

DOMESTIC VIOLENCE

by Laura A. Queen

Family Violence. Two words which chill to the bone. They should be an oxymoron but they're not, instead describing a problem ravaging society and increasingly becoming a public concern, no longer considered a private matter within only a few families. Battered domestic partners have, like the poor, been with us always but now we count their numbers as legion.

Batterings occur on a daily basis in even the smallest towns. Spouse abuse used to be considered a private matter, a lovers' quarrel soon resolved. This attitude is no longer acceptable because we now know violence between intimates is rarely an isolated incident, instead becoming over time more frequent, more intense, and its resultant injuries more severe even to the point of death.

Women are at the greatest risk of being murdered when attempting to report abuse or leave an abusive relationship. Every year between two and three million women here in American are battered by their intimate partners. Today domestic violence is the leading cause of serious injury to women in the US, more common than injuries sustained in muggings and motor vehicle accidents combined. Approximately 2,000 women die each year as a result of domestic violence, and here in West Virginia a domestic homicide occurs every fourteen days.

At least 25% of female domestic violence victims are pregnant when beaten, and each year approximately 3.3 million children witness violent acts against their mother. Domestic violence is responsible for 15% of all emergency department visits by women, and 28% of women seen in ambulatory medical clinics report having been battered at some time. There are 3800 animal shelters in the United States and only 1500 domestic violence shelters.

Domestic violence is defined as coercive behavior (including economic coercion) plus physical, sexual, verbal or psychological assault committed by adults or adolescents against their intimate partners or other family members. The perpetrator and victim may be dating, married, cohabitating, divorced or separated. Either or both may be male, female, straight, gay, lesbian, young or old. Some perpetrators consistently repeat specific abusive acts while others employ a wide variety of various assaults. The assaults are intended to keep victims compliant under the control of their abusers.

Because physicians are often the first non-family member to become aware of violence in the home, they have a responsibility to protect those incapable of protecting themselves from further injury. They also have an unsurpassed opportunity to provide appropriate, sensitive interventions. Why then have healthcare professionals failed in adequately responding to these victims' needs? The biggest reasons are lack of domestic violence training and long-standing popular misconceptions with their resultant bias and prejudice.

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THE PRESIDENTIAL BOX

by Paul Sinkhorn, President

San Francisco, one of the world's most beautiful and dynamic cities, hosts our millennial ACOG Annual Clinical Meeting (ACM) May 21-24 this year. I hope you will be able to join us for a convention chockfull of politics, clinical pearls, legal updates, surgical techniques and camaraderie. Those of you who have attended past ACMs know how much fun it is to bump into colleagues you haven't seen for years and renew old friendships. There's no better place to reminisce over wine and dinner than San Francisco!

ASFOG will again play an active role in this year's ACM. On Sunday, May 21, at 5:30 PM we will have a get-together for members and prospective members at the San Francisco Marriott Hotel's Pacific Conference Suite H. Our Speaker at that meeting will be Jeffrey Raynes, a plaintiff's malpractice attorney and President Elect of the California Chapter of the American Board of Trial Advocates. Mr. Raynes's presentation, "The Credible Witness", will give us the benefit of his extensive deposition and trial experience. Immediately following at 7:30 PM, ASFOG and ACOG will jointly sponsor a members-only Caduceus meeting in the same room.

On Monday, May 22nd, at 2 PM Dan Avery will present Clinical Seminar MCS17 on "The Impaired Physician". Dan's not only the Society's founder and Past President, he's also a certified addictionologist and a practicing obstetrician/gynecologist.

Previous ACM attendees know how enjoyable the Luncheon Conferences are, and this year ASFOG is responsible for three. On Tuesday, May 23rd, at 12:30 Dan will discuss "Workplace Drug Testing for Physicians", Conference T2. Michelle Curtis from the University of Texas at Houston will simultaneously lead a group considering discriminatory practices in physician hiring entitled "Gender Discrimination in OB/GYN: Are We Guilty?", Conference T7. Finally, our *Newsletter* Editor, Executive Director and Past President Doug Daniel will conduct a roundtable on Wednesday, May 24th at 12:30 PM on "The Impaired Physician: What Do You Do With a Drunken Doctor?", Conference W3.

Strong stuff, but that's what we're all about. Please mark your calendars to be there and bring your friends. Help us to strengthen this unique group.

THE WITNESS BOX

by Doug Daniel, Editor

"Progress occurs when courageous, skillful leaders seize the opportunity to change things for the better."

Harry S. Truman (1884-1972)
33rd President of the United States

The bad news first: we lost 13 dues-paying members this year. One died, two resigned, two opted for honorary membership and eight were dropped failure to pay dues. The good news? We gained eight new dues-paying members in 1999 by inducting eight new members. Six were active and two were honorary, plus two honorary members opted for active status in 2000. We have additionally gained one active and two honorary members so far in 2000. Final answer? We barely managed to hold our own and cannot reduce efforts to attract new members.

Another milestone. The Society is now officially in the peer-reviewed medical literature as recognized by the Index Medicus. Take a look in the February 2000 Green Journal's Letters to the Editor. In an attempt to build our desperately needed membership, I ask all members to consider if at all possible inserting citations to the *Newsletter* or mentioning the Society in any letters to the editor, articles or books they author for either the medical or contemporary media. Potential members who see our name in print and are interested in joining will make inquiries either directly or through the College's liaison office and we need all the help we can get. For information on reference citations from the *Newsletter*, call or write me.

Things are starting to fall into place for the Society's activities at the College's ACM in San Francisco 20-24 MAY 2000. For more see the President's Box. If you know someone going to the ACM be sure to recommend our membership meeting. Ray Cestero has arranged the program with a well-known plaintiff attorney scheduled to speak on how to best conduct oneself as a medical defendant and how to be an effective medical expert witness. Immediately following in the same room from 7:30 PM to 9:00 PM the Society and the College will jointly host a Caduceus meeting for impaired physicians in recovery and again, if you know someone in recovery who is attending the ACM, ask them to give us a shout.

Dan and I will be presenting a one hour Clinical Seminar (MCS17) on impaired physicians Monday afternoon at 2:00 PM using the Society's monograph "The Impaired Physician" for the syllabus. If you've ever been curious as to our esteemed Founder's appearance, take a look at page 13 of February's *ACOG Today*. He's there in living color beside a description of what he intends to cover. There's also a nice piece accompanied by a full-color head shot on the College's incoming President, our own Ben Harer, which notes his 1997 term as the Society's President. The only time my picture has appeared anywhere other than a high school yearbook was beside the *Webster's Collegiate* definition of buffoon. All in all it should be a great ACM for ASFOG.

Oh, by the way. Some of you have at various times asked why there never has been a really good mock trial at an ACM and shouldn't the Society do one. I never had a good answer for either question, but it looks like there may be just such a presentation at the 2001 ACM in Chicago, probably better than anything we could have done ourselves. It's not for sure yet but if you know anyone on the Committee on Scientific Program, ask them about it and show an interest. It couldn't hurt.

"Now hear this! Now here this! All lesbians proceed to the ASFOG office immediately." Before deciding I've completely lost it, let me explain. For quite awhile I've been trying to get someone to write an article or series of articles on obstetric and gynecologic problems specific to lesbians. I only know two who are either out or sort of out and both have turned me down, perhaps because they were shocked that some ignorant, insensitive, inconsiderate testosterone-crazed buffoon (see above) would dare even ask.

Defining lesbian as a woman who has sex with other women either exclusively or in addition to men, at least ten percent or more of our patients fall into this category. Problem is, I never had the opportunity to attend a lecture or read a medical text on lesbian healthcare. Obviously they are at increased risk for certain diseases and relatively low risk for others, not to mention the need to obtain an appropriate history without coming across as some naive and fumbling adolescent. So if any of you have a partner, colleague or acquaintance who is first of all an obstetrician/gynecologist, secondly a lesbian, and to some extent out, please ask them about enlightening the rest of us to the professional aspects of how to treat lesbian patients properly and professionally without unwittingly committing multiple medical and social faux pas.

