs plus the obviously superior integrity of their lawyers both plaintiff and defense.

There's also a reprint of another *Physician's Practice Digest* article in this issue addressing sexual harassment in your workplace, i.e. your office or department. Coming on the heels of our highly acclaimed July issue dedicated to gender discrimination in hiring obstetrician/gynecologists, it stresses your legal responsibilities as an employer to your employees and as a physician to your patients in preventing the perception or reality sexual harassment. The bottom line? Address this potential problem everyone faces with a clear, strictly enforced, written employee policy on sexual harassment before it jumps up and bites you on the butt with an expensive and preventable civil litigation. Be assured responsible businesses are falling all over themselves to develop and enforce such policies. Those irresponsible are paying the price daily.

There's a final reprint from the Oklahoma State Board of Medical Examiners and Supervisors' *Issues and Answers* Volume 10, Number 3, July 1999 entitled "Illegal Versus Unethical" addressing individual physicians' obligation both ethical and legal to report suspected impaired colleagues. While this may sound like ratting out your buddies, the reality is Oklahoma's Administrative Code describes failure to report suspected impairment "unprofessional conduct" and subject to adverse Board action against one's license.

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, \$15.00 to Society members. A new monograph entitled "The Ninth Commandment: Providing Effective Medical Expert Witness" is available for the same price.

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 BOOK BOX

by W. Benson Harer, Jr., MD

MIND YOUR OWN BUSINESS

Take Charge of Your Medical Practice Before Someone Else Does It For You
Neil Baum, MD, with Elaine Zablocki
Illustrated. 422 Pages. Gaithersburg, Maryland: 1996
Aspen Publishers, Incorporated
Hardback, \$63.00

Neil Baum, a solo practicing New Orleans urologist, has written a straightforward, practical manual on how to build and manage a medical practice in today's more competitive managed care environment. Some of his strategies are obvious and most are creative, but recommended blatant sales techniques such as personal promotional videos require a personality and talents few of us possess.

Newsletter readers will probably be most interested in the chapters dealing with effectively practicing medicine under the financial and administrative constraints of managed care. One of the most valuable pieces of advice is to carefully and completely read all contracts including the fine print, securing the services and advice of an attorney. I think it was Abigail Van Buren who said, "Education is what you get when you read the fine print. Experience is what you get when you don't."

I wholeheartedly agree with his advice to act as your patient's advocate with tight-fisted third party payors. This advocacy is what sets us apart from other professionals and justifies our patients' trust. We are morally and ethically obliged to ensure our patients receive proper medical care, and a gatekeeper's or administrator's refusal to authorize payment for appropriate recommended care does not relieve us of that obligation. Baum urges us to meet our patients' needs even if at the cost of nonpayment for our services. Good advice! He additionally describes techniques for minimizing friction in the interpersonal relationships with our patients, referring and consulting physicians, gatekeepers, clerks and administrators. The most effective advice is to educate those within the system upon whom we must rely for favorable decisions, thereby building a more personal and fruitful relationship.

The book is written and organized exceedingly well, flowing in a logical manner and easily accessible for future reference. Recommendations and strategies are equally applicable to solo or large group practices. Clinicians feeling stuck on an unrewarding and frustrating treadmill of managed care incompetence and red tape will find practical advice on how to use the system to establish a more professionally and financially rewarding practice. Unfortunately too many of us have tried to compensate for the demands and restraints of managed care by simply working longer and harder instead of smarter.

But I do have a bone to pick with Baum. He goes to great lengths to stress the benefits of financially rewarding office staff, hospital employees and even patients for new patients and referrals. "The value of a new patient in our practice is \$700 to \$1000, so staff receive 10 percent of that amount as an incentive to refer friends and acquaintances." That, in my opinion, pushes the medical ethics envelope a bit too far. In the event of an adverse clinical outcome or dissatisfied patient with subsequent malpractice litigation, such a policy could become a defendant's worst nightmare, possibly being interpreted as unethical or even illegal and thereby jeopardizing one's medical license.

The above caveat aside, I found Baum's book easily readable, stimulating and a worthwhile blueprint for building a financially viable medical practice in today's rapidly changing world of managed care. Your favorite bookseller can easily order a copy or you can order direct from Aspen Publishers, Suite 200, 200 Orchard Ridge Drive, Gaithersburg, Maryland 20878, 1-800-638-8437, www.aspenpub.com.

