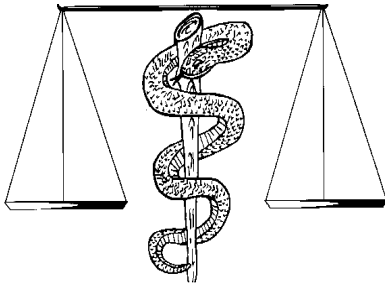


THE MEDICOLEGAL OB/GYN NEWSLETTER



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RECLAIMING THE SOUL OF MEDICINE

by **Mark T. O'Hollaren, MD**

Soul (sol) n. 1. The animating and vital principle in humankind credited with the faculties of thought, action, and emotion. 2. The vital, central part or feature of something. 3. A person considered as an inspiring force, a prime mover. 4. The spiritual nature of man considered in relation to God. 5. The emotional nature in humankind as distinguished from the mind or intellect.

Webster's Illustrated Encyclopedic Dictionary

It is the author's view that physicians' physical and emotional health is prerequisite to quality patient care, even to our entire healthcare system's operation. Yet it seems physicians have never been more emotionally distraught and unhappy. Some even consider the medical profession to be in a state of crisis. The proliferation of managed care has tremendously increased stress in an already high-pressure profession. Consider the following:

- ❑ Seventy-two percent of physicians in a national survey thought managed care increased their malpractice risk by poisoning the doctor-patient relationship in addition to delaying or denying tests, referrals, and treatment.¹
- ❑ Between 1990 and 1997 some disability insurance carriers reported more than a 60% increase in physician claims, driven in large part by increased stress in the medical workplace and professional dissatisfaction.²
- ❑ Over the past two years the incidence of physician suicide in certain areas of the country has increased fourfold, coincident with unusually high rates of managed care penetration.²
- ❑ When surveyed, 30 - 50% of physicians reported that if they had it to do all over again, they would not pursue a medical career.²
- ❑ In a California survey of 454 physicians, 40% reported symptoms of burnout.³
- ❑ In a survey of 30,000 physicians encompassing 150 health plans in 22 metropolitan areas, nearly seven in ten expressed dissatisfaction with healthcare management organizations, almost half adding they "often think about leaving clinical practice".^{4,5}

(Continued on page 18)

THE PRESIDENTIAL BOX

by Dan Avery, President

PRESIDENT AVERY'S INAUGURAL ADDRESS

Dr. Jones scheduled his patient, Ms. Smith, for elective induction of labor. Estimated fetal weight was 7½ to 8 lbs., Bishop's score was 8, length of gestation confirmed by early second trimester ultrasound was 38 weeks, and Ms. Smith was tired of being pregnant. A receptionist at the hospital, she was already familiar with elective inductions of labor. On the appointed day she arrived at the hospital, amniotomy was performed with clear fluid noted, and subsequent progress in an uncomplicated labor was textbook. When complete, complete and at plus one station Dr. Jones had her moved to the delivery room and proceeded with vaginal delivery, but after the head was out a severe shoulder dystocia unfortunately developed which Dr. Jones was unable to resolve in spite of cutting an episiotomy. Fortunately, Dr. Doe was walking down the L&D corridor, heard Dr. Jones' cries for help and rushed into the delivery room to apply suprapubic pressure allowing shoulder rotation for completion of the delivery. Unfortunately, the newborn had no pulse or spontaneous respirations but fortunately Dr. Doe was able to successfully perform neonatal resuscitation while Dr. Jones attended Ms. Smith. Unfortunately, the child demonstrated no movement of its left arm in the newborn nursery and a diagnosis of Erb's palsy was made. Fortunately, with the passage of time function of the effected extremity developed but never to the same degree as the right.

Unfortunately, Drs. Jones and Doe were served just before the statute of limitations expired with complaints in a medmal litigation initiated by Ms. Smith. Fortunately, this all happened in Florida which is unique from the rest of the United States in that upon petition of the court the event in question can be repeated. So, armed with the foreknowledge that a shoulder dystocia would develop with subsequent brachial plexus trauma, Dr. Jones decided that for the "redo" he would deliver Ms. Smith via Caesarean section. As expected, this time there were no injuries with mother and baby doing fine.

Only in Florida. Does that sound familiar after Election Year 2000? One side expects another chance, and another, and another, and another until the desired outcome prevails. We all probably wish medmal tort reform could be that easy, but it's not. The above case did actually occur, but in Alabama instead of Florida. Alabama doesn't have provision for a redo in alleged medmal torts so the final decision is still pending, just like our nation's Presidency did for so long. Since we don't get another chance in these cases it becomes even more important that effective peer review, prevention of unnecessary risk, and provision of the absolute best patient care we can deliver be the benchmark for our profession.

I appreciate your confidence in allowing me to again serve as your Society's President and thank God there were no recounts. Organized in 1992, the Society now has eight years of accomplishments to reflect upon. We were officially recognized by ACOG as a Special Interest Group in 1994 and decided to add American to what had up until then been the Society of Forensic Obstetricians and Gynecologists. I also appreciate the work Doug Daniel has done as our Executive Director and *Newsletter* Editor for the past six years. He has truly dedicated himself to keeping the Society alive. This year's goals as always include continuing to educate the Society's and College's members on medicolegal aspects of obstetrics and gynecology clinical practice, but we must also exert every possible effort to realize a major increase in the Society's membership over the next twelve months. Our annual membership meeting will be during the ACOG ACM next May and I personally extend to each of you an invitation to attend and bring at least one guest. Due to a schedule change placing the meeting's welcome party on Sunday evening, the Society's membership meeting will be on Monday afternoon from 5:30 to 7:00. At the moment the tentative program consists of a presentation by a plaintiff attorney and a defense attorney from the Foundation of The American Board of Trial Advocates and it promises to be a barnburner.

We must get new members. If you have someone to whom you wish information sent or a personal contact made please write, call or fax Doug or myself at either of these addresses.

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THE WITNESS BOX

by Doug Daniel, Editor

"Roe (v. Wade) fanned into life an issue that has inflamed our national politics in general, and has obscured with its smoke the selection of Justices to this Court in particular, ever since. . . . (B)y keeping us in the abortion-umpiring business, it is the perpetuation of that disruption, rather than of any Pax Roecana, that the Court's new majority decrees."

Supreme Court of the United States Justice Antonin Scalia

In his dissenting opinion to *Stenberg v. Carhart*

Quoting his previous dissenting opinion to *Planned Parenthood of Southeastern Pa. v. Casey*

This month we gain ten new members. Peter Greenspan is ACOG Past President Jim Youngblood's Associate Chairman and an Assistant Professor in the Department of Obstetrics and Gynecology at University of Missouri Kansas City's Truman Medical Center Lakewood. I met Peter through the *Newsletter's* ACOG Past Presidents Project while he was writing a piece on Jim. Jeff Richardson practices in Ventura, California, and has the distinct honor of being our first new member recruited through www.asfog.com. (Ray and Paul, you were right! It's already paid for itself!) Jeff Komins is Chief of the Department of Obstetrics and Gynecology at Virtua Memorial Hospital of Burlington County in Mount Holly, New Jersey, and is well recommended by being a FOB (Friend Of Ben), so kudos to Ben Harer for bringing us another new member. Julia Anderson practices with Howard Shaw at OU Tulsa and also joined through the web site. Thanks, Howard. Karl Rugart was trained by Ben Harer's dad and has remained a close friend of Ben's. Karl recently retired in the Philly area and we also met via the *Newsletter's* ACOG Past Presidents Project while he was writing a piece on Duke Kimbrough. Sandra Reilley is a member of The Reilley Group in Tacoma, Washington, and a FOR (Friend of Rob, Olson that is). She graduated with an MD from the University of Washington plus completed internship and residency there. Thanks, Rob. Anant Bhati is another author on the *Newsletter's* ACOG Past Presidents Project, writing on Richard Schmidt and currently practicing in Cincinnati, Ohio. He's a MBBS graduate of the SMS Medical College of Jaipur, India, and completed internship and residency at Good Samaritan Hospital in Cincinnati.

My most professionally satisfying experiences in clinical practice have been fellow physicians presenting themselves or family members as patients. The same thing holds true with Society members who encourage or sponsor membership for family. We have for several years had a father-son team on the rolls in Stratton Sterghos Jr. and Sr. down in Florida, but now we have a mother/daughter/son combination in Jo Hall, her daughter Gillian Esser practicing in Silverdale, Washington, and her son Jesse who is a resident at the University of Hawaii. Thank you so much, Jo. **Welcome aboard, y'all.**

If you're reading this you must have paid your 2001 dues. Thank you. If you're reading this in January 2001 you must have paid them promptly. Thank you very much. The next *Newsletter* will include an accounting of how the membership numbers fared with 2000 and 2001 new members plus renewals from 2000. So far the poll on whether we should establish an "ASFOG Man of the Year Award" is about evenly split. Jo Hall voted for it but said we couldn't spend any money. My thinking exactly since you can't spend what you don't have. Unless, that is, you're the federal government. Regardless of how the voting goes, be absolutely assured there will be no challenges or recounts.

I am humbled. Several months ago Dan Avery told me we should be forthright with the membership regarding the Society's critical financial situation. I resisted, saying there were already too many begging hands stuck out to physicians and into their pockets. I feared we would scare off what few members we had left if they actually knew how deep a hole we were in. There was also the concern that perhaps the membership would feel I had not been a good steward of their Society's assets. As usual Dan was right. To date we have received \$1325.00 over dues payable by a combination of deliberate overpayments, contributions both designated and undesignated, and honorary members converting to active status. There have also been leads on three new members, all of whom have joined. To those of you who so responded, a heartfelt thank you. This sucker may just fly after all, but only with your continuing help.

The *Newsletter's* ACOG Past Presidents Project is moving slowly but surely. I had hoped to be able to publish them in order but problems in securing authors have dictated otherwise. Six in appear in this issue. Hope you enjoy their reading as much as I have their preparation.

Bill Harrison had a letter to the editor of *Ob.Gyn.News* published in the 15 DECEMBER 2000 issue. He thinks the availability of mifepristone for medical outpatient elective abortion won't automatically improve the availability of abortion services and he's probably right. If you missed it and want a copy send me a SASE and you'll get one.

The North Carolina Medical Board's *Forum* published Ben Harer's review of [A Prescription for Murder: The Victorian Serial Killings of Dr. Thomas Neill Cream](#) by Angus McLaren, first published in our *Newsletter* back in July last year, in its Volume

5, No. 3, 2000 issue. Congratulations, Ben. The same issue of the *Forum* also published a letter to their editor I wrote disagreeing with the Board's Executive Director on the subject of individual physicians' responsibility for eternal maintenance of medical records even when employees. And this month they will be publishing a piece combining two articles published in the *Newsletter* on the IOM medical errors report. If you want copies send a SASE. Tom, you're now on the Board's mailing list and should get future *Forums* via direct mail.

Dan Avery also has a solicited editorial on impaired physicians to be published in the *Obstetrical and Gynecological Survey* but there's no publication date available yet. I'll let you know when to watch for it. Not to toot one's own horn, but I also have a solicited editorial to be published in Ralph Hale's *ACOG Clinical Review* on today's lack of attention to principles of asepsis during labor and delivery. No publication date yet but I'll let you know.

For those interested in things digital, here's an update on www.asfog.com. During the month of November 2000 we had 47 visits to the site by 35 different guests and 5 returned at least once. Surprisingly, only one came via www.acog.com but most of the 32 whose referral source could not be identified probably came through the College homepage also. There were 23 visits to either the current *Newsletter* or the archives, 10 to the membership list, and 2 downloads of membership applications plus 6 more looks at information on how to join. Three hits were international, i.e. Japan, France and the United Kingdom. We averaged 2 visits each weekday (Wednesdays were the busiest with an average of 4) and 2 each weekend with the most active time the noon hour. Three search engines referred interested parties and we had 4 visits by spiders including Lycos and Gulliver. Bottom line? The site has brought two new members so far. Check it out!

Speaking of digital, in December the College mailed all members a CD ROM with highlights of the 2000 ACM and the necessary multimedia software. Mark Graves managed the project and as expected it's strictly top shelf. Of more than passing interest to our members, Ben Harer's Inaugural Address as ACOG President is included with video and audio. My outdated computer didn't have the right stuff to run it properly but what I saw was awesome. If you missed going to San Francisco, do yourself a favor and give it a look and listen.

There's also an interesting change in the latest ACOG Committee Opinion, No. 243, November 2000, entitled "Performance and Interpretation of Imaging Studies by Obstetrician-Gynecologists". This is the first College publication I've seen in years that didn't refer to its membership as "care givers", "providers", "doctors", "physicians", "women's healthcare whatevers", or the dreaded "ob/gyns". I've always considered myself a physician first and an obstetrician/gynecologist second. One could argue that we're also surgeons but this infers we're the same as general and specialty surgeons and we're not. I've always found the term ob/gyn offensive, especially when officially used by the College in referring to its members or the specialty. It seems similar to calling pediatricians "pedipods", orthopedic surgeons "orthopods", and internal medicine specialists "fleas". Certainly acceptable in informal conversation among colleagues provided no bias is inferred but not acceptable if one wishes to be perceived as a medical professional, especially when used by one's specialty medical organization.

