

SURVIVING MEDMAL LITIGATION

by Richard M. Soderstrom, MD, FACOG

Potentially compensable events are incidents involving unexpected or adverse outcomes which may precipitate claims demanding compensation for alleged injuries or financial losses incurred by patients, their spouses, their guardians or estates as direct or indirect results of healthcare providers' (physicians, nurses, hospitals, corporations) negligence. For physicians this translates as medical malpractice; anticipating such claims is crucial to their defense. By contract, Medmal insurance carriers require policyholders to report all such events under the no less penalty than invalidation of their policy and subsequent lack of coverage for defense of the claim or payment of any settlement or judgment. Abiding by this requirement does not, in and of itself, increase one's premium. Every physician should be well-versed on his reporting obligations to his carrier before signing a policy contract.

All medical and surgical complications are unexpected to some extent, especially by the patients to whom they occur. Even though patients may be informed beforehand that a percentage of similar patients will have certain serious complications as a result of their proposed treatment, they will still wonder if their complication was preventable or avoidable. One flag for a potentially compensable event is persistent and repeated questions by a dissatisfied patient, spouse or parent despite your honest and forthright answers. Another is noncompliant patients including those who sign out of emergency or impatient wards Against Medical Advice (AMA), refuse diagnostic testing or refuse hospitalization. Anticipation means having the noncompliant patient sign an informed refusal or AMA discharge form after appropriate and properly documented counseling.

Effective risk management of a potentially compensable event first of all requires honesty by explaining to the patient what happened, why it happened, how it happened, what must be done and what is the prognosis. Lying, covering-up, evading questions or avoiding the patient especially after referral or transfer only increases the risk of a claim being filed. Next notify your medmal carrier and, if the event occurred in hospital, alert the hospital's risk manager. This allows both to record and evaluate the facts of the case early, not only preserving an accurate record and possibly exculpatory evidence but also determining whether a claim would have merit if filed. Risk managers say meritorious potential claims can be handled much more economically, more efficiently and with more financial benefit to patients if compensation is offered early, sometimes even before a claim is filed. This may involve nothing more than writing-off the hospital and physician charges or it may involve the insurance carriers' financial contribution.

Continued on page 17

THE PRESIDENTIAL BOX

by Paul Sinkhorn, President

IN THE YEAR 2000

It's here. By the time you read this, assuming the world is still spinning, we will have willingly or unwillingly ushered in the new millennium. I am honored to be the first ASFOG President of the new era and would like to thank Ray Cestero and Doug Daniel for their fine efforts in keeping our Society vital and Y2K compatible.

Long-term members will notice the *Newsletter* has expanded and its editorial content improves with every issue. We now publish on a bimonthly basis to keep you better informed of rapidly evolving changes in medicolegal obstetrics and gynecology, and over the next year will make a special attempt to cover the technological and ethical frontiers of our speciality. I plan to discuss the forensic implications of such topics as advanced laparoscopic surgery, prenatal testing, assisted reproduction and cancer diagnosis. We all have opinions on managed care as it relates to medical liability and should freely express them in the *Newsletter*.

Who can dispute the amazing growth of the medical Internet? The California HealthCare Foundation, a division of the California Medical Association (CMA), estimated in its January 1999 report that 43% of adult Internet users searched for health information on-line in 1997. I attended a CMA Leadership Conference in November and heard that up to 80% of Internet searches involve a request for health-related information.

We must recognize the medicolegal dangers of providing advice via the nebulous World Wide Web. I predict sharp growth in claims against Internet medical providers, some of whom already prescribe medications on-line for patients they have never examined, patients who may even reside across state boundaries.

On entering the 21st century we will be called upon to defend or testify against medical practices undreamed of a decade ago. We must face these new issues head-on and become fluent in the language of new technologies already shaping our future, guiding legal thought toward better health for our patients.

Please join me in celebrating the opportunities a dawning millennium engender. Speak to acquaintances in medicine and law. Invite them to join and strengthen our Society. Lastly, please write us with your opinions, complaints, or observations. Controversy should never frighten as long as well-reasoned argument is its currency.

THE WITNESS BOX

by Doug Daniel, Editor

"No one's death comes to pass without making some impression, and those close to the deceased inherit part of the liberated soul and become richer in their humanness."

Herman Broch (1886-1951)

The Society has passed yet another milestone, though this one an occasion for sorrow instead of celebration. Since becoming your editor I have always known that eventually one of our members would die, but we've been lucky the past four years. I also knew on a conscious, rational level that he would be only the first and others would inevitably follow. Herb Hopwood died suddenly 31 OCTOBER 1999 secondary to a myocardial infarction.

Herb had been a member of the Society since 1993 and though we never met, I did have the opportunity to speak with him several times by phone. I wish I had known him better, and this is one reason I look forward to our membership meetings during the ACMs. Those of you whom I've met personally are more than names in a book, and only now am I getting to know Herb through what other people write or say about him. His obituary is on page six.

We gain four new members this month. Lead author Dick Soderstrom is one, Jim Bofill another and Bob Berkowitz still another. You know these three from their introductions in The Witness Box, Bob having been one of the contributors to the *Newsletter's* dedicated issue on gender discrimination last July and Jim writing in November on elective induction of labor in addition to a reply in this month's Mail Box. Jim Cadwallader of Racine, Wisconsin, is the fourth, graduating from the University of Nebraska School of Medicine and completing his residency there. Welcome aboard!

The most dangerous occupations I know are prophet, pundit and seer. Most of those in the Old Testament came to an ignominious end. Frequently one gets blind-sided by the future when daring to prognosticate or predict. I now have only the utmost respect for Jean Dixon, Dionne Warwick, and all their networking psychic friends. Just last month in the Book Box review of Bill Harrison's There is a Bomb in Gilead I opined as how John Irving's Cider House Rules would never be made into a movie because it dealt with the divisive issue of elective abortion and therefore could never be a commercial success. Well, guess what? It came to a theater near you in December starring Michael Caine, but probably only if you lived in a big city. I still doubt Rules will play here in Buckhannon or even in Weston, Elkins or French Lick, but am fully prepared to drive three hours to Pittsburgh if the same little theater near the Pitt campus that showed "The Last Temptation of Christ" runs it. Of course we have a pretty decent video store here and if they don't have what you're looking for, they always try to get it. I'll let you know.

This month's lead article is the third and last in a series by Dick Soderstrom. It gives tips on how as a defendant to get a handle on your next medical suit, beginning even before it's filed. There are also excellent explanations of what's going to happen to you and why, thereby allowing you to anticipate and prepare while increasing your chances of a favorable outcome.

Paul Sinkhorn's Presidential Box debut addresses Y2K and its associated threat via the internet to medicine as we know it. The College recently addressed the dangers inherent in all aspects of telemedicine (ACOG Committee Opinion No. 221, September 1999, "Telecommunications in Medicine") by primarily alerting members to their perceived risks as paid physician participants in both clinical and informative patient interactions, but the risks posed to unsuspecting patients far exceeds the risks to ethical physicians.

We are following the same path taken by our forefathers 100 years ago. Similar to the computer revolution of the late 1990s, the marked and rapid advances in distribution of information and advertising via widely and cheaply available print media during the late 1800s created the quackery of nostrums, patent medicines, and useless medical devices and treatments. Lack of effective certification, licensure and regulation resulted in a level of medical education and practice ranging from deplorable to outstanding. Like our geopolitical western frontier of that era, the practice of medicine and dentistry was wide open and easily susceptible to the abuses of ignorance, charlatans and scoundrels. Years later the reforms precipitated by the Flexner Commission's report and mandatory licensure treated and presumably cured these problems, only to have them now recur like a deadly malignancy, infinitely more dangerous. For more, see the future Book Box reviewing the life of turn-of-the-century serial murderer Thomas Neil Cream, MD.

Paul also clearly defines the route he plans the Society taking during his presidency. One thing always necessary to success is leadership, and we are obviously fortunate to have Paul's.

In this issue's Book Box Ben Harer reviews David Rubsam's Diagnostic Errors in Primary Care: 84 Case Illustrations. Dave's not exactly Stephen King but he can still make your blood run cold by showing how the physician/patient relationship can go terribly awry.

