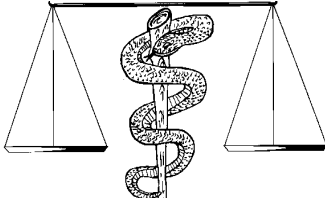


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THE ADOLESCENT GYNECOLOGY PATIENT

by Sunita B. Saxena, MD

Renee R. Jenkins, MD, FAAP

Abstract: Combining confidentiality with sensitivity to cognitive, emotional and physical development is the key to successful gynecologic examination, sexuality education and management of female adolescent patients.

Adolescent gynecologic examinations account for 25% of all healthcare visits made by female teenagers, many occurring in obstetric and gynecology offices. Optimum care necessitates reviewing sexual issues such as contraception, pregnancy, sexually transmitted diseases (STDs), normal development of sexuality and contemporary sexual behaviors related specifically to adolescents, at the same time emphasizing patient/parent/physician communication and education. This article should familiarize you with taking developmentally appropriate sexual histories from and performing gynecologic examinations upon female adolescent patients.

Development of our sexuality involves much more than just the capacity to procreate. Puberty's hormone surges drive the expression of adolescent sexuality. Early adolescents age eleven to fourteen years think about sex a great deal and develop idealized mental images of potential sexual partners. Actual romantic encounters however are few and these are riddled with anxiety over self-perceived sexuality and projected perceptions of their sexuality by partners. In middle adolescence (age fourteen to seventeen years) romantic relationships are more intense but usually still relatively short, possibly a series of brief encounters or serial monogamy. By late adolescence (age eighteen years and older) most young people have developed a more mature capacity for true intimacy, capable of longer and more meaningful romantic relationships.¹

Physicians are often reluctant to address sexual and reproductive issues with adolescents but the Center for Disease Control and Prevention (CDC) periodic youth risk behavior surveys support a proactive approach. These surveys define sexual intercourse as vaginal, oral or anal penile penetration in terms understandable by adolescents. Based on the 1999 survey², almost 50% (49.9 %) of high school adolescents grades 9 through 12 reported ever having had sexual intercourse, although only 36.3% admitted having had intercourse during the three months preceding the survey. Female students in grades 11 and 12 were significantly more likely (53.8% and 65.8% respectively) to report ever having had intercourse than those in grades 9 and 10 (32.5% and 42.6%). Very few first experienced sexual intercourse before age thirteen years (8.3% overall, 4.4% of females and 12.2% of males).

Although 58.5% of currently sexually active students reported either they or their partners used a condom during their last intercourse, 16.2% admitted a lifetime history of four or more partners. Girls in the 9th grade were significantly more likely to report condom use than those in the 12th grade (63.1% vs. 41.1%) but many continue to have unprotected sex. Among students who had ever experienced intercourse, 27.3% were abstinent for the three months

(Continued on page 15)

THE PRESIDENTIAL BOX

by Paul Sinkhorn, President

PRESIDENT SINKHORN'S FAREWELL ADDRESS

During the past year the *Newsletter* has brought you articles and opinions spanning large segments of our specialty. You have read my thoughts on the futures of our Society and Internet medicine. It has been an honor and pleasure to serve as your President in 2000. In my final missive I want to thank Dan Avery and Doug Daniel for their tireless dedication to a crucial concept, forensic obstetrics and gynecology. Through their and other scientifically minded clinicians' and researchers' work we are gaining recognition for this relatively new area of specialized expertise within obstetrics and gynecology.

In the courtroom we now see reason triumphing over innuendo more frequently. This is a welcome sight to those of us treating patients every day yet we must never relax our vigilance. In California there is an annual political onslaught against our MICRA medical reforms, particularly award caps. One awry vote in the state's legislature and the insurance crisis of the mid-1970's can easily return. I encourage each of you to do your part supporting the hard-working men and women who keep the flame of judicial moderation and fairness alive. I know you join me in welcoming such a man, Dan Avery, to our helm in 2001.

I am also pleased to announce our Society's new homestead on the World Wide Web. You are probably aware of our affiliates link on ACOG's home page (www.ACOG.org), but now we also have our own domain name and site. The next time you sit down to read the jokes in your e-mail file, fire up your browser and visit www.ASFOG.com. Once there you will be able to check out past issues of our illustrious *Newsletter*, read our bylaws and objectives, peruse our membership list or assist your colleagues in joining ASFOG. The site is new and will certainly evolve. Please let me know (cpaul@pe.net) if you have any criticisms or ideas about new features.

Thank you all for a stimulating and thought-provoking year. Best wishes in facing your clinical and courtroom challenges.

THE WITNESS BOX

by Doug Daniel, Editor

"When written in Chinese, the word crisis is composed of two characters. One represents danger and the other represents opportunity."

John F. Kennedy (1917-1963)

Thar' she blows! At 1753 hours, 11 SEPTEMBER 2000, we got a legitimate internet address, www.ASFOG.com, which also links to our space on the ACOG website with keyword links to the major search engines. It looks simply mahvahlus! Paul Sinkhorn is working with Blaine McCormick and Mark Graves to develop a professional quality page on the College's server at the least possible cost. Since no one notified me of their wish to opt out of the site's membership directory, everyone's there. If you are licensed in more than your state of residence, notify me and we'll list you in the others also. Thankfully the College doesn't yet charge for space on their server although the possibility of future user fees must be recognized. No one has volunteered to receive their *Newsletters* exclusively by e-mail so that's dropped off the screen until further interest is expressed.

This is a continuation of the Society's efforts to reach potential members plus provide more and better services to those members we already have, but it's also the direct result of a financial commitment by one of our members who voluntarily sent a sizeable donation earmarked for website development. Members so inclined to contribute above and beyond their dues to any of the Society's projects or programs are encouraged to do so, and separate accounts will be maintained to ensure these contributions are used only for the purposes intended. Donations beyond member dues will be receipted on Society letterhead with confirmation of our tax-exempt status. Areas of acute need are the *Newsletter*, Impaired Physicians Project, computer fund, copier fund and our ACOG/ACM educational activities. We are at the point where dues income is almost completely absorbed by the costs of maintaining an administrative office.