And while we're at it, it also bothered me that by using various terms other than obstetrician/gynecologist the College could be perceived as quite presumptuous in setting ethical, clinical and professional standards, guidelines, criteria or whatever for those not members of the organization. In my opinion the College has no business dictating or suggesting how nurses, general practitioners, physician assistants or any other non-obstetrician/gynecologists should practice their profession. Of course the caveat is that as obstetrician/gynecologists we are responsible to a greater or lesser extent for what these people do for and to patients under our care, but that is best addressed by properly supervising them and providing clear direction as to how our patients are to be treated. It all comes down to being responsible for your patient and literally being an attending physician. This may only be an aberration related to the current composition of the Committee on Gynecologic Practice feeling the same as I, but on the other hand it just might be a conscious effort by the wise men from the East to elevate our professional status. Certainly one can hope.

So Tell Me Something Else I Didn't Already Know Department: In the last issue of *ACOG Clinical Review* [Decreased incidence of UTI associated with circumcision in the first year of life. ACOG CLIN REV 2000;5(6):2] Ralph Hale commented on a recent article on newborn circumcision published in *Pediatrics* [Schoen EJ, et al. Newborn circumcision decreases incidence and costs of urinary tract infections during the first year of life. *Pediatrics* 2000;105(4):789]. It's a well-done study from California Kaiser pediatricians of 15,000 male newborns, 65% of whom were circumcised. All 15K boys' records were retrospectively reviewed for the incidence of UTI and related hospitalization over their first year of life. And guess what? There were 154 UTIs with 132 (86%) occurring in those who had been spared that unkindest cut of all. Of the 154 boys with UTIs, 42 required hospitalization and 38 (28% of all UTIs and 90% of uncircumcised UTIs) of these were uncircumcised with two being subsequently circumcised. None of this should come as a surprise to anyone from my generation who trained when newborn circumcisions were SOP. The only surprise is pediatricians wrote it.

This month's lead article by Mark O'Hollaren examines the train wreck known as physician burnout. I was recently told by a reliable source that a survey found physician suicides tripled in a major metropolitan area during its proliferation of mismanaged care enterprises. Folks, it was bad enough before these spawn of Satan stole the candy store. Today the financial, physical and emotional stresses of medical practice, especially obstetrics, are taking a tremendous toll on its workforce. We may not be able to go back to the good old days but we can adjust our priorities and attitudes.

Mark is Medical Director of the Allergy Clinic in Portland, Oregon, and a Clinical Professor of Medicine at Oregon Health Sciences University (OHSU). He went to med school there and then did his internship and internal medicine residency at Stanford University Medical Center in Palo Alto, California. A fellowship in allergic diseases at Rochester, Minnesota's, Mayo Clinic came next and then he returned to Portland as Director of OHSU's Allergy and Asthma Clinic for eight years, afterward being appointed Laurence Selling Professor and Vice Chair of the Department of Medicine at the med school. He held that post until January 1999 when, upon his private practice partner and uncle's death, he decided to devote himself fulltime to their Allergy Clinic.

Mark also speaks internationally on allergy and physician quality of life topics with over 200 invited presentations to his credit. He is or has been a member of the Board of Regents of the American College of Allergy, Asthma and Immunology; President of the American Association of Certified Allergists; Vice Chair (soon to be Chair) of the section on Asthma, Rhinitis and Respiratory Disease for the American Academy of Allergy, Asthma and Immunology. Needless to say he's widely published including the *New England Journal of Medicine* and *Annals of Internal Medicine*. Now he can add ASFOG's *Newsletter* to that list.

Dan Avery's President's Box this month looks through a glass darkly at the medmal situation, wishing it were like presidential elections and could be done over and over until you got the desired result. But it ain't and no amount of wishing will make it so. He also makes a heartfelt plea for new members and their importance cannot be over emphasized.

This month's "Hot Box" addresses the FDA's recent response to the ever-metastasizing medical errors mania, specifically newborn circumcision injuries. I never cease to be amazed by the importance of ignorance, stupidity and apathy in the medmal equation. Regardless, hysterical knee-jerk overreactions do more harm than good.

This month's Book Box is by Camilla M. Buchanan, MD, FACOG. For several years I've been trying to find someone to write for the *Newsletter* on lesbian healthcare issues. Don't know about you, but it's an area in which I'm woefully deficient. What little I think I know comes from watching "The Man Show", "Saturday Night Live", pornographic movies, and reading *Penthouse*. Not exactly the most reliable and accurate sources for legitimate medical research, but that's all changed now. This month Camilla reviews an excellent book entitled The Lesbian Sex Book, or as I like to call it, Lesbianism For Dummies. If we're lucky she'll have more to tell us in the future and perhaps even write a "Dear Camilla" column as a regular feature.

Camilla earned her BS in Chemistry from the College of William and Mary, MD from the Medical College of Virginia Commonwealth University, completed her residency at the Medical College of Virginia, and is a member of both AOA and the National Gay and Lesbian Medical Association. She practices general obstetrics and gynecology in Williamsburg, Virginia, where she lives with her life partner and their daughter. Holding multiple United Cycling Federation Masters National Championships, Camilla can frequently be seen biking through the Virginia countryside.

In the "Suggestion Box" this month Bob DeMott directs our attention to the other side of the Caesarean section on demand coin by questioning Ben Harer's previously stated advocacy. Bob has a private practice in Green Bay, Wisconsin, and with his partner Herb Sandmire has published four other papers on their Green Bay Cesarean Section Study. He holds undergraduate, masters (Radiological Sciences) and MD degrees from the University of Wisconsin in Madison and completed his residency at Magee Women's Hospital-University of Pittsburgh. He's currently President of his medical staff and a director of the Wisconsin State Medical Society.

I'm always thrilled to add a new column to the *Newsletter*, and making up those cute little titles is so much fun sometimes I could just bust. The latest addition is this month's "Tool Box", intended to be a repository for helpful hints on running the business side of your office. The first installment is on how to fire employees. This is a distasteful task for most and something I could never do, instead making them so miserable they decided to quit on their own. Perhaps that's even worse.

Elizabeth W. Woodcock, MBA, provides the answer, originally published in *Physicians Practice Digest*. She's Director of Knowledge Management for Physicians Practice, Incorporated, and an expert at decreasing costs while increasing cash flows in medical practices, a great way to improve your bottom line when you think about it. Questions can be sent to her via email at ewwoodcock@ppdnet.com, via fax with cover sheet at 410.863.5700 or via snail mail at Elizabeth W. Woodcock, *Physician's Practice Digest*, Suite 108, 811 Cromwell Park Drive, Glen Burnie, Maryland 21061. Hey, pass that 9/16ths box end and a 5/8ths ten-point socket on a 3/8ths drive with a 3" wobble extension, would you?

In this month's "Litter Box" I introduce you to Al Strunk, either again or for the first time. Al wrote a landmark editorial on the medmal problem in *ACOG Today* and I was so impressed I just had to write about it.

This issue contains the first six articles in our series on ACOG Past Presidents. It's a celebration of the College's Silver Anniversary and each future issue should have six more until we publish all 51. They're preceded by a piece I wrote on how they came about.

Philip Krupp knew Woodard D. (Woody) Beacham, ACOG's Founding President, for many years as a personal friend and colleague. Phil earned BS and MD degrees from Tulane University in 1944 and 1947, serving as President of his medical school senior class and Charity Hospital of Louisiana intern class. Subsequently he was a resident in obstetrics and gynecology at

Charity plus City Hospital of Mobile in Alabama. Joining the US Navy as a Seaman Apprentice in 1942, he advanced to Ensign by 1946 and later served in the US Air Force Medical Corps from 1950 to 1952.

Phil is currently Clinical Professor Emeritus, Department of Obstetrics and Gynecology, at Tulane University Medical School. He was previously Full Professor and Head, Section of Gynecologic Oncology, from 1973 to 1974. He is a Past President of the Louisiana Chapter of the American College of Surgeons and the New Orleans Gynecological and Obstetrical Society. This is only the last in a long line of Phil's numerous contributions to the specialty's literature.

Joe Thompson was a resident of Carl P. (The Boss) Huber, ACOG's second President, at Indiana University Medical Center 1956 through 1960, afterward a close friend and colleague. Joe earned his BS and MD degrees at IU followed by an internship at Wesley Memorial Hospital in Chicago and three months of residency at Chicago Maternity Center. The United States Army Medical Corps then utilized his services at Fort Campbell, Kentucky, for two years after which he completed a four-year residency with Huber in Indianapolis. After five years in private practice he earned an MPH from the University of Michigan School of Public Health in Ann Arbor and returned to join the fulltime faculty at IUMC until retiring in 1992.

Over the years Joe made multiple presentations at the Central Association of Obstetricians and Gynecologists meetings. He also served as Medical Director and President of Planned Parenthood of Central and Southern Indiana. Since retirement he has become a recognized historian and author, editing a compilation of his father's World War II correspondence in addition to a history of the IUMC Department of Obstetrics and Gynecology, a history of Planned Parenthood's activities in his home state, and a history of Indianapolis' Saint Paul's Church. He and his wife Ann divide their time now between homes in Drummond Island, Michigan, and Carmel, Indiana.

Karl Rugart was a resident of Robert A. (Duke) Kimbrough, ACOG's third President, back in the 1950s. He graduated from Princeton with a BA and from the University of Pennsylvania School of Medicine with an MD, followed by a rotating internship at Presbyterian-University of Pennsylvania Medical Center, two years' residency in obstetrics and gynecology at Philadelphia's Pennsylvania Hospital, then one year's residency in gynecology and another as a cancer fellow at Philly's Graduate Hospital.

In 1941 Karl enlisted in the United States Naval Reserve but was allowed to finish college before being assigned to Bainbridge Naval Training Station, Point Deposit, Maryland as a hospital corpsman until he began medical school several months later. After completing internship and initial residency training he again served on active duty for two years as Head of the Obstetrics and Gynecology Division at United States Naval Hospital, Lakehurst, New Jersey. Following military service Karl returned to the University of Pennsylvania and private practice where he remained until retirement as a Clinical Associate Professor.

Melvin Gerbie was trained by and worked for John I. Brewer, ACOG's ninth President and undeniably a strong factor in Mel's subsequent academic and clinical success. Mel graduated from the University of Toledo (Ohio) in 1958 with a BS and then earned an MD from Northwestern University Medical School in 1960. A rotating internship and obstetrics/gynecology residency at Chicago's Passavant Memorial Hospital followed and then he was off to an American Cancer Society Fellowship at New York Medical College/Metropolitan Hospital in the Big Apple, after which Uncle Sam made use of his talents for two years at the 97th General United States Army Hospital in Frankfurt. He then returned to Northwestern and has remained there ever since.

Currently Professor of Obstetrics and Gynecology at Northwestern University Medical School, Mel is also its George Gardner Professor of Clinical Gynecology and Chief of its Section of Gynecology and Gynecologic Surgery. He is a Past President of the Central Association of Obstetricians and Gynecologists and the Chicago Gynecological Society, having served on many of their committees in addition to those of the American College of Obstetricians and Gynecologists, the American Society of Colposcopy and Cervical Pathology, the Gynecological Laser Society, the American Medical Association, the Illinois Medical Society, the Society of Gynecologic Surgeons, and Phi Delta Epsilon Medical Fraternity. He is a member of Alpha Omega Alpha, the Lincoln Park Zoo's Medical Advisory Board, and is a perennial presenter at ACOG ACMs. Since 1981 he has served the American Board of Obstetrics and Gynecology as an oral examiner. He has made numerous contributions to the peer reviewed medical literature and is a reviewer for the *American Journal of Obstetrics and Gynecology*, the *International Journal of Obstetrics Gynecology*, and the *Journal of Pelvic Surgery*.

Bruce Drukker was a resident of C. Paul (Hodge) Hodgkinson, ACOG's tenth President, back in the 1960s and is now Professor of Clinical Obstetrics and Gynecology at the University of South Carolina School of Medicine in Greenville. Prior to moving south he was Professor and Chair of Obstetrics, Gynecology and Reproductive Biology at Michigan State University College of Human Medicine for twelve years and for the last five years was also Residency Program Director for Sparrow Hospital Health System's Department of Obstetrics and Gynecology in Lansing, Michigan. A gynecologic oncologist with a special interest in breast diseases and cosmetic reconstruction, Bruce trained as an intern and resident at Henry Ford Hospital until 1964, then served two years as a Captain in the United States Army Medical Corps and returned to Henry Ford. In 1972 he became Chair of Ford's Department of Gynecology and Obstetrics plus director of its obstetrics and gynecology residency training program. In 1984 he became Department Chair at Michigan State University.

Bruce is author or co-author of over 50 papers and articles plus lead author of 22 book chapters. He is a Past President of the American Society of Breast Disease, the Central Association of Obstetricians and Gynecologists and the Society of Gynecologic Surgeons. He has been a member of the Residency Review Committee for Obstetrics and Gynecology and for over fifteen years was a senior examiner for the American Board of Obstetrics and Gynecology. With his vast experience in postgraduate education, he served six years as Coordinator of the ACOG Council on Residency Education in Obstetrics and Gynecology's (CREOG) consultation service and since has continued to act as a consultant.