The Suggestion Box this month contains Sid Wilchins's musings on the Society's future, such as it may be. As usual he cuts right to the heart of the problem. Some of his suggestions have already been tried, a few with success. The rest will be tried. The most important point he makes is that some time, some way, some how we've got to get the membership roll up.

The Litter Box this month reviews one of the College's latest publications on induction of labor, somewhat apropos considering Jim Bofill's article last issue and the reaction to it. There seemed to be several changes from past tech bulletins and common clinical practices. If anything, the minimum standard of care seems to have relaxed somewhat and those reviewing cases should be aware of the current recommendations.

Howard Shaw is one of our members on the faculty at UO Health Sciences Center, Tulsa, as is his co-author Julie Anderson. This month they tell us about their training program's experience trying to implement ACGME's requirement for six months of primary care in obstetrics and gynecology residencies. Sounds pretty gruesome as they tell it, but judge for yourself.

I guess I just don't get it. Back when I graduated from med school everybody had to complete an internship before they could get a Georgia license. Uncle Sammy's training programs gave you few choices, but mine was for a rotating 0 internship with three months surgery, three months medicine, three months ob/gyn, two months peds and one month in the ER. I learned a lot, mostly what colleagues were going to be doing to my patients and how to at least carry on an intelligent conversation outside my speciality. There was also the benefit of being able to sometimes diagnose conditions and illnesses I couldn't treat but could appropriately refer.

Ob/gyn residencies at that time were three additional years, and somehow my attendings managed to get me up to speed technically and academically within that allotted period. Now the internship is gone, probably forever. The residency has expanded to four years and our specialty's knowledge base has expanded exponentially, not to mention the additional diagnostic and manual skills required of today's graduating residents, but somehow we're failing to teach them the things they need to know to be at least adequate specialists in obstetrics and gynecology. Instead we waste valuable training time on the things nurse practitioners and physician assistants do in most busy clinics. I personally think we should go back to the future and re-institute the old one year internship, giving the future specialist an opportunity to test the waters in other fields of endeavor and develop a minimal working knowledge of their practice. Those desiring further postgraduate training, either as specialists or generalists, could use this year's experience to choose and apply to residency programs more likely to meet their expectations. At the same time it would probably be wise to take a good dose of reality and keep the four year residency, but sans requirements for primary care experience. Then again, I could be wrong.

Jerry Weinberg has written for us before and I'm confident he will again. This time he relates his personal experience with the money monster. Jerry and his partner sold their practice to their hospital in what at the time seemed like a sweet deal with money and security for everyone, a win-win situation. But like Dad used to say, "If it seems too good to be true it usually is." The honeymoon was over fairly quickly, eventually becoming the marriage from Hell. Unlike Dr. Faust, Jerry and Milt were able to reclaim their souls and start another private practice all over again. Makes for interesting reading.

There's also another reprint this month from *Unique Opportunities: The Physician's Resource*, this time written by Neils Kronborg Andersen and addressing the changing physician employment environment. He's a consultant in healthcare administration, practice management and physician compensation in addition to working with practice acquisitions and physician recruitment for Sacred Heart Health System in Pensacola, Florida. Until recently managed care entities, multispecialty clinics and hospitals increasingly preferred employing generalist or family practice physicians plus non-physicians to staff their ambulatory and to a lesser extent inpatient care facilities. This seemed an obviously sound business decision since speciality physicians demanded such outrageous and exorbitant salaries. Apparently experience has proved the opposite. Specialist physicians are now thought to provide more efficient care by relying to a large extent on experience and ability, less on expensive and often unnecessary diagnostic testing. Their inpatients also have shorter lengths of stay. I suspect that intelligent and informed patients, those with the best reimbursement programs, prefer direct access to specialists without intervening gatekeepers, not only for diagnosis but also for treatment.

Once again Catherine Canning, Editor of *Physician's Practice Digest*, has graciously allowed us to reprint two excellent articles. This time it's an article on problems currently facing state medical boards and another on recent activity in the ERISA arena.

Oh, by the way. A recent *ACOG Practice Bulletin* (Number 6, SEPTEMBER 1999) entitled "Thrombocytopenia in Pregnancy" mentioned the rare occurrence of drug-induced thrombocytopenia in pregnancy with a list of several known causative agents. There is no mention however of phenothiazines such as Phenergan®, Compazine® and Thorazine®. Apparently all the drugs in this class, especially in oral dosages, can rarely cause acute or delayed aplastic anemia, agranulocytosis,

pancytopenia and thrombocytopenia. I've seen one such case which was fatal to both mother and infant prior to fetal maturity, and since the withdrawal of Bendectin® from the US market many pregnant patients are being exposed to these drugs during the first trimester as treatment for hyperemesis gravidarum.

As usual we encourage submission of letters to the editor, articles and guest editorials for publication consideration. Letters are subject to editing only for space requirements with articles and editorials typewritten and double-spaced. Free reprints of individual past *Newsletter* articles are available to members 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.

IN MEMORIUM:

Herbert Gladstone Hopwood, Jr., MD, FACS, FACOG

14 JUNE 1932 - 31 OCTOBER 1999

On 31 OCTOBER 1999 Herb Hopwood's travels along the broad level of time ended when he died suddenly at his home in Arlington, Virginia. His wife had just welcomed him from a visit with his grandchildren. A few minutes later she found him sitting peacefully in his favorite chair and unresponsive. God must have thought a great deal of Herb to take him like that. We all should be as fortunate.

Herb had been a Society member since 1993 but only now am I getting to really know him, unfortunately by reading his obituaries and talking to his grief-stricken colleagues, employees and friends. God apparently wasn't the only one who held Herb in high regard. Born in Philadelphia the son of a United States Navy Admiral, Herb grew up on the move. His high school years were spent in Washington, DC, with undergraduate education at Franklin and Marshall College in Lancaster, Pennsylvania. During these years he was a class officer and varsity athlete. His medical degree was from Jefferson Medical College in Philadelphia where he was active in the glee club, history society, surgery society and obstetrics/gynecology society, later becoming an active member and officer of the alumni association.

Most of the people I talked with remembered serving with Herb during his years on active duty with the US Navy Medical Corps. During his internship at Oakland Naval Hospital he was Chief Intern, the next year completing the first year of a general surgery residency there. He was then assigned to the cruiser USS Helena (CA-75) and served as First Fleet Medical Officer. After a year at sea he transferred to the obstetrics and gynecology residency training program at Great Lakes Naval Hospital, graduating in 1964 and subsequently serving four years as Assistant Chief of the Department of Obstetrics and Gynecology at Bethesda Naval Hospital. Upon release from active duty he opened a solo private practice in Arlington and remained clinically active up to his death, having served as President of the Arlington County Medical Society and the Arlington Rotary Club. He completed his military career in 1990 as a Captain in the US Naval Reserve.

Herb was certainly a skilled physician and active in community affairs, but also highly regarded as an academician and teacher. He was a teaching fellow in obstetrics and gynecology at Baltimore City Hospital during the late 60s and later a clinical associate professor in the obstetrics and gynecology department of Georgetown University School of Medicine in Washington, DC. He frequently delivered presentations and lectures to lay, nursing and medical audiences in addition to publishing multiple papers in the medical literature. He was a Free and Accepted Mason, Shriner, Elk, Rotarian and avid scuba diver.

Istvan Nyirjesy, one of his close friends and colleagues for years, had the following to say:

"Herb and I were residents at Great Lakes Naval Hospital. He was a hard worker and a loyal fellow-resident. He was well-liked and respected by patients, peers and superiors. Our close cooperation in patient care and teaching residents continued while we were stationed at Bethesda. We both were released from active duty the same day and opened practices in the Washington area. Herb's obstetric practice was one of the busiest in Northern Virginia, including many underprivileged patients. He literally worked night and day with little rest, but maintained a strong devotion to his family and friends. He died suddenly of cardiac arrest following trick-or-treating with his grandchildren. Friends and patients stood in line for over an hour to view him for the last time. We will all miss him."