The *Newsletter's* celebration of the College's 50th Anniversary next year by publishing a series of personal remembrances of Past Presidents written by their residents and close colleagues has been extremely well received by almost everyone concerned. Potential authors have been thrilled at the prospect of honoring one of the most influential people in their personal and professional lives. In fact, five are already finished for the January 2000 issue. Hope you enjoy their reading as much as I have their preparation.

Marian Wiseman at *ACOG Today* did a really nice piece on the Society's Impaired Physicians Project in her September 2000 issue on page 13, complete with pictures (Dan's is the movie star glossy 8x10, mine's the serial killer mugshot). The article again reinforces the College's commitment to Fellow education on impaired physician issues, and it's obvious they're on board for the long haul. If you missed it, let me know and I'll send you a copy.

We also received requests from the Association of American Physicians and Surgeons' *Medical Sentinel* to reprint two of our September 2000 issue's articles, Dan Jordan's on their history and mine on the conflicts of interest faced by physicians working under ERISA-regulated managed care entities. Both were of course gladly granted and should expose potential new members to the Society. A final draft of the editorial requested by *The Obstetrical & Gynecological Survey* on routine drug testing in the healthcare workplace has been submitted and publication should be next year. We'll let you know when the publication date is definite.

So Tell Me Something Else I Didn't Already Know Department: According to the 1 SEPTEMBER 2000 issue of *Ob.Gyn.News*, "Breast Cancer Treatment Outcomes Best at Large-Volume Hospitals". One of our surgeon colleagues at Chicago's Northwestern University surveyed 1238 US hospitals for 5-year survival rates of 173,000 non-metastatic, surgically treated, female breast cancer patients treated between 1985 and 1991. Fifteen percent of the study's hospitals treated ten or less breast cancer patients a year (1.3% of study patients), over half treated 26 to 100 cases a year (57% of study patients), and three percent treated more than 150 cases a year (12.3% of study patients). Hospitals treating 51 to 100 cases a year met statistically expected five-year survival rates, those treating ten or less achieved 80% of statistically expected five-year survival, and those treating over 150 cases a year beat expected five-year survival by 3%. Previous investigations have found that when physicians practicing at multiple hospitals are studied, outcome statistics tend to vary by institution, not by physician. Bottom line? Same as when buying a new car: Go with a volume dealer.

Want some more? In the 15 SEPTEMBER 2000 issue of the same publication there's a piece on page 7 describing a study from Denmark covering data 1978 to 1992 which found that based on the mother's age at conception, "(t)he rate of fetal loss due to spontaneous abortion, ectopic pregnancy, and stillbirth rises steeply with increasing maternal age". Even more? The next page reports on a study from England of 283 Irish and United Kingdom infants born at 20 to 25 weeks gestational age during March through December 1995 who survived to age 30 months. "About half of all extremely preterm infants are

measurably disabled by age 30 months, and nearly one in four meet criteria for severe disability.” If this sounds a familiar chord, go back to our JULY 2000 dedicated issue on extremely premature deliveries.

We are fortunate this month to have a lead article on adolescent sexuality and the single gynecologist by Sunita Saxena and Renee Jenkins, both of Howard University’s Department of Pediatrics and Child Health in Washington, DC. In spite of Richard Gere’s lead portrayal in a currently popular film comedy, most of us seldom take a proper sexual history unless prompted by the patient, especially from minors. Point is, if we intend to impact the preventable yet soaring unintended pregnancy and STD rates among teens we’ve got to ask the hard questions and start early. Not only must we be willing to question but also to educate. You may have heard all this before but it’s worth listening to again, even though you may not think there’s time available to use it.

Sunita earned her undergraduate degree in 1970 from Delhi University in India, her MD from the All India Institute of Medical Sciences in 1973, completed her pediatric residency at Rutgers Medical School in 1979 and an adolescent medicine fellowship at DC’s Children’s Hospital National Medical Center in 1980. Since then she has been an Associate Professor of Pediatrics at Howard and for the past eight years its Director of Adolescent Medicine. She trains pediatric, family practice and internal medicine residents during their rotations in her clinic in addition to supervising her department’s inpatient service two months a year.

Renee earned her undergraduate and MD degrees from Wayne State University followed by a pediatrics residency at NYC’s Albert Einstein/Jacobi Hospital and an adolescent medicine fellowship at its Montefiore Medical Center. She was the first Director of Adolescent Medicine in Howard’s Department of Pediatrics and Child Health, has served as President of the Society for Adolescent Medicine, and been active on many American Academy of Pediatrics committees. She is a member of the Board on Children, Youth and Families of the National Academy of Sciences and frequently writes on minority adolescent health and sexuality, violence prevention and health in general plus currently working as the principal investigator on a National Institutes of Child Health and Disease (NICHD) study of adolescent pregnancy prevention in DC schools.

Paul Sinkhorn’s President’s Box this month is regrettably his last, coming at the end of an outstanding year under his leadership. Paul will continue as a valuable member of our Board of Directors for another year. He mentions www.ASFOG.com and should be duly proud. The site is his baby, a technically professional job. Its only limitation is relevant content, and we all share the responsibility of suggesting and contributing information to be posted there.

This month’s “Hot Box” revisits the fen-phen problem. There hasn’t been the expected deluge of medical cases yet but the manufacturer is taking a pretty hard hit between individual product liability cases and the class action suit. It appears the fat lady ain’t gonna sing just yet.

This month’s Book Box reviews one of the most personally moving books about physicians I’ve ever read. It’s out of print but should have been a best seller. The author presents an intimate and honest examination of what makes us tick, the answer to that classic psychotherapeutic question, “How does that make you feel?”

In the “Suggestion Box” Dan Avery, our 2001 President, strongly defends the high ground in the abortion controversy as a committed opponent of abortion. He’s Director of Medical Ministries for the Pregnancy Health Center of Alabama, Member of the Board of Directors of the local Guiding Hands Crisis Pregnancy Center and Medicolegal Consultant to Life Dynamics, Incorporated, in addition to being a member of Alabama Physicians for Life and the American Association of Pro Life Obstetricians and Gynecologists. Not one to take his position lightly, he also provides free obstetrical care to unwed mothers and others who think they have no options. If you’ve been reading the *Newsletter* for very long, you already know he and I disagree on this issue. While Dan may not be able to change your position on the subject, he will give you something to think about. The more information you have and the more detailed your analysis, the better your decision on this divisive question.