Newton Long worked closely with Nicholson J. (Nick) Eastman, ACOG's eleventh President, as a member of his Johns Hopkins attending staff. Newt graduated from the Johns Hopkins University School of Medicine in 1943, then proceeded to internship and residency with Arthur Hertig at Boston Lying-In Hospital. During the Korean War he served with the United States Public Health Service at Navajo Medical Center, Fort Defiance, Arizona, afterward returning to Hopkins to join its faculty. He later moved to Emory University School of Medicine in Atlanta where he has been Professor Emeritus since 1986. He now spends most of his time with his wife on their farm in Flowery Branch, Georgia, in addition to traveling and visiting family.

I first met Tony Onorato several years ago when he joined the West Virginia University Hypnosis Study Group. Tony is a licensed professional counselor with offices in Morgantown, West Virginia, home of the WVU Mountaineers. He earned his undergraduate degree there in physical education, in the process becoming a nationally-ranked collegiate wrestler. A master's in counseling at WVU followed and, no surprise, Tony possesses exceptional talents as a sports performance enhancement specialist. He's also an experienced, caring and very effective grief counselor. This month he graces us with a piece on grieving as related to loss in general, pertinent as our lead article bemoans the loss of our profession and its psychological sequelae. It also gives us some insight into our patients' reactions to loss and grief.

Of course any loss including divorce, unemployment, medical litigation, licensure or hospital privilege revocation, etc. can provoke a grief reaction in physicians. We as obstetricians/gynecologists face these relatively rare losses but also the more frequent emotional traumas posed by our patients' and even their unborn or newborn children's deaths. Tony gives us some tips on keeping it together, or getting it back together if we lose it.

Another friendship led to Jeff Lane's article on controlled substance prescribing. I met Jeff while doing some peer review work for the Georgia State Medical Board. He's their Director of Investigations and one of the friendliest folks I've ever met, although probably capable of a darker side *a la* Harry Callahan when necessary. This month he gives us the benefit of his experience regarding what gets docs in trouble and how to stay out of it. He has a BPA from the University of Mississippi and a Masters in criminal justice from Georgia State University where he has been a member of their adjunct faculty since 1997. Jeff frequently has articles in law enforcement periodicals both peer-reviewed and popular plus invited presentations to educational meetings sponsored by the likes of the Georgia Association of Chiefs of Police. His law enforcement career began just outside Atlanta in a Clayton County Police Department blue-and-white patrol car. After two years responding to radio calls he became a medical practice investigator for the Georgia Secretary of State in 1981 and their Director of Investigations in 1991. In February 2000 he moved out of the Secretary's office when the Board became an independent agency. May all our meetings be social ones.

Mike Ross gives us the low-down this month on vacuum-assisted vaginal delivery, one hot medical topic what with the FDA's recent report on the incidence of complications and the medical errors whirlwind. Conventional wisdom used to be any idiot could deliver a baby with suction without worrying about instrument trauma but I never bought it. It's good to be right.

Mike earned a BS degree from MIT (Yes, that MIT), simultaneous MD and MPH degrees from Harvard (Yes, that Harvard), then completed his internal medicine internship at UCLA Sepulveda followed by a residency in obstetrics and gynecology at Brigham and Women's in Boston and a maternal-fetal medicine fellowship at Combined Harbor/UCLA Medical Center and Cedars-Sinai Medical Center (Yes, that Combined Harbor/UCLA Medical Center and Cedars-Sinai Medical Center). He's currently Chair of Harbor/UCLA Medical Center's Department of Obstetrics and Gynecology in Torrance, Vice Chair of the UCLA School of Medicine's Department of Obstetrics and Gynecology in Los Angeles, and a Professor in the UCLA School of Medicine's Department of Obstetrics and Gynecology plus its Department of Community Health Sciences in the School of Public Health in Los Angeles.

To no surprise, he's also a Phi Beta Kappa who has lectured all over the planet with a trip to Mainland China just last spring as a visiting professor. He is author or co-author of 127 (Yes, 127) peer-reviewed professional articles, sixteen textbook chapters and two textbooks. I've got to find out what brand of vitamins he's on.

Washington Hill tells us all the bad things about tocolytics. We've heard the good things for years and everybody's got a favorite cure for threatened premature delivery. There's also lots of conditions associated with threatened and real premature labor which are only made worse by ill-advised attempts at tocolysis such as large or extending abruptio placentae, placental insufficiency, chorioamnionitis, premature rupture of membranes, umbilical cord compromise, intrauterine growth retardation, multiple gestation, cocaine abuse, and many others oftentimes better treated after 28 weeks gestation with maternal-fetal transfer to a level three perinatal center and delivery.

Previously Chairman of the Department of Obstetrics and Gynecology and currently Director of Maternal-Fetal Medicine at Sarasota (Florida) Memorial Hospital, Washington graduated from Rutgers University with a BA in Chemistry and

from Temple University School of Medicine with an MD. He then did a rotating internship at the United States Army's Walter Reed General Hospital in DC followed by a residency at Fort Bliss's William Beaumont General Hospital in El Paso and a maternal-fetal medicine fellowship at UC San Francisco-Children's Hospital of San Francisco. He's an AOA, American Board of Obstetrics and Gynecology Examiner, and has reviewed articles for the *Southern Medical Journal*, *American Journal of Obstetrics and Gynecology*, *Obstetrics and Gynecology* plus *The New England Journal of Medicine*. He has either authored or co-authored numerous articles in the peer reviewed and popular medical press.

There's another piece that sort of complements the FDA/circumcision injury "Hot Box". Some of you will question my use of words like ignorant, stupid (No, they're not the same) and apathetic when writing about physicians but recent advice from California on streamlining prenatal care just rubbed me the wrong way. My cousin Lulu was recently fired from her job at the Buckhannon Executive Massage Parlor for rubbing the customers the wrong way.

I've got another piece, this one examining the murky future of abortion in general and especially on demand here in the good ol' US of A. Haunted by the Ghost of Prognostications Past, I nevertheless went out on that by now familiar limb and tried to give you an idea of what could, might, possibly and probably will happen. It's either courageous or ignorantly reckless. You decide.

There's also a reprint from *Physician's Practice Digest* by J. Leonard Lichtenfeld, MD, on the inevitability of change, specifically in the practice of medicine within our Von Neumann machine of a healthcare system during this new millennium. While a given, change must improve more than investors' return or the solvency of government-run welfare schemes. My opinion is if it doesn't improve patient care, stick with the tried and true.

Two articles are reprinted this month from the North Carolina Medical Board's *Forum*, the first on how to write prescriptions legally by Don Pittman of their investigations office and complementing Jeff Lane's article on controlled substance prescribing. The second is on prescribing in general by Dave Work, Executive Director of the North Carolina Board of Pharmacy. Don earned a BS in Business Administration from UNC in Chapel Hill, North Carolina, and then worked in insurance sales plus the food and beverage industry before joining the Board as an investigator in 1981. He's currently supervises their field investigations.

Dave holds a pharmacy degree from the University of Iowa and a law degree from the University of Denver. He's done it all by working as a pharmacist, Blue Cross corporate lawyer, UNC professor, and administrative staff member at the National Association of Retail Druggists. He's published over 100 professional articles and is a commentator for North Carolina's public radio system. Currently serving as an adjunct professor at UNC School of Pharmacy gives him 30 years experience in teaching the law and ethics of pharmacy.

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. Also available on request are large print editions of the *Newsletter*. Contact the Society offices for details. 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

HOW I SPENT MY FOUR YEARS OF MED SCHOOL

by Doug Daniel

Sometimes I wonder what today's student physicians do with that four-year block of time called med school. It's becoming more and more apparent they aren't learning what they're supposed to. I'll spare you stories about how twelve months a year for four years I had to walk barefooted five miles through the snow uphill both ways to get to my classes at the Medical College of Georgia once a month after they had let me go back to the miserable hovel where I lived around midnight the night before.

All this is occasioned by a recent letter on circumcision injuries related to Gomco™ and Mogen™ clamps from David W. Feigal, Jr., MD, MPH, Director, Center for Devices and Radiological Health, Food and Drug Administration. There's a copy following this article. It was supposedly sent to all physicians back in August 2000 but I don't remember seeing one so perhaps you didn't either. It popped up on my screen thanks to an item in *Ob.Gyn.News*, 1 OCTOBER 2000, p. 14, headlined "FDA letter issues warning about circumcision clamps".

Apparently Dave got a rash of mail about newborn studmuffins getting their goods damaged by Gomco™ and Mogen™ clamps during circumcision, to the tune of 105 reported instances between JULY 1996 and JANUARY 2000. The IOM report on medical errors probably made it seem like a good idea at the time for Dave to give a little heads-up on eliminating these errors. I would expect the peds anticircumcision lobby also played a role. Remarkable by its absence was the Plasti-Bell™ and similar appliances.

Essentially Dave said what I was taught in the newborn nursery at MCG's University Hospital about 30 years ago, immediately prior to doing my first newborn circ: Put the clamp together first, making sure all the parts fit properly and tightly, or afterwards you'll be chasing bleeders and calling urology to put Junior's plumbing back in working order. And that's exactly what I've done over the years. I can't tell you how many times in how many hospitals I've had newborn nursery or L&D nurses wanting to give me a H₃ colonic (High, Hot and a Helluva lot) because I kept asking them to open more circ sets until there were enough parts on the table to put together one that would work properly. It always amazed me how you could tell them that a clamp was worn out and should be replaced only to have it show up again the next morning on circ rounds.

The fault, dear Reader, lies not in our tools but in ourselves. Dad used to say you could judge a workman by his tools, implying that work done by a craftsman using cheap, neglected, shoddy tools will probably be the same. This is just one more example of how the IOM's medical error report is a mixed blessing. If we were doing our jobs right in the first place we wouldn't have these people chasing us around the hospital nipping at our heels. On the other hand, should the overreaction to this point continue we're going to spend the next 25 years trying to get back to taking care of patients.

The whole thing is a no-brainer. First, we should go back to ensuring medical students know how to do the things they're supposed to instead of whateverthellose we're teaching them. I personally think we have the federal government to thank for this. Back when I was a lad we had charity patients (euphemistically called teaching cases) before everybody had the government micromanaging healthcare. Students at all levels had folks to learn on. Today third-party payers won't send the check unless a board certified specialist actually does the work, eliminating all that hands-on clinical teaching material.

Secondly, those of us in practice need to remember what we were taught and do our jobs right, not with one eye on the clock while trying to see how many corners we can get away with cutting, pardon the pun. I'm not very smart but it became painfully apparent early in my career there was a good reason for most everything people told me or I read during my training.

Finally, the rest of the healthcare system needs to listen when we tell them something is broke and needs fixing, otherwise the same preventable and unnecessary problems, complications, injuries and deaths will continue. This ain't rocket science folks, but it is everyone taking a responsible attitude toward their work 24/7 and trying to make the best widget we can. In manufacturing it's called Continuous Quality Improvement and there's 50 years experience in making it work. So far Universal Megabucks Healthcare Corporation, Inc., ain't got a clue.

POTENTIAL FOR INJURY FROM CIRCUMCISION CLAMPS

Dear Colleague:

This letter is to alert you to the potential for injury from two commonly used circumcision clamps, the Gomco/gomco-type and Mogen/mogen-type clamps. Both are widely used during circumcision to remove the foreskin while protecting the glans penis.

Although research suggests that circumcision is generally a safe procedure, we are concerned that some serious device-related complications have occurred. We received 105 reports of injuries involving circumcision clamps between July 1996 and January 2000.¹ These have included laceration, hemorrhage, penile amputation and urethral damage. We are providing recommendations below that can help avoid these complications.

Nature of the Problem

Gomco and Gomco-type Clamps

The use of Gomco and gomco-type clamps that have been reassembled by users with parts from different manufacturers or that have bent parts or mismatched components has led to clamps breaking, slipping, falling off during use, tearing penile tissue or failing to make a tight seal. Please note that although Gomco and gomco-type clamps may appear to have interchangeable parts, these parts may not always be safely interchanged because they may vary slightly in dimensions.

Mogen and Mogen-type Clamps

The use of Mogen and mogen-type clamps that have jaw gap dimensions greater than those in the manufacturer's specifications or use of clamps inappropriately sized for patients has led to patient injuries. In such cases the clamp may allow too much tissue to be drawn through the opening of the device, thus facilitating the removal of an excessive amount of foreskin and in some cases a portion of the glans penis.

Recommendations

General

Before performing a circumcision procedure examine the clamp to determine that all parts are available, undamaged and within the manufacturer's specification.

Gomco and Gomco-type clamps

If you cannot be certain that a clamp component is part of the original clamp or if the clamp has stripped threads, a warped or bent base plate, a bent arm, twisted forks, or a scored or nicked bell, either contact the device manufacturer to obtain replacement parts² or ***discard the clamp***.

When requesting a replacement part obtain the assurance of the manufacturer or supplier that the part ordered is compatible with the other components of your device. Do not substitute parts from different clamp manufacturers.

Make sure that you reassemble a clamp from ***only its own parts***. Do not mix up parts from different clamps, even from the same manufacturer, unless the manufacturer has assured you that the parts are interchangeable.

If you choose to mark clamp parts to assure that you correctly reassemble them ask the manufacturer about the best way to do this. Some marking methods may weaken the device or compromise your ability to sterilize it.