THE SUGGESTION BOX

by W. Benson Harer, Jr., MD

During last June's annual convention in Ottawa of the Society of Obstetricians and Gynecologists of Canada (SOGC) I was invited to attend a meeting of their medical-legal committee and afterward a day's seminar entitled "Medical-Legal Obstetrics: Can We Stay Out of Trouble?" The answer was a resounding "No, not as long as there are bad results!" Canadians face the same problems we do, but their solutions are quite different.

They certainly enjoy significant advantages such as all physicians having unlimited medical coverage through the Canadian Medical Association's captive insurance carrier, Canadian Medical Protection Association (CMPA), for a yearly premium of only \$20,000 to \$30,000 US. This eliminates trial conflicts between defendants' various carriers concerned with limiting their own liability. There's also no undue pressure to effect settlement within policy limits since there are none.

Canadians are spared the maudlin histrionics which inundate our courts. "A Day in the Life" videos are nonexistent and jury trials are driven by facts instead of emotions. Canadian society has not adopted our lottery mentality of liability and apparently regards our stereotyped courtroom smoke and mirror antics with disdain, thereby encouraging plaintiffs to seek judges instead of juries as their arbiters. An excellent example of this attitude is the continued availability of Bendectin® in Canada under the brand name of Dicletin® (see "The Expert Medical Witness: Under the Microscope", *Newsletter*, Vol. 8, No. 2, April 1999, page 23).

With CMPA managing all claims, medical expert witnesses are easily checked for shepardizations or inconsistencies in their testimony. Claims can be more easily screened for defense or settlement, and consequently only seven percent are actually tried. Plaintiffs choose whether to have a judge hear their case or request a jury trial, with the vast majority opting to forego the unfathomable jury.

A major difference from our judicial tort system is that both plaintiff and defense attorneys are apparently more concerned with justice prevailing than scoring large financial rewards, probably because there is no contingency fee incentive for plaintiff attorneys. If an independent evaluation finds merit to a case, legal aid resources are available to assist needy potential plaintiffs' claims.

Another difference is while our primary liability in gynecology is failure to diagnose (usually cancer), our northern colleagues' most often involves laparoscopy. Their most expensive claims are vascular injuries. Bowel injuries are more frequent but cost less.

There are also similarities. The major source of claims and the most costly awards both north and south of the border are obstetrical cases with surviving brain-damaged infants, but in Canada these awards run \$1 to \$1.5 million US while ours are much more. Along the same lines, a Canadian intrapartum fetal demise with liability is usually awarded only \$20,000 to \$30,000 US while the same case here can go for five times as much or more. Another similarity is their increasing number of claims involving attempted Vaginal Births After Caesarean Section.

But the grass is not always greener on the other side. In Ontario for instance there is no privileged information. Anything and everything can be discovered via subpoena and is usually admitted in evidence including records and minutes of medical staff meetings, morbidity and mortality conferences, quality assurance proceedings, peer reviews, credentialing files, etc. Hospitals attempt to circumvent such access by only discussing hypothetical cases in their records but sharp plaintiff attorneys can usually apply these hypotheticals to their case.

Another relatively unique problem up north is frequent cross-complaints between hospitals and physicians, obviously benefiting plaintiffs. Residents in training are often sued separately and can fall into an ill-defined limbo where they may be covered by their hospital as employees or by CMPA as physicians.

Medical expert witnesses play a critical role in both systems' medical litigations. The SOGC's medical-legal committee is currently developing a data base with pertinent entries on experts' medical training, experience and testimony. As here, the quality of medical expert witness testimony unfortunately varies widely.

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This little vignette illustrates the problems faced by medical expert witnesses who accept both plaintiff and defense cases. Since we physicians are only human and therefore blessed with both faults and abilities, all of us will occasionally make mistakes. The problem is how to determine when human error falls below the minimum acceptable standard of care expected of a reasonable and prudent physician. It is neither a mere difference of opinion nor a variation in judgment.

Of course the first question is whether to even consider doing medical work. The next is whether to accept plaintiff cases. It's easier if they are from out of state, but even then some highly qualified experts will evaluate plaintiff cases and then refuse to testify in those with merit.