Doug Daniel

THE MAIL BOX

21 OCTOBER 1999

Dear Doug,

Seldom have I read an article with which I disagreed so vehemently as “Our Little Secret: Elective Induction of Labor” (*The Medicolegal Ob/Gyn Newsletter*, Vol. 7, No. 5, November 1999, p.19). There are two developments in obstetrics that have helped make the life of an obstetrician more tolerable: the increased usage of epidural anesthesia and so-called “elective induction of labor”. At age 56 I have been in practice long enough to have experienced (endured?) obstetrics before these choices were readily available and still deliver 15-20 babies each month. Perhaps the more widespread acceptance of these practice tools will reduce the high rate of retirement from obstetrics at age 50 of many of our associates.

Firstly, since the advent of near universal ultrasound screening in the second trimester the unfortunate occurrence of iatrogenic prematurity is basically of historic interest only. Secondly, I would defy anyone, Prysak and colleagues included, to demonstrate a difference in Caesarean section rates between patients who enter labor spontaneously at term and those who are “electively” induced at 38 or more weeks with a favorable Bishop’s score. Studies showing otherwise have been confounded by the inclusion of patients who start their induction with an “unfavorable” cervix, and no matter which techniques are used always end up with a higher section rate.

Besides the fact that Caesarean section rates should be virtually identical in both patient groups if only appropriately selected mothers are included, there are a number of advantages gained by the induced patient group that are ignored in Dr. Bofill’s article. Patients scheduled for induction start labor with an empty stomach and are psychologically prepared to enter the hospital. Family members can be easily assembled and the entire hospital’s resources are readily available including lab, x-ray and consultants. All involved personnel are awake, alert and not suffering the sleep deprivation so commonly seen in our colleagues. Each mother’s labor is monitored from the very first contraction and, theoretically at least, fetal distress should be detected at its earliest manifestation.

ACOG’s Technical Bulletin lists one of the appropriate indications for induction of labor as “for logistic reasons”. All elective inductions performed in our institution are coded under this indication; it’s hardly a “little secret”. I personally induce every patient in my practice who achieves a term pregnancy and in whom I am able to identify a favorable cervix prior to the onset of labor. In my experience the refusal of induction by a properly informed patient is quite uncommon. I feel strongly that this mode of practice is completely ethical in every respect, and I am confident that my Caesarean section rates plus maternal and fetal morbidity will compare favorably with any of my fellow obstetricians’.

Of related interest, a very thought-provoking pro/con debate was contained in the latest *Ob.Gyn.News* which explored the question: “Should patients be allowed to request an elective Caesarean section in the absence of an obstetric indication?” As a firm believer in patient autonomy I can see no good reason why a patient educated by her physician should not be able to participate in planning her own care. Hopefully she would utilize her physician for guidance but her ultimate destiny should logically be of her own choice.

Terry J. Witt, MD

30 OCTOBER 1999

Dear Terry,

Thanks for your letter. I sent it on to Jim Bofill for the reply below. For my part I couldn’t agree with you more, but with a few caveats.

I hope “universal ultrasound screening” is not routine yet since it’s quite expensive and unless indicated by a suspected or known abnormality, in my opinion unjustified. As I have opined on untold prior occasions, “the entire hospital’s resources” should be “readily available” to every pregnant patient 24/7 or a hospital should not represent itself as a provider of obstetric care. It goes without saying that physician impairment by prolonged duty hours and lack of adequate sleep is a problem not best addressed by elective induction of labor.

In the best of all possible worlds the College would reverse its position against elective induction of labor and leave this a matter strictly between its members and their patients. As for those bean-counting sons-of-bitches who now sign everybody’s

check, it is obviously more efficient to completely staff a labor and delivery suite 24/7 and then manage productivity by admitting appropriate patients for elective induction, thereby maintaining a production schedule with relatively steady patient throughput over all three shifts instead of the prolonged periods of underutilization interspersed with dangerously overburdened facilities and personnel we have traditionally had.

Doug

3NOVEMBER1999

Dear Doug,

I am pleased to respond to Terry's letter. While my manuscript was *in press* the group from Northwestern (Chicago) again demonstrated that elective induction of labor is undoubtedly associated with higher Caesarean delivery rates in nulliparous patients.¹ Terry says he induces every patient in his practice and that these inductions are indicated for "logistical reasons." This is just a euphemism for "elective" induction and the procedure is truthfully performed for the purpose of convenience. I'll wager that he does not counsel his patients regarding a heightened risk of Caesarean delivery with elective induction.. Terry opines that the Caesarean delivery rate should not be higher with elective induction of labor; it is a contention unencumbered by any supporting data. Perhaps someone should remind him that we have moved into the era of evidence-based medicine. If you have no data, then you have no argument.

Terry has bought entirely into "the culture of obstetric convenience." This is so evident that he even proposes elective (unindicated) Caesarean delivery at term. What could be more convenient than that? Unfortunately, that strategy exposes the patient to higher rates of hemorrhage, infection, thromboembolic phenomena, and possibly complications in a future pregnancy whether from placenta previa/accreta or from repeat Caesarean. I think it is like most things in life: Doing what is right is usually more demanding than taking the easy way out.

James A. Bofill, MD

REFERENCES

1. Seyb ST, Berka RJ, Socol ML, Dooley SL. Risk of cesarean delivery with elective induction of labor at term in nulliparous women. *Obstet Gynecol* 1999;94:600-7.

10 NOVEMBER 1999

COMMENTARY

First of all, let me say I agree with everything said so far. Sort of. I'm not all that impressed with Jim's reference from Chicago. Like Dad used to say, "You usually see what you want to see and ignore the rest." When it comes to evidence-based medicine it all depends on how objective your evidence is, not necessarily how good your medicine. I suspect our academic colleagues at Northwestern were opposed to elective induction of labor from the get-go and just needed some numbers to confirm what they already knew to be true. Our private colleagues there were probably, like Simon and Garfunkel, just trying to keep their customers satisfied.

The Chicago study limited its investigation to nulliparous patients (an already dicey group to be electively inducing) either admitted in active labor, for "elective" induction, or for medically indicated induction of labor. Their section rates for elective and medically indicated inductions were the same, 17.5%. That alone should jaundice one's eye. Epidurals increased the risk of section in spontaneous labors in addition to those electively and medically induced, more than 4 1/2 times as often if placed before four cm cervical dilation and about twice as often if after. Duh! More on epidurals later.

Patients "electively" induced included the following diagnoses:

- | | |
|--|------------|
| 1. Elective
(Term, favorable cervix or "impending" postdates) | 88 (61.5%) |
| 2. "Suspect" preeclampsia
(blood pressure less than 140/90 and/or less than 1+ proteinuria) | 9 (6.3%) |
| 3. "Suspect" fetal growth restriction | 12 (8.4%) |

	(no ultrasound documentation of estimated fetal weight less than 10th percentile)	
4.	“Suspect” macrosomia (no ultrasound documentation of estimated fetal weight greater than 4000 g)	14 (9.8%)
5.	Decreased amniotic fluid (with amniotic fluid index greater than or equal to 5)	10 (7.0%)
6.	Other	10 (7.0%)
	History of multiple pregnancy losses	
	Idiopathic polyhydramnios	
	Remote history of genital herpes	
	Paraplegia	
	Gastroenteritis	
	Family history of preeclampsia	
	Successful external cephalic version	
	History of cholelithiasis	
	Infertility with donor oocyte.	

I think we can now bid a fond adieu to “evidence-based medicine” as it just casually ambled out the door.

A lot of questions can be answered by looking at the patients’ service assignment. The private service had 1230, resident service 257 and midwifery service 74 of 1561 nulligravid admissions. All three services “electively” induced a total of 143 patients. The privates “electively” induced 139, 11% of all their patients but 97% of all “elective” inductions; the residents 3, 1% of all their patients and only 2% of all “elective” inductions; and the midwives 1, 1% of their patients and only 0.6% of all “elective” inductions. Now we know where those oddball diagnoses came from.