Mogen and Mogen-type clamps

Ensure that the clamp being used is appropriate for the patient size. Some manufacturers have two sizes of clamps, one for adults and the other for infants.

Periodically measure the gap between the device's clamping jaws to ensure that it is within the manufacturer's specification.³ Using a device with an inappropriate jaw gap could allow the tip of the penis to be drawn through the clamp with the foreskin and inadvertently severed or injured.

Reporting Adverse Events to FDA

The Safe Medical Devices Act of 1990 (SMDA) requires hospitals and other user facilities to report deaths and serious injuries associated with the use of medical devices. This means that if the use of a Gomco/gomco-type clamp or a Mogen/mogen-type clamp results in a death or serious injury you must report that event. We request that you follow the procedures established by your facility for such mandatory reporting.

If a circumcision clamp malfunctions you can report this directly to the manufacturer. You can also report directly to MedWatch, the FDA's voluntary reporting program. You may submit reports to MedWatch four ways: online to <http://www.accessdata.fda.gov/scripts/medwatch>; by telephone at 1-800-FDA-1088; by FAX at 1-800-FDA-0178 or by mail to MedWatch, Food and Drug Administration, HF-2, 5600 Fishers Lane, Rockville, MD 20857.

Getting More Information

If you have questions regarding this letter please contact Sherry Purvis-Wynn, Office of Surveillance and Biometrics (HFZ-510), 1350 Piccard Drive, Rockville, Maryland, 20850; by fax at 301-594-2968 or by e-mail at phann@cdrh.fda.gov. A voice mail message may be left at 301-594-0650 and your call will be returned as soon as possible.

All of the FDA medical device postmarket safety notifications can be found on the World Wide Web at <http://www.fda.gov/cdrh/safety.html>. Postmarket safety notifications can also be obtained through e-mail on the day they are released by subscribing to our list server. To subscribe send a message to fdalists@archie.fda.gov. In the body of the text type "subscribe dev-alert".

Sincerely yours,

David W. Feigal, Jr., MD, MPH
Director
Center for Devices and Radiological Health
Food and Drug Administration

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*From www.fda.gov
(Uploaded August 29, 2000)*

THE BOOK BOX

DIFFERENT STROKES

by Camilla Buchanan

The Lesbian Sex Book
Wendy Caster
Illustrated by Julie May
191 Pages. New York:1993
Alyson Books
Trade Paperback, \$15.95

“Then the question began to live under my blankets: How did lesbianism begin? What were the symptoms? The public library gave information on the finished lesbian--and that woefully sketchy--but on the growth of a lesbian, there was nothing. I did discover that the difference between hermaphrodites and lesbians was that hermaphrodites were ‘born that way’. It was impossible to determine whether lesbians budded gradually, or burst into being with a suddenness that dismayed them as much as it repelled society.”

Maya Angelou (b. 1928), US author
I Know Why the Caged Bird Sings, Vol. 1, ch. 35 (1969)

How many of you have in the past year asked a patient “And what are you using for contraception?”, only to have her answer “Nothing. My sexual partner is another woman and we don’t need contraceptives.” Lesbians in the year 2000 are more willing than their sisters of yesteryear to acknowledge their sexuality. They also expect their gynecologists to be knowledgeable concerning the unique aspects of their healthcare such as whether lesbians are at greater or less risk for HIV infection, need routine Pap smears, can decrease their high risk of bacterial vaginosis, of face different fecundity rates with artificial insemination compared to straight patients.

Ten percent or more of gynecology patients are exclusively lesbian or bisexual and we must be knowledgeable about lesbian sexual practices in order to understand their healthcare needs. The Lesbian Sex Book is an excellent addition to your professional library for an introduction and quick reference on all aspects of lesbian sexuality. Wendy Caster’s original purpose was to write an entertaining and frank book answering the question, “What do lesbians do in bed?” It’s aimed at newly out lesbians and curious women who chose not to label themselves. The answer is a comprehensive discussion of that question plus many more, organized in an annotated dictionary beginning with “Afterplay” and ending with “Who’s on Top” that includes in between topics both serious and lighthearted.

Caster defines lesbian sex as any sex that happens between two (or more) women, and lesbian as any woman who identifies herself as one. Some entries, i.e. aphrodisiacs, are only several paragraphs while others such as dildos run several pages. While the text explains quite well what for some may be difficult concepts, Julie May’s line drawings tastefully ease comprehension. There’s also an extensive resource list of popular media books, magazines and articles. Just like everyone else, lesbians run the gamut from sexually conservative to kinky, from monogamous to multipartnered. Unfortunately they’re also subject to partner-inflicted domestic violence.

This is not a footnoted scientific text but an unabashedly anecdotal collection based upon the author’s research, personal knowledge, experience and reading lesbian plus mainstream sexual literature. As part of the research she did in-depth interviews on individual sexual preferences, practices and attitudes with seven lesbians of various ethnic and racial backgrounds ranging in age from 22 to 56 years. If you’ve been searching for an entertaining, easy-to-read introduction to the world of lesbian sexuality, this is it. Caster doesn’t answer the questions about lesbian healthcare I posed in the first paragraph but future columns in this *Newsletter* will. Feel free to write or email questions to me at:

Womancare of Williamsburg
1215-A Mount Vernon Avenue
Williamsburg, Virginia 23185
bikercam@widomaker.com.

The Lesbian Sex Book is available from your local or Internet bookseller, or directly from:

Alyson Publications, Incorporated
Post Office Box 4371
Los Angeles, California 90078-4371
Website: www.alyson.com.

THE SUGGESTION BOX

ELECTIVE CAESAREAN SECTION DELIVERY: WHY NOT?

by Robert K. DeMott, MD, FACOG

“First do no harm.” This important tenet applies to obstetrics as well as every other aspect of medicine. The current proposal that we routinely offer elective Caesarean section delivery to all pregnant women at term¹ has no sound scientific evidence to support its alleged benefits. The ultimate obstetrical intervention of Caesarean section, relatively dangerous and potentially life threatening compared to vaginal delivery, interferes with the normal physiologic processes of labor. We should never circumvent normal physiologic processes unless there is compelling evidence of benefit, and in most pregnancies there is none. A recent post-Caesarean section maternal death in New York City due to necrotizing fasciitis emphasizing this point was widely covered in the popular press. Although rare, such anaerobic bacterial infections have a high mortality rate in spite of our best treatment.

Why are we suddenly treating pregnancy as if it were a disease? Offering elective Caesarean section delivery at term or consenting to perform it upon request is in my opinion irresponsible, dangerous and ultimately unfair to many of our patients. It's unfair because such a philosophy corrupts the concept of informed consent. Like it or not, we wield a great deal of power and influence over our patients and most heed our advice.

Is it possible to accurately relate the surgical risks of Caesarean section delivery versus vaginal delivery to the majority of our patients? I suggest that only a small number are able to actually understand these risks. Some patients may also be swayed by unfounded fears for their and their babies' safety during labor or erroneous perceptions regarding the risk of intrapartum neurological fetal injuries. We must neither purposely mislead our patients nor profess unfounded wisdom.

At the least vaginal delivery benefits the fetus by expelling amniotic fluid from its lungs and airway, thereby decreasing transient tachypnea of the newborn.² Subdural and cerebral hemorrhages occur less often after spontaneous vaginal delivery than after elective Caesarean section delivery prior to the onset of labor.²

Sensible and knowledgeable patients will fortunately see through this guise and reject it. There is insufficient scientific evidence to support routine elective Caesarean section delivery and a wise woman can be expected to rely upon the normal physiologic processes of labor to protect herself and her fetus. Our less educated, less aware and more fearful patients will however fall for this ruse and consent to delivery by elective scheduled Caesarean section rather than awaiting labor. Therein lies the basic unfairness. As we said at the outset, there is at all times the unavoidable duty to first do no harm.

Contrary to what has been intimated in recent literature^{4,5}, few women actually request Caesarean section delivery. Although more frequent intrapartum, here in the upper Midwest it is very rare indeed for a prepartum patient to request foregoing labor and proceeding directly to Caesarean section delivery. Are patients having this so-called option foisted upon them? How did we so quickly get to the opposite extreme from previously ill-advisedly coercing all eligible patients to undergo VBAC? Is this nothing more than the overreaction of medical malpractice-paranoid obstetricians to those disasters? Remember that most basic of scientific principles, i.e. the mere presence of the observer affects the outcome of the experiment.

James Thorp describes a slow evolution in intrapartum nursing care in Kansas City labor and delivery suites experiencing increasing percentages of labor epidural analgesia. Eventually the nursing staff became unwilling or unable to manage patients previously recognized as experiencing normal labor pain, instead calling anesthesia to start epidurals before patients even mentioned it. If we adopt this philosophy of delivering via elective Caesarean section on request we will eventually be unable to safely manage any labor or vaginal delivery.

Since we must always examine motive, exactly why do some obstetricians advocate elective Caesarean section delivery prior to labor? What would their life be like? Potential ulterior motives abound. First of all, everybody would get more sleep! Scheduled Caesarean section deliveries usually occur shortly after 08:00 hrs instead of in the middle of the night. Secondly, everybody would get paid more. Many healthcare plans reimburse more for Caesarean section than vaginal delivery although the

latter almost always requires more obstetrician and nurse resources. Thirdly, we could send the L&D nurses home and fire the midwives.

We could also stop using that expensive antibiotic prophylaxis for those pesky Group B strep bugs. We probably would have fewer cystoceles and rectoceles in our older patients but at what cost? There would be no need for obstetricians except to deliver prenatal outpatient care and we could use underemployed general surgeons to perform the delivery operations.

On the other hand we would probably have more dead mothers and even one is too many. We would expect to treat far more cases of endomyometritis, wound infection and deep venous thrombosis. We would expect women to die more frequently from pulmonary emboli and postpartum hemorrhage.⁶ It's just not worth it.

We should stay the course with normal, proven physiologic processes and use Caesarean section delivery only for truly indicated obstetrical reasons. It is in my opinion medically inappropriate, unfair and unethical to do otherwise.

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THE TOOL BOX

OUT, DAMNED SPOT

By Elizabeth W. Woodcock, MBA

Firing an employee is not a simple task and there can be consequences for mishandling it. So, before you decide to dismiss someone make sure you have gone over her job description with her and she understands what is required of her. Also, you should set definitive timelines for specific improvements that subsequently have not been met.

If you have done all this and still believe it necessary to fire an employee, here are some tips for handling the termination professionally:

- ❑ Because this job is never easy, it is best handled quickly and decisively.
- ❑ Hold the meeting in a private place.
- ❑ Be direct and clear about the purpose of the meeting and why it is necessary.
- ❑ Explain how the now-former employee can collect her final paycheck and other money owed.
- ❑ Explain the now-former employee's rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- ❑ Allow the employee to vent emotion but resist any urge to respond. This is not a good time for teaching lessons.
- ❑ Do not get emotional yourself.
- ❑ Keep the meeting to ten minutes or less.

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THE LITTER BOX

THE HOME RUN KID

by Doug Daniel

I'm sure you all know Al Strunk, if not the man at least the name. If you don't, you should. Al's the most recent addition to the College administration and the sign on his door reads "Vice President, Fellowship". He's an MD/JD who first graduated law school and then practiced law for several years, later enrolling in med school and completing a residency in obstetrics and gynecology followed by clinical practice. You should get to know him because the College's Department of Professional Liability falls in his bailiwick, so if it's doing its job let him know. Likewise if it ain't.

The reason I mention Al is his editorial entitled "Keep Your Eye on the Ball" on page two of the OCTOBER 2000 *ACOG Today*. If you missed it look in the back of this issue on page 44 for a reproduction. He initially refers to the recent 1999 survey he and his folks did of the Fellowship on medmal experience and attitudes. Nothing new there but read on. In addressing why we get sued, Al has the following to say:

"What may be less appreciated is the number of neurologic impairment cases in which the attending physician was not present for the delivery, the gestational age was not accurately determined, or the choice of delivery site was inappropriate for the patient's level of risk. ... (F)ailure to plan ahead for the appropriate institutional site, necessary assistants, special instruments, and less common anesthesia requirements or blood-banking requirements is often responsible for bad surgical outcomes. Laparoscopy ... occasions increased morbidity and mortality over conventional surgery. ... (O)ur focus must always be on that which we control and , therefore, which we can change. A risk management approach to professional liability improves patient safety and diminishes medicolegal risk. Let's keep our eye on that ball!"

Everybody say "Amen, Brother Al!" This may well be the first time the College's official party line response to the medmal monster has been other than "Circle the wagons, boys! Shoot anything that moves and let God sort 'em out!" "So", you may ask, "why the sudden change?" A couple of possible reasons come quickly to mind.

First of all the IOM report on medical errors. Better to convince the public and their politicians that we're minding the store after all before they take it over lock, stock and barrel. Another is that the College is actually changing its philosophy on medmal issues. This may be more likely than you think. Look for increasing references to "risk management" instead of "professional liability".

Makes no difference to me. I don't care what it's called as long we recognize that a goodly number of medmal cases, especially those that go to trial, involve acts of omission or commission by the attending physician which directly or indirectly caused unnecessary harm or loss to his patient, deserving of compensation and, in the occasional instance of gross negligence, punitive awards.