The “Ballot Box” examines the College’s professed interest in forming a Political Action Committee (PAC), which I personally oppose. Most importantly, the guys driving the bus are asking their passengers where they want to go for the first time I can remember. If you don’t respond to this request for your opinion, quit griping about how the College doesn’t represent your interests and views anymore. Remember, the squeaky wheel gets the grease.

In this month’s “Litter Box” I take on the IOM report and recommendations regarding “medical errors” again. Seems more and more people are starting to question its findings, apparently with good reason.

Mike Schatz gives us the straight skinny on asthma and allergies in pregnancy, the threat they pose to mother and infant plus how to treat them safely and when to refer. He's a grad of Northwestern University Medical School where he also completed his internship and internal medicine residency, later adding an allergy fellowship there. A stint in the US Navy included serving as head of the Allergy Branch, Naval Regional Medical Center San Diego. Afterward he joined the staff of Kaiser Foundation Hospital, San Diego, and accepted a clinical professorship at UC San Diego School of Medicine. Currently he is Chief of the Allergy Department of Southern California Kaiser-Permanente Medical Group.

Mike is also a prolific medical author and co-chair of the Pregnancy Committee of the American College of Allergy, Asthma and Immunology plus a member of the American Academy of Allergy, Asthma and Immunology's Board of Directors. He's in with the feds as a member of the Asthma Subcommittee of the Maternal Fetal Medicine Unit Network of the National Institute of Child Health and Human Development.

I have a piece on the WHO's ranking of nations' by healthcare. Since WHO's director is Norwegian, a country known for its remarkably accurate and extensive recording of healthcare statistics but lack of innovative clinical research, it's no surprise the survey is a poorly veiled polemic advocating socialized medicine. You can read another opinion on it in the reproduction section at the end of this issue on page 23. It's from the American Institute for Economic Research's 24 July 2000 issue of *Research Reports* and goes into more detail.

There're also three reprints from *Physician's Practice Digest*, the first by Kelly Cowie on the joys of mentoring medical students and residents. I always seemed to have a more special relationship with some of my students and residents than others, and maybe that's mentoring. These relationships have survived the ravages of time and memory, and today I still hope to run into some of my trainees at the ACMs. It's good to know they may have benefited as much as I did.

The second is some advice from Lisette Hilton on how to tell the HMOs you don't need their stinkin' provider contracts. While certainly not easy, opting out of managed care is probably the only effective action we can take. Mismanaged care corporations cannot exist unless physicians voluntarily become their slaves.

The last is a piece by Edward Martin on noncompete agreements. If you don't already know, these are the legal protections against future competition employers and partners are allowed to provide themselves when taking you in as a member of their practice. There is some judicial relief from unreasonable and punitive restrictions on where you can work after you leave a practice, but it's best to negotiate reasonable terms before you enter a contractual agreement with prospective employers.

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 HOT BOX

DÉJÀ VU, AGAIN

by Doug Daniel

The *Newsletter* has twice before addressed the liability potential of fen-phen (Daniel WD. The fen-phen phrenzy. Vol. 6, No. 4, OCTOBER 1998, p. 32. Herzog CA. Fen-phen redux. Vol. 7, No. 3, JULY 1999, p. 10). I originally thought this would be a major medmal threat but, once again, I blew it.

On 28 AUGUST 2000 US District Judge Louis C. Bechtle gave final approval to a national class action settlement proposed by American Home Products, the same folks who brought you the Tylenol® scare, to award \$3.75 billion to claimants, or as much as \$1.5 million each.

Over 9000 suits from the more than six million patients estimated to have taken fen-phen have been filed against the manufacturer while another 45,000 exposed patients have refused to participate in the settlement, instead reserving their right to sue for punitive damages under product liability. An additional 226,000 patients have registered to join the class action suit but may still reject the settlement, preferring to sue for compensatory and not punitive damages.

There was also pre-trial settlement in February 2000 of a Texas patient's fen-phen product liability case against American Home Products to the tune of an estimated \$8 to \$9 million. While the company's stock has been taking a beating during the past months, it rose almost as soon as the settlement became public.

Physicians could still face potential liability, but it seems improbable unless they kept patients on the drug after the *New England Journal* article on the Mayo study or especially if they continued dispensing it after the recall. The most likely cause of action against physicians is still failure to inform patients of their risk and recommend appropriate screening as per Charles' article. We ain't out of the woods yet.

This article was compiled using Associated Press and Reuters news reports posted on cnn.com, abcnews.com and msnbc.com.

THE BOOK BOX

TRUE CONFESSIONS

by Doug Daniel

M.D.: Doctors Talk About Themselves

John Pekkanen

Unillustrated. 294 Pages. New York:1988

Delacorte Press (Out of Print)

Hardback, \$6.00 to \$15.00 on Amazon.com ZShops and Auction, plus S&H

“All of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all, inherent in the relationship.”

David Hilfiker, MD
In Healing the Wounds, 1985

Ever wonder what compels those people on HBO’s “Taxicab Confessions” to candidly reveal the most intimate details of their sex lives? I’ve always assumed they’re shells, paid actors either working from a script or riffing for the camera. Pekkanen apparently didn’t fabricate his interviews with physicians about their experiences in medical school, residency and practice. He’s a legitimate medical journalist with fifteen prior years of experience whose previous literary efforts included an in-depth study of Viet Nam-era Chief of Naval Operations (US) Admiral Elmo Zumwalt and his son, US Navy Lieutenant Elmo Zumwalt, III, entitled My Father, My Son and co-authored with the subjects. Both the Zumwalts are now deceased, father of old age/natural causes and son of a myeloproliferative malignancy thought to be related to Agent Orange exposure in-country during Dad’s tour as CNO. How’s that for Karma?

Pekkanen’s also a former *Life* bureau chief, *The Washingtonian* senior writer, *Reader’s Digest* roving editor and two-time winner of the National Magazine Award. Not too shabby a C.V. M.D. is an oral history along the lines of Studs Terkel’s work and has the same ring of truth. When reading the interviews it’s impossible not to associate them with past acquaintances, even yourself. Anonymity allowed the interviewees’ innermost feelings, fears and failures to be laid bare without regard for possible reprisal or judgment.