A total of 271 patients did not have epidurals, i.e. 231 spontaneous labors (45% of all spontaneous labors), 8 “elective” inductions (6% of all “elective” inductions) and 32 medically indicated inductions (11% of all medically indicated inductions). According to the authors, “Women being electively induced declined epidural analgesia less frequently and tended to have a higher mean birth weight.” And therein lies the tale.

In case you’ve forgotten, Bishop’s score evaluates cervical dilation, effacement, consistency, position and station of the presenting part with 0 to 3 points awarded in each category. A total score of 4 or less is unfavorable, 5 to 7 intermediate and 8 to 15 favorable for induction of labor. In the Chicago study’s “elective” induction group there were 21 (15%) whose cervix was less than 1 cm dilated (closed = Bishop’s 0), 89 (63%) whose cervix was 1-2 cm dilated (Bishop’s 1), 30 (21%) whose cervix was 3-4 cm dilated (Bishop’s 2) and 2 (1%) whose cervix was 5 cm or more dilated (Bishop’s 3). As to cervical effacement, 26 (18%) of those “electively” induced had a long cervix (0-30% effacement = Bishop’s 0, 40-50% = Bishop’s 1), 85 (60%) had 50-90% effacement (60-70% = Bishop’s 2, 80% or more = Bishop’s 3) and 31 (22%) had more than 90% (80% or more = Bishop’s 3). “Cervical ripening was used for...21 women (14.7%) in the elective induction group.” Another telltale clue.

“There were no proportional differences between the groups of women experiencing postpartum complications. Neonatal outcomes were not significantly different with respect to the incidence of meconium, Apgar scores at 1 and 5 minutes, UA cord blood pH, and NICU admissions.” That’s sort of a gross endpoint, but all this tempest in a teapot may not really matter after all.

“We found that the total hospital cost of providing care for nulliparous women undergoing elective induction is 17% higher than what is required for nulliparous women in spontaneous labor. This is largely due to the requirement for more labor and delivery resources and more frequent cesarean delivery.”

“It appears that overuse of induction incurs risk. Women classified in the elective induction group in our study included some with a relatively unfavorable cervix who were being induced for indications not associated with fetal jeopardy, for example, after 40 weeks’ gestation but not yet postdates.” Amen, brother.

This may be a statistically valid study with sound evidence, but its basic medicine sucks. In the first place, 97% of the “elective” inductions were private patients and most were for any number of “indications” except truly elective, i.e. me and my patient thought this would be a really neat idea. In the second place, who do you think got almost all those epidurals, the private patients or the resident/midwife patients? In the third place, how can you possibly call these inductions elective when 78% had an unfavorable cervix by dilation and effacement, even requiring cervical ripening prior to induction in 15%? In the fourth place, when has the mean cost per stay and length of stay ever been less on a private service than a resident teaching service?

Perhaps a truly clinically relevant study of this question is impossible. Private clinical attending obstetricians march to a much different drummer than their residents. Unless the world has reversed its direction of rotation recently, residents, salaried full-time attendings and midwives still tend to put off as much avoidable work as possible for the next shift. Therefore they will

never be totally unbiased in selecting outpatients qualifying for admission and real elective induction if they're on call that night. Privates still tend to schedule their unavoidable workload for more convenient times. Therefore they too will never be totally unbiased in selecting patients for real elective induction, instead trying to push the envelope and squeeze one more under the wire.

Perhaps if one experienced, full-time attending in a very busy resident clinic did cervical assessments one morning a week on all patients 38 weeks' gestation or more; then selected those with Bishop's score 8 or better while exercising some clinical judgment; then offered admission and induction to enough selected patients to keep two approximately equal study groups, one electively induced and another allowed to spontaneously labor; then had that night and the next day on L&D so he could personally supervise the inductions, labors and deliveries, we might get some clinically pertinent comparisons.

One last parting shot. The College just released "ACOG Practice Bulletin No. 10, November 1999, Induction of Labor". There's a discussion of some relevant changes in standard of care issues in this month's Litter Box. One thing there isn't is any reference whatever to elective induction of labor, pro or con. The Bulletin does however say this:

"Generally, induction of labor has merit as a therapeutic option when the benefits of expeditious delivery outweigh the risks of continuing the pregnancy. The benefits of labor induction must be weighed against the potential maternal or fetal risks associated with this procedure...

Labor also may be induced for logistic reasons, for example, risk of rapid labor, distance from hospital, or *psychosocial indications* (emphasis mine)."

Well, thanks a lot for that bit of helpful advice. One other thing Dad used to say, "Trust your instincts, they're usually right."

Doug

30 NOVEMBER 1999

Dear Doug,

I didn't intend for this discussion to be the never-ending story, but I hope if you print Jim's response you will include these comments as well. I have reviewed the paper out of Northwestern, "Risk of Cesarean Delivery with Elective Induction of Labor at Term", and am impressed with their conclusions as the data is cluttered with patients few of us would include as elective. In their own words:

"Women classified in the elective induction group in our study included some with a relatively unfavorable cervix who were being induced for indications not associated with fetal jeopardy, for example after 40 week's gestation but not yet postdates."

Comparing these results to those of true elective inductions carried out chiefly for convenience is unfair and misleading.

I was stimulated to review my own data over the past two years to confirm what I intuitively knew to be true. Over this time I performed 357 deliveries. One hundred and thirty one had labor induced and of these there were an even 100 for convenience only, equally divided between primigravidas and multiparas. In this subgroup, five Caesareans were performed, three at full dilatation for failed forceps delivery and two at five centimeters for CPD/failure to progress. Four of the infants were of normal size and one had unrecognized fetomegaly. All the surgical interventions occurred in primigravidas.

It would be difficult for me to believe the outcome in any of these five patients would have differed had they spontaneously labored. With this evidence in hand I plan to continue to offer elective induction of labor to selected patients. They will not be counseled on a "phantom" increased risk of operative delivery. The latest issue of *ACOG Today* interestingly mentioned a planned review of this subject next year in a new technical bulletin.

Regarding offering patients elective Caesarean section, the relative outcomes both maternal and fetal, costs, etc. will remain speculative at best without solid data from a comparative study which will likely never be performed. Many physicians as well as patients might be surprised by the results if such a study were done.

Finally, an experienced obstetrician in a community hospital may be able to achieve results difficult to realize in a teaching institution with patient care provided by physicians of widely varying skill levels.

Terry

4 DECEMBER 1999

Dear Terry,

Thanks for the letter, again. I congratulate you for doing what we have been asking since the Society first began, i.e. frankly relating our clinical and litigation experience even while realizing it may expose us to future criticism or the remote possibility of repercussions in a medmal case. Unless we do honestly and objectively share this experience, both the good and the bad, fairly with an open-minded discussion among ourselves, no other physicians or patients will profit. This study should be printed in the green journal and if you need some help putting it together, call me.

Back when I was a resident my chairman used to say the definition of a clear thinker was someone who agrees with you. 'Nuff said.

Doug

THE BOOK BOX

by W. Benson Harer, Jr., MD

GRIM SCARY TALES

Diagnostic Errors in Primary Care: 84 Case Illustrations
David S. Rubsamen, M.D., LL.B.
Unillustrated. 218 Pages. Hercules, California: 1999
Professional Liability Newsletter, Incorporated
Hardback, \$29.00

“This book analyzes 84 medical malpractice cases arising from diagnostic errors. These are cautionary tales, illustrating the problems that arise when we are too busy, or continuity of care is lost, or a normal part of a diagnostic evaluation is slighted, and so forth.” So begins this must read book in which Dr. Rubsamen concisely presents 84 medical malpractice liability suits involving diagnostic errors by primary care physicians and their paramedical employees. Like Grimm’s Fairy Tales or Aesop’s Fables each anecdotal case study is a short story, but with the same recurring moral: “There, but for the grace of God, go I.” In keeping with this comparison, a better title would have been Grim Scary Tales.