It's certainly possible the next issue of *ACOG Today* will contain a retraction, a disavowal by Ralph Hale of Al's editorial position, or even notice of Al's new replacement in the College line-up. I don't think so. For me this marks a new era in trying to slay the medmal dragon. Maybe we're finally going for its head instead of blindly swatting at its tail while blaming everybody else for our scorched butt.

RECLAIMING THE SOUL OF MEDICINE, Continued From Page 1

A great deal has been learned about career burnout but unfortunately not applied in any practical way to the medical profession. Quite the contrary, managed care pressures have changed the daily work life of physicians into the perfect recipe for professional burnout, namely:

1. Loss of autonomy and independent decision-making,
2. Loss of financial and job security,
3. Loss of perceived status and prestige,
4. Loss of freedom of choice in practice location,
5. Loss of professional collegiality, especially between specialists and Primary Care Providers (PCP's),
6. Loss of adequate recognition and reward,
7. Loss of influence in determining policy,
8. Loss of variety in daily work,
9. Imposition of excessive bureaucratic interference and paperwork,
10. Imposition of quantitative work overload,
11. Imposition of barriers to the patient/physician relationship,
12. Imposition of role conflict (i.e. business vs. professional).^{2,4}

This has markedly changed the quality of physicians' daily work life, job description and literally their professional identity, converging to oftentimes insidiously erode the feeling that their professional efforts have meaning and significance.² The medical profession has certain unique and inherent stressors which, in order to ensure physician well-being, require specific attention. They are not being adequately addressed among our ranks.

The practice of medicine is different in today's world. Physicians flirt with unions. Words new to the healthcare lexicon such as bankruptcy, fraud, boycott and dispute keep popping up in conversation and medical periodicals.⁴ Discussions in the halls of medicine have moved from the sharing of interesting clinical cases to how physicians no longer counsel children to enter their chosen profession, peppered with comments such as "It's just not fun anymore."

Competitive market forces introducing competitive tension between specialists and PCPs have significantly injured medical professionals' long and well-known collegiality. In the face of ever-increasing applications of new technologies to healthcare, physicians are also aware of patients' concerns over these applications. While most patients demand access to the latest in healthcare technology, 34% seek complementary, alternative or "natural" therapies.⁴ The ideal physician as imagined by the bright-eyed first-year medical student has later often proved illusory in the harsh reality of a tough, competition-driven market subject to conflicting goals and agendas.⁴

Why are these changes hitting physicians so hard? Although it is hard to make generalizations, there are some shared attributes among physicians which may play a role in their response to recent changes in healthcare provision. Those choosing to enter the medical profession are often dedicated, hardworking individuals with an intense altruistic desire to serve others. They frequently consider themselves decision makers, accustomed to dealing daily with the consequences and gravity of these decisions. They must often sort through mountains of information, prioritize what is important in a short period of time and then incorporate psychological, medical, pharmaceutical and social data into the best option for their patient. The consequences of a wrong decision may be grave.

Physicians successfully discharging this responsibility have in the past been rewarded for their efforts with high levels of professional satisfaction in addition to society's respect. That emotional foundation has however been recently shaken. Although responsibilities remain unchanged, decisions are now expected to be made more quickly and accurately with less diagnostic testing, all the while paying the decision-maker less and less despite increasing efforts. Given the unavoidable rise in personal stress, this has forced many physicians to question whether or not the rewards of medical practice are still worth the price.

How did we get into this situation? Our traditional professional self-image and expectations make us particularly vulnerable to the stresses of managed care. Dr. Rachel Naomi Remen, a pediatric oncologist at the University of California, San Francisco, has done a great deal of important work in the area of physician stress, striving to help them recover a sense of professional significance. This article's title is in fact based upon one of her lecture titles and I have relied heavily on her work since it so succinctly describes the essence of our current problem. According to her our professional culture is created by our education. There is considerable data to suggest medical education is part of the problem, so we must reconsider how we educate doctors.

UCSF first-year medical students in her studies were enthusiastic and ready to take on the world. By the end of their third year 75% showed signs of clinical depression and they hadn't even experienced managed care yet. The fundamental

teachings of professional distance and objectivity, in addition to the influence of society's expectations on the medical profession, combine with our strong work ethic in contributing to the current crisis in meaning.

To understand how we got where we are, it is important to first better understand ourselves. Throughout our medical careers many have derived professional meaning through a sense of accomplishment, a good fit since most physicians are highly goal oriented. As pre-med students we worked hard so we would be accepted into medical school, frequently using grades as our benchmark. After getting into medical school we had to once again work hard to be accepted by a good internship and residency. Grades and letters of recommendation were important; we had a report card mentality. If we weren't making the grade we would simply buckle down, study harder and raise our level of performance. Once in residency, fellowship became another goal for many followed by finally joining or starting a successful practice. Once in practice the goals are to keep it successful, provide for a family, care for a large group of patients and save for retirement.

One big change with entry into practice however is physicians no longer have the benchmark of grades to judge their performance. Subconsciously many physicians look at the size of their practice, their appointment backlog or their income as a measure of professional success. When it comes to evaluating how we're doing as a person and a doctor, old habits learned during training do not adequately transfer to the practitioner. Sometimes deciding to just work harder only makes matters worse.

Because medicine can be an all-consuming profession, we frequently fall into the trap of equating success as a physician with success as a person. In the United States, and I believe especially for men, we tend to equate what we do with who we are. They are not the same. What we do is only a *part* of who we are. Our income has nothing to do with who we are, how good a physician we are or how good a person we are. This is a fundamental tenet, not only lost in the background noise of the medical profession but also in society in general.

The first step in reclaiming the soul of medicine is to realize there are five existing conditions that will not change even if we work 24 hours a day. Dr. Howard Kirz describes them as follows:

- ❑ Unlimited funding of healthcare is over, with or without managed care.
- ❑ With constraints in healthcare resources extending well into the millennium, continued competition for those resources is guaranteed.
- ❑ Success is no longer assured by past performance. Winners and losers in healthcare will be determined more by what patients think of us rather than what we think of ourselves.
- ❑ Pluralism is alive and well among Americans, who will never accept a one-size-fits-all healthcare plan despite politicians' claims to the contrary. There will continue to be a variety of choices for patients and physicians. Working for multiple revenue sources is highly likely in our future.
- ❑ Patients (a.k.a. customers) place high value on their personal well-being and will continually adjust to assure receiving what they consider to be appropriate healthcare access, quality and service. Increasing demands for mobility and information, especially via the Internet, will magnify this trend. Tomorrow's customers have no reason to accept mediocre care or service from average do-everything-for-everybody providers. Do you accept this for your family now? Neither will your future patients.⁶

Accepting these trends is the cornerstone for building your personal future and the future of healthcare. Physicians continue to work harder and harder, sometimes believing that if they just put out that extra effort they can avoid the inevitable. It's not working. We're burning out. A physician who is chronically exhausted, impatient, forgetful and depressed serves no one well, especially his patients. We need to change the way we work and the way we evaluate ourselves. Failure to do so will result in ever-increasing stress-induced disease, depression, burnout, loss of the sense of wonder at what we do every day and, most concerning, quite possibly the literal loss of our lives. We need to develop a new attitude toward our personal and collective futures.

So where do we go from here? According to Dr. Leland Kaiser the limitations we face in the healthcare future are not "out there" but "in here", perceptions and self-imposed limitations pertaining to both our personal lives and our futures in healthcare delivery.⁷ We sometimes hear that with reduced compensation for patient care services, heavier workloads and the need to guard against the ever-present threat of litigation, there is just not enough time left to get to know our patients or for them to get to know us. We somehow believe that others are responsible for our attitudes about changes in the healthcare environment. We should not expect change in our profession or healthcare in general to come from outsiders, but instead should change our perceptions and expectations.⁸

Dr. Kaiser reminds us that we cannot have what we cannot imagine. Many physicians accept the current situation regarding healthcare delivery systems and are working as hard as they can within that model. He also reminds us that a future delivery system could be more community based, more centered on health rather than disease, with partnerships among many community resources to improve the population's general health.⁷ In order to see our healthcare delivery system clearly we must look as a profession, not as individuals. These changes in personal and global perception are very difficult. The only way we will survive this transition intact is to maintain an open dialogue among ourselves while supporting our peers. Doctors know doctors better than anyone else. Here are some suggestions.

Suggestion No. 1: *A psychological sense of community with one's peers is vital to a physician's sense of personal well-being.*

Increased efforts by professional societies are needed to foster this sense of collegiality. Peers must be aware of the signs of burnout and excessive stress in their colleagues, intervening to help them if need be. Physicians need to talk to each other about what concerns them. If speaking with peers is not sufficient, they may need professional counseling and support. We should not tough it out. We usually try to in spite of the obvious adverse health effects stress causes. Physicians rarely seek help on their own but are often amendable to the suggestions of a respected colleague.

Often physicians seek fulfillment in the pursuit of scientific knowledge, but not without certain pitfalls. A working knowledge of science is critical to the effective physician, summarized by Herman Blumgart (1895-1977): "Without scientific knowledge, a compassionate wish to serve mankind's health is meaningless."² We have seen tremendous advances in medicine, many within our lifetime, including vaccines, antibiotics, diagnostic imaging and minimally invasive surgery. We are now on the verge of predicting and preventing disease upon completion of the human genome project. Despite the tremendous value of these and other advances the fundamental meaning derived from the practice of medicine is not science but service. Dr. Remen does not consider service a technique or skill; it is not the work of experts but the work of hearts and souls.

This quest for knowledge has advanced our healthcare system to the best in the world. We have cutting-edge healthcare in numerous areas including technology, pharmacotherapeutics and diagnostics. I agree with Dr. Remen that as physicians, the pursuit of scientific knowledge is by itself usually not enough to give anyone a sense of fulfillment. We need something other than science alone, something more satisfying and sustaining.³ We need to teach students pursuit of meaning in their life along with pursuit of scientific knowledge. We need to educate for a sense of meaning in much the same way we educate for the pursuit of scientific knowledge. In times of crisis a sense of meaning brings strength. This does not change life or what may happen to us, but it does change our feelings regarding the experience.

Suggestion No. 2: *The true meaning of the practice of medicine is found in our patient relationships.*

Excepting basic scientific investigators, the majority of physicians do not find meaning in the pursuit of scientific knowledge exclusive of the patient-physician relationship. This encourages patient confidence and trust, a crucial ingredient in the healing process. Sir William Osler once quoted Galen: "He cures most successfully in whom people have the greatest confidence."² Our sense of meaning is under siege right now. Fatigue, numbness and overwork all erode that sense of meaning. We need to see the value of what we do through new eyes.

Today's society faces ever-increasing pressures to make more money. There is never enough. When asked what they consider an adequate income, Americans typically answer 20% over their current income. There is virtually no reinforcement in our media, movies, magazines, literature or culture in general for those who might not aspire to an ever-growing paycheck. Advertisers who tout their products as necessary prerequisites to happiness foster this materialism. One can neglect his children and have a string of failed marriages for the sake of a career, yet if he makes a great deal of money he is considered successful.

In my opinion the relationship of income to happiness is not linear but inverse. Most wealthy people I know are not very happy. Everyone enjoys nice things and financial security, and there's nothing wrong with that. Where most people, including physicians, go wrong is in thinking a certain income level will provide meaning and happiness to their life. It won't. As physicians we're already in the top 5% of earners in this country. Do you enjoy using everything you have or does much of it sit idle for lack of time? Are possessions your master or your servants? Try scaling back and you may actually be happier. Your income has nothing to do with who you are as a person, how you compare with others or how competent a physician you are.

Suggestion No. 3: *Although everyone has basic needs to be met, there is no real correlation between income and perceived value or meaning in one's personal or professional life.*

Society and the media continually bombard us with the message that if we make more money we will be happier. You are a unique individual who possesses valuable talents combined with a strong altruism. This is where your renewed sense of awe with medicine lies, not in reaching the next income tax bracket. What you earn does not determine who you are.

One factor that has played a role in the steady erosion of the meaning of being a physician is the emphasis on objectivity. Objectivity in evaluating data, research, etc. is an asset to the astute physician but harmful in excess. Sir William Osler is often misquoted as saying "Objectivity is the one true quality of a physician." What he did say was "***Equanimity*** is the one true quality of a physician."¹⁰ He defines this equanimity as an inner peace or stillness despite being surrounded by human suffering and life-threatening emergency situations.

Excessive objectivity is dangerous if it becomes too prominent in our professional lives; it must instead be balanced with the warmth and humanity characteristic of the art of medicine. Too much objectivity begins to resemble the numbness of burnout.

Suggestion No. 4: *We need to move from the study of disease to an awareness of illness.*

In seeking the human dimension of our work we will discover the integrity, range and power of our profession, and each of us may then rediscover the blessing that has been in this work for generations. You cannot find meaning if you are too distant. You can only serve in a way that brings meaning if you are touched by and connected with your patients. Our listening and understanding is as important to our patients in their healing process as our scientific knowledge. For all its science medicine is really about relationships. Although we need some emotional distance from our patients' problems, too much distance makes us more likely to burn out. Meaning can only be found up close and personal.