In 1987 President of the American College of Obstetricians and Gynecologists George Morley asked his Committee on Ethics to define the role of the obstetrician/gynecologist as medical expert witness. The Committee realized that without qualified, unbiased medical expert witnesses to provide evaluations and testimony for both plaintiff and defense there would by default be less-qualified "hired guns" providing these services. The following is from their published Committee Opinion No. 56, "Ethical Issues Related to Expert Testimony by Obstetricians and Gynecologists", October 1987.

1. The physician should have current experience and ongoing knowledge in the areas of clinical medicine about which he or she is testifying.
2. The physician's review of medical facts should be thorough, fair, and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant.
3. The physician's testimony should reflect an evaluation of performance in light of generally accepted standards, neither condemning performance that clearly falls within generally accepted practice standards nor endorsing or condoning performance that clearly falls below these standards.
4. The physician should make a clear distinction between medical malpractice and medical maloccurrence. the practice of medicine is a mixture of art and science, and science is a dynamic and changing discipline based to a great extent on concepts of probability rather than on absolute certainty.
5. The physician should make every effort to assess the relationship of the alleged substandard practice to the outcome, since deviation from a practice standard is not always causally related to a bad outcome.
6. The physician should be willing to subject transcripts of depositions and courtroom testimony to peer review.

In compliance with these recommendations I have always been available to both plaintiff and defense. My experience has led me to the conclusion that a large number of potential plaintiff cases can be resolved without even filing suit. By routinely providing services to plaintiff attorneys within the Committee's recommendations I am often contacted by them before suit is even filed. About half these cases do not involve malpractice and therefore never reach a formal filing.

I have also served as a consultant to several medical insurers by providing in-house review of potentially compensable events. There are three basic types of claims: frivolous nuisance claims, those based upon maloccurrences, and those probably involving medical malpractice. It is my opinion, confirmed by insurance claims managers, that across the country each accounts for about a third of all claims. This means that frivolous claims and maloccurrences, 66% of medical suits filed, could be quickly dismissed by qualified medical expert witness reviews. Considering that the same experts could reliably identify those possible negligence cases which were indeed meritorious and assuming carriers would offer reasonable settlements, 75% of medical suits currently being filed could be resolved either by dismissal or settlement without going to trial.

The standard I use in determining whether or not there is medical malpractice is what a reasonable and prudent patient would anticipate of her physician given the degree of common medical knowledge and technical skills expected of a licensed physician at the time of the incident. I also ask myself several questions. If this happened to my daughter could I say it was a known, accepted risk under the circumstances? Even if the maloccurrence was the result of obvious malpractice, did it make a difference in the ultimate outcome? If the answers are no to the first and yes to the second, I take the case as a medical expert witness for plaintiff.

Among one's peers it is more acceptable being a qualified medical expert witness for defense, but a word of caution is appropriate. When working for the defense one can unwittingly become a hired gun. Insurance claims managers prefer experts who consistently provide favorable opinions, but encouraging an aggressive defense only to lose at trial is an expensive venture which only drives up future premiums and thereby increases costs to both physicians and their patients. Our trial by jury system of civil justice is fraught with uncertainty but a meritorious case clearly and concisely presented will usually prevail. In my

opinion any defense attorney would prefer his expert devote equal time to both defense and plaintiff cases, often making that point to the jury.

Agreeing to serve as a medical expert witness demands one also be a responsible witness. Know the case well enough to support opinions with medical literature easily accessible to practicing physicians. Opinions should be formed considering the incident's time frame. Time for dissemination of information should be allowed when practice standards have changed due to evidence-based medicine, and in reality it usually takes up to five years for such changes to reach the prudently practicing physician.

For those just starting to do medical expert witness work, expect an initial insecurity, trepidation or stage fright. This will pass with time and the gratification of helping a meritorious cause will prevail. It's never easy to look a fellow physician in the eye across a deposition table or courtroom and say, "In my professional medical opinion, this physician's care fell below that expected of a reasonable and prudent physician under same or similar circumstances." This too shall pass if your opinions are sound, well-founded and understood by the jury.

My caller's daughter's case was filed, discovery taken, and the matter settled without trial. Each side's position on damages was reasonable. On occasion plaintiff attorneys shoot for a runaway jury's windfall verdict and there is little choice except for the defense to do the best it can while hoping the jury will recognize the unjustified damages demanded and either find for the defense or a more reasonable judgment. Windfall verdicts are more likely if defense experts are perceived by the jury as evasive, failing to support their opinions at trial or stretching the truth. To paraphrase Mark Twain, "If you remember to tell the truth, there is little else left to remember."

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