The practice of evidenced-based medicine allows no place for anecdotal reports, but they are the most efficient way to teach physicians risk management and reduce their medical liability. The first chapter covers the basic legal terms and concepts relevant to medical actions, including the author’s statement that the applicable standard of care by which an individual defendant physician is judged is whatever the medical expert witnesses in deposition or trial say it is. Rubsamen calls it “...a pragmatic concept, decided case by case.” Also explained is physician error:

“Recall that the physician’s error cannot be automatically equated with negligence. If the doctor makes the mistake ‘carefully’ (i.e. lives up to a hypothetical due care standard in all aspects of the management of the case), then the mere fact of an error does not ring the bell for the patient-plaintiff. Thus, when an ‘understandable’ error is combined with evidence that the doctor is caring and conscientious, one may well have a defensible case...(T)he doctor’s attention to the patient (may reinforce) the jury’s favorable impression gained from his appearance on the witness stand.”

Each case study can be easily read in only a few minutes, making Errors ideal for bathroom, bedtime or lunchtime reading, but the topics merit more detailed consideration. There are instances of failure to report, review or record diagnostic results or consultations coinciding with the onset of rare diseases, thereby raising questions of negligence and causation. There is a case involving a false negative newborn PKU test which results in delayed diagnosis of preventable permanent mental retardation due to phenylketonuria even after developmental delays become obvious. There are several cases in which failure to repeat another’s recent physical examination or reconsider their diagnosis results in untreated serious conditions, even easily preventable death. And of course there are those reflecting the well-recognized consequences of not routinely performing rectal examinations even in cases of acute abdominal pain because the physician and/or patient see them as embarrassing, distasteful, unnecessary and/or uncomfortable (See “Routine Rectovaginal Examination: Good Economics vs. Good Medicine”, *The Medicolegal OB/GYN Newsletter*, Vol. III, No. 2, November 1995).

Rubsamen also goes further regarding physician responsibility for patient failure to follow recommendations. It is his opinion that “...it is best to make the appointment (with a consultant) while the patient is still in the office. Where consultation is urgent...particularly where it is known the patient has been poorly compliant in the past, the secretary’s follow-up call will be a final precaution.” Good advice for improving the defensibility of unforeseen medical cases.

The devil is in the details, and many of these cases hinge on deficiencies in care you will recognize as occurring all too frequently in our contemporary practice of medicine. Most such errors don’t significantly injure patients, which is fortunate for both patients and physicians. Running a stop light doesn’t usually produce an automobile accident, but when it does there is almost no defense to excuse liability for the resulting losses, injuries or deaths.

Only about fifteen of these studies involve obstetrician/gynecologists, but all teach valuable risk management lessons in office operation and medical practice. Of particular relevance are those involving physicians’ failure to communicate with their patients, consultants, employees, nurses, and diagnostic services such as clinical laboratories and imaging departments. Special emphasis is given to the repercussions of paramedical personnel evaluating and diagnosing patients without clear representation

of their non-physician status. The most costly of all are miscommunications between physicians themselves. Rubsamen compares these communication glitches to opportunistic infections, gaining entrance at vulnerable points in the system.

I present one of these cases to my residents and medical students once or twice each week as an educational enhancement. Those in training exist in a sheltered medical environment due to their attendings' required supervision and assumption of liability. I think we should show these neophytes the pitfalls of independent medical practice before we throw them to the lions.

Although these cases are compiled from Rubsamen's *Professional Liability Newsletter* and therefore mostly come from California, any physician anywhere can learn from them and thereby decrease his medical liability or increase his defensibility. The same argument holds true for the fact that most of his reported cases involve managed care institutions, realizing the high penetration of California by such schemes and their problems with refused certification/authorization of physician-recommended care, overutilization of underqualified personnel, physician disincentives for proper care and work overload. At \$29.00 a copy Errors is an unequalled bargain, and a whole year's subscription to *Professional Liability Newsletter* is only \$49.00.

For your own copy or subscription you can reach Rubsamen at:

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THE SUGGESTION BOX

by Sid Wilchins

ON DIMINISHING RETURNS

For the first time since its inception our organization over the last year suffered a decrease in membership. During this time we continued to pursue our two major areas of interest and involvement, impaired physicians plus forensic obstetrics and gynecology. The Impaired Physicians Program has achieved remarkable gains and continues to find acceptance, especially at the College offices. Our forensic activities however have seem to have fallen on hard times. In view of the fact that our slight dues increase is both moderate and tax deductible, I must assume there are other causes for our loss of members.

A number of the Society's original functions have been assumed by the College's Committee on Professional Liability, perhaps eliminating some Fellows' motivation to join our happy band. Renewed interest in the Society might result were we to offer our expertise to the College, specifically for peer review by objective evaluation of medmal depositions and court testimony in grievances filed against medical expert witness Fellows. We could also play a role in the College's programs already providing educational and support activities to Fellows faced with defending a medmal suit. Certainly our core membership should be recognized as a valuable asset in the College's efforts to influence federal HMO liability legislation. Prospective members need a good reason to join the Society. Apparently we aren't giving them one.

I suggest we first contact the College executive staff and request a more active role in the Committee on Professional Liability. Strengthening our relationship with the College should make recruiting new members much easier. Your comments would be appreciated.

THE LITTER BOX

by Doug Daniel

INDUCTION OF LABOR

The College recently mailed "ACOG Practice Bulletin Number 10, November 1999, Induction of Labor" and there've been some interesting changes from what I considered standards of care. For those of you reviewing cases this may be a relaxation of accustomed requirements for cervical ripening and induction of labor with oxytocin and prostaglandins. There may be others, but these were the changes I noted.

1. Prostaglandins and mechanical dilators such as laminaria or Foley catheter balloons are the only recommended agents for cervical ripening. Pitocin® is specifically listed with several currently investigational agents as "safety and efficacy...unclear".
2. Induction of labor is acceptable in patients with one or more prior low-transverse sections, breech or floating presentations, and multiple gestations.
3. Patient evaluation via cervical and pelvic assessment plus determination of fetal size and presentation still should be performed before ripening or induction is initiated, but not specifically by a physician. The only requirement for physician attendance during induction is that "a physician capable of performing a cesarean delivery should be readily available", whatever that means.
4. Pitocin® induction may be initiated as soon as 30 minutes after removal of Cervidil Inserts® (dinoprostone, prostaglandin E₂, 10 mg, Forest Pharmaceuticals) but must be delayed at least six hours following insertion of Prepidil Gel® (dinoprostone, prostaglandin E₂, 0.5 mg, Pharmacia & Upjohn Company) or Prostin E₂® suppositories (dinoprostone, prostaglandin E₂, 20 mg, Pharmacia & Upjohn Company). Neither Prepidil Gel® nor Prostin E₂® suppositories is controlled/sustained release as is the Cervidil Insert® (~ 0.3 mg/hr x 12 hrs).
5. Use of misoprostol (PGE₁, Cytotec Tablets®, 100mcg, Searle) for cervical ripening or induction of labor requires "further studies". [Cytotec is not FDA-approved for ripening or induction and is clearly labeled as contraindicated in pregnancy, primarily due to its action as an abortifacient in addition to possibly causing congenital anomalies, fetal death and premature closure of the fetal ductus arteriosus. Thus some would characterize its use in these circumstances as "off label", others as "experimental" and still others as "contraindicated". Mifepristone (RU 486) is also mentioned as "suitable" for induction of labor but is at this time truly experimental and not otherwise approved or available for any use in the US. Arthrotec tablets are another Searle product containing misoprostol but in combination with diclofenac, another NSAID. ed.]
6. Both PGE₁ and PGE₂ may be used to induce labor in the presence of premature ruptured membranes (only at term) although there is no FDA approval for their use without intact membranes. See above.
7. Although some investigational centers use prostaglandins for ripening outpatients, "PG preparations should be **administered at or near** the labor and delivery suite, where uterine activity and fetal heart rate can be monitored **continuously** (emphasis ed.)." Monitoring may be discontinued and the patient transferred elsewhere to a lower level of care (?discharged?) as soon as thirty minutes following administration of PGEs "if there is no increase in uterine activity and the fetal heart rate is unchanged after this period of observation." The exception is the Cervidil Insert® which serves a controlled, sustained release function. Therefore continuous monitoring should be utilized, presumably in or near the labor and delivery suite, throughout the time it is present in the vagina and for fifteen minutes following its removal, assuming no contractions and stable fetal heart rate. The insert should also be removed with the onset of labor. "Larger controlled studies are needed to establish an effective and safe dose and vehicle for PGE₂ (Prepidil Gel® and Prostin® suppositories) before application on an outpatient basis can be recommended. However, outpatient use may be appropriate in carefully selected patients." Not much help there unless "carefully selected patients" is a euphemism for investigational trials.