A 1998 Harris poll still lists physician as the nation's most prestigious occupation, reflecting society's strong feelings regarding the calling physicians have to serve others. Most physicians endure long and arduous training plus unpredictable hours, yet still cope with the conflicting demands of balancing career and family life. Approximately two thirds of physicians provide charity care.

We as a profession need to recognize the inherent value of our calling and support each other through this transition in American healthcare. We need a strong physician leadership to help us navigate these rough waters. We must encourage change but control its pace. We must realize we are only human despite the fact that society sometimes expects superhuman results. We must educate patients on what we can and cannot do.

It is important to reflect on why we went into medicine in the first place. Medical practice is unique in many ways. We can utilize all our senses, continually challenge our intellect, form close and lasting relationships, dramatically change people's lives for the better, and at the end of each day say we did nothing but good for others. Realize this and accept the compliments that your patients pay you. Don't brush them off and rush on to the next patient. Take them to heart. Enjoy them. Bask in them. You are helping patients realize the potential in their own lives through good health.

Medicine is one of the humblest yet noblest of professions. This will not change with marketplace fluctuations. There's nothing I'd rather be doing. As it has for physicians practicing the healing arts for hundreds of generations before us, the soul of medicine will continue to challenge and reward those who have chosen it as their life's work.

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TO DOCTOR, WITH LOVE

by Doug Daniel

Last summer I was thinking about the College's 50th anniversary this year. It's certainly an auspicious occasion yet the Society and *Newsletter* had completely ignored it in the celebration over Ben Harer's election as ACOG President. Upon reflection it seemed I knew almost nothing of those who had preceded him, so with the usual reckless abandon born of ignorance and inexperience I decided to publish a series of articles on ACOG Past Presidents. As the project developed the concept became to solicit pieces from those who knew these men and women best. Then I started thinking about my residency training program and its Chairmen, the impact they had on me personally and professionally, and the extremely high regard and fond affection I felt for them. The obvious strategy was to solicit personal remembrance pieces from trainees and protégés.

Having no concept of how difficult this task would prove to be, the emotions in myself and others of love, respect and even hate that would be stirred, or the personal satisfaction to be gained by working with some of the most gracious physicians, spouses and secretaries who must be walking this planet, I plunged right in. The project is a little over half finished and my only regret is it wasn't started in time to be finished by now. Susan Rishworth of the College's Jacobs Library will be curator of an exhibition on the College's first fifty years during the 2001 Chicago ACM and I regret she didn't have access to all these memories.

There have been priceless personal rewards. I watched from the sidelines as some elderly authors valiantly fought illness and disability while trying to preserve the personae of their mentors before leaving us. Many thanked me for the opportunity to pay tribute to their closest friends, father figures and heroes. Others frankly talked of recovering fond memories they had almost forgotten. As for myself I had always assumed many of my students and residents over the years were unappreciative of efforts to help them learn and practice our art at its highest conception, most of the time simply tolerating an outdated old fart who seemed to expect too much of them and ridiculing him within the sanctuary of the residents' call room. While this may still be true, I now have hope that at least a few of them harbor to some degree the same feelings for me as these authors obviously have for their subjects.

This issue of the *Newsletter* publishes six articles on the early Presidents. I wish they were the first five but unfortunately they are not and that is entirely my fault. Eventually there will be a collection available to Society members of all 51 in chronological order with an introduction and a recollection of the College's early years. Until then I hope you enjoy reading these as much as the authors and I did producing them.

WODDARD D. BEACHAM, MD, 1951-1952

(b. 1911 – d. 1987)

by Philip J. Krupp, Jr., MD, FACOG

Woodard David Beacham was a gentleman as well as a dedicated physician, immaculate in dress and polite in manner. I had known who he was while a student at Tulane but our first personal contact came in 1946 with a request for his assistance in securing a residency at New Orleans's Charity Hospital. He immediately impressed me as a naturally compassionate person, interested in his students and his profession. I remember when, upon hearing of my fathers' death, he sent not only a personal letter of condolence to me but also a financial memorial to the American College of Obstetricians and Gynecologists. Woody was one of the most considerate physicians I ever met.

His father was also a noted Mississippi physician in private practice and organizer of the Mississippi State Health Department, four of whose five sons followed him into medicine. Hugh became Professor and Chairman, Louisiana State University Department of Urology while younger brother Dan practiced obstetrics and gynecology with Woody at New Orleans's Baptist Hospital.

Woody was a high school honor student and after graduation he enrolled in the University of Mississippi, earning his BA in 1932 and BS in 1933. He then gained distinction attending medical school at "Ole Miss" for two years, afterward transferring to Tulane for the final two years, graduating second in his class and receiving the prestigious John H. Musser Award as a senior medical student. Internship and residency followed at Charity Hospital, then positions as urology assistant at LSU and subsequently Instructor, Department of Obstetrics and Gynecology at Tulane. Eight years later he was a full professor at Tulane.

Diminutive in physical stature, Dr. Beacham commanded great respect in his profession. He was an active member of 50 medical organizations while maintaining a busy private practice and traveling frequently. He was also an erudite author frequently writing with his brother Dan and Robert J. Crossen. Woody and Dan coauthored the fifth through tenth editions of C. V. Mosby Company's Synopsis of Gynecology.

Beacham was elected Founding President of ACOG in 1951 in addition to serving as President of the Southern Obstetrical and Gynecology Society, the New Orleans Obstetrics and Gynecology Society and the Tulane Medical Alumni Association. Over his long and illustrious career he also served as a member of the American College of Surgeons' Board of Governors and Chairman of its Advisory Council on Obstetrics and Gynecology; Chairman of the National Federation of Obstetrics and Gynecology Societies Committee; member of the AMA's Executive Committee; member of the American Gynecological Society and member of the International House Executive Committee. He received Distinguished Service Awards from ACOG and the Southern Medical Association in addition to being installed in the University of Mississippi's Alumni Hall of Fame. He was also a frequent financial contributor to his alma maters and ACOG. I best remember him as a happy man, faithful in his friendships and a great joy to know.

CARL P. HUBER, MD, 1952

(b. 1903 – d. 1974)

by Joseph F. Thompson, MD, FACOG

Carl Parker Huber was at all times a gentleman, probably one of the last to chair a department of obstetrics and gynecology. He was also one of a small group of loosely organized obstetricians and gynecologists who envisioned, later founded, an organization which today represents our specialty's and patients' interests worldwide. Initially The American Academy of Obstetrics and Gynecology, it became The American College of Obstetricians and Gynecologists.

Huber's father was Chairman of the University of Michigan Medical School's Department of Anatomy and, as frequently is the case in academic families, he matriculated through the same university where his father was a faculty member. Graduating in 1924, he earned an MA the following year and an MD in 1928, all from the same institution. He completed a residency in obstetrics and gynecology there in 1932, afterward one of the first Reuben Peterson Fellows in its Department of Pathology and spending part of a year studying in Europe. He remained an instructor in Michigan's Department of Obstetrics and Gynecology until 1936 when he joined for two years the faculty of the Chicago Lying-In Hospital of the University of Chicago.

Huber's arrival in Indianapolis in 1938 and his ultimate appointment as Chairman of the newly combined Department of Obstetrics and Gynecology in 1945 was associated with a fair degree of serendipity. He skillfully navigated treacherous waters as the first full-time clinical faculty department chair in a medical school where the Chairman of the Department of Surgery, a general surgeon in private practice, was also Dean of the Medical School.

The move was made possible when Indiana passed legislation in 1936 to utilize federal funds from the Children's Bureau to establish a Bureau of Maternal and Child Health within the Indiana State Board of Health. Howard B. Mettel, an Indianapolis pediatrician and also a graduate of the University of Michigan, was the Bureau's first part-time director. It was Mettel's relationship with Huber, a college fraternity brother, that resulted in his coming to Indianapolis.

In Indianapolis Huber initially had a half-time appointment in the state's Division of Maternal and Child Health and a half-time appointment in the medical school's Department of Obstetrics. Gynecology was at that time a division of the Department of Surgery and headed by a largely self-trained gynecologic surgeon.

Huber's early academic responsibilities were somewhat hazy. Initially he organized postgraduate courses for practicing physicians and in one of these the state medical journal listed him as "Resident Advisor and Research Director of Obstetrics and Gynecology at the Indiana University School of Medicine." The medical school bulletin listed him as an assistant professor in 1939 and an associate professor in 1940. In another of his postgraduate courses the Journal of the Indiana State Medical Association ad completely omitted his association with the medical school; in still another he was identified as Resident Advisor and Research Director of Postgraduate Education in Obstetrics at the State Board of Health. Finally in 1940 when the Central Association of Obstetricians and Gynecologists made his presentation entitled "Blood Prothrombin Levels in the Newborn" the Prize Award Essay, he was identified as an associate professor and full-time member of the medical school faculty. With the retirement of the Dean cum Surgery Chairman in 1945 Huber successfully united obstetrics and gynecology into a single Department. He was appointed Chairman of this combined department and the university bulletin listed him as a full professor.

Simultaneously he lengthened a one-year residency in obstetrics, initially established in 1927 with the founding of Coleman Hospital for Women, into a three-year training program in both obstetrics and gynecology with two residents at each year level. It remained a three-year program until 1956 when he combined it with the training program at nearby Marion County General Hospital and added a year, making it a four-year training program.

The first two decades in Indianapolis were not easy, full of frustrations and delays unforeseen when he made his initial decision to move from Chicago and probably influenced by promises of ample support and expectations of rapid progress. When he arrived in 1938 he was the Department's only salaried (half-time) faculty member. His training program accepted only one applicant a year. Its only employee was a secretary, probably on the Coleman Hospital payroll. His private patients, when there were any, were seen in the residents' first floor clinic at the east end of the hospital near the Department offices.

When he retired in 1969 there were six fulltime clinical faculty physicians and two PhDs presiding over a four-year residency approved for four residents at each year level, yet there was still no formal departmental organization. There was a secretary, bookkeeper, several nurses, and a maid - all hospital employees. Although the faculty maintained limited private practices they were charged no office overhead. There were no faculty retreats, no five-year plans, no individual progress reports or annual performance ratings. We wrote papers and investigated subjects that interested us without support by or much thought to research grants. We geared our presentations to what the audience needed or wanted to hear. We were promoted by a visit to the Dean's office when Huber thought we were ready. There were no medical school or university-wide promotion committees.

When the entire department faculty was present (we were out of town infrequently) we would sit down to lunch and discuss departmental problems or issues.

I never heard Huber raise his voice to anyone, instead getting red in the face when he was irritated or piqued. As faculty we all worked for "The Boss", and working for him was like working for your grandfather. We did things a certain way because that was how we thought he wanted them done, not because he said so.

Huber spoke in a distinct manner easier to imitate than describe. He used few words and pauses so long we frequently didn't know if he was finished or not. He conveyed information by what wasn't said as much as by what was. When speaking he usually pursed his lips with an increased pitch in his voice preceding the frequent long pauses.

All the residents could repeat their favorite "Dr. Huber" stories, usually mimicking his laconic use of words and long pauses. Here are a few.

Senior medical students attended a weekly lecture with a resident's case presentation. Huber usually had no foreknowledge of the resident's topic. He would slowly rise after the case presentation, light the first of two or three cigarettes smoked over the next 30-45 minutes and proceed to lecture in his distinct fashion, completing his discourse exactly as the bell rang denoting the end of class.

His residents occasionally adopted some of his characteristics, particularly after their association with him over several years. In the 1950s Huber made formal ward rounds with the residents and medical students once a week. A junior resident claimed that at one of these afternoon sessions no one said anything! The Boss and his chief resident only mumbled "Uh, hum" following each student's bedside presentation.

Sometimes his advice concerning an obstetric problem would be couched in a unique way. It was the chief resident's responsibility to "staff" cases that were admitted during the night by calling the faculty member on call at home. One night after admitting a preeclamptic patient the resident on duty sent her to Long Hospital, the location of our Radiology Department, for x-ray pelvimetry. While there she started to labor. He hurriedly called Huber. "Dr Huber, Dr. Huber, I admitted this term preeclamptic and she went into labor over at Long Hospital during her pelvimetry!" After a prolonged pause The Boss's slow, measured response was, "Well, George, if you send her to Riley Hospital maybe she'll rupture her membranes."

On another occasion he was again called at home. After being presented with the resident's assessment of the problem he agreed with the proposed management. There was the usual long pause and the resident, assuming the conversation to be over, hung up the phone. Almost immediately the phone rang and it was The Boss. "I wasn't finished."

Each fourth-year resident scrubbed on The Boss's cases for three months. He always called Huber with tissue examination results before the formal reports appeared on the patients' charts. On one occasion Huber did two diagnostic D&Cs, an unexpected cervical carcinoma and an unexpected endometrial carcinoma. Wishing to see Huber at his best when informing the unsuspecting patients of their diagnoses, the resident asked The Boss to call him before visiting the bad news upon them. He was duly called and followed Huber into the first patient's room expecting to observe a seasoned clinician dealing with a very complex and sensitive problem. Huber stood at the foot of the bed and said, "You'll have to have some radiation", to which the patient responded, "Oh, no." There were no questions, no further conversation, and The Boss walked out of the room.