The College recently published two of its better opinions. The first, *ACOG Practice Bulletin: Intrauterine Growth Restriction*, No. 12, January 2000, is a very concise and well-considered discussion of IUGR which is up-to-date, easily understood and clinically applicable. It contains the latest thought on etiology and therefore negligence or lack of same, plus this is the first time I can remember Doppler ultrasound being recognized as useful in following suspected IUGR. The other is *Committee Opinion*:

Maternal Phenylketonuria, No. 230, January 2000, addressing the almost guaranteed fetal damage caused by untreated maternal phenylketonuria either due to patient noncompliance with restricted diet during pregnancy or obstetrician failure to diagnose and/or treat preconceptionally and prenatally. With the advent of effective neonatal screening and treatment for PKU it should be no surprise that our obstetric patients may now not only pass the gene to their offspring but, if homozygous and effectively treated as a child, severely damage their fetus neurologically if elevated maternal serum levels are not treated.

Remember my admission of incompetence last issue, having incorrectly divined the movie moguls' investment choices by predicting in the preceding issue that The Cider House Rules would never be made into a major motion picture? It was nominated today for seven Academy Awards including Best Picture, Best Supporting Actor, Best Director and Best Adapted Screenplay (by John Irving, the book's author). Please pass the salt, and could I have another serving of that delicious crow?

This issue's lead article is by Laura Queen. I count Laura and her husband long-standing friends and she has been a patient ever since I first came to West Virginia seventeen years ago. They are talented artisans who handcraft beautiful and uniquely useful wooden kitchen utensils from locally grown trees like maple, cherry, walnut and hickory. Unbelievable wedding or anniversary gifts and they ship. She's also Upshur County Outreach Coordinator for WAIC (Women's Aid In Crisis) and he's a coal miner.

Laura is daily on the frontline in the fight against spouse and child abuse around these parts. Not only is she highly motivated in doing her job but she's good at it, helping rescue untold numbers of women and children from all sorts of abuse and then helping them put their lives back together. She's never mentioned an adult male being victimized, but if one ever is I'm sure she'll be there for him, too. Her voice has the ring of truth tempered by experience and she can tell stories that will literally bring tears.

This month she tells us about the Family Violence Prevention Fund, specifically its pilot projects here in West Virginia and a few other states dedicated to providing assistance to victims of family or domestic violence. If there's a project in your state, get to know them. If not, maybe you should start asking why and thinking about how to change that.

As a special lagniappe, Linn Parsons adds a commentary on Laura's article which makes denying its relevance to our clinical practices almost impossible. Linn is an Assistant Professor in the Department of Obstetrics and Gynecology, Section on Gynecology, Bowman Gray School of Medicine, Winston-Salem, North Carolina, and previously was an Assistant Professor in the UNC School of Medicine's Department in Chapel Hill, North Carolina. She earned both her BS and MD degrees at UNC followed by a residency there. During her Junior Fellowship in the College she served as National Vice Chair plus Section, District and National Chairs, afterward Advisor to the North Carolina Junior Fellow Section. Linn is a Reviewer for the *American Journal of Obstetricians and Gynecologists Women's Health Issues*, a member of the National Coalition Against Domestic Violence, and her professional research and writing has addressed intimate violence in addition to many other topics. She has written sections on domestic violence for several major medical textbooks while authoring and co-authoring untold articles with such recognized names as Droegemueller. Not surprisingly, she has been the recipient of several local and national teaching awards. Thanks, Linn.

Paul Sinkhorn's Presidential Box is a pep rally for the Society's San Francisco ACM plans. If your planning on going, check us out. If you haven't decided, we're just one more reason to go. If you're not going, we'll miss you.

In this issue's Book Box I review Steve Klasko's The Phantom Stethoscope. He's currently Chair and Residency Program Director of the Department of Obstetrics and Gynecology at Lehigh Valley Hospital, Allentown, Pennsylvania, plus Professor of Clinical Obstetrics and Gynecology in addition to Associate Chair of the Department of Obstetrics and Gynecology at Pennsylvania State University College of Medicine, Hershey Medical Center, Hershey, Pennsylvania. Previously he was in private clinical practice and an Assistant Professor of Clinical Obstetrics and Gynecology at Hahnemann University School of Medicine. Steve holds a BA with double majors in chemistry and biology from Lehigh University; an MD from Allegheny University of Health Sciences/Hahnemann University in Philadelphia; an MBA from The Wharton School of Business, University of Pennsylvania in Philadelphia; and spent his residency at HealthEast Teaching Hospitals in Allentown. The book's a fun read which might even teach you something. Can't beat that.

Mike Kreitzer, one of our members, ably fills the Suggestion Box this month with his take on the crisis currently threatening to destroy our practice of medicine and healthcare in general as we know them. Mike is a 1962 graduate of City College of New York (CCNY), earned his MD from State University of New York Upstate Medical Center (SUNY Upstate) in Syracuse in 1966, and completed his internship in 1967 at St. Joseph's Hospital also in Syracuse. He then spent 1967 and 1968 in residency training at St. Barnabas Medical Center in Livingston, New Jersey, and Newark City Hospital. Afterward he spent two years on Active Duty with the United States Air Force at Holloman Air Force Base in New Mexico, moving to Los Angeles County/University of Southern California (LAC/USC) in 1970 where he worked with pioneers such as Quilligan, Freeman, Hon and Paul in the development of clinically applicable antepartum fetal testing and continuous intrapartum EFM until completing his training in 1972. He currently practices at Overlook Hospital in Summit, New Jersey, and the University of Medicine and Dentistry of New Jersey Hospital in Newark where he is an Associate Professor. I have a related article on the recent member poll concerning the College position on universal healthcare at the end of this issue.

The Litter Box this month contains my potpourri of kudos and suggestions for improvement regarding the College's recently formed Grievance Committee. It issued its first report to the Fellowship in January this year by direct mail plus an item in *ACOG Today*, but fell far short of what I expected. We certainly can anticipate that with time and experience the Committee will expand its role to more effectively inform and protect College members.

On page 25 there's a relatively in-depth look at the most common reason why obstetricians get sued, how much it costs and how to avoid the common missteps that often lead to medical court, all courtesy of Physician Insurers Association of America (PIAA).

Baseball, like medicine and war, is a complicated matter. Team managers must remain off the playing field with only rare visits to the mound to confer with their pitchers and catchers, much like a general of the army who only occasionally visits his soldiers in the field. But someone must be the manager's alter ego on the playing field, a communication link relaying signs from the dugout to base runners and batters; literally a field commander constantly assessing changing situations, quickly making sound decisions based on accurate data and experience, and advising players when to steal or bunt or slide or go for an extra base or sprint for home. In baseball this someone is the third base coach. During war it is the field commander, and we all remember how important General Schwarzkopf was to the success of Desert Storm. In medicine it's PIAA.

We take a peek at PIAA's 1998 61 page report entitled "Neurologic Impairment in Newborns: A Malpractice Claim Study" examining data collected between January 1988 and December 1997. Before anyone gets their panties in a wad, the term "fetal distress" is used in the report because that's the term medical records and litigation documents used during the ten years studied. Probably the next ten year report will use the more descriptive terms the College recommends but that will largely depend on language used by defendant obstetricians, attorneys and medical expert witnesses. Dad used to say the best advice is worthless if you don't take it. He was right.

The cowtail this month asks some tough questions about the College and its public positions on healthcare/political issues, using as an excuse its position on universal health insurance. If you remember completing the survey forms to be sent in with your 2000 dues or got calls from me on this year's poll, take a look. The results surprised even me.

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.