The author fairly portrays us as replete with human emotions including doubt, guilt, anxiety, grief and anger, yet he recognizes physicians are “damned and deified, accused of arrogance, incompetence, and greed and looked to as saviors, helpers, and consolers.” Over seventy interviews with researchers, clinicians, academics and private practitioners included both male and female obstetrician/gynecologists, surgeons, internists, radiologists, anesthesiologists, pediatricians and psychiatrists. Many expressed anger over the rapid and radical changes in their profession even prior to 1988; one can’t help but wonder what they would say today.

Especially interesting were colleagues’ experiences as medical students and residents, some of the most touching in the book. There was also an excellent chapter on the emotional effects of medical suits, known by those who’ve been there to be devastating. A personal favorite was the fellow who, like myself, had “a little ritual I go through when I pick up my mail. Before I open anything, I sort through the envelopes to see if any of them have a lawyer’s letterhead.” Amen, brother!

Pekkanen described the threat of suits as “like the sword of Damocles ... an undeserved and painful assault on themselves and on their profession.” Another favorite was the California surgeon who was “going bare” even back in the 1980s. When threatened with a suit he would send the plaintiff attorney a letter stating there was no malpractice insurance coverage and if he wished to pursue the case, he should contact the surgeon’s attorney. None of these threats ever materialized.

There’s also the obligatory chapter on death and dying, both our patients’ and ours. This is probably the most emotionally traumatic facet of clinical practice and one we obstetrician/gynecologists thankfully see only infrequently. Of course we more than make up for that with our sky-high rate of medical suits. The chapter on impaired physicians adds several disaster epics to the legion of those Dan Avery relates so well.

I found my copy several years ago in a bookstore specializing in heavily discounted publisher's returns. As you can tell, I really liked it; a solid 10.0, two thumbs up. It's well written and especially therapeutic for those of us facing the demons associated with our chosen profession. If you or a friend is currently going through a rough patch, try to find a copy or borrow this one from the Society's lending library. Unfortunately it's out of print but still available through Amazon.com's Zshops and auction. Go to their home page, enter the author's name in the search box and you'll see everything he's written, mostly now out of print. Click on this title and you will link to its availability and price.

THE SUGGESTION BOX

A PROLIFE VIEW OF ABORTION

by Daniel M. Avery, MD

There's been much controversy since the Supreme Court of the United States in 1973 recognized the "right" to have an abortion. We go to great lengths discussing the pros and cons of legalized abortion with advocates raising their concerns over increased maternal death rates, inappropriate weddings, failed careers and such if abortion on demand is not available. The fact remains that termination of any pregnancy is killing a living individual. An intrauterine pregnancy is a living being inside its mother's womb. After conception many processes begin forming a human being, usually culminating nine months later in the birth of a child. Destroying that growing, living being is murder.

If we accept killing our unborn it will soon become acceptable to kill our elderly. An ailing grandparent may be unproductive, inconvenient, suffering and consuming valuable limited healthcare resources but none of these reasons justifies terminating their life.

When I was a resident much was made of terminating for "medical reasons" those pregnancies carrying children with spina bifida, anencephaly, chromosomal abnormalities such as Down's syndrome and other developmental disorders, calling them "therapeutic abortions". Such cases have been quite rare in my experience, instead most abortions seemingly have been for the mother's convenience.

During the early 1990's I worked in the former USSR. Abortion was the most commonly used method of birth control. Other methods such as intrauterine contraceptive devices, oral or injectable hormonal contraceptives, spermicidals or barriers were simply not available to the general population. One young patient I saw related a history of seven prior elective abortions. It was not unusual for a patient to have had as many as 20 during her fertile years. Elective abortion was cheap and it was the accepted method of fertility control, but it wasn't right.

There's also the question of paying for abortions. Consider an indigent pregnant patient at eight weeks gestation desiring an abortion. Without public funding she won't get one unless she takes cash to a freestanding abortion clinic. None of the university clinics will perform an elective abortion without payment.

For decades we have danced around the basic issue of killing other human beings. We have tried to make it okay to kill a growing baby as long as it is not greater than 24 weeks gestation. We have tried to make it okay to kill an abnormal baby during the third trimester by transecting its cervical spinal cord (partial birth abortion). None of this is okay, it's wrong. If I shoot my grandmother I will be charged with and tried for murder; probably convicted, sentenced and punished. If I do an abortion somebody will pay me \$300.00, thirty pieces of silver at today's exchange rate.

Unfortunately we have sold our soul whether we are entangled within our legal system, dazzled by lucrative income or trying to decide who can decide. We have missed the whole point. Abortion is wrong. It always has been and always will be. It was wrong in 1973. It is wrong in 2000. It will be wrong forever. Yet I see no arrests for performing elective terminations at twelve weeks gestation.

Fifteen years ago while a resident I observed an abortion performed at eight weeks gestation upon a patient with advanced cardiovascular disease. It was justified by the attending's opinion she would probably die trying to carry the pregnancy. Such cases are quite rare. Since then I've not seen any real medical emergency that mandated terminating one life to save another.

Six years ago I underwent a mandibular and maxillary advancement partial glossectomy T₃ and genioplasty for severe sleep apnea. There were unforeseen severe postoperative complications and I became ventilator dependent, contracted lobar pneumonia, developed profound postoperative anemia and almost died. My wife and I had to face the questions of whether I would refuse resuscitation and life support, even request the ventilator be turned off in certain circumstances.

In the Bible, Genesis describes man as made in the image of God. Over the past six years this has taken on a much greater meaning for me. Who am I to presume to terminate such a creation as life itself? Every human being is made in God's image. Who am I to destroy that? Whether we are for or against abortion, one fact remains. Each of us will be held accountable for his actions one day. I have no problem opposing abortion under any circumstances.

THE BALLOT BOX

THANKS FOR ASKING

By Doug Daniel

Last March I carped about how sometimes the College seems to be unconcerned or perhaps even oblivious to it's members' political positions ("The sum of it's parts". *The Medicolegal Ob/Gyn Newsletter*, Vol. 8, No. 2, p. 30). Now Ralph Hale is asking all the membership to participate in a survey on whether the College should establish a Political Action Committee (PAC) ("Should ACOG form a PAC for women's health?" and "Express your views on formation of a PAC". *ACOG Today*, Vol. 44, No. 8, SEPTEMBER 2000, pp. 2 and 5).

