

DISCRIMINATION AND ABUSE OF RESIDENTS

by Douglas W. Laube, MD, FACOG

The general public as well as legislators and judges have become increasingly intolerant of discrimination and abuse in and beyond the workplace. This is particularly true for gender-based discrimination against women including sexual harassment, discriminatory wage practices, verbal abuse and physical abuse. There have been several prominent highlights such as the 1991 *Time* interview with Francis K. Conley, MD, in which she alleged 25 years of “gender insensitivity” which led to her resignation from Stanford University Medical School’s Neurosurgery Department (See “Hell Hath No Fury”, a review of Walking Out on the Boys by Conley in *The Medicolegal OB/GYN Newsletter*, Vol. VII, No. 3, JULY 1999). At approximately the same time the Anita Hill-Clarence Thomas controversy became public. Scattered articles have subsequently appeared addressing discrimination/harassment during physicians’ training as well as their employment (See *The Medicolegal OB/GYN Newsletter*, Vol. VII, No. 3, JULY 1999)..

As an educator I am particularly interested in the sociological and educational aspects of our specialty, the currently most significant being the dramatically changing ratio between male and female obstetrics and gynecology residents. This ratio has rapidly reversed over the past ten years and now 72% of our current first-year residents are women (National Resident Matching Program database 2000). The increasing predominance of female residents is coupled with a patient population which is 100% female, thereby encouraging the development of a unique social dynamic within our profession. I have particular interest in identifying factors which will encourage all future physicians to maximize their practice and leadership opportunities in obstetrics and gynecology irrespective of gender. In January 1997 the American College of Obstetricians and Gynecologists’ (ACOG) Council on Resident Education in Obstetrics and Gynecology (CREOG) surveyed approximately 4700 obstetrics and gynecology residents. The survey, blinded to both respondents’ names and programs, was intended to determine the degree to which obstetrics and gynecology residents *perceived* discrimination or abusive behavior had affected the process and content of their medical education. An unusually high response rate (94%) allowed us to accurately determine how many residents nationwide see these abuses to be occurring.

Discrimination and/or harassment is legally defined in various Federal statutes reported in the Federal Register, including Title VII - Civil Rights Act for the Workplace (1964) and Title IX - Equal Opportunities for Schools and Universities (1972). In 1980 the Equal Educational Opportunities Commission (EEOC) expanded these to make employers liable for violations. EEOC Article III defines a violation as “...conduct that has the purpose or effect of unreasonably interfering with an individual’s work performance”.¹

Our survey was designed to assess gender bias and discrimination via the following as previously defined by Rowe²:

- Unconscious slights
- Invisibility
- Conscious slights
- Exploitation.

All four are “nonactionable” but represent damaging “micro-inequities” which would extend the 1980 EEOC definition of discrimination to areas not yet recognized by the courts.

Respondents were equally distributed across all four years of residency and conformed to known demographic profiles of obstetric and gynecology residents.

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|--------------------------|------------------------|-----|
| <input type="checkbox"/> | Female | 60% |
| | Male | 40% |
| <input type="checkbox"/> | Heterosexual | 94% |
| | Homosexual or bisexual | 3% |
| | No response | 3% |
| <input type="checkbox"/> | Caucasian | 66% |
| | African-American | 10% |
| | Asian | 13% |
| | Hispanic | 7% |
| | No response | 2% |

<input type="checkbox"/>	University-based	50%
	Community-based	22%
	Combined	22%

Questions regarding abuse and discrimination were categorized as psychological abuse, sexual harassment, racial discrimination or homophobic comments. Each was explored in detail and analyzed statistically by sex, year of training, sexual orientation and race. Considering 60% of respondents were female and 33% other than Caucasian, the results are particularly significant when compared according to the demographic variables of gender and race.

Psychological Abuse

A series of questions designed to discover how many residents felt they had been psychologically abused asked if they had ever been the object of repetitive verbal abuse, humiliation, threats or extra work assignments. A total of 26% responded that they had experienced one or more of the above. The most frequently perceived abusers were attending faculty (16%) and more senior residents (14%) with other healthcare workers accounting for 6.5%. The total of 36.5% reflects multiple responses. There were statistically significant differences in positive responders' gender (women greater than men), year of training (seniors more likely than juniors), sexual orientation (bisexual/homosexual more often than heterosexual) and race (minorities more often than Caucasian). The most common abuses reported were verbal harassment and humiliation.

Twenty-two percent reported they had been verbally harassed, 7% verbally threatened and 8% given "unfair" work assignments including extra on-call duties. Responders perceiving verbal abuse, verbal threats and unfair work assignments were similarly significant by gender, year of training, sexual orientation and race.

Sexual Harassment

Ten percent stated they had personally experienced sexual harassment, most often verbal humiliation and most commonly by attending faculty. Highly significant differences were found by correlating the perpetrator (attending faculty in 7% of instances) with gender and race. The nature of sexual harassment was predominantly verbal humiliation such as gratuitous remarks (8%) but also included unwanted touching and coerced sexual activity (3.5%). All three were again similarly significant by gender, year of training, sexual orientation and race of the responder.

Racial Discrimination

Eight percent stated they had personally experienced racial discrimination, all Non-Caucasians. The most frequently perceived discriminators via discriminatory remarks or behavior were patients, followed by faculty. The type of racial discrimination most often exhibited was verbal humiliation via a request that the resident be removed from a patient's care. Approximately 20% of these positive responders felt "educational information had been withheld" or "information had not been provided which had been provided to the other residents" when faculty were perceived to racially discriminate. Again, women reported this more often than men.

Homophobic References

Fourteen percent had been the object of or overheard homophobic comments, most often from other residents and attending faculty. There was a highly significant difference between homosexual/bisexual and heterosexual residents' perceptions. Homosexuals/bisexuals almost always considered themselves the object of such references while heterosexuals usually did not.

What does the future hold? A majority of current ACOG Junior Fellows are women. Considering the previously noted gender shift the obstetrics and gynecology workforce will be equally male and female by 2014.³ Our specialty must maintain its diversity while refusing to restrict opportunities during this gender shift, avoiding what some have referred to as reverse gender bias.⁴ Gender shifts are occurring to some extent in almost all professions, but will impact the practice of obstetrics and gynecology more dramatically than others due to its unusual momentum within our specialty. It is therefore imperative that medical educators not only be alert to discriminatory and/or abusive actions against minorities based on race, color, creed, sexual preference, religion or female gender but also against men and other previously recognized majorities. Although there are anecdotal references of reverse gender bias within our specialty, it appears these are sporadic and much less frequent than those perceived by women and minorities.

Both academic and clinical leaders should remain cognizant of and indeed have a heightened sensitivity to the implications of any form of discrimination or abuse since these behaviors are recognized to begin early in medical training. Recent articles in the medical literature have addressed abuse of medical students, usually public belittlement and humiliation in apparently misguided efforts by faculty and residents to reinforce learning.⁵ Other authors have reported the harassment of lesbian medical students and physicians.⁶ Charney used a computerized literature search to assess the impact of sexual harassment, discovering a widespread phenomenon reportedly affecting 42% of women and 15% of men in all occupations, 73% of women and 22% of men in training for medical occupations.⁷

This is greater than our data which indicates 26% of obstetrics and gynecology residents experience psychological abuse and 10% experience sexual harassment. These differences are difficult to explain but may relate to the exclusive female gender of our patients, the practically exclusive female gender of our nurses, the relatively young age of obstetric patients, or other demographic and sociologic variables. Regardless, we must adopt a zero tolerance for such behavior.

There are no statutory guidelines for managing patients who, based on personal traits or characteristics such as race, gender or sexual preference, refuse to be seen by a resident physician. These incidents must be considered individually and their resolution based upon what attorneys refer to as “relative availability”. A patient’s request for a female physician may be considered reasonable if physicians of that gender are readily available, but may be considered unreasonable if a female physician is not readily available since honoring the request would require locating extra personnel. I know of no laws or hospital policies addressing this dilemma, so in our department the most senior personnel present have authority to resolve the problem at their discretion.

When based upon a patient’s religious conviction, request for provision on or exclusion from their patient care team of any provider requires preplanning. This includes emergencies and unexpected visits. Notification of her request and the preparations necessary to meet the request should be noted beforehand in the medical record. Failure to supply a healthcare provider of requested gender or race is not actionable. Common sense however tells us compliance with our patients’ religious convictions is important but must be properly planned well in advance. Any patient could sue for damages claiming lack of consent, battery and subsequent injury based upon failure to honor their religious convictions, but to my knowledge no judicial precedent exists.

While the influx of female obstetricians and gynecologists into the workforce should narrow gender-based salary inequities, it will also diminish employment opportunities for their male counterparts and perhaps even require males to alter their expectations of clinical practice in obstetrics and gynecology. Medical data bases do not currently follow gender-based shifts in the marketplace, so these changes remain speculative. In any case we must remain alert to such actions against our male colleagues.

REFERENCES

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Editor’s Note: Following a hearing on 16 March 2000, the North Carolina Medical Board on 27 April 2000 suspended indefinitely an obstetrician/gynecologist’s license effective retroactively to Midnight 14 April 2000. It was claimed and found that:

1. He intentionally discharged a surgical staple from a contaminated staple gun into the finger of a second year medical student during a surgical procedure;

2. He required her to place her hands in the sterile field where blood and other bodily fluids were present even though she was not gloved or gowned, placing both the patient and student at risk and increasing the risk of surgical site infection;
3. He potentially placed the patient at risk for infectious disease and potentially increased the risk of a surgical site infection by placing the staple gun and the forceps used on the student on the Mayo stand.

The Board additionally stated that all but six months of the suspension *might* be stayed if the physician signed a consent order, the specifics of which were not available at deadline.

THE PRESIDENTIAL BOX

by Paul Sinkhorn, President

BUT WHAT HAVE YOU DONE FOR ME LATELY?

Haven't we all asked that at one time or another? It's a question you may legitimately ask me, your Society's President. Where does your dues money go, anyway? I recently asked myself what ASFOG had done for me lately, and the answer was surprising. For only \$100 a year I:

1. Belong to a prestigious international professional society that numbers respected physician leaders, professors and clinicians among its members;
2. Converse and consult easily with other members, gaining valuable information and advice at no additional expense;
3. Put my money where my mouth is by working within ASFOG to improve the medical system and advance the cause of reason in the courtroom;
4. Enjoy the administrative and editorial expertise of Doug Daniel and his editors;
5. Receive semimonthly a stimulating, topical, thought-provoking, cutting-edge *Newsletter* which has grown from a couple of pages into a respected journal;
6. Gain access to an excellent medical expert witness seminar every year at the ACOG annual clinical meeting;
7. Stay current in the rapidly evolving world of legal and clinical medicine;
8. Improve my own standard of practice by heeding the advice of those who have already been there.

I'm definitely getting my money's worth, and I'll bet you are, too.

But we're always looking for ways to draw new members into our Society and add further value for the dues you pay. That's why we're expanding our presence to the Internet, an idea suggested recently by Ray Cestero. There is little disagreement that medicine and law are becoming more entwined with electronic media, and the World Wide Web undeniably has been a driving force. Ray proposed the establishment of an ASFOG web site for members' use via a password with an unrestricted subsite for the public.

Our site could have many components, including a membership list with pictures for those who wish. Old issues of our *Newsletter* could be archived online allowing you to clear one of those shelves in your office. Indeed, your semimonthly *Newsletter* could even be delivered via e-mail, saving the society printing costs. A site search engine could be added to help you find a particular article or phrase. A "malpractice case corner" could discuss interesting and representative lawsuits by publishing submissions from members. An ASFOG site could be listed with various web search engines to gain visibility for our Society and its constituency, adding vitality and credibility to our mission. Most importantly, we could put together a credible Internet site for less than \$500 a year.

As a stop-gap measure, our page on the ACOG website now provides a welcome letter with general information about the Society and unlimited access to back issues of the *Newsletter*. In the future we plan to add a membership list in addition to our Bylaws and Objectives, also including a membership application for those so interested. Simply access the College website at www.acog.org and look for "Affiliates" on the home page.

What do you think? My e-mail address is cpaul@pe.net, and my office address is 4310 Orange Street, Riverside, California 92501. Please send your opinions on the following questions.

- Should we establish a free-standing ASFOG website?
- Would you accept your *Newsletter* sent electronically instead of via snail mail?
- What other features would you like to see in the *Newsletter*?

Also, could those of you with e-mail addresses please send them to me? If you'd like it included in your ASFOG directory listing, please so note.

Lastly, I would again ask each of you to bring in one new member to our Society. More members not only mean more dues money for expanded services. They also supply fresh ideas and expertise, the lifeblood of any intellectual society.

THE WITNESS BOX

by Doug Daniel, Editor

"When I first began to practise, I determined to follow the method of these gentlemen (recognized contemporary medical experts); but having by those means lost several children, and sometimes the mother, I began to alter my opinion, and consult my own reason."

William Smellie, MD (1697-1763)

Early Scottish midwife-obstetrician and preeminent medical educator cum author who began medical practice in 1720 and obtained his MD degree in 1745. Described by his biographer as the bridge from "blundering medieval midwifery to the beginnings of the science and art of obstetrics", and recognized as "The Master of British Midwifery", he is primarily remembered today for his early innovations in design and use of obstetrical forceps plus his contribution to safe management of the aftercoming head in vaginal breech deliveries.