THE MAIL BOX

03 JANUARY 2000

Dear Doug,

ACOG Technical Bulletin No. 217, December 1994, describes induction of labor as a stimulation of uterine contractions before spontaneous labor for the purpose of delivering a baby. It describes the indications for induction when maternal or fetal situations mandate delivery such as pregnancy-induced hypertension, premature rupture of the membranes, chorioamnionitis, suspected fetal compromise, serious maternal health problems, postdatism, etc. It also describes logistical factors such as history of rapid labor, prolonged travel to the hospital and psychosocial indications. I believe the last indication is loose enough to encompass almost any reasonable need for delivery.

There are also some obvious contradictions enumerated such as placenta previa, transverse lie, umbilical cord prolapse, previous classical Caesarean section and active genital herpes infection. Other relative contraindications are listed, i.e. multiple gestation, maternal cardiac disease, grandmultiparity, breech presentation and unengaged presenting part.

I enjoyed Jim Bofill's article (Our Little Secret: Elective Induction of Labor. *The Medicolegal OB/GYN Newsletter*, Vol. 7, No. 5, November 1999, p.19) but elective induction of labor is a fairly widespread practice. It is true that many hospital charts do not make it obvious, but I don't consider this any secret. The Technical Bulletin certainly does not resolve the question of truly elective induction.

Many of my prenatal patients ask early-on how long I will let their pregnancy continue before recommending induction. My hospital insists there be some reason for medical induction of labor compliant with ACOG clinical publications. The real trick in elective induction of labor is patient selection. No responsible obstetrician would disagree that a patient at term with an engaged vertex presentation and a cervix three to four centimeters dilated, soft and well-effaced is not a good candidate for induction of labor. A term patient with a cervix "slammed shut closed" is probably a Cesarean section just looking for a place to happen.

Certainly it is essential to discuss with all patients indications, alternatives and risks, including the risks of no treatment, when obtaining informed consent. I tell my patients induction of labor has a risk of failure and Cesarean section with subsequent prolongation of expected hospital stay, increased risk of intraoperative and postpartum bleeding, and increased risk of postpartum infection in addition to intrapartum fetal distress and other complications, but not a great deal more than those of spontaneous labor.

I have never seen an elective induction of labor performed before 39 weeks gestation. The timing of an offer to electively induce labor should be based on the same criteria as elective repeat Cesarean section, and after that it's still a matter of patient selection. Problems are inevitable if an elective induction of labor is attempted for psychosocial reasons with a closed cervix at 40 weeks gestation or with a slammed shut cervix at 42 weeks. Both are difficult situations.

I have never seen a patient-requested elective primary Cesarean section in any hospital where I've practiced. Patients have on occasion requested them but were always refused unless some reasonable obstetric justification could be found. An argument can be made for patient-requested elective primary Cesarean section but should a disaster occur such as exsanguination due to transection of a great vessel or uncontrollable hemorrhage, fatal postoperative pulmonary embolism, or fatal postoperative necrotizing fasciitis, one would spend eternity with the knowledge it was unnecessary and shouldn't even have been considered in the first place.

As a matter of perhaps more than passing interest, I also know of no female obstetrician during my residency or since who has delivered vaginally in Central Alabama. It seems that around these parts they always end up with a Cesarean section one way or another.

I honestly believe elective induction of labor at term is no deep, dark secret. Some patients even expect it based on past experience. Informed consent is, as always, essential.

Daniel M. Avery, MD

13 JANUARY 2000

Dear Dan,

Thanks for your letter. I sent it on to Jim Bofill and his reply follows. Obviously you didn't have the opportunity to see our little *tete a tete* in the January *Newsletter* before writing, but be assured many of us share your position.

Doug

20 JANUARY 2000

Dear Doug:

I would like to thank Dr. Avery for his very thoughtful letter in response to my article (Our Little Secret: Elective Induction of Labor. The Medicolegal OB/GYN Newsletter, 1999;7). I enjoy the discussions stimulated by professional disagreements on this and other subjects. I have privately corresponded with Dr. Terry Witt, author of another response to my article, and our disagreements are entirely professional, not personal.

I do not think the question regarding elective induction of labor will ever be adequately answered. The United States Preventive Services Task Force has a system for grading the quality of evidence derived from clinical studies. The highest quality data comes from randomized clinical trials. Results of cohort studies can be used to perform a sample-size analysis and construct a randomized clinical trial. The Northwestern data on Caesarean delivery in nulliparous women subsequent to elective induction of labor¹ can be used to plan such a study. The rate of Caesarean delivery in the above study was 17.5%, so let's round that up to 18%.

Our randomized clinical trial would need a sufficient number of patients to demonstrate a statistical difference of $p < 0.05$. Low risk nulliparous women with well-dated gestational ages would be recruited to undergo a detailed informed consent process at 39 weeks gestation, realizing that some if not many would refuse any randomization which essentially reduced their clinical management to a coin flip.

Strict entry criteria would be necessary. All feti would have to be vertex prior to randomization with weekly prenatal visits including Bishop scoring afterward. Electively inducing only those with a favorable cervix, clearly defined as Bishop score of ≥ 6 , ≥ 7 or ≥ 8 , would eliminate the use of cervical ripening agents such as Prepidil®, Cervidil® or misoprostol. The study group would undergo induction of labor when the predetermined Bishop score was reached, the control group at 42 completed weeks if undelivered. Labor management would be the same for both groups.

My statistics package tells me that we would need 248 patients randomized to two arms of 124 each to have an 80% chance of detecting a Caesarean section rate increase from 9% to 18%, assuming such a difference truly exists. The planning does not however end there. I would guess that about 30% of those in the control group would undergo an indicated induction of labor for antepartum complications such as pregnancy-induced-hypertension, prolonged premature rupture of membranes, non-reassuring fetal status, etc. while awaiting a Bishop score adequate to allow elective induction. Therefore we should randomize 322 women in order to finish the study with 124 pairs.

Most academic centers would consider such a study frivolous and not be interested. I doubt if a private service would undertake it either. Many obstetricians would be needed to enroll the large number of patients necessary to complete the study within in a reasonable time period, say twelve to eighteen months. In addition research nurses would have to be hired to collect data and obtain the detailed informed consents necessary to all clinical trials. There's absolutely no incentive for private obstetricians to undertake such an expensive and time-consuming project.

The data which has been generated, however imperfect, demonstrates elective induction of labor is associated with a statistically significant elevation in Caesarean section rate. But let's face it: Private obstetricians will continue to electively induce labor without high-quality data demonstrating benefit.

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.

THE BOOK BOX

by Doug Daniel

BEAM ME UP, SCOTTY

The Phantom Stethoscope: A Field Manual for Finding an Optimistic Future in Medicine
Stephen K. Klasko, MD, MBA and Gregory P. Shea, PhD
Unillustrated. 259 Pages. Franklin, Tennessee: 1999
Hillsboro Press
Hardback, \$24.95

Some of you may have recently read in these pages Ben Harer's excellent review of Neil Baum's Take Charge of Your Medical Practice Before Someone Else Does It For You (*Newsletter*, Vol. VII, No. 4, SEPTEMBER 1999). Klasko and Shea now give us a somewhat different take, albeit with a back-to-the-future science fiction flavor, on the same topic, i.e. the practice of medicine circa Y2K under today's system of mismanaged care. Like the song says, a little bit of sugar helps the medicine go down. There are some similarities between the two books but many more differences.

Baum for instance is more of a tactician, presenting very specific and detailed ploys to be used for increasing patient and cash flows, marketing medical practices and personae, negotiating with tight-fisted bean-counting administrators and generally using the system to get what we want instead of just being used by the system. Klasko and Shea are more strategic in their perspective, providing an overview of ante-bellum medical practice and the cold realities under post-bellum reconstruction after we lost the War of Third-Party-Payor Aggression without even a token resistance. Baum's advice is fairly cut and dried with the only references to humor addressing its use as a practice builder. Klasko and Shea on the other hand keep their collective tongue thrust firmly in cheek while relating the sci-fi perils of their heroine, a 1985 senior medical student named Mila who is abducted immediately before graduation by a married menage-a-trois of three benevolent extraterrestrials. One is male, another female and the third an asexual Spock-like logician named Ajax, a free-spirited alien who uses virtual reality metaphoric illusions and minilectures by holographic Barbie dolls representing some of Mila's role models from the past and experts from the future to give a short course in surviving the inevitable managed care system.