If this again strikes a familiar chord, I also once wrote that The Cider House Rules would never be made into a movie, much less nominated for seven Oscars and God-forbid even win. There's certainly a need for pundits who calls 'um like they sees 'um, but this is getting ridiculous. A horseplayer with a similar record of prognostications would be a bookmaker's ticket to a comfortable retirement.

All kidding aside, I think this is one of the best moves the College has made in a long time. Not necessarily the formation of a PAC, but requesting Fellowship input before making controversial, blatantly political commitments. I personally am adamantly opposed to medically-sponsored PACs, instead believing physicians as a profession should be above petty politics. There's already a plethora of both physician-oriented and broader-based PACs representing every conceivable political agenda. One more isn't going to help.

If you want to send money to advance someone's political agenda, go for it but pick one consistent with your opinions. The College membership is too politically diverse to agree on anything, much less who should be elected to national and state offices. While a PAC's contributions may be voluntary, its choice of campaigns to fund paints all the parent organization's members with the same brush.

There's no deadline given for responses but I suspicion anything sent in after the first of next year will be too late. I've already done mine via the web at www.acog.org/questionnaire/pacQuest.cfm but you can also call the Department of Government Relations at 1.800.673.8444, extension 2511 or fax them at 202.488.3985 and they'll send you a hardcopy via snail mail or fax. Power to the people!

THE LITTER BOX

THE SKY ISN'T REALLY FALLING, BUT IT COULD

by Doug Daniel

Last issue I used this space to question the Institute of Medicine's (IOM's) report on errors in medicine and the subsequent hysteria it ignited (America's favorite pastime. *The Medicolegal Ob/Gyn Newsletter* 2000. Vol. 8, No. 5, p. 15). Seems like I'm not the only one to be so concerned. *Ob.Gyn.News* published a guest editorial by a gentleman named A.E. Miller, a solo practitioner of undisclosed stripe from rural Idaho, questioning the same report and its resultant rush to judgment. Dr. Miller trots out the expected criticisms but adds one I hadn't heard before, and it's pretty significant.

The Harvard Medical Practice Study, basis for the IOM report, made at least one very biased assumption. If you were a terminal, critically ill, severe multisystem trauma, or otherwise at-death's-door-waiting-for-him-to-answer-your-persistent-ring patient and your demise was in any way related to or coincident with what was retrospectively judged to be a medical mistake, you were counted among the "99,000 deaths from medical errors" alleged to occur each year.

We all know patients past reasonable chances of salvage are frequently used as clinical material for teaching technical procedures to students, residents and fellows. While this may raise the ire of some patient advocates, it's a cold, hard fact of life that everyone must develop their professional skills on a learning curve whose slope can get mighty slippery. Better this gaining of experience at the expense of those already on their way to the daisy farm than a 25 year-old mother of four toddlers.

While obviously overstating the case, this clearly makes a valid point. All life is valuable and should be saved when possible and within reason to do so. Without the first condition, there's no alternative. If both conditions exist, it's a no-brainer but that's not always the case. Often expertise and technology is available but their use defies reason. We have the ability to send a manned space mission to the sun to explore its surface but to do so would be ridiculous. Coding a ventilator-dependent, comatose 55-year-old with a chest full of inoperable lung cancer is not only dumb, it's an assault upon her physical person and spiritual dignity unless there's some benefit to be realized, something to be learned which will increase the inexperienced respiratory therapist, nurse or physician's chances of successfully resuscitating future patients under their care. If mistakes must be made, and they must in order to learn, try to at least let them be made where they don't significantly influence the ultimate outcome.

But there's always a very necessary caveat to this attitude. "First, do no harm." To me this means not causing pain without reasonable chance of cure. It also means respecting and appreciating the sacrifices our dying and dead patients make to advance our knowledge and ability. This attitude does not give carte blanc for those in training to try willy-nilly whatever they please without consultation with and supervision by someone experienced and capable in the procedure, but it does recognize the value of practice, practice, practice in more than just getting to Carnegie Hall.

I've made plenty of mistakes over the years; we all have. I've also been extremely fortunate in that none of my mistakes as a physician have killed anyone, at least that I know of. Some of my patients have died but not directly from my mistakes and I don't think anyone short of Jesus Christ himself could have given them a better chance. Some patients have experienced unnecessary complications or expense but all have been salvaged, albeit more than occasionally with the consultative assistance of other physicians.

The flood of demands for government interference and regulation has already begun, as have acquiescence to these demands. The College has created a subcommittee of the Committee on Quality Assessment to "study errors in ob/gyn and develop strategies to reduce them." For more see "ACOG forms new subcommittee to look at errors in ob-gyn" and "First, do no harm: IOM report on medical errors recommends national patient-safety agency" in *ACOG Today*, SEPTEMBER 2000, pages 14 and 15, or the College website.

It's my opinion that the most dangerous errors in medicine are the result of worker inexperience, unconcern, ignorance or impairment whether it be on the part of a physician, nurse, technician, clerk, the guy mopping the floor or any other healthcare worker. Fortunately such workers are the exception, not the rule, and their failures usually of little consequence, but they are still disasters looking for a place to happen.

Medicine's most common errors, with or without serious consequences, are errors in system functions easily amenable to prevention utilizing available technology and management techniques already employed for years by manufacturing industries

worldwide. Some of us have held this opinion for ten or twenty years but no one has yet effectively considered the hospital and its peripherals as a manufacturing operation, subject to the same problems and solutions as any other factory.

Even if we become Demming Disciples embracing short-cycle manufacturing or “Just In Time” principles (see Daniel WD. Medical quality assurance services. The Medicolegal Ob/Gyn Newsletter 1996;Vol. 4, No. 2, p. 1), we still must identify those potentially disastrous workers and either motivate, educate, rehabilitate, or eliminate them. It’s time to do it and do it right, not with halfhearted lip service and buzzwords but with a hard and honest look at our workforce, total dedication to the philosophies of continuous quality improvement, and immersion in eliminating system errors; in short what Japanese manufacturers started doing in the early 50’s. Unfortunately the naysayers will use the same excuse our American industries did, “But we can’t afford to do that!” Point is that like General Motors and Ford, now we can’t afford not to.