Hoping to learn more than he had up to this point, the resident followed Huber into the second patient's room. They again stood at the foot of her bed and The Boss said in his slow, distinctive style, "You will need another operation." This patient's response was almost identical to the first's, "Oh, no." There were no questions, no further comments from Huber, and he left the room. This was his usual style, conveying to the resident that when breaking bad news to patients you should be brief and concise, then wait for questions. If there are none, don't elaborate. The reader must remember that in an era when all therapeutic decisions were made by physicians and patients were presented few choices, one didn't explain too much. A lot of questions from a patient was frequently interpreted as demonstrating a lack of confidence in her physician.

Following his retirement in 1969 Huber was provided office space at nearby Marion County General Hospital, subsequently renamed Wishard Memorial Hospital. In due time the Department had his portrait painted and hung it in the Departmental library in Wishard Memorial Hospital, subsequently naming it the Carl P. Huber Library in his honor. He would occasionally lecture at the Wednesday morning staff conferences on subjects of historical interest, but except for continuing to attend the ACOG ACMs he gradually disappeared from the scene of his professional triumphs.

After retiring he and his wife continued their yearly vacations in Wisconsin with Dr. and Mrs. Ralph E. Campbell, later ACOG President 1955-1956, and it was during one of these that The Boss died in 1974. Following his death and after the passage of two subsequent Department Chairmen, the portrait found its proper home at University Hospital, built about the time of his retirement, in the Department of Obstetrics and Gynecology's library and conference room. Upon his death the Department established its annual Carl P. Huber Memorial Lecture, given each April during the Indiana Section meeting of ACOG.

ROBERT A. KIMBROUGH, MD, 1951-1953

(b. 1899 –d. 1967)

by Karl F. Rugart, MD, FACOG

The American Association of Obstetricians and Gynecologists, the American Academy of Obstetricians and Gynecologists which later became the American College of Obstetricians and Gynecologists (ACOG), the American Board of Obstetrics and Gynecology (Director, Past Vice President), the American College of Surgeons, the American Gynecological Society (Past President), the Obstetrical Society of Philadelphia (Past President), the Philadelphia College of Physicians, the Society of Pelvic Surgeons, and Alpha Omega Alpha all benefited from Robert Kimbrough's keen mind, wit, gregarious personality and perspicacious application of Robert's Rules of Order. His father had been Dean of Classics at the University of Mississippi and it was common for the family to converse in Latin or Greek at the breakfast table, perhaps on occasion even in Hebrew. In later life this early linguistic training aided Dr. Kimbrough in learning Sicilian and Italian during his three and a half years as a United States Army Colonel commanding the 81st Station Hospital and the 64th General Hospital in World War II's Mediterranean Theater. He also became a close friend of General Mark Clark and was instrumental in arbitrating disputes between widely divided factions among the Allied forces and civilians. He was awarded the United States Legion of Merit.

On one occasion his unit was heading to its port of embarkation for overseas duty. Another train with higher priority temporarily sidetracked the troop train and he stepped off to enjoy a cigarette. A stir came from the adjacent tracks and a group of passengers approached him with a hand generously proffered from their leader.

"Dr. Kimbrough, how wonderful to see you again." It was Eleanor Roosevelt. They chatted for several minutes. Dr. Kimbrough was so impressed that for years afterward he told anyone making jest of her in his presence that she was the most charming and sincere lady he had ever met. Several years before this trackside meeting he had delivered her daughter of a Presidential granddaughter. President and Ms. Roosevelt at that time had eluded reporters by using the connecting tunnel under Spruce Street between Philadelphia's Lying-In division and the main hospital when visiting the two of them.

Robert Kimbrough was always an excellent student, at the head of his class from elementary through medical school. After graduating from "Ole Miss" and playing halfback for the football team he attended medical school there for two years, afterward transferring to the University of Pennsylvania where he completed his MD degree.

As a student his classmates recognized him as the "top poker player in Penn's medical school". The popular nickname of "Duke", not necessarily liked by Kimbrough, became permanently attached when one of his hometown friends visited him at Penn and used it within earshot of fellow students. It supposedly came from a distant relative named Marmaduke Kimbrough.

The Duke also completed his internship and residency at Penn. Although later considered by many to be the best qualified candidate for a chair on the medical school faculty, he was instead appointed Professor of the Graduate School of the University of Pennsylvania, head of the Department of Obstetrics and Gynecology at Pennsylvania Hospital and chief gynecologist to the Graduate Hospital.

Legend has it that an operating room head nurse became appalled at his language during particularly difficult procedures and complained. The offensive words were justified as his means of relaxing the tension of the moment. Supposedly this was the origin of his famous "Tut, tut", heard many times over succeeding years by those who worked closely with him. Upon overcoming a particularly difficult surgical task such as controlling a stubborn bleeder deep in the pelvis, he would on occasion quote Biblical scripture, "The fervent prayer of the righteous man availeth much."

Another classic story involves the husband who brought his wife to the obstetrical triage area one Sunday morning in early labor with a term breech. She was the private patient of an obstetrician on the staff of another hospital only 20 minutes away and since there were no problems, the resident on call advised she proceed to the hospital where she was to deliver. Twelve hours later after a very busy day on labor and delivery the resident was called back to the triage area. The husband had refused to take his wife to the nearby hospital and she was now ready to deliver, in fact the resident delivered her in an elevator on the way to labor and delivery. While mother and baby were fine, the husband became very angry and demanded to know the name of the chief of service, to which the resident replied "Robert A. Kimbrough". Thinking the irate husband might call his chief at home, the resident called Dr. Kimbrough and advised him of the circumstances. At the end of the presentation The Duke asked, "Are you bigger than the husband?" The resident replied that he was. "Then you have nothing to worry about." Forty years later the resident still tells this story with relish and unabashed love for his mentor.

Kimbrough loved the game of golf and became quite an accomplished player, bragging at one time of shooting 27 successive rounds under 80. This was all the more impressive since his home courses, the Philadelphia Country Club and Pine Valley Club, were the area's most difficult. Many evenings were spent with his sons shagging his shots at a polo field near his

home. The Duke was also an inveterate cigarette smoker. In his later years he rode in a golf cart and carried a lightweight metal stool to sit on while his foursome puttied out. He was active in the Philadelphia Doctors' Golf Association for many years.

One of Kimbrough's closest friends was ACOG's ninth President Dr. John Brewer of Chicago, with whom he frequently roomed when in town as an examiner during American Board of Obstetrics and Gynecology oral examinations, attending ACOG meetings, or attending other medical meetings. The annual tri-city meetings rotating between Boston, New York and Philadelphia were everyone's favorites. During the day we would attend dry and so-called wet clinics at host hospitals. A black tie dinner preceded by Manhattans and Martinis would then set the stage for critical reports by the visitors who had attended the host's clinics. These reports poked good-natured if not completely harmless fun, especially if the stagings had not gone smoothly. The victims of these barbs always looked forward to the next year's meeting.

The Duke was also a fixture in Dr. Phil Williams' quarterly maternal death meetings and his department's semimonthly pelvic cancer case discussions, serving as a discussant and/or apologist skilled at pointing out treatment shortcomings or delays in a non-threatening manner. When the reality of medical malpractice liability came on the scene these meetings were unfortunately cancelled on advice of counsel, even though they had greatly improved Philadelphia's obstetrical statistics.

Every Saturday morning Dr. K. would be in the hospital's ninth floor operating theater performing surgery on a patient the residents had selected from the gynecology clinic. During these cases he would deliver a lecture for the 25 to 50 graduate students looking down from the tiers above. Students and colleagues alike were impressed with this rare professor of obstetrics and gynecology who was accomplished in both disciplines. Kimbrough inspired those around him to be a part of his teaching and research. Quick to recognize excellence and scholarship, he selected Dr. S. Leon Israel to be his successor as Professor of the Graduate School of the University.

Once he nicked the inferior vena cava while performing a radical hysterectomy during a Saturday morning surgery/lecture. Efforts at repair were unsuccessful and the nick became a rent. He summoned a vascular surgeon upon whose arrival at the operating table he removed gown and gloves, climbed into the gallery, took a seat, and said to the graduate student next to him, "Move over. I'm as much a student of this operation now as you are."

ACOG was incorporated in 1951 and evolved from the American Academy of Obstetricians and Gynecologists with Dr. Kimbrough being elected its third President in 1952. Shortly thereafter it became evident that the fulltime leadership of a physician was required and in 1960 he retired from clinical practice to become ACOG's first Medical Director, a title shortened to Director in 1964. Upon his retirement from this position in 1966 the ACOG Executive Board named him its first "Distinguished Fellow".

For years a cast of his hands, a gift to the Pennsylvania Hospital, graced its private waiting area. The love and esteem in which he was held may best be seen in one of his residents from the Graduate Hospital years later naming his favorite horse, a Virginia fox hunter, Rak. Another ACOG Past President, close personal friend and colleague William F. Mengert, eulogized him as follows: "He was always a man of great poise and dignity, albeit a warm and likable human being. So much was this true that he earned rather than acquired the title of 'Duke'". S. Leon Israel described him as "the best of teachers, the most thoughtful of beloved physicians, the wisest of administrators, and the most helpful of counselors."

Editor's Note: The author wishes to thank Drs. Harry K. Ziel and Louis E. Fettig for assistance in the preparation of this article.

John I. Brewer, MD, 1959-1960

(b. 1903 – d. 1997)

by Melvin V. Gerbie, MD, FACOG

Until 1972 two adjoining hospitals, Passavant Memorial and Wesley, were the teaching hospitals for Northwestern University Medical School. They had two completely separate Departments of Obstetrics and Gynecology with Dr. George Gardener academic chair at the medical school and clinical chair at Wesley while Dr. John I. Brewer was clinical chair at Passavant. Each hospital had an independent residency training program and, surprisingly, there was little communication between the two. In 1972 they merged into Northwestern Memorial Hospital and Prentice Women's Hospital was built.

Brewer was salaried by neither Passavant nor the University's medical school since at that time there were no fulltime faculty attendings. All were volunteers and a medical school clinical faculty appointment was necessary to hold privileges at either hospital. Passavant's patients were either private or service with the latter coming from the medical school's clinics. Supervision of house staff was provided by attendings on a rotating schedule. He was always well aware of all the service's patients and their complications, occasionally questioning indications for surgery, selection of procedure and operative findings, even canceling an elective procedure for what he considered inadequate preoperative medical evaluation.

Brewer was also a strict disciplinarian. None of his attendings dared miss a clinic or lecture, not even when they had patients in active labor. He was focused and, most important in a teacher, very consistent. His patients were treated exactly as described in his textbook without exceptions and his surgical technique was superb, especially in vaginal procedures. There was a huge volume of surgery in the program and he did at least two or three major cases three days a week plus untold minor procedures. His major cases remained hospitalized for thirteen days while most other surgeons' patients were discharged six or eight days postoperatively. Supposedly one of his patients had developed postoperative hemorrhage at home on postop day twelve. He also would not allow his patients to go to the hairdresser while hospitalized or for two weeks after discharge. Apparently one had fainted at her beauty shop appointment and he was concerned about harm to his reputation.

Brewer's surgical technique was so precise that each resident kept a file in his OR locker with a template copy of each procedure's operative note to aid dictation, complete with swear words at appropriate points. He always used cutting-tip trochar needles and single suture ligatures on all pedicles. Resident assistants used a needle holder to sponge his operative field, pull needles and retract tissue but were not even allowed to assist until completing at least the first half of their training. I was expected to pull his needle from the pedicle, toss it onto the Mayo Stand, flip the needle holder into my palm and tie the chromic catgut suture.

After each abdominal case I remained scrubbed while the patient's legs were lifted into the dorsal lithotomy position and he visually inspected the vaginal cuff for bleeding. During four years of residency I saw only one occasion when a suture was necessary. Very precise in answering patients' questions, he had a problem remembering their names but they still loved him and did unusually well. On rounds the resident would give a quick summary of the patient's history before Brewer would walk into her room with a cheerful "Hello, lady."

Upon my return from an oncology fellowship and the military we had a much different relationship and he treated me as a colleague. As Editor of the *American Journal of Obstetrics and Gynecology*, writing a paper with him was an event to be remembered. Innumerable drafts would be required for clarifications and elimination of all extraneous verbiage. We had an excellent gynecologic pathology course taught by two attendings at a time and rotated among us all. While teaching the course I feared him even more than when I was a resident.

John Brewer is the major reason why I am today an academician/clinician, read professional literature very critically, and teach and practice conservative surgery. All his trainees had a love/hate relationship with him but we also later realized how inspiring were his examples of excellence in patient care, teaching and research.

C. PAUL HODGKINSON, MD, 1960-1961 (b. 1907 – d. 1999)

by Bruce H. Drukker, MD, FACOG

C. Paul Hodgkinson was a pre-eminent physician known for his gentleness. In the words of Dorothy A. Porter, MD, former resident and subsequent colleague, "Surely Dr Hodgkinson's most notable accomplishment was the great respect and affection in which he is still held by colleagues, patients and friends." His professional and personal life was imbued with an infinite curiosity about medicine, life and the natural sciences.