This brief outline may sound totally nuts but the schizophrenic combination of a science fiction novella with a business seminar actually works fairly well. The table of contents easily differentiates between chapters fictional and didactic even though the two are interspersed, but there is no index, always a big help for future reference. I found myself looking forward to the sci-fi chapters and the lectures weren't unfathomably obtuse. The first are witty, imaginative and entertaining brain candy while the second are scholarly, well-researched, reasonable explanations plus opinions on how our profession's train wrecked including what we can do to get it back on the tracks and running even if it's no longer a luxury Pullman express. For those who want more, there're references at the end of each didactic chapter plus a pretty good glossary.

Shea is a faculty member of the University of Pennsylvania's Wharton School of Business and a graduate of Harvard, Yale and the London School of Economics. Klasko is Chairman of Lehigh Valley Hospital's Department of Obstetrics & Gynecology and a graduate of Lehigh University, Hahnemann University School of Medicine and Wharton School of Business. Both apparently enjoy science fiction since the title is a homage to Norton Juster's classic The Phantom Tollbooth. Stethoscope is best recommended for residents and medical students with a short attention span who are relatively uninformed about how medicine was practiced prior to its hostile takeover by government and big business. There isn't a whole lot of meat here for those who've already been there and done that although there are useful and interesting chapters on MBA topics such as conflict management, negotiation, medical law, physician business and administrative leadership, and medical ethics. Most importantly there is an excellent chapter on stress management with a discussion of the increasing problem of physician burnout due to managed care's economic and professional pressures. I suspicion one or more of Klasko's MBA research papers and many after-hours conversations with professor Shea were the impetus for their successful collaboration.

You can order a copy from your favorite .com or local bookseller through Ingram Distribution, or directly from the publisher by calling 1-800-321-5692.

THE SUGGESTION BOX

by Mike Kreitzer

SAVING PRIVATE HEALTHCARE

In the November 1999 Executive Director's Report Doug polled the membership regarding whether we supported or opposed the "Seven Sisters", including ACOG, position on mandatory universal health insurance. For those unfamiliar with this challenge presented to all candidates in the 2000 US presidential election, I urge you to read John Queenan's outstanding series of editorials published in *Contemporary OB-GYN* last fall and reprinted here on pages 12 through 19.

It's easy to support universal health insurance and its admirable goals as expressed by Dr. Queenan, but history has taught us nothing if not the impossibility of a satisfactory government solution to our nation's health insurance problem. Government must of necessity be involved but future change will be driven by those interests with the most political influence, i.e. large corporate employers, managed healthcare and insurance industries, organized labor and patient advocacy groups. The 650,000 physicians currently providing healthcare represent only 0.25% of our country's overall population of about 260 million. We need to understand that after many years as reactive and independent professionals, by accepting the newspeak appellation of "managed care providers" we ceded whatever political influence we once had. Remember how the panel of experts tasked with developing Clinton's first-term healthcare debacle excluded practicing physicians? With all due respect to Dr. Queenan, I seriously doubt organized medicine will be perceived as having "thrown down the gauntlet" before our next President unless we also effectively challenge the managed healthcare cabal.

I offer a modest proposal that concentrates our efforts where we have the most influence, with our patients and other healthcare professionals. We have failed to convince the patient population that we value the quality of their healthcare above our financial gain. Patients comprise 100% of healthcare consumers and 100% of political constituents. We must somehow make them our allies if we are to win this fight.

We were not forced to join managed care programs and those of us who joined early, seeking a financially competitive advantage, created economic pressure on our colleagues to do the same. In the process we overlooked the fact that without our cooperation managed care had no product to sell. As a solo practitioner and with some initial trepidation, I began terminating my managed care contracts over two years ago. Within twelve months I had terminated them all. My overall financial situation has not appreciably changed and a healthy sense of professional satisfaction has returned to my practice. I have since encouraged others to do the same.

Successful negotiation with managed care companies is and will remain impossible. While inconceivable to most physicians at the present time, resignation from provider panels is the most effective way to challenge managed care. Many will consider this heresy but by joining or remaining a part of managed care we voluntarily concede our supposedly revered status as independent fiduciary professionals, our obligation to always counsel our patients honestly and freely while providing them the best healthcare available, not to mention our Constitutionally-guaranteed right to bitch about our masters' injustices and abuses. by while working on his

It's a no-brainer when 35% of your patient volume generates only 10-15% of your income with an automatic three to six month delay in payment. Why not just resign from one managed care plan every month or so? It may take a year or more to completely cure one's financial addiction to managed care and there will unquestionably be temporary withdrawal symptoms, but it can be done with the end result a healthier professional practice and practitioner. Individual resignation requires no organization, collusion or conspiracy so there's no threat of antitrust or restraint of trade charges.

Many hospitals are losing money on managed care and their survival is threatened. All have tried to cut their nursing staff with subsequent deterioration in quality of care. If a hospital considers terminating a managed care plan's contract we should support such action by resigning from the plan and advocating adequate nurse staffing to reestablish quality care. As with our patients, we must form mutually supportive alliances with our hospitals and nurses.

We must also recognize managed care, not fellow physicians and hospitals, as the competition if we are to have any hope of saving our healthcare system. Here in New Jersey we have successfully formed a cooperative hospital and physician healthcare organization called Qualcare, becoming in only a few years the fifth-largest managed healthcare entity in the state. Experienced managers and business professionals operate the company with physicians well-represented on all policy boards and management committees. Qualcare reimbursement exceeds that of comparable for-profit plans and there is no intentional delay in payment of claims. The company is physician, hospital and patient friendly and it is ours. You can compete successfully with the bad guys if you're not afraid to walk.

The United States developed the world's best healthcare system by financially rewarding individual initiative, quality medical research, dedication, innovation, entrepreneurship, cooperation and hard work. We must rediscover and reward these same attributes in order to restore the system. We cannot expect Dr. Queenan's "challenge" to be taken seriously if we don't make patients, hospitals and nurses our political and professional allies in an effective counterattack against the managed care juggernaut.

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THE LITTER BOX

by Doug Daniel

YOU TALKIN' TO ME?

The ACOG Grievance Committee was born of the need to insure that the College membership be at all times composed of ethical, responsible, competent, qualified and unimpaired obstetrician/gynecologists. Its mandate is to address reports and complaints of a Fellow's or Junior Fellow's behavior filed by a Fellow or coming to the Committee's attention via reported adverse actions by state medical licensing boards. As long as you paid your dues, there never before had been provision for taking adverse action against your membership status. Now those failing to meet these criteria [defined as violating ACOG's Bylaws, its Code of Professional Ethics or "for any other cause which in its (the Executive Board's) judgment shall be deemed sufficient"] may be warned, censured, have their membership suspended for an unlimited period of time or be expelled (termination of membership) for at least five years. Suspension and expulsion are reported to the National Practitioner Data Bank if "...based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient". It is to be hoped that members temporarily failing to meet these criteria will be rehabilitated by remedial actions short of suspension or expulsion, but obviously all cannot.

While the Committee's deliberations and actions are vitally important to those whose names come before it, there is also the potential for an educational role by keeping the rest of the membership informed of the specific nature of complaints brought and actions taken, similar to the public record information provided by state medical licensing boards regarding adverse disciplinary actions. Some physicians know their misdeeds if discovered will have dire consequences on their privilege to practice their profession. Obviously the Presidential assassin, espionage agent for an enemy nation or serial killer knows that if caught he will no longer be allowed to practice medicine. Oftentimes less egregious behavior though deemed unacceptable by others is considered by its offender to be reasonable. Sometimes it's very difficult to know what rules currently govern one's behavior.