This month we gain two new honorary members. Greg Alexander was the first author and Donna Petersen one of his co-authors on the July *Newsletter's* lead article addressing extremely low birthweight infants. Both are on the faculty at the University of Alabama - Birmingham and there's more on their backgrounds in July's "Witness Box". **Welcome aboard!**

I need the membership's help with a project celebrating the College's golden anniversary, 1951 - 2001. With the assistance of various ACOG Fellows plus Susan Rishworth and Warren Pearse, the College's history gurus, I plan to solicit personal reminiscences on what Past Presidents were like as teachers, mentors, clinicians and persons, written by their former residents if possible. If any of our members were trained by or worked for an ACOG Past President, please call or write ASAP. I need at least five pieces a month with the first to be published in January 2001, so submissions must start almost immediately. There could ultimately be a wider distribution than just in the *Newsletter*.

Good things always seem to come in threes, same as bad things. I'm waiting for the third request to republish Laura Queen's article on domestic violence from our March 2000 issue. Dale Breden used it in his *Forum* for the North Carolina Medical Board and now the West Virginia Board of Medicine has also asked permission to republish in their newsletter, granted of course. Next?

Dan and I have also been solicited to write an editorial on routine drug testing in the healthcare workplace for *The Obstetrical & Gynecological Survey* and of course we have happily complied. There'll be more as to when it's to be published as information becomes available. The request came from the *Survey's* Editor-in-Chief, Robert C. Cefalo, and was even more appreciated since Bob was one of my attendings during residency. Along the same lines, Marian Wiseman at *ACOG Today* is doing a piece on our advocacy of routine drug testing of physicians and other healthcare workers which will focus on our educational activities at the San Francisco ACM. Like the man said, there's no such thing as bad publicity.

Your Board of Directors met via telephone conference call 15 AUGUST 2001 and elected by acclamation Kenny Stall of Indianapolis, Indiana, as our next Vice President - President Elect. He's a founding member of the Society and has shown a continuing interest in its activities. Kenny will take office 1 JANUARY 2001.

On the same date Ray Cestero will rotate off the Board. For the past three years Ray has been an unfailing source of encouragement and help to me and the Society. He has made innumerable contributions including enrolling new members, arranging programs for membership meetings, suggesting ways to make the *Newsletter* better and build our membership, plus always being accessible and available when called upon. Thanks, Ray.

Your Board also discussed the Society's finances which are pretty bleak. As it stands now we have been so successful in pursuing our Objectives that we already owe as much as is expected in next year's total dues receipts, meaning we will face a bare money cupboard on 1 JANUARY 2001. Expanding the membership roll is more important than ever as the Society's very existence now depends upon it. In spite of some members' comments that the benefits of membership, primarily this *Newsletter* and being a part of our educational efforts, are worth far more than the current dues of \$100.00/year, **we will not increase dues.** The *Newsletter* consumes a major portion of our budget and could be severely curtailed to previous standards, but this would only make recruitment of new members more difficult. If anyone has access to those granting corporate or foundation educational grants to non-profits, please call me.

The Society's expected status as the first special interest group to have a page open on the College's web site was discussed and it actually opened 21 AUGUST 2000. It's at www.acog.org on the College's home page under "Affiliates" and has several back issues of the *Newsletter* plus contact info for prospective new members. We plan to include a Society membership list

so if anyone doesn't want the world-wide-web to know they're member, better call me ASAP. It's expected to help membership growth but that remains to be seen. Blaine McCormick has been working with Mark Graves at the College on this for over a year so check it out.

Another topic of discussion related to cost-cutting involved transmitting the *Newsletter* to member's e-mail addresses thereby avoiding printing and mailing costs. Any members willing to receive e-mail issues in lieu of hardcopies should call or write me. I personally enjoy holding it in my hands but in today's Stephen King electronic publishing world I may be a dinosaur.

And the hits just keep on coming! Dan, Blaine McCormick and myself had an article on impaired physicians published in the JULY/AUGUST 2000 issue of *Primary Care Update for Ob/Gyns*, Volume 7, No. 4, pages 154-60. It's essentially portions of the monograph ASFOG published on impaired physicians, but it was extremely rewarding to have Ron Chez, one of *Update's* Editors, solicit the article and even more so to see our names in a peer-reviewed medical journal with an attribution to the Society. If you would like a copy and have trouble finding one, call me.

So Tell Me Something I Didn't Already Know Department: According to the 15 AUGUST 2000 issue of *Ob.Gyn.News*, a north-of-the-border PhD type reported before an assemblage of our Canadian obstetrician/gynecologist colleagues that "[t]he risks of shoulder dystocia and cesarean section are higher among short women, particularly those with large fetuses, than among tall women." Her study included 7,543 low-risk pregnancies with short people defined as maternal height <62 inches, tall people defined as maternal height >65 inches. Short mothers overall had about a two-fold risk of Cesarean section delivery, greater for multiples than nullips. Tall mothers had less than half the risk of Cesarean section delivery if nullips, the same if multiples. Shoulder dystocia risk followed the same trend, short mothers twice the risk and tall mothers half the risk. Comparisons were made to mothers of "average" height, 62 to 64 inches. "We determined that when weight gain was over 33 pounds ... there appeared to be an increase in the risk of adverse outcomes." Randy Neuman must have been right after all.

This month's lead article is by Douglas W. Laube, one of the names forever inscribed above the portals of our profession. He graces us with the results of a recent poll he conducted on harassment and abuse of residents while Chairman of CREOG. Doug was born of medical missionary parents in Calcutta, India, better known as home of the Black Hole and Mother Theresa's orphanage. He grew up all over the world including mainland China while accompanying his parents on their assignments. A 1966 graduate of Macalester College in St. Paul, Minnesota, Doug both earned his MD in 1970 and completed his residency in 1974 at the University of Iowa, in between completing a rotating internship at Hennepin General Hospital in Minneapolis, Minnesota. He subsequently served two years on active duty with the United States Naval Reserve as a medical officer at Quantico Naval Hospital, Marine Base Quantico, Quantico, Virginia. Coinciding with his interest in medical education, Doug found time to pick-up a Masters in Health Sciences in 1978 while on the faculty at the University of Iowa between 1976 and 1993, then accepted the Chairmanship of the Department of Obstetrics and Gynecology at the University of Wisconsin which he still fills.

Doug has also served the American Board of Obstetrics and Gynecology (ABOG) as an Examiner; the Council of Resident Education in Obstetrics and Gynecology (CREOG) as a member and current Chair; the Committee on Inservice Testing for Residents in Obstetrics and Gynecology (CITROG) as a member and Chairman; the Association of Professors of Gynecology and Obstetrics (APGO) as a member; the American College of Obstetricians and Gynecologists (ACOG) as a Fellow and Chairman of its Technical Bulletin Committee; the National Board of Medical Examiners (NBME) as Chairman; *Obstetrics and Gynecology*, *American Journal of Obstetrics and Gynecology*, *Academic Medicine* and *American College of Obstetricians and Gynecologists Primary Care Update* as an editorial reviewer; and all students of obstetrics and gynecology as author of a premier textbook. Awards and honors include Teacher of the Year and Faculty Initiate of Alpha Omega Alpha. Needless to say I have no idea in Hell how I ever got someone like this to write for the *Newsletter*. Maybe I should apply for Frigidaire's sales rep to the Aleutian Islands.

Dave Morrison and Vanessa Goddard supply the whipped cream to top Doug's strawberry shortcake with a superb take on the legal consequences of discrimination against medical students and residents by patients, more senior contemporaries and attendings. While such behavior may have been in the past *de rigueur*, it just won't wash in today's world. Truth be told, it should never have been tolerated in the first place.

Dave and Vanessa, both attorneys with Steptoe and Johnson, are well known to those who remember the dedicated July 1999 *Newsletter* issue on gender bias for their excellent article on discrimination against male obstetrician/gynecologists' employment.

Paul Sinkhorn's President's Box this month examines the benefits of Society membership and they're pretty impressive. He's also working to expand our presence on the Internet and increase electronic services to members. Everyone is encouraged to respond to his requests for opinions and suggestions because otherwise, without a defined interest by the membership, working the web will be less of a priority.

Ben Harer's book review this month blends smoothly into his already established position on maternal choice for mode of delivery. As always, Ben gets right to the crux of the issue and doesn't spare the horses. Just Take It Out! calls for patients to take charge of their healthcare, and they really should have unlimited choice of available options when decisions are a toss-up.

In this month's "Litter Box" I try to come to grips with some peoples' penchant for exaggerating or even ignoring the true state of affairs in order to benefit their own political or social agendas. More specifically, it addresses the flurry of attention the IOM report on errors in medical care and their consequences is getting. Let me know what you think.

Dan Jordan gives us a brief history of an organization near and dear to his heart, the Association of American Physicians and Surgeons. This through-and-through red, white and blue professional medical organization has been around since 1943 trying to preserve what it can of the millennia-old ethics and traditions of medical practice. Dan has been a member since 1966 and a director since 1975, serving as President in 1978-1979 and currently on the Editorial Board of their journal, *The Medical Sentinel*. He's a native of Birmingham, Alabama, earning BA and MD degrees from Emory University in Atlanta. His surgical training was at Grady Memorial Hospital in Atlanta, among the nation's busiest city-county receiving hospitals and one of Emory's teaching hospitals. Dan practiced vascular surgery in Atlanta until his recent retirement, serving ten years as Chief of Vascular Surgery and two years as Chief of Surgery at Piedmont Hospital. In the process he operated on Dad (Have I mentioned Dad before?) numerous times for carotid artery, renal artery and abdominal aorta atherosclerosis. Dad and I agree there's no finer gentleman, physician, or vascular surgeon around than Dan Jordan. Following his article there are reprints of the Association's *Code of Medical Practice* and *Principles of Medical Ethics*. See below for more on two editorials reprinted from *The Medical Sentinel* in this issue.

Stephen Vermillion is with the maternal-fetal medicine department at the Medical University of South Carolina, this month gracing us with an article summarizing the latest thoughts on antenatal repetitive maternal dosing with corticosteroids, both the good news and the bad news. It's a pertinent topic since for years clinical practice has been mostly based on smoke, mirrors and wishful thinking since we all wanted to do everything possible to improve outcomes in pregnancies complicated by threatened premature labor. While disappointing in some ways, the article is well-founded on large, reliable studies.

Stephen is a graduate of the Medical College of Virginia with internship, residency and fellowship at MUSC where he is now an Assistant Professor. He is a member of AOA, a Junior Fellow of the College and has authored more peer-reviewed articles, textbook and yearbook chapters, and even ACOG Technical Bulletins than you can shake a stick at. Sounds like maybe we ought to listen to what he has to say.

For the past four years I've been trying without success to get someone to write an article on the ERISA debate and how it affects clinically practicing physicians. U.S. Supreme Court Justice David H. Souter unwittingly did exactly that with his opinion for the recent unanimous ruling from the Court on HMOs' fiduciary liability under ERISA. The whole ERISA/mismanaged care thing is a can of worms but Mr. Justice Souter put it all in perspective, confirming my worst fears. A piece by me relates ERISA to the biblical injunction that one cannot serve two masters, applied to the quandary faced by physicians practicing in managed care environments with their inevitable rationing of care and physician financial incentives to provide as little care as possible. Most patients would agree that neither is in their best interests. The jewel in the crown for this one is a commentary piece by Cynthia Jones, Esq.

Cynthia is another Steptoe & Johnson attorney, working in their Morgantown, West Virginia, office and specializing for the past fifteen years in employee benefits law. She is a busy lecturer on legal matters in addition to representing employers, fiduciaries and third parties in employee benefits and tax matters. Her opinions are hers alone and not necessarily those of Steptoe & Johnson.

There's also a highlighted verbatim copy of Justice Souter's opinion enclosed. To me it's like the Special Prosecutor's Report on Clinton-Lewinsky: if you really want to understand the issues involved and discuss them intelligently you've got to read the original unabridged version.

I've got another article which at first glance may seem to be only the story of one man's travails in the practice of medicine but on closer examination should be recognized as a warning of how far wrong a situation can go once it hits the fan. This is the best argument yet for mandatory random drug screening of all healthcare workers, especially physicians, if for no other reason than to protect them from unexpectedly vigorous enforcement of sometimes arbitrarily applied rules and regulations. Dan Avery adds his usual cogent and pointed commentary showing me the error of my ways. At least he didn't preface it by calling me an ignorant slut. My only regret is that the North Carolina Medical Board chose not to respond to an advance copy of the piece.

There's also two reprints from the JULY/AUGUST 2000 issue of AAPS's *Medical Sentinel* (Vol. 5, No. 4, pp. 123), the first an editorial by their editor, Miguel A. Faria, Jr., MD, on Medical Savings Accounts (MSAs). These are definitely the wave of the future. The only thing holding them back is federal legislative restrictions, probably at the lobbying of existing HMOs and other healthcare insurance schemes. Their innovative healthcare payment plan is probably the last chance we'll have to put the words private, medical, and practice back together into one meaningful phrase. In the second reprint President Lawrence R.

Huntoon addresses the socialization of medical care by shooting down some of the politically correct arguments being bandied about for national health insurance.

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. Books reviewed in the *Newsletter* as well as an audio cassette tape of the Society's 2000 ACM presentation "The Impaired Physician" are available at no cost to members through the Society's lending library.

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

20 JULY 2000

Dear Doug,

As threatened I read the latest *Newsletter* on the plane from D.C. to home. Again it is an outstanding product.

Regarding "Politically Incorrect" (*The Medico/Legal Ob/Gyn Newsletter*, vol. VIII, no. 4, page 14), the May "green journal" has an article showing about a 30% injury rate to the anal sphincter and 6% fecal incontinence in a series of approximately 150 patients with no grossly observable obstetrical lacerations who were later surveyed and studied by perineal soft tissue ultrasound. I too liberally used forceps and episiotomies with careful repair and never had a dehiscence or abscess. In 1965 I published a series of 500 caudal epidural anesthetics with a 40% forceps delivery rate. I still believe the anesthesia increases need for operative intervention but overall is less traumatic.