8. Infusion rates of Pitocin® for induction of labor may range from an initial low-dose regimen of 0.5 mU/min to a high-dose regimen of 6 mU/min [0.05 cc/min or 3.0 cc/hr to 0.6 cc/min or 36 cc/hr of a solution containing one amp (10 units, 10,000 mU) of Pitocin® per liter]. Increases of 1.0 to 6.0 mU/min may be made every 15 to 40 minutes.
9. “It is imperative that a dilute oxytocin infusion be used even in the immediate puerperium.” No more “one amp IV push and one IM” at delivery.
10. Cervidil Inserts® cost \$165.00 each, Prepidil Gel® kits cost \$75.00 per dose, Cytotec® tablets as little as \$0.36 each.

SURVIVING MEDMAL LITIGATION, Continued From Page 1

Document the circumstances and your decision-making process in the medical record as soon as possible and, if necessary, in a more complete and detailed memorandum to your personal attorney. Redictation or delayed dictation of history and physical examinations, operative notes, delivery notes, progress notes or discharge summaries is automatically suspect. **NEVER ATTEMPT AFTER THE FACT TO ALTER ANY MEDICAL RECORD OR DOCUMENT!** Such alterations are usually discovered and can make litigation of a defensible case impossible.

Immediately notify your insurance carrier if served either by mail or in person with a Complaint, Declaration, Declaration of Intent to Sue, or Summons whether or not you provided notification of the potentially compensable event. An Answer is usually required to be filed with the court clerk by your personal or carrier-appointed defense attorney within 30 days of service, and you will have to support these positions for the rest of the trial process. This is a good time to consider securing the services of a personal attorney in addition to your carrier-appointed attorney.

A personal attorney is especially important if you sense more than an "arm's length" relationship between your carrier and your appointed attorney. The addition of personal counsel acts as assurance there will be no unrecognized conflicts between your best interests and those of your carrier, especially when co-defendants are represented by the same insurer and a common defense strategy becomes economically sound for the carrier but possibly disastrous for you. Your personal attorney should be well-qualified and experienced in medical malpractice and dealing with medmal carriers. Good plaintiff attorneys frequently make the best ones but it must be someone respected by the carrier. Check with your state bar association or American Trial Lawyers Association (ATLA) chapter.

Do not try to negotiate a settlement directly with the plaintiff patient. All contact between you and your patient regarding her claim should be through your respective attorneys. Although rare, it is not unheard of for a plaintiff to expect to remain your patient after filing suit or even winning a judgment/settlement against you. If you do not wish to continue the patient/physician relationship, contact your attorney for advice on how to avoid further claims of negligence through abandonment.

Keep a copy of all legal documents you receive and forward the originals to your attorneys. With rare exception all verbal and written discussions of the event are discoverable in court unless between you and your attorneys, so be very careful what you say or write to anyone else including your carrier. In some states correspondence to your insurance carrier is discoverable, in others not. Requested reports should be completed truthfully and promptly returned. Maintain a file separate from the potential plaintiff patient's medical chart for all correspondence or records of conversations with your attorneys; otherwise they will be subject to discovery.

Promptly provide complete, legible copies of any patient's medical records upon receiving a properly executed request, more especially for those identified as potentially compensable events. Never provide your original office records unless subpoenaed by the court. Record copies may be personally handed to patients while present in your office or mailed to their requested address, usually at no charge. Provision of medical record copies to others, especially attorneys, may be accompanied by a reasonable charge which in some jurisdictions is recognized as up to \$1.00 per page. Do not provide record copies or discuss outpatient care or diagnoses with anyone except your attorneys, including your medmal carrier and the hospital risk manager, until so instructed in writing by your patient or a claim is filed. An extra bit of advice is to always check the patient signature on the release of or request for medical information form against a specimen of the patient's signature on file in your office. Assume nothing.

Always be honest and open with both your carrier and attorneys. Early on tell your attorneys if you legitimately feel your care fell below the minimum acceptable standard, but first review the relevant medical literature. It may confirm your suspicions or not, but if you progress to the discovery portion of a trial it will become necessary for you to give deposition and possibly trial testimony to justify your care. All defense attorneys have frequent nightmares about clients who have withheld information or misrepresented facts. When later confronted with the truth in court, as is the case almost without exception, the damage may be irreparable. Both defense and plaintiff attorneys have a saying; "Your case never again looks as good as the first time you saw it." This implies that almost anything, no matter how embarrassing or detrimental to the case, can be represented more favorably if known in advance.

Always remain calm and avoid expressions of hostility toward the plaintiff, other defendants, or the attorneys, more especially in deposition or at trial. Keeping your cool is one of the most important contributions you can make toward your defense.

While you are expected to be at least civil to plaintiff attorneys, it is vitally important you have confidence in and a sound working relationship with your defense attorneys. Determine if they are experienced in medical malpractice defense and decide if they are willing to learn the medicine necessary to successfully defend you. Check their personal and their firms' professional reputations with other attorneys you know and respect. Be sure they are reasonably available to your phone calls

and requests for meetings plus receptive to your suggestions on managing your defense. If you can't view your attorneys favorably via these criteria, notify your carrier and demand a replacement or replace your personal attorney. If the carrier refuses, consider suing them for not meeting the contractual obligation imposed by their policy to provide you a proper defense. This is why you pay hefty premiums.

You have certain responsibilities as a defendant. Always be available, cooperative and an active participant in your attorneys' attempts to manage your defense. This includes making time to:

1. Assist in answering plaintiff interrogatories
2. Perform medical literature searches
3. Assist in identifying and securing medical expert witnesses
4. Assist your attorneys in understanding the medical issues of the case by reviewing the medical records with them plus explaining your rationale for the proposed treatment, other alternatives available and your method of securing informed patient consent
5. Research and evaluate plaintiff medical expert witnesses' prior testimony, publications, and testimony in your case
6. Most importantly, prepare for and punctually attend all depositions and trial.

Your attorneys also have certain responsibilities such as keeping you currently informed and up-to-date on developments in the litigation while preparing you for your next role in the process. Defense and plaintiff strategies should be explained to you and discussed in detail. The credibility of you and your medical expert witnesses must constantly be evaluated and critiqued. Prior similar cases in your jurisdiction require research and discussion with you.

Settlement should always be considered as an option from the initial occurrence of the potentially compensable event until the final jury verdict. Far more meritorious cases are settled than tried. Factors to consider are your non-recoverable costs including income-generating time lost in trial preparation, deposition and trial in addition to the non-financial adverse effects of a plaintiff verdict such as personal and family emotional distress, damage to your professional reputation and credibility with colleagues and potential new patients, and increased risk of current or past patients filing similar suits. If it is in your best interests to settle, your attorneys are obligated not only to mention the option but also to persuade you to accept. They must be sure you understand the possible adverse financial consequences of refusing offered settlement such as being personally responsible for a judgment or award in excess of the recommended settlement amount. Be realistic and objective when considering settlement while relying heavily on the advice of your personal counsel.

Settlements must be reported to the National Practitioner Data Bank including the names of all defendants in the initial Complaint, and it's your responsibility to be sure the information reported regarding you is accurate. There is an appeals process for amending Data Bank information but the time window for such appeals is limited. Your attorneys can advise you and assist with any appeals.

There may be many unfamiliar events and processes occurring during litigation. A Request For Admission of Facts by either plaintiff or defense proposes one or more statements which, if agreed upon as undisputed fact by both sides, streamlines litigation by removing the need to argue and prove these points.