Colleagues coming to the Committee's attention via state board actions would ideally have their ACOG status primarily depend on their licensure status, i.e. if one's medical license is permanently revoked, Fellowship or Junior Fellowship would be also unless there were very unusual circumstances to be considered. No one convicted of a felony and imprisoned should be allowed to remain a Fellow or Junior Fellow while incarcerated, but after their release should they be denied reinstatement if they regain their medical license? Should those with a license restriction against treating female patients be continued in or reinstated to Fellowship?

Of most interest to our Society's members are complaints alleging unethical conduct in provision of medical expert witness services plus the Committee's subsequent findings and actions or lack of same, but as currently reported there is only a statistical profile of the Committee's work. A detailed case-by-case account would be more enlightening and likely to deter similar future behavior in others. State boards' public records of adverse actions contain names and addresses of those disciplined but that's really not necessary in the Committee's report to the membership and would serve no useful purpose except in those rare instances when membership status was terminated for cause or not renewed while under investigation. I certainly am interested in why my colleagues are the target of adverse actions by their state boards, the DEA and the College in order to avoid such actions myself.

How should the College deal with impaired physicians? Most will never come to the Committee's attention since usually no long-term adverse action is taken by licensing boards as long as the physician in question fulfills the conditions of his recovery contract or complies with the demands placed upon him by his board. Even those who are the subject of adverse licensing board actions will, if successfully rehabilitated, usually have their licenses reinstated. They should then be determined qualified for College membership unless prohibited by other considerations. It seems to me that even a convicted felon should be allowed to be a member of the College if his medical license is intact or reissued following release from prison and he meets the same requirements as the rest of us. Otherwise there is no opportunity to become truly rehabilitated or ever "pay one's debt to society" for past misdeeds.

The College has in the past and continues to support its impaired and recovering members by cosponsoring "Twelve Step" meetings of the Caduceus organization at the ACMS. For the first time to my knowledge there will be a formal CME offering in San Francisco this year on impaired physicians via a Clinical Seminar. Last year there were and again this year will be Luncheon Conferences on routine drug screening for all healthcare workers plus how to identify and work with impaired colleagues. All these are steps in the right direction but there is the opportunity to do much more.

There are untold committees, task forces, staff contacts, departments and related organizations listed in the *ACOG Directory* which address such issues as ethics, government relations, grievances, history, honors, international affairs, domestic violence, genital mutilation, gifts and jewelry, meeting dates cards, pharmaceutical company liaison, press inquiries and releases, retirement opportunities, smoking cessation, marketing, and the ProLife movement plus gay, lesbian, spanish-speaking or forensic obstetricians-gynecologists. Don't get me wrong; all these represent important issues, considerations or functions of the College and none is less than deserving of its interest and support. But where is the Committee on Impaired Physicians or Caduceus? I can assure you Caduceus has not requested listing as a related organization, but has it been invited?

The College should be applauded for again taking the initiative in dealing with a difficult and embarrassing, though rare, problem within our profession by establishing an effective Grievance Committee, not surprising since we were the first national medical organization to effectively address medical malpractice with a Committee on Professional Liability. The Grievance Committee must not only consider the best interests of our patients and the membership at large but also when warranted explicitly protect the confidentiality of those called before the Committee and deal with them in a fair and unbiased manner. After all these are accomplished we are entitled to a full accounting which should be seriously studied by every member.

DOMESTIC VIOLENCE, Continued From Page 1

There are many reasons why physicians may be reluctant to ask about problems at home. Some may have current or prior personal experience with domestic violence as an observer, victim or even perpetrator. Others may be concerned about perceived increased demands on their already limited time allotted for patient visits. There's also the fear of becoming entangled in criminal investigations or prosecutions, viewing these as someone else's responsibility. Instead, by virtue of their profession they are uniquely situated to relieve the suffering of domestic violence victims. These patients commonly visit emergency departments for treatment of their injuries but other physicians also frequently encounter the results of domestic violence.

Obstetricians and gynecologists have an excellent opportunity to help their abused patients. Prenatal patients report a 10% to 32% incidence of past domestic violence, and physical assaults during pregnancy jeopardize both mother and fetus. Abused women have higher rates of miscarriage, stillbirth, intrauterine trauma, premature labor and low birth weight infants compared to those not experiencing abuse. Pediatricians often see children whom they suspect of being physically or sexually assaulted in addition to those brought by concerned parents or family.

Psychiatrists and allied mental health workers see many anxious, depressed, substance abusing, suicidal patients. Orthopedists daily set fractures and treat other musculoskeletal complaints or injuries. Otolaryngologists treat facial fractures and dislocations, ear traumas and temporomandibular joint syndromes. Dentists see broken teeth plus jaw and intraoral injuries. Ophthalmologists encounter trauma to the orbit or globe including fractures, lacerations, hyphemas and other retinal/corneal/scleral injuries. Surgeons are called to attend patients with severe lacerations, stabbings, gunshot wounds and traumas both blunt and sharp. All may be confronted by patients complaining of dyspareunia, chronic pelvic pain, vaginismus, headaches, chronic aches and pains, or functional disorders. Any of these common conditions can be the result of domestic violence, yet domestic violence victims' presenting complaints often are correctly diagnosed only when the abuse is obvious.

This is no longer acceptable. Current clinical guidelines recommend that physicians routinely discuss domestic violence with all female patients. Such routine screening is justified and can be lifesaving. Routinely discussing these issues with all patients will decrease the physician's perceptible discomfort or embarrassment. Clinicians should routinely inquire about domestic violence, understand its dynamics, familiarize themselves with services in their community available to victims of violence and appropriately refer patients. They can also put their patients at ease by framing questions in language which tells victims they're not alone, no one deserves to be abused, their problem is taken seriously and help is available.

When discussing domestic violence with patients it is important to ask direct and specific questions such as:

1. "We now know domestic violence is a very common problem. About 20% of women in this country have been abused. Has that ever happened to you?"
2. "Because violence against women is so common in today's world, I now discuss domestic violence with every patient I see. Has anyone ever hurt you?"
3. "Some patients are uncomfortable bringing up their abusive relationships or other problems at home, so I've started asking everyone about it. Has this ever been a problem for you?"
4. "How did you get that bruise? Did someone hit you? Who? Was it your partner/husband?"
5. "I'm concerned that your injuries may be from someone hitting you. Has someone been hurting you?"
6. "Does your partner/husband ever try to control you by threatening harm to you, your children or family?"
7. "Has your partner ever forced sex on you?"
8. "Do you feel controlled or isolated by your partner?"
9. "Do you ever fear your partner? Do you feel safe at home?"

Routinely asking such questions will put both patients and physicians at ease. Abused patients may not respond the first, second or even third time the subject is broached, but they will eventually realize their physician is sincerely interested in their welfare and wants to help, not just nosy.

The Family Violence Prevention Fund founded the National Health Initiative on Domestic Violence, a project designed to train medical, paramedical and nonmedical personnel to reliably recognize clinical signs of abuse in battered women and then intervene effectively. The Initiative is based on a successful project the Fund first developed in Arizona, California and Pennsylvania hospitals, then expanded to Alabama, Florida, Nevada, New Hampshire, New Mexico, Texas, Washington and West Virginia. Within each state multidiscipline teams from fifteen hospitals and other healthcare organizations were trained in:

1. Routine screening techniques intended to identify battered patients
2. Development and adoption of domestic violence response protocols
3. Development of resource materials for patients and staff
4. Effective strategies for expanding their institution's response into a broader community response utilizing available resources
5. Establishing continuing education programs on domestic violence for all their organization's staff.