A note on the campaign. It is unusual for Mike Mennuti to be unopposed for College Secretary. That office has been contested for at least the last fifteen years. Consider it instead a tribute to his performance and ability. Chuck Hammond is the front-runner for President Elect but one never knows. It might be better to express a personal wish for success rather than an apparent Society endorsement which perhaps would not be echoed by some of our members whom we would not want to alienate. Meanwhile, could you send me an extra copy of the JULY *Newsletter* to circulate out here?

Ben Harer

P.S. Michael Swango is the current US equivalent of Dr. Cream - and he is alive and well!

28 JULY 2000

Dear Ben,

Thanks as always for your letter. Avoiding the proverbial injunction to take first things first, I probably should explain how I came to the endorsement of Dr. Hammond for ACOG President Elect. It was not without considerable thought beforehand. I perhaps made too fine a distinction between political endorsement by the *Newsletter* as opposed to by the Society and should have referred to "the *Newsletter's* editorial offices" instead of "the Society's editorial offices". Maybe that fine a distinction actually cannot be made but editors in our country have traditionally made their publications' endorsements known to readers either to promote personal political beliefs or to subjectively guide readers in voting for the candidates perceived most qualified, albeit usually when the periodical was privately owned. In this instance everybody knows the Committee on Nominations' slate of candidates is as good as inaugurated barring a wholesale revolt by the Fellowship's withholding their proxies and personally taking over the ACM business meeting, a remote possibility which I hope never to see. Neither I, the *Newsletter*, the Society nor any other Fellow, clique, special interest group or medical professional organization should have a political agenda for College leadership since such only causes unnecessarily damaging dissatisfaction within any institution, more especially this one of ours, and is best evidenced by the often embarrassing partisan conduct of our national government's elected leaders.

About 25 years ago I had the extreme pleasure of being introduced to Dr. Hammond during an ACM in Chicago by one of his trainees who was at the time more or less my residency mentor. Over dinner with a small group in a local restaurant I found him to be unusually personable and approachable, and years later found the same to be true when I called him about accepting a private patient for treatment of recurrent trophoblastic disease. Certainly he has one of the top reputations in our speciality for research, teaching and clinical care. Without taking anything away from the other candidates, I simply do not know anything more about them than what I read in *ACOG Today*.

Secondly there was the purely selfish motivation that perhaps the "Ballot Box" piece would at least stir up some response from our readers. One out of two ain't bad.

Now to address your clinical comments. You couldn't be more right. Dad used to tell me the definition of a clear thinker was someone who agreed with you and Ralph Hale seems to be backing us both up in his latest *ACOG Clinical Review*,

Volume 5, No. 4, JULY/AUGUST 2000. He makes some cogent observations about two particular articles suggesting more than slightly hyperbilirubinemic sclerae on his part. The first article was published in *The British Medical Journal* and investigated the incidence of anal incontinence via self-reported unintended passing of feces or flatus among surveyed postpartum primigravidas delivered at Harvard's Brigham and Women's Hospital (Signorello LB, et al. Midline episiotomy and anal incontinence: Retrospective cohort study. *BMJ* 2000;320:86-90). If anyone's interested it's available for free at the British Medical Journal's website, www.bmj.com/cgi/content/full/320/7227/86 along with an accompanying editorial plus e-mail and published snail mail responses.

The authors retrospectively and observationally studied 626 term (>37 weeks gestation), singleton, vaginally delivered primiparas of whom approximately 1/3 delivered over an intact perineum or spontaneous 1st degree perineal laceration; 1/3 over a spontaneous 2nd, 3rd or 4th degree perineal laceration; and 1/3 over an episiotomy (almost exclusively midline). There's no indication whether patients were from the private service, teaching service or a mix of both. The only clue as to the expertise of those performing the deliveries and repairs is the term "physician or midwife who attended the birth". Obviously accoucheur training, experience and expertise are major determinants in how often, early and extensive episiotomies are cut not to mention how well they are repaired. I suspicion the study involved only patients on the teaching service attended by either residents and midwives in training or fully-trained midwives, all three known to be stereotypically biased against episiotomies and therefore usually without benefit of extensive expertise in their repair.

First contact regarding the study occurred via letters mailed the week before patients would have been six months postpartum asking if they could remember experiencing fecal or flatal incontinence as late as three months postpartum and if they still experienced these symptoms. Ralph was concerned about possible bias related to the phrasing of questions asked but these were not quoted in the article so there's no way to tell. After controlling for variables about 10% of episiotomy patients recalled fecal incontinence at three months while less than 5% of the rest did, and all groups reported about half the incidence at six months as recalled for three months. As for flatal incontinence 1/3 of episiotomy patients remembered symptoms from three months and almost 1/4 reported symptoms persisting at six months, while 1/5 of the rest remembered symptoms from three months and 1/10 persisting at six months. The most interesting thing is that every incidence at six months postpartum was markedly less than that remembered from three months, almost always 1/2 or less among those reporting fecal incontinence, yet the study did not continue to follow patients until the symptom incidences stabilized.

These findings are most suggestive of a transient pressure neuropathy. I remember once sustaining a femoral nerve trauma after spending several hours with a deep-sea rod-and-reel firmly planted in my groin while salmon fishing. Within several days a marked sensory anesthesia developed along the medial aspect of my right thigh with tenderness and induration in my right groin. Scared me to death but the neurologist said not to worry, it was only a transient pressure neuropathy similar to the classic "Saturday night palsy" of the ulnar nerve experienced by drunks who spend hours over a weekend passed out and lying head-down on their forearm at a bar or table. He also said it should begin to improve within three and be completely resolved within twelve months, and he was right.

There was also an obvious selection bias for episiotomies. Length of the second stage of labor for those delivering with intact perineum or 1st degree spontaneous lacerations was almost half that for episiotomy patients and markedly less than for those experiencing spontaneous 2nd, 3rd or 4th degree lacerations. Rate of instrumental delivery by vacuum or forceps for the first group was almost 1/10 that of the episiotomy group while the rate for the second group was almost 1/3. Average birthweight consistently increased across the three groups but probably not significantly.

On top of all this the spread of 95% confidence intervals looks like the final score of a Mets - Yankees game. A potentially confounding factor which concerned me but apparently not the investigators was whether patients were taking antihyperlipidemics or adding non-absorbable dietary fats such as Olean® potato chips to their diets, both of which can cause flatal and fecal incontinence. Today more and more patients in the US are being treated for elevated serum lipids and many non-lactating postpartum patients are frequently on weight reduction diets.

The response to the article was the most interesting and perhaps telling aspect of the whole thing. One response from three residents at Georgetown decried the senseless and brutal savagery committed against woman's mystically sacred perineum as referred to in my original "Politically Incorrect" piece. Another from a resident in parts unknown advocated mediolateral episiotomy as superior to midline. As a resident I was easily drawn to recently published radical positions in opposition to the traditional teachings of my attendings, unable to draw upon clinical experience or developed expertise and everwilling to contribute to the reeducation of those now retrospectively recognized as much wiser than I. The same phenomenon was encountered among my charges years later when as an attending I had, so to speak, defected to the enemy.

The remaining responses came from Brits or those apparently practicing in the Commonwealth. Two, one from a lady of unknown credentials and another from a female RN, espoused the politically correct feminist party line. One from a female MD and a gender neutral obstetrician/gynecologist figuratively threw the whole article out the window by criticizing its statistical calculations and study design while advocating mediolateral episiotomy when necessary as superior to midline. An Aussie male MD equivocated about how his insecurity and lack of training in repair of anal sphincters plus medmal liability fears limited him to using mediolaterals while criticizing the article's failure to consider the accoucheurs' expertise or extend follow-up beyond six

months. The BMJ's official editorial response was a refreshingly candid admission that we really don't know what the Hell we're doing. The final response praised the article while rambling about misdiagnosing leprosy (I don't know either.).

If anybody's interested, I'm willing to work on a busy training program's L&D doing routine midline episiotomies and repairs until 200 to 250 patients unselected for parity can be enrolled with term prepartum or intrapartum anal manometry and/or ultrasound to be reevaluated every three months until stable. Simultaneous postpartum cohorts of completely intact perinea and all spontaneous lacerations could be much more easily obtained. The reality is that patients would have to be paid participants since they would experience more than a little inconvenience but it should answer the question once and for all of whether it's the episiotomy or the repair that's responsible for complications. I suspect that for multiparas, timely episiotomy and properly performed repair would improve anal sphincter competence and function.

The second article (Impey L, et al. Epidural Analgesia need not increase operative delivery rates. *Am J Obstet Gynecol* 2000;182:358-63) investigated the incidence of operative delivery among 3000 patients delivered at the National Maternity Hospital in Dublin, Ireland, home of active management of labor and over 7000 deliveries a year. Why we publish the Brit's studies and they publish ours I'll never know.

Over seven years the first 1000 consecutive nulliparas who delivered a cephalic singleton after spontaneous onset of labor during 1987, 1992 and 1994 were studied. The 1987 cohort was determined retrospectively and the other two prospectively. All study patients were candidates for active management of labor (aggressive Pitocin® augmentation and delivery within twelve hours, by Caesarean section if necessary) by being nulliparous. Use of EFM was constant but only a surprisingly low 35% of labors, apparently markedly increased after 1994 by a new departmental regime. Relatively high-dose long-acting epidural anesthesia was induced very early in labor (diagnosed on the average at less than 2 cm cervical dilation) and continued until after delivery without allowing resolution of sensory blockade during the second stage of labor.

Over seven years their epidural anesthesia rate increased from 10% to 57% with essentially no change in their Caesarean section rate (3.8% to 5.0%) or rate of operative delivery via vacuum or forceps (12.6% to 14.1%), pretty impressive at first glance. Considering their overall Caesarean section rate increased from 5.9% to 8.8%, even more amazing. But let's look a bit more closely with our jaundiced, skeptical eye. Pitocin® augmentation of the first stage of labor remained fairly constant by only increasing from 43% to 49%, but initiation of Pitocin® augmentation during the second stage increased from 1.5% to 7.9%. Perhaps a more appropriate title for the article would have been "Increased usage of aggressive Pitocin® augmentation during the second stage of labor maintains operative delivery rates in spite of increased usage of epidural anesthesia early in labor". The extra copies are on their way.

Doug

11 AUGUST 2000

Dear Doug,

I have been serving as a medical expert witness for approximately fifteen years and have done 30 to 50 reviews, approximately 20 formal depositions and one court appearance. In spite of this I was recently snookered by an opposing attorney and I want to share the lesson so others don't have to repeat it.

I was hired by the plaintiffs' attorney to review a complex obstetrical case. During the course of my review I made extensive notes as is my customary practice. I met the attorney who hired me for about an hour prior to the deposition in order to review the case, anticipate questions and discuss strategy. When asked what I should do with my notes, he said to let him keep them since that would protect them from discovery under attorney-client privilege.

About two minutes into the deposition and after asking the usual preliminary questions, defense counsel asked if I had prepared any material for the deposition. I truthfully replied that I had made notes but gave them to plaintiff's counsel. He then asked if I had made the notes for my own use or plaintiff counsel's.

This stumped me because I had never considered that question before, nor had the pre-deposition conference covered it. After thinking for over a minute, which seemed like an hour during the deposition, I replied that the notes were prepared for my own use.

The questioning attorney then smoothly turned to plaintiff's attorney and stated he would therefore like to have a copy of those notes or he would subpoena them. I obviously had given the wrong answer, and instead should have replied that these notes were prepared as work product for plaintiff's counsel.

That seems like a common sense reply in retrospect, but in the tension of the moment and trying to be as truthful as possible I had incorrectly responded that I was making the notes to remind myself of the record. The notes' discovery probably expedited the deposition because the defendant had indeed practiced below the minimum acceptable standard of care and was responsible for the plaintiff patient's injuries. While this may not always be the case, working materials should be kept between the medical expert witness and his side's attorney. out here?

Rob Olson

21 AUGUST 2000

Dear Rob,

Thanks for your letter. It's always easier to learn from the mistakes of others, but I'm not sure you really made a mistake. I, too, make usually copious notes when reviewing cases and even press attorneys to authorize formal written reports, expecting them to be quickly made available to the opposing attorneys. These reports objectively address both sides' strengths and weaknesses, always giving the expected testimony in rebuttal from myself or the opposing expert. If the attorney doesn't want to risk your possibly adverse testimony, he'll ask someone else to go to the dance. Either way you maintain your reputation and credibility.

Some attorneys resist for the very reason you mentioned, protection from discovery. Experience has shown however that written reports, as well as copious notes, usually expedite the discovery process and especially depositions. Many times I simply read the notes into the deposition record. If well executed, they may even prevent prolonged discovery and trial. Of utmost importance to the medical expert witness is that he not shade the truth, misrepresent facts, omit facts or conclusions, or in any way conceal evidence adverse to the client's position. When working for the plaintiff you are allowed to view the evidence in the light most favorable to his position, and I suppose the same is true when working for the defense. Otherwise the only wiggle room you get is in not answering questions unasked by the opposition.

In the predeposition and pretrial meetings I always give the attorney my file and ask him if there's anything he wants to keep during the proceeding. But when directly asked about documents he may have been given, I answer without hesitation that they are in his possession and let the attorneys argue the issue with the judge.

Unlike you, I do make the notes for my own purposes, i.e. to help me prepare my report or discuss the case with the attorney. The thing to remember is that whatever you write or prepare professionally, either clinically or medicolegally, should always be considered discoverable. If you don't want to have to eat it in the future, don't commit it to paper.