Except in a few states depositions are a necessary portion of all medical litigation. Some experts feel your deposition is more important to your defense than your court testimony. Mark Twain once said something to the effect that when you tell the truth there's little else to remember if you have to go to court. Although courtroom formalities are absent, your statements under oath are admissible evidence at trial. Adequate preparation is mandatory. This is not simply a trial rehearsal! It's a chance to display your knowledge of the events in question and how you reached medical decisions. Copies of all providers' medical records past and current may be present and you should be intimately familiar with not just yours, but all of them. Tab reference pertinent sections of your copies and highlight passages or sections you may need to find quickly. If the progression of events in question is confusing, prepare a concise timeline or storyboard relating these events to dates, times, days of the week, weeks gestation, days postop, etc. based upon the medical records. Don't withhold facts from either defense or plaintiff attorneys which you intend to reveal at trial as a "surprise". The best possible outcome of your deposition is to convince the plaintiff attorneys by your testimony that their chances of winning the case are slim, thereby encouraging no response to your attorney's motion to dismiss or on a rare occasion dropping the suit after or without an unanswered settlement request.

Don't expect your medical expert witnesses to solely carry the ball on establishing minimum acceptable standards of care. Review American College of Obstetricians and Gynecologists (ACOG) Practice Guidelines, Educational and Technical Bulletins, and Committee Opinions relevant to your case. Medline searches through your local library save trips to the nearest medical school library or at least minimize them. When you find an article or section of a textbook advantageous to either

plaintiff or defense, read it in toto and review its bibliography. Highlight pertinent passages or write a summary and provide these to your attorneys.

When preparing for deposition and trial assume the opposing attorney has researched the medical literature as diligently as you and probably more. You must be prepared to respond to unfavorable articles and make your attorneys aware of these plus the favorable ones. Conduct yourself during all depositions as if you were at trial. Expressions of hostility on your part during any deposition may be introduced to the jury at trial. Actually anything you say in deposition can be read to the trial jury as your testimony unless corrected in the deposition's errata sheet. Your attorneys should prepare you for your deposition with the questions they plan to ask, if any, and the questions they expect from opposing attorneys. Heed their advice.

Be sure you understand a question before answering. Every answer should be preceded by a brief pause for two reasons, to allow you a brief moment to compose your answer and to allow your attorneys a chance to object in an effort to keep the question and your answer from the jury. Answer only the question asked by opposing attorneys; do not volunteer information or try to explain your answers. Do not guess but feel free to answer "I don't know" or "I don't recall." A guess is most likely to be wrong and come back to haunt you later. Don't testify as to hearsay but be factual and straightforward in all your answers without concealing facts.

Refresh your memory by referring to the medical record if necessary. Answers should be couched in layman's terms a jury can understand. Immediately stop or hold your answer if an objection is made. On a rare occasion your attorney may advise you not to answer a question, but usually you have to answer anyway with the judge considering the objection later and deciding whether the jury may hear the evidence in question.

Answers should be concise and given in a clear, confident tone of voice without exposition. If you feel additional information would be beneficial, ask to consult with your attorneys after opposing attorneys finish their questions. Some depositions are taken for discovery and your attorneys may or may not question you on the record at that time. Occasionally depositions of medical expert witnesses are taken for evidence and submitted to the jury either by being read in court or presented via videotape. In these instances there will be direct examination by the employing attorney and cross-examination by the opposing attorney followed by redirect and recross if necessary.

Always reserve your right to review and sign your deposition after transcription and before filing with the court, and remind your attorney of your wishes before the deposition convenes. The court reporter will send you a copy which you may sometimes keep or will be requested to return. There is a limited time available for you to find errors and correct them on the errata sheet, usually 14 to thirty days. If return of the original errata sheet is requested, make several copies and save them for work sheets. Read your deposition carefully, note all errors with their corrections, and highlight your copy as needed. Read all depositions several times before trial and again highlight as needed.

If your case goes to trial there is little more to do other than what has already been discussed. Dress professionally but conservatively and be at the courthouse or your attorney's office early every day of trial, including jury selection. You may have knowledge of a potential juror which will help your attorney in his voir dire, or questioning of potential jurors and deciding which ones to impanel. Plaintiffs usually present their complaints first and you can expect to hear many uncomplimentary things about yourself, some of which may be true and others not. Avoid body language or facial expressions suggesting anger, disapproval or ridicule. Make notes during others' testimony for your own benefit or to discuss with your attorneys later. Do not distract your attorneys by passing notes or making whispered comments when court is in session; it creates an unfavorable impression and annoys the jury.

As in deposition the same principles apply when giving testimony in open court before the jury. Expect to be nervous before and at the beginning of your stint in the witness box, but if you are well-versed in the facts of the case and strongly believe you are innocent of medical malpractice you should do well. This is your best opportunity to relate clear and concise facts regarding your patient care, your knowledge base and your motivation to the six or twelve people who will decide how well you cared for your patient. Tell the story to the jury members as if speaking to each one individually. Look them in the eye and do not use arcane medical terms. Create analogies from everyday experience to help them understand complicated theories or physiologic processes. Do not use your court testimony to tell your story to either the defense of plaintiff attorneys; they already know it. Use your attorney's questions under direct examination as a doorway or springboard to the jury, but limit your answers to the plaintiff attorney's questions. Smile when appropriate but do not make jokes with the jury. Take the proceedings seriously at all times.

A medical plaintiff attorney once wrote, "Any defendant who is an articulate, bright, well-trained physician with a good medical background and tells the truth scares the Hell out of me." Your attorneys will be the best judge of your demeanor and conduct plus your chances of winning the case, so listen to their advice. Seriously consider their counsel regarding settlement even during trial. Be grateful but not smug should you win. There are always lessons to be learned about how to do the same thing better next time.

Whether you win or lose, make an effective, concerted effort to establish what really happened, determine whether there was a human or system failure, decide what corrective action should be taken, and finally do whatever is necessary to decrease or eliminate the chances of recurrence. It may seem the most difficult of these is the last, but without it everything else is simply wasted effort. Perforations of the great vessels are something else. The U.S. medical literature has reported many such injuries since 1977, but a close reading reveals the authors' stressing the importance of strict adherence to standard technique when inserting trochars. As one author states, "For the most part these injuries are preventable."¹ She does not say *all* such injuries are preventable as there are some that are unavoidable, i.e. patients with severe scoliosis altering their vascular anatomy. The defense must clearly explain to the jury why in a particular instance perforation was unavoidable. Simply to say perforations of the great vessels are recognized risks of laparoscopy is not enough.

The following case was settled after discovery was completed. A 29 year-old patient requested elective laparoscopic sterilization. She was mesomorphic and physically fit. At surgery a Verres needle produced adequate insufflation, the primary trochar was inserted, and immediately blood began leaking between the trochar and sleeve followed shortly by hemorrhagic shock. Emergency laparotomy revealed a through-and-through perforation of the abdominal aorta at L₁, two centimeters above its bifurcation. A replacement aortic graft was used to successfully repair the perforation but afterwards the patient was paraplegic. The defendant surgeon was experienced, credentialed for laparoscopic surgery, and testified that consistent with standard surgical technique he had inserted the primary trochar at a 45° angle to the spine. The defense expert, author of a widely-read gynecologic surgery text, could not explain how such an injury could have occurred under these circumstances, but stated it was a recognized risk of laparoscopy and therefore was not below the minimum acceptable standard of care. The plaintiff expert, author of a widely-read laparoscopic surgery text, used anatomical demonstrations to show that given the plaintiff's known anatomy, the injury could not have occurred if proper insertion technique had been used. The settlement was for several millions of dollars.

Which medical expert witness would the jury have perceived to be honest, credible and objective? Would the lay jury have understood the difference between a published complication and a recognized risk? The insurance carrier was not willing to find out, even though the settlement was huge. Some carriers will risk jury trial of cases involving obvious malpractice in the hope that the jury will find for more reasonable damages if plaintiff's settlement demands are seen as exorbitant.

Each medical case has its strong and weak points for both defense and plaintiff. Early in the process, proper litigation management requires all defendants and medical expert witnesses to objectively consider whether physician error might have caused an avoidable injury. If so, early settlement should be actively pursued. Relying on a recognized risk defense can itself be risky business.