The Fund also has available upon request guidelines and a pocket-sized reference card outlining how to help battered patients.

As a Women's Advocate in rural West Virginia I've become acutely aware of the importance of medical and paramedical personnel reaction and response to family violence victims. You may be their only chance for help, and that chance is severely compromised by a lack of awareness, training and/or initiative. Are you prepared to be an advocate for your battered patients and help them end their misery, even remove a real threat to their and their children's safety or lives?

For more information on the National Health Initiative on Domestic Violence or to obtain the materials mentioned above, contact:

Health Resource Center on Domestic Violence
1-888-RX- ABUSE
Weekdays 9:00 am - 5:00 PM Pacific

Family Violence Prevention Fund
Suite 304
383 Rhode Island Street
San Francisco, California 94103-5133
Phone: 415-252-8900
Fax: 415-252-8991
www.fvpf.org/fund/healthcare/emergency.htm

Ms. Queen has done an excellent job conveying the unacceptably high prevalence of a tragic social and medical problem. Yes, it is a medical problem. Our professional literature strongly supports the increased incidence of a gamut of gynecologic complaints, chronic pain syndromes, mental illnesses, drug treatment and usage, and higher medical costs in women previously as well as currently subjected to domestic violence, sexual abuse and sexual assault. Its medical complications are seen more frequently than those of gestational diabetes, genetically abnormal pregnancies, neural tube defects, syphilis or cervical cancer yet most of us still do not routinely ask about domestic partner violence or sexual assaults as a child, adolescent or adult.

Why do we avoid asking about these problems? Some of us plead a lack of available time in the physician-patient interaction. Nonmedical or paramedical office personnel have long obtained medical histories. Properly trained, caring and sensitive office staff can also ask about violence and abuse.

Others plead lack of knowledge or ability but we are known to be quick learners, else we would never have finished medical school or residency. Many cry they are afraid of offending their patients with such personal questions, yet we routinely ask our patients the most personal of questions possible. Studies have shown that abused women are actually grateful when anyone offers concern for their safety and supportive assistance if they decide to leave an abusive relationship.

Another concern expressed is the fear of becoming involved in an already violent situation or future legal action requiring unpleasant court testimony, but legal expert Sherri Schornstein has advised that a well-documented medical record will benefit patients if they seek relief in the courts, at the same time lessening the chances of our being called as a witness. For those who wish more information Schornstein has authored an excellent book entitled Domestic Violence and Health Care: What Every Health Professional Needs to Know, published by Sage Publications in 1997.

Would you ever consider prescribing oral contraceptives without questioning your patient regarding her previous history of deep vein thrombophlebitis, smoking and hypertension? Would you even consider following a prenatal patient without questioning her on prior obstetrical history and any family history of inherited disorders?

How about prescribing hypnotics, anxiolytics, antidepressants, or scheduled analgesics; performing diagnostic procedures such as laparoscopies, diagnostic ultrasounds or CT scans; or treating migraine syndrome, vaginitis, dyspareunia or sexual dysfunction without at least considering the possibility that the underlying cause of the symptoms you're trying to alleviate are related to domestic violence? These are some of the most frequent medications we prescribe, most frequent and expensive diagnostic procedures we perform or authorize, and most frequent diagnoses we treat yet all are markers for survivors of domestic violence, sexual abuse and sexual assault. Examine your own biases and excuses, then concentrate on how to overcome them. Some of our patients are waiting for us to ask. We won't know which ones unless we ask them all.

Linn H. Parsons, MD, FACOG

THE NEUROLOGICALLY IMPAIRED INFANT

by Doug Daniel

Physician Insurers Association of America (PIAA) is a trade association serving the medical malpractice insurance industry by collecting and maintaining an extensive database to track reported potentially compensable events, claims, settlements, awards, suits, verdicts and defense costs. Its membership is composed of over 50 physician or dentist-operated professional liability insurance companies insuring 60% of all practicing physicians, dentists, hospitals and other healthcare organizations in the US. Additional international affiliate members provide indemnification and other services to over 400,000 healthcare professionals worldwide.

PIAA's Data Sharing Project collects information on closed medmal claims serviced by its members who have voluntarily submitted reports semiannually since 1985, profiling over 150,000 medmal claims of which 3,466 involved neurologically impaired infants. The Project's first report on neurologically impaired infants was completed in 1987; in 1998 a more intensive study was published. Only claims with paid indemnities (read losers either settled or lost at trial) were included in the non-financial portions of the report.

Some of the financial data are based upon all claims filed, with 53% either found for the defendant, dismissed, non-suited or dropped. Although over half of all claims filed did not result in payments to plaintiffs they still incurred expenses and some, i.e. cases successfully defended, probably were quite expensive. Comparisons are made when possible with data from the previous, less-comprehensive study.

Difficulties managing pregnancy and delivery which result in newborn neurological impairment are leading contributors to medical malpractice claim frequency and cost. They have the highest average indemnity payment as reported by the Project. This article is based on "Neurologic Impairment in Newborns: A Malpractice Claim Study", the second PIAA study collecting data on neurological impairment of the newborn 1988 through 1997 and published in May 1998. The first collected data 1985 through 1987 and was published in 1988. Twenty-four domestic member companies insuring more than 110,000 physicians in the United States participate in the ongoing Project which follows a wide range of medmal claims.

This compilation of the Project's data revealed the most frequently filed medmal claims to be for neurologically impaired newborns, 309 of 3466 claims and suits filed from 1988 through 1997. These were also the most expensive in terms of indemnity payments. Average indemnity payment (awards, settlements, judgments) to plaintiff per defendant in a neurologically damaged infant claim between 1985 and 1997 was \$478,000, increasing to \$500,000 during 1997 alone. Total reported indemnity payments for PIAA's 24 member companies was over \$337 million dollars, plus an additional \$15 million in defense costs. More than 47% of claims alleging newborn neurological impairment resulted in payment to the claimant as compared to 31% of all claims. Claims involving neurologically impaired newborns remain a major concern to the medmal insurance industry and its policyholders.

Failure to detect possible complications during the prenatal or intrapartum period can have devastating results. Neurological damage to the newborn is a serious yet sometimes preventable complication which can result from improper obstetric management.

The Project's 1998 study confirms the previously noted difficulty in accurately identifying initial onset and causation of newborn neurological impairment. These are some of the most difficult claims to defend even when multiple defense medical expert witnesses find no evidence of negligence. Conditions thought by conventional wisdom to be risk factors for neurological impairment of the newborn don't necessarily precipitate allegations of negligence, and such impairment may actually result from complex interactions between multiple immeasurable risk factors. As a result, accurately determining initial onset and causation remains difficult.

Here's the gist of the 1998 Study.

- 0 Claims whose medical records had an established date for initiation of prenatal care showed 73% registered during the first trimester and 3% had no prenatal care or registered during the third trimester. Twenty-five percent of cases involved deliveries at 41 or more weeks gestation. Sixty-one percent of infants were male. No association between the onset of prenatal care or the number of visits and any adverse outcome were demonstrated, specifically there was no predictive relationship between prenatal care and neurological impairment of newborns.