THE BOOK BOX

A MATTER OF CHOICE

by W. Benson Harer, Jr., MD

Just Take It Out!
D. Campbell Walters, MD
Unillustrated. 271 Pages. Mount Vernon, Illinois:1998
Topiary Publishing
Softcover, \$16.95 +\$4.00 S&H

Everyone enjoys reading a well-written book, even more if it clearly and concisely presents in compelling fashion a rational position on a controversial subject. Dr. Walters' book espousing the heretical belief that women should have the right to choose between vaginal or Caesarean delivery of their children and also opt for unrestricted elective hysterectomy, given proper informed consent, certainly meets these criteria.

A previous editorial (Harer WB. Patient choice cesarean. ACOG Clinical Review March/April 2000; 5:1) seems in retrospect a Readers Digest condensation of the Caesarean section portion of this book. Just Take It Out! was written for patients, albeit of more than average education. My editorial was written for fellow obstetricians.

Despite having two of his mentors, Philip DiSaia and Edward Quilligan, write the book's forward, Walters is clearly the stereotypical clinical obstetrician/gynecologist laboring in the vineyard of a community hospital and caring for ordinary middle class patients in today's pressure cooker environment created by unconscionably profit-driven managed care organizations working in concert with ill-advised government agencies.

The concept that an ordinary woman could best make choices regarding her own health is an outrage to the mythical male physician who allegedly makes a career of victimizing women. It's also an intolerable affront to the hardcore feminist who has no confidence in her sisters' intelligence or reason. Each of these extremists in their own way knows what is best for their patients/sisters and fears the consequences of allowing independent choices contrary their respective ideology.

This book is clearly a dangerous work which should be suppressed. Not only does it lucidly state the facts but it raises a call to action, going so far as to provide examples of letters activist patients can send to their insurance carriers and government officials. It also provides various patient-doctor contracts or patient-designed care plans intended to restrain medical interventions.

But I'm getting ahead of myself. Walters' introduction is a concise statement of principle which every obstetrician/gynecologist should read. The last two paragraphs are worth quoting in their entirety.

"I refute those who would claim that they are giving advice to women based on a balanced presentation of the facts. The facts as they are currently represented have been heavily loaded in favor of alternative agendas, primarily the financial agenda of the insurance company. I will make no apology for the fact that I have gone out of my way to present a contrary position, which challenges the conventional wisdom of current health care policies for women on just about every point. I suspect that a good many of my colleagues secretly harbor similar views, but are concealing them according to the dictates of political correctness.

"I am throwing down the gauntlet, issuing the challenge for a national debate. But I will not be satisfied to begin this debate with the loaded questions and presumptions which we are currently facing. Let us not ask the question, 'How can we reduce the number of *unnecessary* (sic) hysterectomies and cesarean sections?' Let us rather ask the question, 'Are women receiving the medical treatment which they need and deserve?' We must also ask, 'Are women being given the information to make the right choices? Are they getting all of it?'"

Walters initially attacks the ill-conceived and fortunately now abandoned goal of a 15% Caesarean section rate nationwide. He later examines those common patient questions which can never be accurately answered: “When will the baby will be born? How big it will be? Can I deliver vaginally?” What is so bad about a Caesarean section delivery anyway? His carefully reasoned analysis shows how inclusion of moribund mothers distorts morbidity and mortality statistics. It also shows how inclusion of emergency cases magnifies perceived risks not relevant to elective Caesarean sections. An equally convincing cost analysis confirms my long-held conviction that elective Caesarean section is ultimately no more expensive than vaginal delivery.

Later chapters deal with the supposedly common though rarely discussed postpartum problems of sexual dysfunction, stress urinary incontinence and the allegedly vastly underreported incidence of fecal and/or flatal incontinence. Another demystifies for potential plaintiff patients the medical implications of neurologically damaged infants, additionally providing a simple though detailed explanation of EFM’s interpretation and limitations. Both could go a long way toward averting the filing of nonmeritorious claims. The downside is that patients reading this will have no tolerance for obstetricians’ prolonged efforts at accomplishing vaginal delivery, especially if the cost is a neurologically damaged infant. Little information here is new to those who daily work in Labor & Delivery suites, but its presentation can be easily understood by medically unsophisticated patients.

Almost all obstetricians have been faced with managing an apparently uncomplicated pregnancy near term suddenly found to have absent fetal heart tones. If you haven’t encountered this yet, you will. It is one of the most devastating experiences possible for an obstetrical patient, her family and all members of her healthcare team. Walters’ discussion of this fortunately rare disaster is nicely done for most patients in a valuable though perhaps disturbing read. He advocates elective delivery at 39 completed weeks gestation, either by induction or Caesarean section. This imposes additional liability risk upon those obstetricians who encounter intrauterine fetal deaths after 39 weeks.

We have so effectively reduced maternal and fetal morbidity and mortality that we now find ourselves in the uncomfortable position of trying to decide whether to trouble our patients with the discussion of arcane, infrequent, but still very possible complications. We thereby may inadvertently promote the same unrealistic patient expectations we so often complain about.

Walters alludes to a letter to the editor of *The Lancet* (Al-Mufti R, et al. Obstetricians’ personal choice and mode of delivery. *The Lancet* 1996;347:544) advocating patient choice in mode of delivery. While most patients without recognized medical justification for Caesarean section deliver vaginally, a survey of 206 London obstetric residents and attendings found that 31% of females would prefer Caesarean delivery themselves or for their partners compared to 8% of males. Reasons given were concern over perineal damage with subsequent stress urinary incontinence, anal sphincter damage, sexual dysfunction and fetal damage related to vaginal delivery. When carrying a breech presentation with an adequate maternal pelvis, 57% of nulliparas and 40% of multiparas preferred Caesarean section.

The obstetrical choice section concludes with a prescient vision of life on a future starship where at the appropriate time babies are “transported” out of their mothers’ uteri. The ever-present galactic plaintiff attorney is at the bedside, ready to pounce if there is a millisecond delay in management which could limit the child’s IQ to only 130.

The next section relates to hysterectomy and here the scene becomes a bit murkier. After all, a fetus must come out regardless, but not necessarily a uterus. The compelling argument is that only a patient can choose between the potential quality-of-life benefits of hysterectomy and its risks. The author appropriately dismisses the 10% of hysterectomies done for gynecologic malignancies. Leiomyomata, endometriosis, pelvic pain and abnormal uterine bleeding are all well addressed in a way the typical high school graduate should be able to comprehend, a bit above the 8th grade reading level most patient education materials are written for.

The lack of concordance between symptomatic relief and identified pathology is also skillfully addressed. A cost comparison of no hysterectomy, algorithmic progression to hysterectomy or “just taking it out” to start with is well reasoned. The risks of other therapies are equally well considered. Short-term thinking and cost aversion analysis, both beloved by insurers, are poor approaches to patient care over the long haul if symptoms remain unresolved. That nasty word “unnecessary” is also acutely parsed as related to the interests and perceptions of all parties involved. The final section discusses with candor and sensitivity such issues as medical ethics, informed consent and minimum acceptable standard of care, relating these specifically to patients’ interactions with their physicians, insurers, employers and attorneys.

Walters makes a clarion call for physicians to stop being spineless wimps (my words) and instead become true patient advocates. He challenges them to stand up to oppressive insurance and government edicts by demanding an unrestricted, honest dialogue, most importantly respecting the autonomy of informed women to decide for themselves what is and is not in their best interest.

A thought provoking book. So what is the down side? First of all, it probably won’t get wide distribution despite its modest cost of \$16.95. Secondly, it’s already outdated in the sense that some of its dire predictions, such as all VBAC candidates being forced to undergo a trial of labor, have mercifully been rejected.

Finally, the prologue and epilogue focus on the life and death of Hungarian obstetrician Ignac Philipp Semmelweis. They relate the story of how contemporaries ignored and berated his revolutionary approach for effectively eliminating puerperal fever, but don't quite parallel today's situation. The medical establishment and particularly the American College of Obstetricians and Gynecologists, frequently cited in support of Walters' views, are not as obstinately unenlightened as their 19th century counterparts. I have always wished more folks would credit Semmelweis's contemporary, pathologist Oliver Wendell Holmes of Boston, for his contributions to the demise of childbed fever.

Just Take It Out! is available from your local or Internet bookseller, or directly from:

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Post Office Box 1211
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Fax: 618.242.1813
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Website: www.womensreproductiveinfo.com

THE LITTER BOX

AMERICA'S FAVORITE PASTIME

by Doug Daniel

Unless there has been another players' strike or owners' lock-out by the time you read this, baseball probably still reigns as the traditional favorite pastime of untold numbers of summer and fall couch potatoes/sports fans. I've always been intrigued by the seemingly inconsistent reactions of fans, managers, sportscasters and players to baseball umpires and scorers. Both make judgment calls which may sometimes be questioned yet the umpires get booed, have their shoes scuffed with dirt and spat on, get managers in their face yelling and spraying them with tobacco spittle while the scorers only get occasional groans or headshakes accompanied by frowns and quizzical looks. Why the difference?

For one thing, scorers' determining and assigning errors has no effect on who wins or loses whereas umpires' calls directly influence game outcomes. Scorers in the pressbox mainly compile player statistics regarding hits, runs and errors for the record book publishers and baseball card manufacturers using standard guidelines while umpires keep the game on the field running according to standard rules of play. Probably the most important reason is that recording individual player errors is inconsequential to the final score while calling balls, strikes, foul balls, outs and safes are the exact opposite.

We in medicine today face a somewhat different conundrum: apparently our errors, even trifling slips of no consequence to patient care outcomes, are more important than whether we win the game, i.e. cure our patients. You're all familiar by now with the dust-up over errors in medical care which first surfaced in the late 1970s, grew among patient advocates during the 1980s, became legitimized by the Colorado/Utah and Harvard studies during the 1990s and culminated in the 2000 Institute Of Medicine (IOM) report. Politicians recently trampled each other in their stampede to climb on the band wagon before it left without them, various patient advocates and activists have decried these apparent crimes against society from the rooftops, and some of our most prominent physician leaders and national medical organizations have begun exploring very expensive solutions while crying *mea culpa*. For what? A problem which may not even exist and if it does is apparently of much smaller importance than originally proclaimed.

The first voice of reason to be heard came from three colleagues at the Regenstrief Institute, Indiana University Center for Aging Research, Indiana University School of Medicine in Indianapolis and spoke from the pages of the prestigious *Journal of the American Medical Association* (McDonald CJ, et al. Deaths due to medical errors are exaggerated in Institute of Medicine report. JAMA Vol. 284, No. 1, 5 JULY 2000, p. 93). In the interest of unbiased journalism, *JAMA* had one of the authors of the Harvard study reply (Leape LL. Institute of medicine medical error figures are not exaggerated. JAMA Vol. 284, No. 1, 5 JULY 2000, p. 95).

The gist of it is the guys from Speedway City claim the chaps from Cambridge don't know their statistical stethoscopes from third base, and instead incited widespread panic by irresponsibly throwing around phrases like "Preventable adverse events are a leading cause of death" and "...at least 44,000, and perhaps as many as 98,000, Americans die in hospitals each year as a result of medical errors." More objective statements like "Although some hospital deaths are preventable, most will occur no matter how many 'accidents' we avoid" were heard from the Pacers' home court.

Only an idiot would hold that errors never occur in our care of patients, an even bigger idiot that physicians never make mistakes. Mistakes are a part of life; "To err is human". That's no excuse for not integrating available non-human technology into our patient care whenever possible. Properly designed and operated machines seldom make mistakes and the less input we fallible humans have the better they function. Computer technology has revolutionized almost every aspect of our life today both on and off the planet. Manufacturing and practically all areas of science including medicine use digital technology in ways unimaginable just ten years ago. The exception is direct patient care which in comparison lags far behind hospital inventory control and accounts receivable in computerization.

Most of the preventable medical errors I have seen were related to pharmaceutical treatment. The most common problem has been illegible prescriptions and doctors' orders. Years ago I addressed the first by phoning-in all prescriptions whenever possible, giving me the benefit of communicating directly with a trained pharmacist who can answer questions about costs, newer formulations, effective dosages, adverse reactions and generic alternatives. Living in a small town makes it easier because I usually know the druggist personally and enjoy the chance to chat.

I've never worked in a hospital with computerized medical records necessitating physicians keyboarding their orders but it's obviously the best solution to illegibility. In the alternative I did try to write as legibly as possible. Most importantly I always

took the order sheet to the patient's nurse and asked her to read my orders before I left the nurses' station, encouraging questions.

The next most frequent medication errors I have seen were due to patient misidentification, most commonly in the Emergency Department or Labor and Delivery where occasionally unmanageable workloads were used to justify hastily conferred verbal instead of written communications. This one's a no brainer. The Veterans Administration has already literally got it wired with a bar code on their patient I.D. bracelets and another on their unit doses, both read at the bedside before administration with portable laser scanners just like at WalMart. If all systems aren't go and everything kosher, the pharmacy computer will not approve administration. It knows what every patient's medications and allergies are, their drug dosages, and the proper times for administration. This also eliminates shift change double dosing caused by a nurse forgetting to write a dose on the Medication Administration Record. Thirty years ago the unit dose system was a big step forward in hospital administration of drugs but it didn't go far enough. Today with computer oversight and approval almost every medication error is preventable, even in the E.R. and I&D.

Another frequent and preventable error is misidentification of patients' laboratory specimens, again amenable to bar coding of I.D. bracelets and specimen containers. Some labs already use computer generated bar code labels printed at the site where the specimen is obtained. The same is true of identifying patients for diagnostic imaging studies, not to mention patients in the O.R. suite and recovery room.