THE ADOLESCENT GYNECOLOGY PATIENT, Continued From Page 1

preceding the survey, suggesting prior sexual activity does not necessarily preclude discussion of abstinence as a risk-reducing strategy.

Despite the 1999 survey's evidence of increasing responsibility in many aspects of teens' sexual behavior, the combination of sexual immaturity and sexual activity poses many challenges for teenagers, their families and their physicians. Promoting healthy sexuality in our youth requires a comprehensive approach. Ideally parents should continually teach sexuality education starting at an early age. Physicians can encourage parents beginning open discussions of sexuality with their children appropriate to emotional and physical development, reassuring them it is not a taboo subject. The American Medical Association has developed "Guidelines for Adolescent Preventive Services" (GAPS) which provides many brochures for parent and child education, with more information on the web at www.ama-assn.org/adolhlth/adolhlth.htm. It's probably easier to go the their home page, www.ama-assn.org, find the site map or link for GAPS and go from there. The American Academy of Pediatrics also has similar materials available at www.aap.com.

Effective sexuality care can be provided during an initial office visit if certain specific issues are remembered. Adolescents have repeatedly said they seek physicians who respond to them in a non-judgmental manner while treating them with respect and protecting their confidentiality.³ Most states do not require parental consent for minors to receive family planning services, including diagnosis and treatment of pregnancy or STDs ⁴. Some even recognize those who have been pregnant and either aborted or delivered as emancipated minors, legally competent to provide medical informed consent. Others living independently and separate from their parents are likewise usually considered emancipated minors.

Patients and parents may be unaware of this and some parents will obviously object, occasionally adamantly. Mentioning your position on this issue early in the initial encounter before taking the medical and sexual histories will avoid privacy and confidentiality conflicts.

Terms used to obtain the sexual and reproductive history must be appropriate for the patient's developmental stage. Begin with a menstrual history and explain that by menstrual period you mean the period of time from the first day of a bleeding episode until the last day of a bleeding episode. Ask if she has questions about birth control or catching sexually transmitted diseases. Ask about her sexual orientation and sexual behavior but avoid questions about "sexual activity" since it is an often misunderstood concept. Direct, simple, concrete questions using terms she understands get the most reliable answers and the following are some examples.

- ◆ Have you had a menstrual period yet? When did you have your first menstrual period? When did you have your last menstrual period? Do you have menstrual periods once a month? Do you ever miss a menstrual period? How many days do you bleed with your menstrual period? How many pads or tampons do you use per day during your menstrual period? Do you ever have cramps with your menstrual period? If you have cramps, what do you do to relieve them and how do they restrict your activities?
- ◆ Breast cancer is very rare in teens but it's a good idea to properly examine your own breasts every month about a week after your menstrual period. I'm going to examine your breasts today. Would you like me to show you how to do it yourself?
- ◆ Do you have a special friend? What do you do when you're together? Do you touch or kiss each other? Do you have sex? If so, how do you do it?
- ◆ How old were you when you first had sex? How many different people have you had sex with? How many in the last three months? Have you had sex with boys, or girls, or both? Which do you prefer, if either? What do you do to prevent getting pregnant or catching any diseases? Do you know what condoms are, how to get them and how to use them?
- ◆ Have you ever been pregnant? How many times? How long were you pregnant each time? Did you have the baby and keep it, give it up for adoption or have an abortion?
- ◆ Do you know what STDs or Sexually Transmitted Diseases are and how you can get them? Can you name some? How can you know if you have an STD? How can you protect yourself from them? Have you ever had the HIV or AIDS test? Everyone who's ever had sex should have one done. Would you like me to do one for you today?
- ◆ Has anyone ever made you have sex with them, or do something you didn't want to do, or hurt you while having sex or any other time?

This determines what the adolescent knows about sex, reproduction and the possible consequences of sexual behavior including responsible sexual behavior. Only then can patient education begin and misinformation be corrected. When asked what they most want their physicians to discuss with them, adolescents list birth control, STDs and other important sexuality issues they must confront on a daily basis, plus they want their physicians to initiate the discussions.⁶

Sexually active adolescents and all those 18 years or older should have periodic pelvic examinations and Pap smears.^{7,8} Other complaints such as acute or chronic pelvic pain, primary or secondary amenorrhea, dysmenorrhea, dyspareunia, symptomatic or asymptomatic vaginal discharges, and alleged sexual assault may also warrant pelvic examination. It requires extra time and effort to put an adolescent at ease for her first pelvic examination, but it increases her level of comfort and also her compliance with future examinations. The initial pelvic examination determines a patient's attitude toward future gynecologic care.

Begin by talking to her while she is still fully dressed. Tell her she will need to help with the examination and you will stop whenever she wishes. She may or may not want her mother present during the pelvic examination and it should be her choice. A female employee chaperone must always be in attendance whenever a patient is subject to exposure or examination of breasts, genitals or anus. Talk to your patient and not her mother. Treat her as a person and not as her parent's child.

Selection of the appropriate type and size of vaginal speculum is the key to an atraumatic examination. In virginal adolescents it may be necessary to use a veterinary ear speculum attached to an otoscope handle or in conjunction with a colposcope. The smallest speculum providing adequate exposure should always be chosen. Occasionally digital examination with the fifth finger in the vagina, or in the rectum with a cotton-tipped applicator stick in the vagina, will suffice in cases with a stenotic hymeneal opening. True imperforate hymen requires hymenoplasty under general or conduction anesthesia with complete visual and bimanual examination of the internal and external genitalia. The squamocolumnar junction in early pubertal females normally appears beefy red and should not be confused with cervical infection, trauma or disease.⁷

Obviously abstinence is the safest and most effective preventative of pregnancy and STDs. Physicians' opinions regarding adolescent contraception vary but all agree on one aspect; condom use is critical to practical prevention of both pregnancy and STDs, especially HIV.