- θ At least one neonatal complication was reported in 96% of cases, the most common being anoxia (59%), seizures (19%) and other pulmonary problems (19%). All those with neonatal seizures had “fetal distress”. Liveborn neonatal death rate was 4% in the 1988 study’s cases and 15% in 1998’s with settlement occurring in 90% of these.
- θ Maternal obesity was associated with increased risk of adverse pregnancy outcome. More specifically, there was a much greater risk of those maternal pregnancy complications associated with neurologically impaired newborns such as diabetes mellitus, chronic hypertension and pregnancy induced hypertension with or without preexisting chronic hypertension.
- θ A significant number of cases did not allege mismanagement of other maternal risk factors.
- θ Misinterpretation of or failure to perform indicated antepartum tests or procedures not including electronic fetal monitoring (EFM) was a factor in 17% of all cases. Obstetric ultrasound was the single procedure most frequently involved. Failure to perform indicated antepartum tests or procedures was alleged in 20% of all cases. Failure to perform a Non-Stress Test (NST) was alleged in 22% of these, failure to perform Oxytocin Challenge Test (OCT) or Contraction Stress Test (CST) in 13%, and failure to perform a BioPhysical Profile (BPP) in another 13%.
- θ Failure to perform indicated maternal estriol testing was alleged in 10% of the cases reported in 1988 but none of those reported in 1998. OCTs were performed in 6% of the 1988 study’s cases and 9% of the 1998 study’s cases. Maternal Serum Alpha FetoProtein (MSAFP) was tested in only 2% of the 1988 study’s cases and 40% of the 1998 study’s cases. Diagnostic ultrasound was performed in only 32% of the 1988 study’s cases and 88% of the 1998 study’s cases, mostly as a routine screen without specific medical indication.
- θ Diagnostic ultrasound was performed in 88% of claim cases with radiologic interpretation in 45% of these. Interpretation was confirmed by defense medical expert witnesses in 92% of those with available results. Sixteen cases had inaccurate interpretations upon review and nine of these were pivotal to the defense. When failure to perform indicated antepartum testing (excepting EFM) was alleged, 38% of these claims involved diagnostic ultrasound.
- θ In the 1988 study 14% of all labors were induced, 9% with oxytocin, and approximately one third of all labors were oxytocin-augmented. In the 1998 study 31% of all labors were induced, 45% of these via artificial rupture of membranes and 41% via oxytocin, and oxytocin augmentation was used in 38% of all labors. Use of oxytocin was found to be insignificant in relation to adverse maternal or fetal outcomes.
- θ At least one intrapartum complication was reported in 70% of all cases and failure to recognize complications was alleged in 44% of these. Cord complications and abruptio placentae were the most frequently missed conditions.
- θ When the status was known, 62% of the 1988 study’s labors were monitored with EFM as compared to 96% of 1998’s. Internal EFM was utilized in 23% of the 1988 study’s cases and 48% of 1998’s. There was no predictive link between abnormal EFM interpretation and adverse maternal or fetal outcome related to the type of EFM or who performed the interpretations. There was no reporting on medical expert witness review for confirmation of defendants’ interpretational accuracy.
- θ Approximately 25% of the 1988 study’s cases monitored with EFM reported normal interpretations, and of these 27% of the newborns had evidence of anoxia while 29% had seizures.
- θ At least one EFM abnormality was found in 73% of all cases with 94% of Caesarean sections showing such abnormalities. In the 1998 study early decelerations occurred in 5% of cases, variables in 34%, lates in 32%, bradycardias in 31% and tachycardias in 9%. No significant relationship between abnormal EFM interpretations and adverse outcomes was found.
- θ When failure of or delay in performance of Caesarean section was at issue 96% of cases showed EFM abnormalities, 98% when the delay exceeded 30 minutes.
- θ “Fetal distress”, defined as EFM abnormalities, was a factor in 41% of the 1988 study’s cases and 88% of 1998’s, probably related to increased utilization of EFM (62% to 96%).
- θ Vaginally delivered infants were extracted in 37% of all deliveries, 29% of these by vacuum and 27% by low forceps. Rotations were performed in 16% of known cases, 62% of these manual.
- θ Caesarean section was performed in 36% of the 1988 study’s cases and 59% of the 1998’s. Low transverse uterine incision was used in 86% of the 1988 study’s cases and 62% of 1998’s. “Fetal distress” was the justification for Caesarean delivery in 64% of the 1998 study’s cases, and delay

exceeding 30 minutes was found in 61%. Delay was an allegation in 71% of all Caesarean sections. Among vaginal deliveries, failure to perform a Caesarean delivery was alleged in 71%.

- Ø Presence of meconium, defined as identification of gross meconium or meconium staining of amniotic fluid or newborn, was a factor in 96% of all cases, markedly associated with “fetal distress” (84 of 85 cases with meconium). “Light staining” was recorded in 13% of cases and “heavy staining” in 21%. Among 85 newborns with meconium present, 84 were determined to have suffered “fetal distress”.
- Ø Ninety-three percent of one-minute APGAR scores were determined to be valid and 75% were below 3. Ninety-two percent of five-minute APGAR scores were determined to be valid and 75% were below 6. Eighty-six percent of cases with “fetal distress” had 1-minute APGAR scores of 6 or below. Among those with one-minute APGAR scores of 6 or below, 91% had “fetal distress”, over 95% had one or more neonatal complications and 95% lacked evidence of congenital anomalies. Sixty-nine newborns had both one and five-minute APGAR scores below 3 plus a cord blood pH below 7.00. All 35 newborns who subsequently died had five-minute APGAR scores of 6 or below. Among newborns with five-minute APGAR scores of 6 or below, 93% were determined to have suffered “fetal distress”
- Ø Neonatal complications including seizure disorders (19%), respiratory problems (19%) and evidence of anoxia (59%) occurred in 96% of all cases with 60% of these presenting two or more.
- Ø Average indemnity payment (awards, settlements, judgments) to plaintiff on behalf of all defendants in a neurologically damaged infant case between 1988 and 1997 was \$1.3 million, decreasing to \$717,939 when congenital anomalies were present and \$702,000 when the infant subsequently died.
- Ø Average indemnity payment (awards, settlements, judgments) to plaintiff per defendant in a neurologically damaged infant claim between 1988 and 1997 was \$568,283 with similar decreases as above for congenital anomalies and neonatal death.
- Ø Average indemnity payments increased in direct proportion to severity of adverse outcomes. One minute APGAR scores of six or less had an average case payment value 50% greater than those over six, \$1,128,000 compared to \$750,000. Abnormal newborn neurological examination increased average indemnity payments by a factor of 3.6 from \$320,000 to \$1,143,380. EFM abnormalities increased average indemnity payments by 81% from \$681,000 to \$1,166,000.

Some observations were gleaned from an intensive case-by-case review of all available medical records, the most relevant ones being:

- Ø Medical record documentation was frequently incomplete and/or inconsistent
- Ø Failure to timely and accurately diagnose complications of labor, particularly during the second stage, frequently resulted in allegations of improper management
- Ø Delay in obstetrician consultation was common, including failure of L&D nurses to timely notify and Certified Nurse Midwives (CNMs) to timely request consultation from attending obstetricians after intrauterine “fetal distress” was or should have been identified
- Ø Allegations of improper management of the second stage of labor were common
- Ø Allegations of improper management of pregnancies extending beyond 42 completed weeks gestation and postmature pregnancies were noted, especially failure to perform or correctly interpret antepartum fetal testing
- Ø Relatively few cases involved VBACs, but notable among these were allegations of failure to diagnose iatrogenic intrapartum uterine rupture and failure to properly obtain informed consent by allegedly inadequate explanation of associated risks and relative risks compared to elective repeat Caesarean section
- Ø Failure in early diagnosis of nuchal cords and other umbilical cord compressions occurred with significant frequency but EFM was determined to be unreliable in identifying such cord compressions.

The following comparisons can be made between the 1988 and 1998 Studies.

- Ø Utilization of EFM during labor increased from 62% to 96%.
- Ø Diagnosis of “fetal distress” increased from 41% to 88%, probably associated with the increased utilization of EFM.
- Ø Utilization of diagnostic ultrasound markedly increased from 32% to 88%.
- Ø Quality of medical record documentation improved somewhat but a significant problem with consistency between entries persisted. On occasion important data was not recorded due to lack of agreement concerning various healthcare team members’ documentation responsibilities. Conversely, on occasion multiple entries of inconsistent data occurred. Unlike the 1998 Study, the 1988 Study found incomplete documentation to be more frequent than duplication.