None of these solutions addresses the problem of physician errors due to faulty subjective reasoning, lack of expertise, lack of attention or simply failure to properly discharge patient care responsibilities. There are no computers to prevent such mistakes nor will government regulation, oversight or mandatory reporting stop them. Instead we must rely upon responsible credentialing procedures, being our brother physician's literal keeper via effective and fair peer review, commitment to a philosophy of risk management focused on eliminating future recurrences of preventable adverse events and not on covering our backsides *post facto*, advocacy for identification of impaired healthcare workers via routine drug screening with an emphasis on rehabilitation, and of course professional licensing. There will still be instances when individuals or entities decide such solutions are too expensive to implement and don't apply to their special circumstances anyway. For these there will also still be smart and dedicated medmal plaintiff attorneys to make business as usual with its inevitable mistakes too costly to continue.

There's another widely proclaimed travesty of 44 million Americans suffering under the burden of no health insurance, addressed in one of this issue's reprints from the Association of American Physicians and Surgeons' *The Medical Sentinel*. The whole thing reminds me of Dad's warning years ago about people trying to convince me it was raining while they pissed on my shoes. It's always wise to question the illogical, instead relying on common sense and personal experience.

LEGAL RAMIFICATIONS OF ABUSE AND DISCRIMINATION

by C. David Morrison, Esq.
Vanessa L. Goddard, Esq.

One need not consult a crystal ball to know that today the majority of our society considers morally reprehensible any discrimination or harassment based on gender, race, national origin, sexual preference or other immutable personal characteristics. Innumerable state and federal laws have been enacted to both deter these behaviors and compensate their victims. Determining the applicability of these laws to the broad spectrum of potential discrimination and harassment claims while considering possible factual permutations is about as accurate as fortunetelling or palmreading.

Discrimination against and abuse of obstetrician/gynecologists takes place in a very unique environment, so legal protections can be somewhat cloudy. Like any good fortuneteller, we can however reasonably predict the legal ramifications of such conduct by applying basic assumptions of applicable law. Undoubtedly many residents are abused and harassed by superiors as part of their "rite of passage". Without question many male obstetrician/gynecologists experience discrimination by their patients which is rationalized using claims of preference, privacy or religion. With these assumptions we look to the law only to discover that such discrimination and harassment have not been specifically addressed either by lawmakers or the courts. Is it illegal? Perhaps. Let's consult our crystal ball.

Abuse of Residents

Title VII of the Civil Rights Act of 1964, as amended in 1991, makes it unlawful for an employer "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin[.]"¹. If a resident can link the abuse he or she has received to one of these protected traits, then the law provides a remedy.² Even " 'nonactionable' but . . . damaging 'micro-inequities' " can lead to legal problems. For one, it is not that difficult for an individual to make a preliminary showing of discrimination, known as a *prima facie* case, nor is it difficult to allege harassment. Thus medical employers can face substantial losses in time and adverse publicity plus professional fees for legal and public relations services before these "nonactionable" claims are finally put to bed. For another, one cannot predict when formerly unprotected conduct will become actionable. To date no claims of resident abuse have made it to trial but their time may yet come.

Although not actionable under Title VII these "micro-inequities" might be litigated under other legal theories. One is intentional infliction of emotional distress, otherwise known as the tort of outrage. To make this claim the plaintiff must prove that the abuser's conduct was so outrageous in character and so extreme in degree as to be beyond all reasonable bounds of decency, regarded as atrocious and utterly intolerable in a civilized community.³ The plaintiff must also suffer severe emotional distress.

In the case of an abused resident, he would have to show that the manner in which he was singled out, embarrassed, threatened, verbally abused, ridiculed or humiliated was outrageous. While there are no reported cases in the context of resident abuse, and this is typically a difficult claim for plaintiffs to win in some jurisdictions, it remains a real possibility for future litigation.

Similar claims have been brought by employees against their employers for harassment at the hands of their supervisors. Last year in Texas some GT&E employees brought a successful claim for intentional infliction of emotional distress.⁴ On a daily basis their supervisor yelled at and cursed them, forced them to do humiliating things like wear Post-It® notes on their person when they forgot something, assigned them menial tasks like vacuuming their offices even though GT&E had a cleaning service, and called employees into his office to simply stare at them for prolonged periods of time.

The court noted that neither insensitivity, rude behavior nor "insults, indignities, threats, annoyances, petty oppressions, or other trivialities" rose to the level of extreme and outrageous conduct. In the workplace employers must remain free to criticize and discipline their employees so something more must be shown. In this case the supervisor's behavior as a whole put his conduct beyond ordinary employment disputes and into the realm of "extreme and outrageous conduct".

The bottom line is that neither healthcare professionals, employers nor patients have *carte blanche* to abuse residents, yet they also need not cater to supersensitive residents. In analyzing the legal ramifications of resident abuse one must consider the conduct involved *in toto*. Individual incidents of humiliation and verbal abuse must be tolerated but an extreme pattern of this type of behavior may culminate in a successful claim alleging intentional infliction of emotional distress. Thus, a conservative soothsayer would foretell of future lawsuits based upon egregious incidents of resident abuse while warning hospitals and

healthcare providers to promptly address such abuse with employee training programs, clear prohibitions in personnel policies and procedures, and prompt disciplinary actions against all violators.

Discrimination by Patients

The legal mists within our crystal ball become much thicker when queried about discriminatory obstetric and gynecology patients, only compounded by a unique 100% female population. Patients typically discriminate for one of three general reasons: preference, privacy or religion. We can dispose of patient preference quickly. Leaving aside for now the issue of gender, hospitals and other medical employers cannot justify discrimination by laying blame on their customers, i.e. their patients. No court would find Caucasian race to be a Bona Fide Occupational Qualification (BFOQ) for being an obstetrician/gynecologist simply because some patients prefer to be cared for by Caucasians.

A BFOQ is a recognized exception to Title VII's ban on discrimination. It permits employers to hire based on sex, religion or national origin qualifications, and only on these, when it is "reasonably necessary to the normal operation of that particular business or enterprise."⁵ The Equal Employment Opportunity Commission (EEOC) has issued guidelines stating that the BFOQ exception to Title VII is not applicable to the "refusal to hire an individual because of the preferences of coworkers, the employer, clients or customers[.]"⁶

Does the guideline resolve the matter when gender is at issue? This question has been tested in legal forums regarding other job categories such as labor and delivery nurses or prison guards with varying degrees of success but it has not been tested with specific reference to male obstetrician/gynecologists. Precedent cases are of limited assistance in determining how courts would view discrimination against these physicians because there are unique differences between the jobs in question.

For instance, unlike male obstetrician/gynecologists, male labor and delivery nurses are not preselected by their patients. Labor and delivery nurses are often complete strangers to their patients. The law has recognized the privacy rights of patients to "shield one's unclothed figure from view of strangers, and particularly strangers of the opposite sex"⁷, so male labor and delivery nurses usually lose their lawsuits. The law notes that prisoners have fewer expectations (and rights) of privacy than the rest of society when guards are assigned to prison areas housing inmates of the opposite sex, so these cases more often are decided in favor of the guards. Given the above-stated EEOC general guideline, medical employers should nonetheless hesitate before making a hiring decision based upon an obstetrician/gynecologist's gender.

When we consider the remaining two general reasons for discrimination against male obstetrician/gynecologists, privacy and religion, we find that medical employers face another obstacle: their bottom line. Most healthcare professionals obviously strive to respect their patients' privacy and religious beliefs. If they do not and nonconsensual touching takes place, they may be charged with criminal or civil assault and battery. Unfortunately for medical employers obstetric and gynecology patients have increasingly shown a preference for treatment by other females, a trend which arguably may cut nondiscriminating employers' profits but is no excuse for discrimination. The safest practice and the right thing to do is hire based upon professional qualification instead of gender, arranging when reasonably possible the preferred coverage for all objecting patients.⁸ Attempting to discern patients who object for religious or privacy reasons is likely to lead to trouble, so it's best to resist the urge.

Conclusion

As spouses of a physician and a psychologist and as lawyers who defend medical employers, the authors are especially sympathetic to physicians, employers and patients facing these issues. Our crystal ball has revealed a myriad of competing rights and hazy or nonexistent legal precedents. We are strong proponents of diversity training to heighten the sensitivity of every healthcare worker to these issues. Providing such training may indeed benefit any employer later accused of harassment or abuse. He may demonstrate to a court or jury that he tried to show his employees and doctors the evils of discrimination and prevent its practice.

What does the future hold? We can only guess, but forward-looking medical employers and physicians will be well-served to treat everyone with respect.

References

1. 42 U.S.C. § 2000e-2(a)(1).
2. *See, e.g., Lipsett v. Univ. of Puerto Rico*, 864 F.2d 881 (1st Cir. 1988).
3. *See, e.g., Dzingliski v. Weirton Steel Corp.*, 191 W. Va. 278, 445 S.E.2d 29 (1994).
4. *GT&E Southwest, Inc. v. Bruce*, 998 S.W.2d 605 (Texas 1999).

5. 42 U.S.C. § 2000e-2(e).
6. 29 C.F.R. § 1604.2 (a)(1)(iii).
7. Local 567 Am Fed'n of State, County and Mun Employees v. Michigan Council 25, 635 F.Supp. 1010 (E.D. Mich. 1986)(quoting York v. Story, 324 F.2d 450 (9th Cir. 1963), cert. denied, 376 U.S.939, 84 S. Ct. 794, 11 L.Ed. 2d 659 (1964).
8. Patients admitted to hospital typically consent in writing to accept appropriate medical treatment and therefore accept the ministrations of hospital personnel. They then assume the hospital has selected a competent staff. Thus professional qualifications, not gender, is the appropriate hiring consideration for medical employers. *See* Elsa M. Shartsis, Privacy as Rationale for the Sex-Based BFOQ, 1985 Det.C.L.Rev. 865 (1985).

A FRESH APPROACH - REVISITED

by **W. Daniel Jordan, MD, FACS**

Some time ago a small group of physicians gathered to discuss two related problems. In their opinion organized medicine was not fulfilling its role in maintaining the integrity of medical practice and various financial schemes were disrupting their patient-physician relationships by introducing financial pressures into their decision-making processes. These pressures, though subtle at times, were clearly being exerted on both the physicians and their patients.

The pervasive influence of the schemes seemed to preclude resistance by individual patients or physicians. Since the next logical step would be for groups of physicians to act in a concerted fashion, it was decided that organized medicine should take the lead in promoting, reinforcing and educating patients and physicians as to the professional ethic which should govern the patient-physician relationship. This was the genesis of an organization known as The Association of American Physicians and Surgeons, AAPS. The place was Gary, Indiana. The time was 1943.

With remarkable prescience they composed a Code of Medical Practice which described the principles of medical care and the responsibilities imposed on physicians and their patients by this unique relationship. In both abstract and concrete terms it first described and then decried modes of providing medical services inimical to the interests of their patients and the general public, detrimental to the quality of their services and destructive to the professional nature of medical practice. This Code was adopted in the first years of the organization's history and today remains a benchmark for independently practicing physicians. It's reprinted at the end of this article along with the Association's Principles of Medical Ethics.

Initially AAPS attempted to preserve the traditional patient-physician relationship and resist encroachment by government as well as other various insurance schemes by working within the American Medical Association (AMA). This became increasingly difficult over the ensuing years as the AMA lost confidence in its ability to resist a pervasive liberal social upheaval euphemistically called "progressivism" and characterized by an incrementalism culminating with the enactment of Medicare legislation in 1965. Thus began the decline of our profession, today rotting away the very heart of our medical care system.

Immediately following Medicare enactment AAPS adopted a policy of non-participation as the only legal, moral and ethical means of effectively expressing its unequivocal and complete disapproval of Medicare's spirit and philosophy. The currently popular concept of risk sharing was so abhorrent to AAPS members that it was not even mentioned. Passive resistance via non-participation today remains the prime tactic in the fight to maintain physicians' professional and financial freedom, applying not only to Medicare but also to all forms of contract medicine. Any physician who reads the various contracts proffered by the managed care organizations will quickly realize third party payors' intent to control physicians' treatment of their patients as well as their fees, both previously negotiated with and agreeable to patients and consistent with their ability to pay. Though occasionally offering charity, traditional medical practice never considered welfare and therefore didn't erode less affluent patients' sense of responsibility and independence necessary to good citizenship and democracy.

Over ensuing years AAPS continued its efforts to warn patients and physicians of the inherent dangers and unavoidable eventual financial collapse of Medicare's thinly-veiled attempt at socialized medicine which irresponsibly promised unlimited free healthcare to the elderly. In 1973 AAPS filed suit in federal court against The United States Department of Health, Education and Welfare (HEW), now The United States Department of Health and Human Services (HHS), seeking to overturn executive branch regulatory fiat collectively then known as PSRO (Professional Services Review Organization). Our government elected "of, by and for the people" argued persuasively through its lawyers that "patients whose medical care is paid for by government funds have no constitutional right to the type of medical care or the physician of their choice." Unfortunately neither most physicians nor their patients took notice. Another suit filed by AAPS several years later sought to derail centralized regional healthcare planning by government but was also unsuccessful.

In 1984 AAPS again went to federal court to secure physicians' and Medicare-covered patients' right to contract between themselves for healthcare on a fee-for-service basis independent of government intervention. The Supreme Court amazingly affirmed Congress's power to promulgate physician fee schedules because:

1. Physicians were not forced to treat Medicare patients,
2. Congress was only trying to protect its Medicare-covered constituents from exploitation by unscrupulous physicians, and
3. Congress apparently intended these economic restrictions to only be temporary anyway.

One can only wonder what the Court's concept of temporary was.

Probably AAPS's most publicized suit was over the Clintons' attempt to secure passage of their 1993 Health Security Act. The suit did not question HHS's authority to initiate far-reaching, expansive, authoritarian regulations, but instead attacked the proposed legislation on a legal technicality of the Federal Advisory Committee Act. The Act required disclosure of all members of advisory committees assisting Congress in writing its legislation, a necessity the Clintons' conveniently overlooked. As a result of the subsequent publicity members of Congress and the general public both became aware of the proposed legislation's true nature. The proposed Act never got out of committee. The Court ultimately awarded AAPS financial damages as sanctions against HHS, but to this date no payments have been received.