The authors find that adolescent patients often prefer Depo-Provera® since it doesn't require daily dosing. Oral contraceptives are also effective and if patients so choose, we usually prescribe tri-cyclic preparations. Emergency contraception with certain oral contraceptives is often overlooked, the only significant differences in recommended available products (see Table 1) being availability of identical pills in monophasic 21 or 28 count packaging, dosage, price per course of therapy and the home pregnancy test included with Preven™. Packaging with all pills of the same color and content is probably less confusing to the patient. Specific dosages vary but all may be initiated within 72 hours of unprotected intercourse and consist of an initial dosing which is repeated twelve hours later, notify your physician if you vomit. If you think it necessary that patients have a negative pregnancy test before using emergency contraception, prescribe Preven™ at a patient cost of approximately \$30.00 per course. If not, prescribe one of these oral contraceptives for the patient to use at her discretion for approximately \$8.00 to \$60.00 per course.

When the examination is complete the patient should be allowed to dress in private before discussing findings, diagnoses and recommended treatments alone with the patient. She should then be asked if there is anything she doesn't want her parent to be told. Obviously any request should be honored. One way to do this is by answering parents' questions about confidential matters with "You need to ask your daughter about that." Finally, a joint discussion should be held with parent and patient together.

BRAND NAME	PILLS/DOSE	MONOPHASIC	PACKAGING	APPROXIMATE COST/COURSE
Preven™	2	Yes	4 Pills With Home Pregnancy Test 1 Course	\$30.00
Ovrette™	20	Yes	28 Pills Only (7 Inert) ½ Course	\$60.00
Nordette™	4	Yes	21 or 28 Pills (7 Inert) 2 Courses	\$15.00
Levlen™	4	Yes	28 Pills Only (7 Inert) 2 Courses	\$15.00
Lo/Ovral™	4	Yes	21 or 28 Pills (7 Inert) 2 Courses	\$15.00
Triphasil™	4 Yellow Pills (Third Phase)	NO	21 or 28 Pills (7 Inert) 2 Courses	\$15.00
Tri-Levlen™	4 Yellow Pills (Third Phase)	NO	28 Pills Only (7 Inert) 2 Courses	\$15.00
Alesse™	5	Yes	21 or 28 Pills (7 Inert) 2 Courses	\$15.00
Ovral™	2	Yes	21 or 28 Pills (7 Inert) 5 Courses	\$8.00

TABLE 1. ORAL CONTRACEPTIVES COMMONLY USED FOR EMERGENCY CONTRACEPTION

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EDITORIAL COMMENT: Always a concern when providing gynecologic care to minors is how to respond to their sexual history. It is of primary importance that their physicians not be judgmental, sometimes quite difficult. Patient confidentiality must also be respected in order to maintain trust and credibility. Society however demands all healthcare practitioners act as advocates and protectors of minors, especially in sexual matters, posing a potential conflict of interests.

If nonconsensual, any inappropriate carnal knowledge of a minor, usually defined as viewing, touching or penetrating genitals, anus or breasts, constitutes secondary sexual assault or statutory rape in most jurisdictions and is required by law to be reported to the appropriate investigative authority. Nonconsensual by definition ordinarily includes use of psychological or physical threats, intimidation, rewards, or mind-altering substances. There is no unanimity among jurisdictions as to what constitutes the various degrees of sexual assault and/or abuse.

When required by statute, suspicions of illegal sexual activities involving minors should be reported to appropriate law enforcement, investigatory or child welfare agencies. Otherwise you may be held accountable for violating the law. The problem arises in what to do about consensual sexual activity among peers since age differential may be a significant factor in some jurisdictions. Many investigators consider a two years or less age difference to preclude action in the absence of other complicating factors. An exception occurs if either partner is a legal adult. Even if sexual assault or rape charges are not pressed,

the adult may still be charged with influencing the morals of a minor. Cases involving minors with substantial age differences are frequently investigated and prosecuted if warranted. Consultation with your personal or state medical association attorney, local child welfare office, chief of police, sheriff or state police detachment commander on these matters and the legal requirements for their reporting is strongly recommended.

Herb Underwood
Doug Daniel

ASTHMA AND ALLERGY MEDICATIONS DURING PREGNANCY

by Michael Schatz, MD

Asthma is one of the most common potentially serious medical conditions to complicate pregnancy. Severe asthma increases the risk of antepartum, intrapartum and postpartum complications, yet adequately controlled asthmatics and non-asthmatics have similar outcomes.

The National Asthma Education Program Working Group on Asthma and Pregnancy in 1993 published recommendations for the management of asthma and associated conditions during pregnancy. The American College of Allergy, Asthma and Immunology (ACAAI) and the American College of Obstetricians and Gynecologists (ACOG) recently convened an ad hoc committee to consider subsequent therapeutic advances and update the previous recommendations. This "Position Statement" was published in *Annals of Allergy Asthma and Immunology* (2000; 84:475-480) to provide information and recommendations on newer asthma and allergy therapies during pregnancy.

A summary of specific recommendations is presented in Table 1 while Table 2 presents a step-therapy approach for the management of asthma during pregnancy based on the Statement, the Working Group on Asthma and Pregnancy's report and the Expert Panel II's report.

Several additional points require emphasis. First, patients should do everything possible during pregnancy to avoid asthma triggers including cigarette smoke and allergens. Second, the risks of severe, uncontrolled asthma appear to be much greater than any known risks of appropriately chosen asthma medications.

Third, treatment of acute asthma during pregnancy must include careful attention to maternal oxygenation. Normal fetal brain development is extremely sensitive to relatively small decreases in maternal and subsequently fetal pO₂. Relatively mild maternal hypoxia which may be tolerated well by the mother can cause subtle or more obvious neurological damage to her fetus. Supplemental oxygen should be used to maintain maternal arterial pO₂ at or above 70 mm/hg, O₂ saturation at or above 95%.

All these current recommendations will of course need to be continually updated as newer information and medications become available. It is important to both clinical treatment and risk management that, like management of diabetes mellitus in pregnancy, these therapies be tailored to the varying needs of each individual patient. Informed consent or refusal must be obtained and documented. Although not discussed in the Position Statement, I personally recommend consultation with an asthma specialist and subsequent co-management of pregnant patients with persistent asthma.