The following advice is based upon the Project’s findings regarding the most prevalent problems in managing pregnancy, labor and delivery. It is the author’s only and should not be construed as in any way reflecting opinions, conclusions or recommendations of PIAA. Early identification of complications which could possibly lead to neurological impairment is often difficult. These risk management strategies are intended to improve quality of care plus minimize malpractice losses, and utilizing them in your clinical practice will decrease your medical risk. This is not a comprehensive list and should **NOT** be construed as clinical guidelines.

1. Communicate effectively with all those responsible for providing care to both mothers and infants antepartum, intrapartum and postpartum by insisting upon proper medical record documentation in addition to being informed of everyone’s observations and diagnoses.
2. Thoroughly document previous pregnancy and delivery history including all complications and outcomes. When combined with the present medical history this creates a profile identifying significant maternal and fetal risk factors.
3. Promptly document all patient complaints, symptoms and maternal risk factors.
4. Promptly record all remarkable or questionable diagnostic findings and address them immediately.
5. Monitor postdate and postmature pregnancies extremely closely.
6. Utilize EFM as an effective pregnancy and labor management tool, improving your and other patient care team members’ cognitive skills if indicated.
7. Demand prompt communication between the labor and delivery patient care team and yourself, essential at the earliest sign of maternal or fetal compromise.
8. Promptly identify and treat all intrapartum complications.
9. Monitor the second stage of labor extremely closely. Suspected problems should be immediately addressed and if confirmed, promptly resolved. Prolongation of the second stage is especially dangerous.
10. Consider the presence of meconium a marker for the high-risk fetus.
11. Respond promptly to all calls from the labor and delivery suite.

For a copy of the study’s full report, “Neurologic Impairment in Newborns: A Malpractice Claim Study”, contact:

PIAA
Suite 250
2275 Research Boulevard
Rockville, Maryland 20850
Phone: 301-947-9000
Fax: 301-947-9090
Internet: www.thepiaa.org

Editor’s Note: Larry Smarr, PIAA President, and Lori Bartholomew, PIAA Director of Loss Prevention and Research, were indispensable in the production of this article. They have my eternal undying gratitude.

THE SUM OF ITS PARTS

by Doug Daniel

Mike Kreitzer's Suggestion Box appears elsewhere in this *Newsletter*, a superb piece on how to resist managed care which obliquely mentions the "Seven Sisters" national physician professional organizations, including the College, taking a strong political position by endorsing universal healthcare coverage regardless of how realized. John Queenan's cogent series of four *Contemporary Ob/Gyn* editorials on universal healthcare are reprinted immediately following Mike's article.

I'll not burden anyone with my personal opinion regarding universal healthcare, but instead ask you to consider whether the College accurately represents the interests of a majority of its membership. I've asked myself this question before and this time I'm concerned it hasn't, in fact probably opposing the majority's position.

This year's ASFOG poll was whether the Society's members supported the College position on mandatory universal health insurance, perhaps not an exact quote of the position but more specific. All 62 1999 dues-paying members were contacted by mail. Those not responding within two months were personally contacted by phone except for one who died and two who could not be reached on multiple occasions. One of those personally contacted resigned without responding. Among 58 responders 36 (62%) opposed and 22 (38%) supported the College's position, by ACOG Districts as follows.

ACOG DISTRICT (% of Membership)	ASFOG MEMBERS	SUPPORT ACOG POSITION	OPPOSE ACOG POSITION
I (7%)	4 (7%)	2 (50%)	2 (50%)
II (8%)	3 (5%)	2 (67%)	1 (33%)
III (8%)	4 (7%)	2 (50%)	2 (50%)
IV (19%)	11 (19%)	3 (27%)	8 (73%)
V (11%)	5 (9%)	2 (40%)	3 (60%)
VI (9%)	2 (3%)	Ø	2 (100%)
VII (16%)	12 (21%)	5 (42%)	7 (58%)
VIII (9%)	5 (9%)	Ø	5 (100%)
IX (10%)	12 (21%)	6 (50%)	6 (50%)
ARMED FORCES (3%)	Ø	Ø	Ø
TOTAL (100%)	58 (100%)	22 (38%)	36 (62%)

So what does this tell us? Not much about the College but a lot about the Society. There are obvious statistical faults with the poll, the biggest its unbelievably small sampling of the College membership (0.1%). Another is the unmatched distribution of College and Society membership in Districts VI, VII and IX with the Armed Forces District not represented. District VI is underrepresented but unanimously opposed. District VII is slightly overrepresented with a 16% margin opposed. District IX is grossly overrepresented but split 50-50. An of course the unrepresented Armed Forces District would be expected to predominately support the College position but only composes 3% of its membership. Otherwise the Society's average member fairly reflects the College's: clinical instead of academic, active instead of retired, upper middle-class relatively conservative in political and personal matters. Of course another big difference is the overpowering bias of medical expert witnesses in the Society's membership, but in my experience we are not significantly different from your average Fellow.

The fact remains that opposition to the College's high-profile position on an at best controversial issue which directly affects our livelihoods and profession is almost two to one. Agreed that academics and salaried employees are relatively insulated from the economics of entrepreneurial medical practice, but their representation is about equal in both organizations with the exception that the Society has relatively few salaried members.

The fact also remains that only one district, politically and socially liberal District II (New York), had a clear majority (67%) supporting universal healthcare. New England, the Atlantic Coast states and California (Districts I, III and IX) were evenly split, surprising for usually liberal New England. Of course no one can figure out California which is ultraliberal on some issues and the heart of conservatism on others. No surprise in the traditionally conservative southeast's (District IV) opposition but I didn't expect the usually liberal northwest to totally oppose universal healthcare. I'm told this may reflect the Oregon experience in attempting universal healthcare via government mandate, as I remember with a tax-supported severely curtailed payment system.

While we can't draw any statistically valid conclusions, the poll does add credence to a criticism I've heard from more than a few Fellows and ex-Fellows who don't feel the College always represents their or their patients' best interests. The most

common remark heard from responders opposing universal healthcare was “Yes, we may have a problem with our healthcare delivery system, but I am opposed to any solution which further damages private medical practice and advances the socialization of medical care in order to accomplish a political agenda.” Here’s some of the comments both pro and con the College’s position.

“(No) First step toward socialized medicine.”

“ACOG should not take positions on political issues.”

“(Yes) I support the College’s position but physicians must provide input and some reasonable measure of control and balance.”

“(Yes) With 45,000 uninsured we are at risk of imposition of a single-payor government-run disaster. The question is, should everyone have coverage? If we agree on that the next question is how do we achieve it.”

“(Yes) Given the choice of corporate or socialized medicine, make mine socialized!”

“(No) The old city-funded charity hospital worked well. Residents provided care supervised by attendings. A Medicare-like system will lead to medical ‘mills’ providing poor care.”

“(Yes) The US is the world’s last remaining industrialized nation without this. It doesn’t need to be at all similar to single-payor systems a la Canada and England. All that’s needed is a law requiring everyone to have health insurance, like auto insurance. People, not their employers, should own their policies and premiums should be a tax credit. For the indigent, the federal and state governments pay. Policies should have highly regulated, mandated coverage which insurance companies would have to provide if they wished to participate. There should be no first dollar coverage and deductibles should vary, increasing with the financial means of the patient.”

“(No) I advocate funding healthcare by linking the funding to behavior as recommended by Sen. Hatch and Sen. Childs.”

If the College was legitimately concerned about whether it was voicing the opinions of the majority it could poll the members occasionally, especially on controversial issues, either by automated toll-free call-ins or at the ACMs by offering attendees a chance to approve or oppose selected positions with a pass of their magnetized ID card. It could even progress to a computerized interactive survey via the acog.org website or at ACM terminals. Probably none of these will happen unless a relevant number of Fellows protest, but our worst nightmare might be opening the abortion, “beginning of life”, viability or universal healthcare can of worms.