There are important lessons to be learned here. Over the past 30 years the political and social forces attempting to bring medical care under the control of the state have not wavered. AAPS's legal actions have clearly defined this agenda but also have unfortunately legitimized its success. It is now imperative that those physicians who value their freedom to practice medicine independent of influences outside the traditional patient-physician fiduciary relationship, especially government or corporate micromanagement, declare themselves and recognize their ethical responsibility to continue providing medical care in the venerable Hippocratic tradition of their predecessors.

Clearly we must first reject contractual arrangements with third parties whether they be government or other paymasters. Preserving our independence is obvious and it is unassailable, reinforcing the traditional concept of a totally free profession beholden to no one but its patients. This may appear too simplistic but it attacks the root of the problem. One can only speculate on the sweeping benefits to be realized by all if only assignment of benefits were abolished.

The 1996 Kennedy-Kassebaum legislation passed the Senate without a dissenting vote, regrettably criminalizing previously ethical medical practices. Its widespread adoption by the various medical insurers has thrust the ubiquitous tentacles of federal government regulation and investigation plus threatened prosecution and incarceration into an already strained relationship. In essence another overshadowing interloper has crashed the previously amicable patient-physician private party, albeit with the admirable utopian purpose of deterring fraud and abuse while protecting unsophisticated and vulnerable citizens. Thus far it would appear to have only increasingly intimidated an already frightened physician population. If this sounds familiar, it is an established strategy of terrorists and dictators seeking to overcome persistent opposition with the same intimidation and resulting fear. Sign on to www.aapsonline.org for the details of AAPS objections to these laws and regulations plus various commentators views.

So where does this leave us? It should be clear by now that over the past fifty years there has been little change in the liberal social agenda within our country. It should also be clear that the salvation of traditional, independent, private medical practice is not going to be our legislatures, mainstream organized medicine or even the courts of justice. Relief lies with the individual physician and his patients. If a significant number of us again don the previously discarded mantle of a principled profession practicing medicine in the ageless Hippocratic tradition we will become a rallying point for our colleagues, a beacon of trust for our patients and an impregnable fortress for the assaults of all unwelcome interlopers including government.

Judge Elbert Tuttle of the 5th Circuit Federal Court of Appeals said it best in a September 1957 Atlanta, Georgia, graduation address to Emory University's schools of theology, law and medicine.

"The professional man is in essence one who provides services. But the service he renders is something more than that of the laborer, even the skilled laborer. It is a service that wells up from the entire complex of his personality.... In a very real sense his professional service cannot be separate from his personal being. He has no goods to sell, no land to till; his only asset is himself. It turns out that there is no price for service, for what is a share of a man worth? If he does not contain the quality of integrity he is worthless. If he does, he is priceless. The value is either nothing or it is infinite.

"So do not try to set a price on yourselves. Do not measure out your professional services on an apothecary's scale and say, "Only this for so much.".... Do not debase yourselves by equating your souls to what they will bring in the market. Do not be a miser, hoarding your talents and ability and knowledge, either among yourselves or in your dealings with your clients, patients or flock. Rather be reckless and spendthrift, pouring out your talent to all to whom it can be of service! Throw it away, waste it; and, in the spending, it can be of service.

"Do not keep a watchful eye lest you slip, and give away a little bit of what you might have sold. Do not censor your thoughts to gain a wider audience. Like love, talent is useful only in its expenditure, and it is never exhausted. Certain it is that man must eat, so set what price you must on your service. But never confuse the performance, which is great, with the compensation, be it money, power, or fame, which is trivial."

CODE OF MEDICAL PRACTICE

Of The

Association of American Physicians and Surgeons

- I. The members of this Association stand united in their conviction:
- A. That medical care can never be without cost to someone inasmuch as nothing is available to man in inexhaustible supply, and resources of time, energy, and material devoted to medical use cannot be used for other purposes;
 - B. That health, like happiness, is by its nature personal and is primarily an interest of the individual (as contrasted with environmental factors bearing on health, some of which may be primary interests of society);
 - C. That responsibility and control are by their nature inseparable, and that every right or privilege carries with it a corresponding obligation or responsibility;
 - D. That certain modes of providing medical services to the individual are inimical to the interests of the patient and the public, detrimental to the quality of the service, and destructive to the professional nature of medical practice. Such obligations include:
 1. Any method that (a) implies that health or physical well-being **can** be sold, provided, conferred, or otherwise obtained without **primary** responsibility of the individual to achieve it through his own adjustment to situation and circumstance, his own effort, and his own bodily processes; or (b) promises or pretends to shift such **primary** responsibility to any other person or agency; or (c) implies that professional medical care **can** be substituted for, or be effective in the absence of, the basic natural necessities of life;
 2. Any method that implies that professional medical services can be standardized or mass-produced, or that the medical needs of any individual can be determined “scientifically” or otherwise without **primary** regard to his unique personal capacities and limitations (physical, psychological, educational, social and economic) and his personal preferences;
 3. Any method that involves financial transactions wherein:
 - a) Price fixing is encouraged,
 - b) Professional services are evaluated in terms of the technical procedures that are involved, or
 - c) The value of a doctor’s professional service to his patient is determined, or his fees dictated, by any process except mutual agreement between him and his patient, subject to legal proceedings in case of dispute;
 4. Any method that requires any individual to pay brokerage on medical services, or permits any third party to derive a profit from the financial transactions between a patient and his doctor;
 5. Any method whereby any person is required, through taxation or otherwise, (a) to give involuntary financial support to any system of practice or to any practitioner whose services he does not use, or (b) to pay for services unrelated to his complaint as a condition to obtaining the services he desires;
 6. Any method that implies that truth or scientific validity can be established by fiat or by governmental edict:
 - a) By limiting academic freedom,
 - b) By governmental discrimination, upholding any health doctrine or system of practice, or
 - c) By giving to any medical or scientific dictum the force of law except insofar as may be unavoidable in protecting persons who take reasonable precautions of self-protection against manifest danger from communicable disease;
 7. Any method that degrades the standards of medical care by permitting anyone having lesser qualifications than are required for licensure to practice medicine:

- a) To assume responsibility for, or control over, any investigation made for purposes of diagnosis, or upon which decisions regarding treatment will be based, or
 - b) To assume responsibility for the direction of treatment;
8. Any method that infringes the patient's right to the complete fidelity and undivided loyalty of the practitioner to whom he entrusts his welfare in any way, for example:
- a) By permitting any third party, by reason of financial interest or otherwise, to influence what the doctor does for his patient, or to interfere in the free exercise of the doctor's best professional judgment in the patient's behalf,
 - b) By making the doctor responsible as agent or otherwise, to any person or agency other than the patient or to one who stands *in loco parentis* to the patient, except to such minimum degree as may be necessary in controlling contagious disease, or
 - c) By limiting the doctor's freedom to withdraw whenever he is asked to assume or to share responsibility for anything he thinks contrary to the patient's interest.
9. Any method that infringes the inalienable right of any individual to personal privacy and to seek health in his own way (subject only to the authority of the government to take such reasonable additional steps as may be necessary in protecting others who take reasonable precautions of self-protection against manifest danger from communicable disease or intolerable social maladjustment):
- a) By subjecting him to assault or to uninvited investigation in the name of medical care,
 - b) By subjecting him to pressure to accept medical care he does not want,
 - c) By impairment or prejudice of his freedom to select at the time he wants medical help, the particular practitioner to whom he will entrust his welfare,
 - d) By impairment or prejudice of his freedom to decide when, to what extent, and for how long he will follow the advice or accept the help of any practitioner, or
 - e) In any other way.

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REPETITIVE ANTENATAL CORTICOSTEROIDS

by Stephen T. Vermillion, MD, FACOG

ABSTRACT: Multiple courses of antenatal betamethasone are associated with an increased risk of early-onset neonatal sepsis and sepsis-related neonatal death. Repeated antenatal corticosteroid administration is best avoided except in very limited circumstances until more information is available.

In 1994 a National Institutes of Health Consensus Development Conference addressed the effect of maternal corticosteroids on fetal lung maturation and perinatal outcome, recommending their widespread use in pregnancies at risk for preterm delivery prior to 34 weeks gestation with intact amniotic membranes and prior to 32 weeks with Prolonged Premature Rupture Of the Membranes (PPROM). This recommendation was based on substantial evidence available at that time that at least a single course of antenatal corticosteroids reduced the morbidity and mortality associated with premature birth. The Conference's report also noted the lack of sufficient data specifically addressing the benefits and risks of repeated courses of steroids demanded further research.

Up until 1994 antenatal corticosteroids had been grossly underutilized and the report recommended increasing obstetricians' awareness of their potential benefit, moderately successful for several years until the evidentiary pendulum began to swing back toward center. The notion that if a little bit helps then more must be better became ever more prevalent, in part derived from older data implying that the benefits of antenatal corticosteroids were self-limited and after seven days disappeared. Thus evolved the practice of weekly or serial dosing. Several recent surveys have furthermore confirmed that prophylactic administration of repeated courses of antenatal steroids is a common practice among physicians providing prenatal care despite the absence of definitive supportive evidence.

To date there have not been any published prospective randomized trials specifically evaluating the effects of multiple courses of antenatal corticosteroids although one is pending publication. The few available nonrandomized studies comparing the effects of single and multiple courses of corticosteroids have yielded widely conflicting results, possibly due to confounding influences introduced by the inclusion of heterogeneous populations of patients such as those with multiple gestations, PPRM and preeclampsia.

An interim analysis of one currently ongoing prospective randomized US multicenter trial does not suggest multiple courses of betamethasone are more beneficial than a single course. Several recent retrospective studies addressing potential risks and benefits of repeated courses of antenatal corticosteroids have demonstrated conflicting results. Banks and colleagues performed a post hoc analysis of data collected from the North American Thyrotropin-Releasing Hormone Trial, reporting that neonates exposed to two or more courses of antenatal corticosteroids had significantly lower birthweights and those exposed to three or more faced an increased risk of neonatal death. They were also unable to demonstrate any difference in the incidence of Respiratory Distress Syndrome (RDS) or IntraVentricular Hemorrhage (IVH) between neonates exposed to single courses of antenatal corticosteroids and those exposed to multiple courses.

Elimian and colleagues concluded that compared to a single course, multiple courses of betamethasone reduced the incidence of RDS with no apparent increase in neonatal sepsis or death. Your author and associates have reported studies of patients with and without PPRM which found a positive association between serial or repeated dosing of betamethasone and perinatal infectious morbidity including chorioamnionitis, endomyometritis and early-onset neonatal sepsis. We also demonstrated an association in patients without PPRM who received multiple courses of betamethasone and neonatal sepsis/death. Our findings of an increased risk of neonatal death after multiple courses of betamethasone without improvement in neonatal morbidity is more consistent with Banks' study than Elimian's.

Banks found no difference in the frequency of neonatal sepsis between neonates exposed to three or more courses of antenatal maternal corticosteroids and those exposed to two or less. In that study approximately 40% of the cases of neonatal death following multiple courses of corticosteroids were attributed to sepsis compared to almost 70% in our studies. We were unable to demonstrate any effect on the frequency of IntraUterine Growth Retardation (IUGR) between the two study groups which is consistent with Elimian's findings.

The concept of an increased risk for early-onset neonatal sepsis and sepsis-related neonatal death after multiple courses of antenatal corticosteroids is plausible. All previous studies have included patients at risk for preterm delivery due to preterm labor and/or PPRM as well as therapeutic preterm deliveries for fetal and/or maternal complications. Infection with inflammation has been identified as a potential cause of both preterm labor and PPRM in as many as 30% of these patients, so it is appropriate to assume that some may have occult decidual, chorioamniotic or intramniotic infections. It has long been

known that corticosteroid therapy may induce a relatively immunosuppressed state by altering the production of humoral mediators, which when combined with an immature immunologic system poses an obvious potential risk of life-threatening immunosuppression to the preterm neonate.

Many perinatologists have resorted to the practice of rescue or booster therapy in light of the emerging retrospective data suggesting potential adverse consequences from repetitive dosing. The decreased risk of IVH following corticosteroid exposure prior to 28 weeks gestation suggests a dramatic effect on the immature fetal and neonatal cerebrovascular systems.

It is hypothesized that prior to about 28 weeks gestation there is minimal corticosteroid effect on developing or absent Type II fetal pneumocytes and the risk of neonatal RDS is therefore potentially unaffected. Pregnancies exposed to a single course of steroids prior to 28 weeks and then presenting with premature labor or PPROM between 28 to 32 or 34 weeks should theoretically benefit from a single repeated corticosteroid dose to stimulate potentially functional fetal pneumocytes. This seems reasonable from a physiologic standpoint but no supporting studies have been published.

In just a few short years we have been advised to modify antenatal steroid therapy in several different ways. We were first encouraged to use steroids in more cases and repeatedly only to later be warned not to use them so often. We have been presented with conflicting data that more is better, no different, and worse. It would appear prudent to avoid the practice of repeated antenatal corticosteroid administration until more information is available from ongoing randomized clinical trials.

SERVING TWO MASTERS

by Doug Daniel

“No man can serve two masters; for either he will hate the one and love the other, or he will hold to one and despise the other. ”

Jesus Christ

Quoted in The Gospel According to Saint Matthew, 6:24, The Holy Bible

On 12 JUNE 2000 the kid gloves came off and it got down and dirty. Previously the only ones to use the dreaded “R word” when discussing or discoursing about the future of healthcare in these United States had been most clinically practicing physicians with enough sense to tie their shoelaces solo and a few conservative politicians on the stump warning of the evils of socialism.