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RESIDENCY TRAINING IN PRIMARY CARE

by

Howard A. Shaw, MD, FACOG

and

Julia A. Anderson, MD, FACOG

In January 1996 the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee changed their requirements for residency program approval to provide a total of six months training in primary care. This was to include four months of ambulatory primary care, one of emergency medicine and another of geriatrics. The result of these curriculum additions plus necessary didactic lectures was less resident instruction and experience in traditional obstetrics and gynecology since there was no corresponding increase in residency length. The increased academic burden for our attendings and decreased time on service for our residents produced a noticeable lessening of residents' mastery of standard obstetric and gynecologic knowledge and technical skills.

Six months training in traditional obstetrics and gynecology has consequently been lost to primary care, raising serious questions regarding the short-term effects on our graduating residents and their patients plus the long-term effects on our profession as a whole. Are our current residents receiving adequate training in traditional general obstetrics and gynecology to qualify them as specialists? Is expertise in primary care really useful when most managed care entities will provide neither approval nor reimbursement for these services if provided by obstetrician/gynecologists? What should we cut to meet these new requirements without adversely effecting our primary responsibility to train competent specialists? Will the Committee allow cuts in subspecialty rotations?

In 1996 Laube and Ling¹ reported that 87% of obstetrics and gynecology residents expected to incorporate primary care into their practice within the traditional concept of the screening and counseling we have always provided. Their study preceded the change in Committee requirements and the authors concluded a more recent survey might produce different responses.

The Council on Resident Education in Obstetrics and Gynecology (CREOG) is a nonregulatory organization with representatives from the American College of Obstetricians and Gynecologists, ABOG, American Gynecological and Obstetrical Society, Association of Professors of Gynecology and Obstetrics (APGO), Council of University Chairs of Obstetrics and Gynecology, Canadian obstetrician/gynecologists, plus obstetrics and gynecology residency program directors and residents. We investigated the effect of the Committee's new primary care requirements on our residents by comparing their CREOG examination scores from 1993 through 1998 and reviewing their National Board of Medical Examiners (NBME) scores plus medical school Grade Point Averages (GPAs) as recorded in application files. Results and conclusions were presented at the March 1999 CREOG/APGO annual joint meeting.

All CREOG scores for our residents between 1993 and 1998 were reviewed and divided into two study groups. The first included scores from 1993 through 1995, representing a traditional curriculum prior to the Committee's changes. The second included scores from 1996 through 1998 following the July 1995 implementation of the Committee's new requirements.

Mean total percent score for 1996 through 1998 was 64.08 compared to 67.09 for 1993 through 1995 ($p=.03$). Mean percent score for reproductive endocrinology, gynecology, general considerations, diagnosis, and mechanisms of disease also significantly decreased while other categories were not significantly changed. Mean percent ambulatory care score increased slightly but not significantly. Our residents' overall performance on the CREOG examination suffered with no improvement in their ambulatory care scores.

We also compared mean NBME scores and GPAs among all residents enrolled in our program during the study periods and found no significant differences, concluding residents taking the CREOG examination after the curriculum changes were not academically inferior to those taking it before. We now believe the primary care curriculum requirements have had a demonstrably adverse effect on our residents' CREOG examination performance.

Following these changes our residents have often complained that their new rotations on internal medicine and family medicine consist mostly of triaging patients' telephone inquiries and treating male patients with minimal exposure to female geriatric, internal medicine or emergency department patients. As a result they have lost an opportunity to learn obstetrics and gynecology without gaining increased expertise in female primary care.

These are only initial indicators of the ultimate short and long-term effects of the Committee's decision. Future passage of legislation currently under consideration by the US Congress may encourage all physicians to do what

obstetrician/gynecologists previously did and some continue to do, provide competent speciality care to our patients and refer them when appropriate.

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THE GRASS IS ALWAYS GREENER

by Jerrold H. Weinberg, MD, FACOG

As an employed physician, what are you forfeiting in exchange for the security of a regular paycheck and freedom from managing an office? Fourteen years ago my partner Milton Nathanson and I left the ranks of the self-employed without considering that question. We sold our thriving, busy practice to a local hospital and thereby became employees of its medical practice group.

At first it was a match made in heaven. The medical malpractice insurance crisis of the 1980s was no longer our problem, no more worries about whether there would be enough deposits to cover our expenses and every payday was guaranteed. But the last three years of what became the marriage from Hell were increasingly miserable.

The honeymoon abruptly ended when our employer hospital began losing money due to the proliferation of increasingly constrained managed care contracts, burgeoning federal regulations and restrictions, and growing competition from larger hospitals expanding their market area. Our loyal, efficient office staff assembled over the years was reduced in a desperate effort to cut costs. When more drastic measures were thought necessary, our best employees were transferred to larger practices and replaced by underqualified neophytes. We were finally forced to share our full-time office manager with several other practices.

My heart would literally sink every time I overheard the new receptionist speak rudely to patients whom we had seen for years, who almost seemed like family. It had taken Milt and I years to build our practice. Now it was self-destructing before our very eyes and there was nothing we could do about it.

Almost nothing. Seeing no other reasonable alternative except retirement and not yet willing to pack it in, we at last decided to return to a self-employed private practice model. There followed a large bank loan, a temporary loss of income and a collective sigh of relief, in that order. As of this writing we have been on our own for several months and never happier.

I am convinced that pie-in-the-sky promises of financial security are not worth losing control over the practice of one's profession and the quality of care one is able to deliver. More and more hospitals are finding themselves unable to profitably operate physician practices and some of you may find yourselves bitten by the same dog we were. Forewarned is forearmed, so heed now the voice of experience.

- 0 **THOU MUST AVOID THE NON-COMPETITION CLAUSE:** Most professional employment contracts contain a clause prohibiting the employee from unfairly competing with the employer by practicing within a defined geographic area for a defined period of time after termination of their contract. Courts have found some limits to be reasonable, but a good attorney can usually find a way to contest the contract. See below.
- 0 **THOU MUST KNOW THY PATIENTS:** Keep a separate home computer file of patient names, addresses, diagnoses and surgeries. Contact them if you privatize and invite them to make their next appointment with your new practice. Office charts are the property of your employer, not you or your patients. You probably won't have access to them after you leave unless the patient signs a release of medical information form.
- 0 **THOU MUST KNOW THY MARKET:** Hire an experienced medical marketer to insure you get the most "bang for your buck" from a generous advertising budget. He can help you identify a limited, unique medical niche which is underrepresented in your community. If managed care has contracted with all your competitors, there may be a market for an upscale "carriage trade" practice. Perhaps with some additional training you could become the local superspecialist laparoscopic surgeon, menopausologist or colposcopist.
- 0 **THOU MUST SPEND MONEY TO MAKE MONEY:** Don't undercapitalize your new practice during the start-up phase. Bankers generally welcome physician borrowers who have an established patient base.
- 0 **THOU MUST THINK OUTSIDE THE BOX:** For instance, don't necessarily recruit your new receptionist from other medical offices. A good receptionist is a people person who can function well under pressure and remain pleasant in unpleasant situations. A friend's excellent receptionist worked in a beauty salon before he hired her!

- 0 **THOU CANST GET A JOB:** Your dad was right! If your patient load and cash flow are both limited initially, augment your income by moonlighting as a utilization reviewer, clinic physician, house officer, on-call attending, locum tenens replacement, medical expert witness, etc.
- 0 **THOU CANST CLONE THYSELF:** If you're going it alone, consider hiring a CNM, NP or PA instead of looking for a partner when your practice starts growing. Salary and overhead for any of these can be expensive, but the first three are still cheaper than another physician plus you're still the boss.

If you've never been in private practice the thought may seem frightening, but the key as always is finding good help and keeping them. In order to succeed you need a good lawyer and a sharp accountant plus a competent and dedicated staff, including an honest office manager knowledgeable in medical billing procedures. Several of my friends and I have temporarily employed our spouses, always trustworthy, motivated, interested and wanting us to succeed.

Privatizing can initially be traumatic but the rewards are truly satisfying. Now every time I walk into my beautiful new office I am greeted by a competent, satisfied staff and patients who know the only clock I'm on is theirs. I know Milt and I made the right decision this time.

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