Medication	Year Introduced	Consider Use in Pregnant Women:
salmeterol xinafoate (Serevent® Diskus and Inhalation Aerosol)	1994	With moderate-severe asthma who have shown a very good response prior to pregnancy Who are inadequately controlled by medium-dose inhaled corticosteroids
nebulized ipratropium bromide (Atrovent® Inhalation Solution)	1993	Presenting with acute asthma who do not improve substantially with the first inhaled β agonist treatment
nedocromil sodium (Tilade® Inhaler)	1993	Who have shown a good response prior to pregnancy
budesonide (Pulmicort® Turbohaler Inhalation Powder)	1997	Who have shown a good response prior to pregnancy Who are starting inhaled corticosteroids during pregnancy Who require high doses of inhaled corticosteroids for adequate control
fluticasone propionate (Flovent® Inhalations 44 mcg, 110 mcg and 220 mcg; Flovent® Rotadisk 50 mcg, 100 mcg and 250 mcg)	1996	Who have shown a good response prior to pregnancy
zileuton (Zyflo® Filmtab Tablets)	1996	No indication at this time
zafirlukast (Accolate® Tablets)	1996	With recalcitrant asthma who have shown a uniquely favorable response prior to pregnancy
montelukast sodium (Singular® Tablets and Chewable Tablets)	1998	With recalcitrant asthma who have shown a uniquely favorable response prior to pregnancy
cetirizine hydrochloride (Zyrtec® Syrup and Tablets)	1995	Who do not tolerate chlorpheniramine maleate or tripelemamine and need an antihistamine in spite of optimal topical therapy (ideally after 1st trimester)
loratadine (Claritin® Reditabs, Syrup, and Tablets)	1993	Who do not tolerate chlortrimeton or tripelemamine and need an antihistamine in spite of optimal topical therapy (ideally after 1 st trimester)
azelastine hydrochloride (Asteline® Nasal Spray)	1996	Based on animal studies, better choices available
fexofenadine hydrochloride (Allergra® Capsules)	1996	Based on animal studies, better choices available
Intranasal steroids	--	Similar recommendations as for orally inhaled steroids

TABLE 1. SUMMARY OF ACAAI-ACOG RECOMMENDATIONS FOR THE USE OF NEWER ASTHMA AND ALLERGY MEDICATIONS DURING PREGNANCY (Brand names added)

Category	Step Therapy
Mild Intermittent	Inhaled β_2 -agonists as needed (for all categories) ¹
Mild Persistent	Inhaled cromolyn sodium (Intal® Nebulizer Solution) Continue inhaled nedocromil in patients who have shown a good response prior to pregnancy Substitute inhaled corticosteroids ² if above not adequate
Moderate Persistent	Inhaled corticosteroids ² Continue inhaled salmeterol in patients who have shown a very good response prior to pregnancy Add oral theophylline and/or inhaled salmeterol for patients inadequately controlled by medium-dose inhaled corticosteroids
Severe Persistent	Above + oral corticosteroids (burst for active symptoms, alternate-day or daily if necessary)

TABLE 2. ACAAI-ACOG RECOMMENDATIONS FOR THE PHARMACOLOGICAL STEP-THERAPY OF CHRONIC ASTHMA DURING PREGNANCY BASED ON THE RECOMMENDATIONS OF THE NATIONAL ASTHMA EDUCATION PROGRAM REPORT OF THE WORKING GROUP ON ASTHMA DURING PREGNANCY, UPDATED TO INCORPORATE NEWER INFORMATION INCLUDING THE EXPERT PANEL REPORT II.

1. Most published human data using albuterol (Proventil® Inhalation Aerosol, HFA Inhalation Aerosol, Inhalation Solution, Solution for Inhalation 0.5%; Ventolin® Inhalation Aerosol, Inhalation Solution, Nebules Inhalation Solution, Rotocaps for Inhalation and Syrup), metaproterenol sulfate (Alupent® Inhalation Aerosol, Inhalation Solution) or terbutaline sulfate (Brethine® Inhalation Aerosol).
2. Beclomethasone and dipropionate (Beclovent® Inhalation Aerosol; Vancril® Inhalation Aerosol and Double Strength Inhalation Aerosol) or budesonide (Pulmicort® Turbohaler) if inhaled corticosteroids are being initiated during pregnancy

Continuation of other inhaled corticosteroid if patient well-controlled by it prior to pregnancy

Consider budesonide (Pulmicort® Turbohaler) if patient requires high-dose inhaled corticosteroids for adequate control

IT'S RAINING, IT'S POURING

by Doug Daniel

Somebody else apparently is trying to tell me an extremely localized thunderstorm is responsible for my wet and stinky shoes. This time it's the United Nations' World Health Organization (WHO?) with the release of their "World Health Report 2000". The good old US of A's "level of health performance" is ranked 72nd among 191 of the world's nations, surpassed by the likes of Mexico, Honduras, Albania, Armenia, Bosnia, Herzegovina, Croatia, Egypt, Sri Lanka and Macedonia. Honduras? They make great cigars but every time I hear some church group going down there to do missionary work there's an accompanying plea for medical equipment, supplies, drugs and discarded eyeglasses to be carried along. The last time I was through the airport, US Immigration and Customs was swamped with people leaving most of these places and coming here in droves, many of them nurses and physicians. Why would they, especially medical and nursing professionals, come here to live and work by leaving a better healthcare system back home? Why do those citizens of the world with more money than they know what to do with keep coming to the US for their medical treatments and surgical operations?

As with everything, there's a simple answer. The WHO used a rather unique rating system in their survey. They obviously didn't put a lot of emphasis on infant mortality rates because numero uno in this category was the Sultanate of Oman with a rate four times ours. They didn't think a whole lot of life expectancy either since Bosnia's is only 58.4 years for men.

So what was important to WHO? "Fairness" and "equality" were two things. I guess if everyone gets malaria that's fairer than almost nobody getting it. There's also a cockeyed weighting to the rating scale, more than just a little slanted in favor of countries with socialized, nationalized or communized healthcare systems regardless of how long or how well their citizens/patients live. Results are judged not by whether patients live, die or recover but how well the system meets it's potential, i.e. if you ain't got no healthcare system and everybody dies, you score 100% in meeting your potential. Larger and more developed healthcare systems are benchmarked to perfection which none of them ever attains.

The following article reproduced from the American Institute for Economic Research's *Research Reports* goes into more detail. Most of their staff probably votes Republican but the arguments are well-founded and persuasive. For years I've wondered how we could possibly be lagging behind the rest of the world in infant mortality rate. It's always been explained by their underreporting and differing definitions of mortality periods. Dad was right, there ain't a cloud in the sky.

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