U.S. Supreme Court Justice David H. Souter, writing the opinion to accompany the unanimous (something almost as rare as unanimity of opinion among physicians) ruling by the Court in *Pegram v. Herdrich*, opined as follows:

“An HMO physician’s financial interest lies in providing less care, not more. ...[I]nducement to **RATION** care is the very point of any HMO scheme, and **RATIONING** necessarily raises some risks while reducing others.” (emphasis mine)

So now the cat’s out of the bag and it’s official. Rationing of medical care for our patients is not only inevitable, it’s laudable, legal and desirable. For some at least. I can assure you from personal observation that Supreme Court Justices are not subject to rationing of their own healthcare.

A complete transcript of the ruling and Mr. Justice Souter’s unanimous opinion are enclosed with this issue of the *Newsletter*, the most relevant passages highlighted. His opinion is the best explanation I’ve found of what ERISA is and what it’s supposed to do. This case was initially filed eight years ago and is only the first of a long line of legal challenges to ERISA, including RICO racketeering allegations, working their way up the food chain to the Supremes. That ERISA survived its first assault intact is no guarantee it will continue to do so, though such is more likely than not unless Congress re-writes the rules.

This has absolutely no effect on medmal liability law and the legal fiduciary definition of the therapeutic relationship as it concerns clinically practicing physicians, still as always under the individual states’ jurisdiction. Since there was a preceding medmal case in state court, we probably should briefly review its facts, complaints and outcome. The medical and court records have not been reviewed but the gist of the case is summarized in Mr. Justice Souter’s opinion.

Dr. Lori Pegram , employee and/or part-owner of Carle Clinic Association, Health Alliance Medical Plans, Incorporated, and Carle Health Insurance Management Company (collectively comprising an HMO), initially saw Ms. Cynthia Herdrich (assumedly in a primary care clinic) who complained of lower midline abdominal pain. Diagnosis and treatment are unknown but either as scheduled follow-up or due to increasingly severe symptoms, Dr. Pegram saw Ms. Herdrich again about a week later. At this time the pain was described as “sharp and severe” with associated “fever and nausea”. Upon examination Dr. Pegram discovered a 6 X 8 cm “inflamed” abdominal mass and ordered an ultrasound to be performed over a week later at one of the HMO’s diagnostic imaging facilities more than 50 miles distant. Immediate diagnostic ultrasound services were however available at a near-by hospital.

The mass, a periappendiceal abscess, ruptured prior the delayed ultrasound and emergency laparotomy appendectomy was performed without significant complications. The medmal case went to trial in Illinois state court with the jury finding for plaintiff and awarding \$35,000.

Anyone reviewing medmal cases has seen this scenario too many times before not to be able to fill-in the gaps. Female patients with acute appendicitis and presenting initially with abdominal pain, low-grade fever and nausea continue to be misdiagnosed, mostly by non-gynecologists, as having “PID” or acute/chronic salpingo-oophoritis. They are usually treated with broad-spectrum antibiotics either orally or parenterally as an outpatient or parenterally as an inpatient for a week or more, rupture their appendix, wall-off the local peritonitis as a periappendiceal abscess with the help of partial and inadequate treatment with antibiotics, and finally rupture the much more voluminous abscess with massive and unmistakable generalized peritonitis and septicemia. Not all survive their inevitable laparotomy since the mortality of acute appendicitis, even with appendiceal rupture or leakage, is much less than that of a ruptured, smoldering, chronic, enlarged periappendiceal abscess.

Assuming this case scenario fits Dr. Pegram's case, she probably was justly found negligent in her care. Not only did she initially miss a relatively obvious common diagnosis without surgical or gynecologic consultation, she also began treatment which only obscured and delayed the correct diagnosis and ultimately necessary treatment at great risk to her patient. Her failure to obtain consultation and diagnostic imaging reasonably quickly, allegedly for reasons of personal financial gain, only made her position as a medical defendant worse. Since Ms. Herdrich would have required a laparotomy appendectomy anyway (we won't argue the pros and cons of laparoscopic appendectomy here) and probably had the good fortune to survive without avoidable injury or permanent disability, the award was relatively low even for Illinois and apparently only recognized compensatory damages while probably ignoring mental anguish/pain and suffering/loss of consortium/etc.

Redress for patients injured due to their insurance company's negligence and accountability for ERISA plans' and other HMOs' actions which injure their insureds will only come from those few state legislatures willing, in defiance of the powerful insurance lobby, to enable patients to sue as personal injury plaintiffs. The fiduciary obligation of the practicing physician to his patient remains intact regardless. Unfortunately the fiduciary obligation of the health insurers to their stockholders has also, and any such obligation to their customers has been essentially ignored.

The only encouraging note in this matter came from the U.S. Court of Appeals for the 7th Circuit which, in its 1998 decision reversing a trial court's dismissal of Herdrich's ERISA claim, opined as follows.

“We are far from alone in our belief that market forces are insufficient to cure the deleterious affects of managed care on the health care industry. An increasing number of Americans believe that dollars are more important than people in the evolving (HMO) system.”

As a sidelight, HMO stock prices went up when news of the Court's decision became public: Aetna by \$3.25 to \$70.63/share, CIGNA by \$2.25 to \$90.75/share, United Healthcare by \$1.50 to \$78.18/share and Pacificare by \$1.50 to \$67.87/share.

This article was compiled using Associated Press news reports plus postings on cnn.com, abcnews.com and yahoo.com.

A Lawyer's View of *Pegram v. Herdrich*

by Cynthia B. Jones, Esquire

Earlier this summer the United States Supreme Court decided that physician-owners of an HMO are not fiduciaries under the federal employee benefits law, better known as the Employee Retirement Income Security Act of 1974 ("ERISA"). Both HMO industry representatives and plaintiffs' lawyers have hailed the Court's decision in *Pegram v. Herdrich*, 120 S.Ct. 2143 (2000), as a victory. Far from providing clear-cut guidance on how managed care systems should operate, the Court's decision simply underscores a known fact: HMO-related issues will be in legal dispute for some time to come.

THE DECISION

ERISA requires employee benefit plan fiduciaries to act solely in the interest of and for the exclusive benefits of health plan participants and beneficiaries. At issue in *Pegram v. Herdrich* was whether a physician was an ERISA fiduciary and violated his fiduciary duties in making medical determinations by accepting financial incentives to provide cost-effective medical care, best expressed by the question "Can a physician be sued under ERISA because the existence of a financial incentive might influence whether and to what extent he prescribes certain courses of treatment?" And the United States Supreme Court's final answer is, "No."

THE HMO PERSPECTIVE

What is clear from the Supreme Court's decision is that HMOs and their attendant rationing of medical care are here to stay, at least until Congress or the states determine otherwise. In a rare unanimous decision the Court recognized there is nothing inherently wrong with the way contemporary HMOs operate, including offering physicians financial incentives to encourage cost containment. This at least allows HMOs to claim a limited victory.

THE PLAINTIFF PERSPECTIVE

Cynthia Herdrich did not originally bring her case in federal court as an ERISA claim. Plaintiffs generally do not want to bring their health benefit claims in federal court under ERISA except in exceedingly rare instances (see below). Defendants on the other hand are at more of an advantage under federal jurisdiction and frequently file motions for "removal," requesting trial in federal court by claiming the plaintiff's allegations are actually ERISA claims.

Most defense lawyers agree there can be distinct advantages to litigating a health benefit claim under ERISA in federal court. ERISA plaintiffs generally cannot recover damages beyond the actual benefits promised by their HMOs, plus punitive damages are not recoverable. The majority of federal courts have furthermore determined that ERISA claims must be decided by a judge rather than a jury. Many plaintiffs' lawyers think juries comprised of local folks are more sympathetic than judges toward their clients.

ERISA's reduced potential for large damages awards and lack of access to a jury trial may discourage lawsuits, particularly when the plaintiff's claims are marginal. The removal of *Pegram*-type claims from ERISA and its inherent limitations allows potential plaintiffs and their lawyers to also claim a victory.

THE FUTURE PERSPECTIVE

Where does *Pegram* leave us? In some respects right where we were before. HMO's should continue to proliferate and plaintiffs' lawyers will continue to bring lawsuits challenging physicians' treatment decisions when they in any way restrict or ration access to medical care. Unless and until Congress resolves some of the issues arising from managed care operations, expect to see some or all of the following in the future.

◆ ***More lawsuits with potentially larger verdicts plus inconsistent and perhaps even contradictory results***

The U.S. Supreme Court has simply determined that treatment decisions by HMO physicians are not subject to the fiduciary rules established by federal ERISA law. Nothing in *Pegram* prohibits plaintiffs from attacking HMOs and physician financial incentives in state courts pursuant to state laws.

Many of the same lawyers who gave us multistate tobacco class action litigation are now eyeing the potential for HMO lawsuits. There are already several large class action suits pending against HMOs in state courts. Expect to see a proliferation of these suits against HMOs claiming larger damages than available under ERISA in federal courts. Without a uniform, national statutory standard these cases are likely to create a hodgepodge of inconsistent and even contradictory legal restrictions on HMOs and their physicians.

◆ ***Increased regulation by states***

While *Pegram* has apparently blessed HMOs' rationing of medical services and proffering of physician financial incentives, it hasn't freed managed care arrangements from state regulation. The Supreme Court may indeed have opened the floodgates of increased state regulation of managed care systems in general and HMOs in particular.

ERISA was enacted by Congress to exclusively occupy the areas it regulates. It accomplishes this by preempting and superseding state laws (with limited exceptions) that "relate to" employee benefit plans. Once ERISA regulates a particular legal issue relating to an employee benefit plan, any state law that would likewise regulate that issue is legally inoperative. By holding that HMO physician incentives do not implicate ERISA's fiduciary rules, the Court has at least implicitly recognized the authority of the states to enact regulating statutes. Several states already have done so both prior to and following the *Pegram* decision with more expected to do so in the future.

◆ ***ERISA requirements for disclosure of physician financial incentives***

The Supreme Court decided only the limited issue of whether a treating physician in an HMO setting could be held liable for treatment decisions under ERISA's fiduciary rules. The Court did not hold that ERISA was wholly irrelevant to HMO regulation. Much of ERISA is devoted to requiring sponsors to provide pertinent information about their health plan to participants and beneficiaries. Although not deciding the issue, the Court strongly suggested those who are ERISA fiduciaries (typically, an employer sponsoring a group health plan) may have an obligation to disclose the existence of HMO physician financial incentives.

This non-binding dicta in *Pegram* continues the line of analysis previously adopted by the Court in which it held that plan fiduciaries have the obligation to disclose benefit plan characteristics materially affecting a plan participant's interests, even if the fiduciary has no duty or power to influence those characteristics. Other federal courts are likely to adopt this analysis and require ERISA disclosure of physician financial incentives.

Does this type of disclosure really matter to health plan participants? Maybe not. Patients will have no empirical data about what level of financial incentive might influence a physician's treatment decisions and no real basis to compare different types of financial incentives. Given ERISA's limitation on damages, there also may be no real remedy when fiduciaries fail to make required disclosures. Wide disclosure of the existence and nature of physician financial incentives nonetheless would probably adversely affect public opinion about the desirability of HMOs and other managed care programs. This in turn could generate increased public pressure for more HMO regulation.

THE CONGRESSIONAL PERSPECTIVE

In 1999 the United States Senate and House of Representatives both passed broad healthcare legislation including many provisions relating to managed care. In February 2000 the bills, popularly known as the "Patient's Bill of Rights", were consolidated as H.R. 2990 and reported to Conference Committee for resolution of the differences between House and Senate versions without further action.

Unofficial scuttlebutt from Congressional staffers indicates that at least initially support of H.R. 2990 was bipartisan, but now the possibility of it becoming the law of the land continues to fade as November's election draws nigh and federal legislators become focused less on legislation and more on reelection. *Pegram* may also have indirectly further impeded the progress of H.R. 2990 by opening the window for greater state regulation of HMOs, thereby indicating to Congress that more federal legislation is not necessary.

The Bottom Line

Folks often caution that you should be careful for what you wish lest it be granted. While both HMO advocates and adversaries have had some of their wishes granted by *Pegram*, it is a mixed blessing for both sides. HMOs may applaud the Court's express approval of rationing and physician financial incentives, but probably face more frequent and costly litigation in state courts. Their adversaries are likely to benefit from additional litigation opportunities but will probably have greater difficulty convincing state

courts of nefarious HMO conduct when the U.S. Supreme Court has at least in concept given its nod of approval. *Pegram* marks only a bump in the road of continuing legal squabbles surrounding HMOs and ERISA with the end nowhere in sight.

CÆSAR'S WIFE

by Doug Daniel

“He (Julius Cæsar) took to wife Pompeia, ...afterward divorced her suspecting her of adultery. ... When summoned as a witness, Caesar declared that he had no evidence, ... and on being asked why it was then that he had put away his wife, he replied, ‘Because I maintain that the members of my family should be free from suspicion, as well as from guilt.’ ”

Gaius Suetonius Tranquillus (c. AD 69 - p. 122)
in De Vita Cæsarum (Lives of the Cæsars): Julius, Sections 6 and 74

Julius Cæsar, unlike modern heads of state, held his wife to the highest standards of behavior and character, i.e. beyond contempt. This may have been an unfair imposition upon her but in view of being first lady of her husband's Roman Empire, it went with the job. Today's physicians are more and more held to the same standard of professional competence and comportment.

Many physicians feel this unfair, unwarranted and a violation of their Constitutional rights but the fact remains: These are the rules in the year 2000, so like it or leave it. As evidence of this trend a summary in a recent issue of the North Carolina Medical Board's *Forum* related the problems precipitated by a physician's seemingly nonexistent or minor offense. Unfortunately the case as recorded in the public record leaves more questions unanswered than resolved.

Dr. A.E. Sculapius, a licensed North Carolina cardiologist, was enjoying dinner at his favorite restaurant one Friday evening after a long week. He was on call for the weekend but had already made hospital rounds and all his patients were doing well.

Being a man of no little refinement, Dr. Sculapius enjoyed an unspecified amount of a fine wine with his meal. Later in the evening he was paged to attend a patient at his hospital, ultimately inserting a temporary cardiac pacemaker. Shortly after his arrival he was again paged to attend a second patient at the hospital and “ordered” to provide a specimen of his blood for Blood Alcohol Content (BAC) by person or persons unspecified.

Instead of submitting a concurrent specimen of his own body fluids, Dr. Sculapius visited the room of one of his patients, drew a specimen from the patient's existing intravenous line “without any medical purpose”, and submitted it as his own in response to the “order”.

After an investigation precipitated by Dr. Sculapius's hospital suspending his privileges upon discovering his deception in submitting a patient's blood specimen as his own and reporting same to the Medical Board as required by North Carolina law, the Board issued the following statement:

“...Whereas Dr. Sculapius's drinking alcohol while on call and his obtaining a blood sample from a patient in a attempt to mislead hospital officials regarding whether he had consumed **any** (ed. emphasis) wine constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6), and grounds exist under that section of the General Statutes for the Board to annul, suspend, revoke, or limit Dr. Sculapius's license to practice medicine and surgery issued to him by the Board or to deny any application he might make for a license...”

Dr. Sculapius surrendered his medical license to the Board when so directed, appeared before their meeting two weeks later, and was found to have “acknowledged the wrongful nature of his conduct and exhibited genuine remorse therefor”. If this sounds familiar, it closely parallels the coerced public confessions of those singled out for public arrest, trial, imprisonment and political reeducation during Communist China's Cultural Revolution. He was ordered by the Board to submit to evaluation by an addictionologist who found he did “not have an alcohol or other chemical dependency” and also agreed to other unspecified Board requirements to “ensure the people of North Carolina and the Board that he can safely practice medicine”.

The interim resolution of this situation consisted of the following:

1. Dr. Sculapius's medical license was reissued
2. Dr. Sculapius's medical license was then suspended for one month during investigation of the matter and one more following resolution

3. “Unless lawfully prescribed for him by someone other than himself, Dr. Sculapius shall refrain from the use of all mind or mood altering substances and all controlled substances including but not limited to, sedatives, stimulants, pain medications, and he shall likewise refrain from the use of alcohol. Dr. Sculapius shall notify the Board in writing within two (2) weeks of his use of such medication or alcohol. This notice shall include, but shall not be limited to, identification of the prescriber and of the pharmacy filling the prescription.
4. “Upon request by the Board, Dr. Sculapius shall supply urine, blood, hair, or any other bodily fluid or tissue sample the Board might reasonably require for the purposes of analysis to determine if Dr. Sculapius has consumed any of the substances mentioned above. All costs of obtaining and analyzing such samples shall be borne by Dr. Sculapius.
5. “Dr. Sculapius shall maintain a contract with the North Carolina Physicians Health Program (hereinafter NCPHP) and abide by its terms, including the timely payment of any fees required by NCPHP.
6. “Dr. Sculapius shall obtain each calendar year, beginning with 1999, and document to the Board by January 31 of each succeeding year, fifty (50) hours of continuing medical education relevant to his practice including at least thirty (30) hours of Category I continuing medical education.
7. “Dr. Sculapius shall meet with the Board or members of the Board for an informal interview at its September 1999 meeting and at any other times requested by the Board.
8. “Dr. Sculapius shall notify the Board in writing of any change in his residence or practice addresses within ten (10) days of the change.
9. “Dr. Sculapius shall obey all laws. In addition, Dr. Sculapius shall obey all rules and regulations related to the practice of medicine.
10. “If Dr. Sculapius fails to comply with any of the terms of this Consent Order, that failure shall constitute unprofessional conduct with (sic) the meaning of N.C. Gen. Stat. § 90-14(a)(6), and shall be grounds, after any required notice and hearing, for the Board to annul, suspend, revoke, condition, or limit his license to practice medicine and surgery or to deny any application he might make in the future or then have pending for a license.
11. “This consent Order shall take effect immediately upon its execution by both Dr. Sculapius and the Board, and it shall continue in effect until specifically ordered otherwise by the Board.
12. “Dr. Sculapius hereby waves any requirement under any law or rule that this Consent Order be served on him.
13. “Upon execution by Dr. Sculapius and the Board, this Consent Order shall become a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof. Additionally, it will be reported to persons, entities, agencies, and clearinghouses, as required and permitted by law, including but not limited to the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank.”

There are several questions of more than passing interest involved in Dr. Sculapius’s case. No one can justify his removal of blood from his patient for non-medical self-interested purposes, perhaps even accusing him of battery or larceny unless the patient’s consent was obtained. His deception in submitting this specimen as his own is also unjustifiable. Both these actions could conceivably be defined as criminal, certainly unethical and unquestionably in bad judgment, but what of the original consideration, i.e. his consumption of beverage alcohol while in an on-call status and its implication of intoxication or impairment? Does the North Carolina Medical Board have a “zero tolerance” policy toward such behavior or are there defined limits within which physicians can consume beverage alcohol. If such limits exist, what are they? To say determinations will be made on a case-by-case basis is arbitrary and capricious at best and undermines guaranteed due process at worst, perhaps even raising a question of Constitutional rights.

The *Newsletter* has previously noted on multiple occasions that transportation workers in the airline, trucking, railroad and maritime industries have long been subject to such a zero tolerance policy for up to 24 hours prior to assuming in addition to while exercising job responsibilities, but these limits are clearly defined with swift and automatic enforcement plus random screening for compliance to strictly defined BACs in up to 25% of those so subject. Why are physicians not entitled to the same protection?

Then there’s the question of the hospital’s “order” that Dr. Sculapius provide a specimen of his bodily fluids. Were there provisions in the medical staff bylaws for dealing with a physician’s, preferably any employee or staff member’s, suspected impairment? Certainly it would have been better if Dr. Sculapius had known there was a 25% chance of random Breathalyzer®

or urine screening should he be called to the hospital. Also there should have been a designation of who had the authority to make such a request of him and the penalty should he refuse.

If the emergency department physician or a member of the nursing staff, even the director of nursing, gave such an "order", it was ill-advised even if legal. Written, clearly defined personnel and drug screening policies should give such authority to the subject's immediate supervisor in the hospital's organizational hierarchy. For physicians this means the chair of their department, president of their medical staff, chief hospital administrator, or those temporarily serving in that capacity. Regardless, such authority should be limited to those specified in the published and medical staff-approved policy. Additionally, the policy should require the manager so authorized to personally ensure the specimen to be unadulterated and representative of the donor so ordered.

Another concern is the purpose of imposing indefinite mandatory sobriety and routine drug screening on Dr. Sculapius when he was found to be "not dependent upon alcohol". Was this considered an integral part of all physicians' reinstatement to practice or a punitive measure for the other offenses? Will he be allowed to consume beverage alcohol temperately when on call after assumedly satisfactorily completing his contract with the NCPHP for reeducation and behavior modification regarding the other offenses? Will he be reported to the Board if he has wine with his meal in a public restaurant, even though not on call? What action will be taken if he refuses to respond to a future disaster mobilization of his medical staff after another such meal, even though not on call? Like Dad used to say, "You can't play the game if you don't know the rules," and I know of no existing guidelines, regulations or precedents to govern one's actions in these scenarios.

State boards of medical licensure can't even agree on a position addressing chaperones during physical examinations (see Stagno SJ, et al. Medical and Osteopathic Board's Positions on Chaperones During Gynecologic Examinations. *Obstet Gynecol* 1999;94:352-4; Daniel WD. Letter to the Editor. *Obstet Gynecol* 2000;95:317). No state licensing board makes it clear if licensed physicians in full-time administrative positions will be held to the same standards in these matters as their clinical colleagues.

Some boards are more specific in their definition of reportable behavior. As a licensee of the Montana Board I recently received my yearly renewal form. Like all boards Montana requests specific information on its licensees' personal lives at each renewal cycle, but unlike others restricts the request to behavior during clinical responsibility:

"Have you, during the last renewal period (April 1, 1999 - March 31, 2000), engaged in **habitual intemperance, the excessive use of, or been under the influence of**, any addictive or mood-altering substance **while on duty or on call** (not otherwise reported to the Board or the Montana Professional Assistance Program)?" (Emphasis mine)

The key words here are "habitual...excessive...under the influence...while on duty or on call". In West Virginia "under the influence" in regard to beverage alcohol use is defined as a BAC of 0.1% or greater, while some other states and European countries use 0.08% or greater. Either produces marked incapacitation. "While on duty or on call" indicates to me that what you do on your own time is okay as long as you don't violate the laws society applies indiscriminately to the rest of its citizens. It even suggests that arrest and conviction for DUI or public intoxication would not, in and of itself, be considered cause to take adverse action against one's license. No doubt any responsible board would automatically initiate investigation, surveillance, and screening of someone so flagged, perhaps even a personal appearance before the board, but only as related to clinical performance.

Tennessee's renewal form this year had no questions whatever related to possible impairment or substance abuse either while practicing, on call or on one's own time. Kentucky's renewal had a separate sheet with two questions related to physician impairment:

"Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine? Since you last registered, have you suffered from or been treated for drug or alcohol abuse and or dependency?"

Evidently the Kentucky board relies primarily upon physician self-diagnosis and self-reporting of impairment or substance abuse without confining their interest to work or on-call situations.

Other concerns are why was Dr. Sculapius specifically required to meet routine conditions of licensure such as appearing before the Board when so summoned, continuing education and "obeying all laws"? Did these demands placed on him exceed those on all other licensees, and if so, why? Why was he expected to waive any rights he might be entitled to?

The Board unfortunately made no apparent differentiation between Dr. Sculapius's three obviously separate actions of consuming beverage alcohol while on call, obtaining the blood sample from his patient without any medical purpose, and

misrepresenting it to the hospital as his own. This only creates a potentially greater problem for every imbibing physician practicing in North Carolina or elsewhere.

Every licensed physician in the US should be asking his or her state board of medical licensure to answer the following question in writing: "What is the board's policy on licensees' beverage alcohol consumption while responsible for patient care or subject to being responsible for patient care?" Every physician in the US should be asking his or her employer or credentialing hospital to answer the following question in writing: "What is the _____'s policy on beverage alcohol consumption by its physicians while responsible for patient care or subject to being responsible for patient care?"

Every physician in the US should also be lobbying vigorously for mandatory random and with cause drug screening of all healthcare workers utilizing recognized BAC definitions of impairment, simultaneously demanding effective personnel and medical staff policies to identify any impaired healthcare worker and protect the rights of those subjected to such screening. Impaired physicians are the last ones who should be asked to self-diagnose their condition or self-report their substance use/abuse. Experience has proven that impaired physicians almost never admit they have a problem until well into treatment, usually after being confronted with irrefutable evidence and dire consequences for failure to cooperate in their rehabilitation, nor do they voluntarily turn themselves in to their physician rehabilitation program. Therefore we might as well quit asking and accept mandatory random and with cause drug screening as the only effective method to reliably identify substance-impaired healthcare workers early in their disease.

The above article is a satire on the North Carolina Medical Board's action against one of its licensees following evaluation for alcohol impairment. It is well-written and raises many questions unanswered by the Board's public record on the matter but Doug's article completely misses the point. The physician in question was lucky to get his license back and be allowed to practice medicine again. The restrictions and demands imposed by medical boards' impairment contracts may be severe but there aren't many alternatives.

Doug readily extrapolates and embellishes the scenario as presented by the Board but commits some serious errors in relating the facts. He states the subject physician was ordered to be evaluated by an addictionologist but in reality only a "substantial assessment" was performed, and not necessarily by an addictionologist. He states the subject physician was found to "not have an alcohol or other chemical dependency", but in reality the Board found "it *appeared* that Dr. (Sculapius) does not have an alcohol or other chemical dependence".

Without doubt many physicians drink while on call or seeing patients in their offices. Others take mood-altering substances such as hydrocodone or Xanax® for pain control or to help them relax when off-duty. Most remain undiscovered. I do not believe there is any question of this physician's obvious impairment by alcohol at the time in question, otherwise why would he have been ordered to submit a sample of his bodily fluids for analysis? His subsequent actions in drawing blood from one of his patients and then representing it as his own only confirms this suspicion since it is behavior expected of an addict, not a competent physician.

The Board is to be commended for its handling of this case since Dr. Sculapius may well be an alcoholic. Treating him the same as any other impaired physician dependent on alcohol or drugs is entirely appropriate, not only potentially lifesaving for the physician but untold patients as well. Details of the impairment's extent are unknown as are the number of patients previously put at risk or injured plus those future patients protected from the same.

Many complain that we physicians are held by American society to a higher standard of occupational performance and ethics, personal morals and conduct, than any other fiduciary professionals. The fact is that transportation workers including airline, railway and maritime crews are held to a standard of zero tolerance for impairment of any kind during their performance of job-related duties. There is no reason why all healthcare workers shouldn't be held to the same standard. Their federal licensing agency requires airline pilots to abstain from consuming beverage alcohol for at least eight hours before entering the cockpit, their employers require at least twelve to twenty-four. I seriously doubt that anyone reading this would want a cardiovascular surgeon to revascularize their coronary arteries while impaired.

Should full-time administrative physicians should be held to the same standards of comportment as their clinical colleagues? Certainly those who do not directly participate in patient care currently are not, but whether this is proper or not is open to question.

Dan Avery

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