Born in New Castle, Pennsylvania, and always known as "Hodge" to close friends and colleagues, he earned a pharmacy degree from the University of Pittsburgh in 1928. Following a sojourn practicing pharmacy he entered Temple University Medical School and received his MD degree in 1936, afterwards interning at Henry Ford Hospital in Detroit, Michigan. Upon completing internship he began a surgical residency there but after three years transferred to Ford's obstetrics and gynecology training program. This dual residency experience culminated in his widely recognized excellence as a gynecologic surgeon. He was truly a master surgeon and teacher.

Drafted during World War II as a Captain in the US Army Medical Corps, Hodgkinson served as Chief of Obstetrics and Gynecology at Fitzsimmons Army Hospital in Denver, Colorado. Following the war he returned to Henry Ford Hospital and in 1952 was appointed Chairman of the Department of Gynecology and Obstetrics to succeed its first Chair, Jean Paul Pratt, MD. In 1972 Hodgkinson relinquished this position and subsequently was a consultant to the Department until his retirement in 1983. Following retirement he remained in the Detroit area and took the opportunity to pursue his interests in travel, writing and natural history. Failing in health he later moved to Grand Rapids, Michigan, nearer his physician son, Charles, daughter-in-law Carole, and their five children. He died there at the age of 91 after a prolonged illness. His first wife Amy Walker, second wife Mary Sterns and daughter Grace Carrier preceded him in death in 1971, 1992 and 1996.

Hodgkinson's research interests early in his career focused on toxemia and coagulation defects in pregnancy, later on chemotherapy in advanced pelvic malignancies. His curiosity, research and surgical innovations are without question the foundation of modern urogynecology and pelvic reconstruction surgery. He refined the Burch procedure for urinary incontinence plus devising and perfecting the suburethral suspension operation for recurrent urinary incontinence. His seminal research on bladder dysfunction introduced electronic urethra and bladder pressure testing for women with bladder instability. He coined the term "Dysynergic Detrusor Dysfunction" or 3-D Syndrome, now called detrusor instability or urge incontinence syndrome. His keen observations, untiring research, plus fair and accurate publications on urinary incontinence mark him as one of the original leaders in today's field of urogynecology.

Hodgkinson was the 10th President of the American College of Obstetricians and Gynecologists and in 1967 was elected 35th President of the Central Association of Obstetricians and Gynecologists. He was a member of many other state, national and international organizations including the American Gynecologic and Obstetrical Society, The American Association for the Advancement of Science and The International Foundation of Gynecology and Obstetrics. He was awarded honorary degrees from Wayne State University, Washington University and the University of Michigan.

As physician, educator and teacher he had tremendous influence on those fortunate over the years to be residents in obstetrics and gynecology at Henry Ford Hospital. Nothing less than excellence, dedication, integrity, compassion and methodical attention to detail was acceptable from himself, his faculty and his residents. He was always ready to help out when things got tough or we were pushed to our limits. He also had an uncanny way of providing challenges which refocused our thinking and often enhanced career opportunities. In retrospect you can see the hand of the "Chief", as his residents called him, in our practices today. For me, working with and learning from C. Paul Hodgkinson was a fortuitous opportunity, a tremendous experience which nurtured a lifelong commitment to obstetrics and gynecology in the delivery of compassionate care, pursuit of scientific inquiry and demand for excellence of myself and others. We learned to be physicians in the truest traditional sense of the word. J. Andrew Fantl, MD, FACOG, another friend and colleague said it best:

"For those of us who had the privilege of knowing him, Dr. Hodgkinson personified the profile of the true 'Master' embodied in a strong but gentle persona who was always ready to listen to his colleagues, friends, students and patients and extend his friendly hand to those who needed it."

NICHOLSON J. EASTMAN, MD, 1961-1962

(b. 1895 – d. 1973)

by W. Newton Long, MD, FACOG

Nicholson J. Eastman was first and foremost a meticulous physician. To his faculty and residents he was also a friend and mentor. To the world he was a renowned teacher.

Between 1950 and 1966 he wrote or coauthored the tenth through thirteenth editions of Williams Obstetrics, well known to medical students and obstetric residents across the nation. In 1950 he also coauthored Nurse's Handbook of Obstetrics, demonstrating a commitment to improving obstetrical care with well-trained nurse midwives.

In 1927 Eastman joined the faculty at Johns Hopkins Hospital in Baltimore, Maryland, later becoming a Professor and Chief of Obstetrics in 1935. He spent much of the intervening eight years in Peking, China, at the Rockefeller Foundation Hospital where he was impressed by its nurses' compassionate and skilled obstetrical care. After his return to Baltimore, Rockefeller's vacationing missionary nurses frequently visited our department.

By this time Yale University offered a masters nursing degree in midwifery and Hopkins' Department of Obstetrics supplied sorely needed teachers. Irving M. Cushner and I served as physician faculty in Baltimore for small classes of Yale nurse midwives, later filling the same role for students and nurse faculty from Kentucky's Frontier Nursing program. Eastman's efforts convinced the Johns Hopkins University administrators that such training benefited the whole nation and subsequently they offered a masters degree in nurse midwifery through the School of Public Health.

He encouraged senior residents and junior faculty to have a limited private practice of ten to fifteen patients per month as he did, with professional fees going to the hospital. They were then paid a small salary since most of their time was taken with teaching and research. Eastman encouraged this clinical and laboratory research and much of it was published, occasionally in his own *Obstetric Survey*. For years he produced and edited the *Survey* as a monthly periodical with authors from his and many other teaching centers.

He recruited the best available faculty for the department such as Robert Hingson and Virginia Apgar. Hingson was a pioneer in the use of conduction anesthesia/analgesia in obstetrics, developing safe and effective caudal and epidural techniques suitable for both labor and delivery by either vaginal or Caesarean routes. Apgar became known worldwide for her work on neonatal pulmonary function and newborn status assessment.

In 1949 my son's premature birth at 30 weeks gestation created a financial burden, which Dr. Eastman eased with a welcomed personal loan. This was only one of many kindnesses frequently shown to both his staff and patients who considered him a friend to everyone whose day he touched.

THE MANY FACES OF GRIEF

by **Anthony P. Onorato, LPC**

The risk of loving is the fear and consequences of loss. Committing one's life to spouse, child or profession risks the pain we know awaits in the future if these connections are severed or drastically altered.

Grieving is the process by which we come to terms with these losses. We slowly replace the pain and the fear of feeling that pain again with the courage to once more risk commitment or love. Trying to skip the grieving process will most likely lead to an inability to make future commitments, ultimately leaving us isolated and alone.

The most commonly recognized form of loss relates to the death of a loved one. We all understand the pain associated with death, yet there are other etiologies for losses we experience that may also elicit the need to grieve such as injury, illness, divorce, infidelity, substance abuse/addiction, civil or criminal charges, unemployment, disability, professional disciplinary actions and many others. Any of these can sever our connection to important elements of our lives.

People who experience serious illness or disabling injury often grieve the loss of the person they used to be. They view their subsequent situation and its limitations in comparison to the health they previously enjoyed. They may miss activities they once performed easily and well, yet now require intense effort and concentration if able to perform at all.

Divorce can foster a sense of loss in parents and their children. Each will lose significant periods of time once spent together as a family. Both may lose friends. Those divorced may lose mutual friends of the couple who have stronger ties to their former spouse. Children may lose friends through changing their place of residence. In large part the adjustment of divorce is related to grieving for lost or altered relationships.

Another form of grieving involves the loss of a dream. We are often faced with the death of dreams for children, careers, lifestyles and relationships. Real and perceived losses of children such as those related to substance abuse, infertility, spontaneous and induced abortions, stillbirths, and newborn through adult deaths often impact one's hopes and visions for the future. Yes, we can grieve the loss of something we never even had.

During the course of life we all inevitably and repeatedly lose people and things we love, valued parts of our lives with which we are strongly connected. These losses come in a variety of ways but hidden within their pain are opportunities for personal growth. Grieving may not be so much about letting connections go as it is about finding new ones, new ways to enjoy life and in the process become more than we were.

CONTROLLED SUBSTANCE PRESCRIBING

by Jeffrey D. Lane

Physicians completing their training and embarking on a medical career are often full of hope, anticipation, enthusiasm and excitement tempered to some degree by apprehension. Their usual answer when asked why they became physicians is, "To help others, of course." The Hippocratic Oath provides a simple yet critical guide for their professional future: "Primum non nocere." First, do no harm.

Undoubtedly the vast majority of physicians continually keep this precept foremost in their mind. Medicine and surgery daily confront practitioners and their patients with unique and dangerous challenges both physical and emotional, though occasionally with often-unforeseen adverse outcomes. These are risks inherent to any profession so dramatically affecting peoples' lives. Every conceivable advantage of training, skill and forethought cannot always predict or avoid these outcomes.

One of the more frequently encountered yet easily avoided perils is inappropriate prescribing of controlled substances. All too often physicians prescribe controlled substances but do not follow and document responses to or length of therapy, number and frequency of refills, or the quantity and variety of drugs being taken, later realizing they now have an addict for a patient.

In many of these cases scheduled drugs were prescribed for no legitimate medical purpose. This is not to say that physicians should avoid prescribing controlled substances when indicated. The government makes controlled prescription drugs available to the public under well-defined, restricted conditions for a purpose, a legitimate medical purpose, i.e. to treat and preferably cure legitimate medical illnesses. State, local and federal law enforcement and regulatory authorities are also constantly on the alert for inappropriate and/or illegal prescribing, sale or use of controlled substances by anyone but more especially physicians. At the same time government not only allows but encourages physicians to utilize all recognized therapies at their disposal including controlled substances in alleviating suffering and providing proper treatment.

This article provides some useful advice for the next time you're faced with a patient requiring or seeking controlled substances, especially for a chronic condition. It is first necessary to consider the law as it pertains to prescribing controlled substances. Practically all states have statutes addressing this issue and most simply mirror federal law, but only federal law will be discussed in order that we may be consistent across all jurisdictions. Title 21, United States Code, section 841(a), cited as 21 USC 841(a) states "...it shall be unlawful for any person knowingly or intentionally to manufacture, distribute, or dispense a controlled substance...". The Code of Federal Regulations, Title 21, section 1306 specifically addresses the prescribing of controlled substances with "...a prescription for a controlled substance to be effective (legal) must be issued for a legitimate medical purpose by an individual practitioner acting in the usual and ordinary course of his professional practice...". Common terms such as "legitimate medical purpose" are used throughout these statutes and regulations, and their scope is determined daily.

In 1973's *Collier* case a physician was convicted of unlawfully prescribing controlled substances and the court made a clear statement as to physicians' place under the law:

"A licensed practitioner is not immune from the law solely due to his status...but rather, because he is expected to prescribe or dispense drugs within the bounds of his professional practice of medicine. A physician is restricted to dispensing or prescribing drugs in the bona fide treatment of a patient's disease.... However, under the guise of treatment a physician cannot sell drugs nor distribute drugs intended to cater to the cravings of an addict.... Congress did not intend for doctors to become drug pushers."

Another problem is physicians who postdate prescriptions. Many instruct patients to fill prescriptions at several pharmacies around town with doctor/patient discussions centering on how to avoid detection instead of how to get better. Scant or even non-existent physical examinations, lack of diagnostic procedures and recorded medical histories, and failure to refer or obtain consultations create problems for physicians attempting to defend their repeated prescribing of controlled substances over prolonged periods of time.

Any prescribing of controlled substances must be for the aforementioned legitimate medical purposes. How can you insure your prescribing will be determined legitimate? Courts as well as state licensing boards apply a standard question: Was the prescribing within a valid doctor/patient relationship? A valid doctor/patient relationship, defined by the following basic principles, is therefore a necessary prerequisite to legitimate prescribing:

The patient must desire treatment for a *legitimate* illness or condition;

- The physician must make a *reasonable* effort to determine what the patient's *legitimate* medical needs are through a history of the present illness, past medical history, physical examination, and/or diagnostic testing; and
- There must be a *reasonable* correlation between the drugs prescribed and the patient's *legitimate* medical needs.

(US DEA Bulletin, 1987)

Let's examine each in more detail. When a patient presents for treatment, consider the following:

- Is this person sincere in seeking treatment for a valid illness or condition?
- Am I as a physician competent to diagnose and treat this condition?
- Does she really have a legitimate medical problem?

If you believe she is sincere and has a legitimate problem, it now becomes imperative that you determine what it is.

- What does this patient need from a medical standpoint?
- What examinations and tests should be performed to accurately diagnose her problem?
- What questions must I ask regarding symptoms, course of illness, previous treatments and other medical problems?

After legitimacy is satisfactorily assured, the best form of treatment must be determined.

- Is drug treatment warranted and if so, which ones at what dosage and for how long?
- Are the drugs I am about to prescribe the proper treatment for this patient?

Upon answering these questions to your satisfaction, freely prescribe the chosen course of therapy but if it involves scheduled drugs, be certain to properly document everything in a detailed patient medical record entry. If problems arise later the medical record will be either your best defense or worst nightmare.

Certain patient behaviors suggest a lack of sincerity or legitimacy and should alert you to the need for more careful consideration:

- Resides out of town or out of state
- Requests specific drugs, usually by brand name
- Relates obviously medically unjustified reasons for needing the requested drug
- Responds that a different recommended drug causes an allergic/adverse reaction or hasn't worked in the past
- Resists examination and diagnostic testing
- Restive behavior and attempts to prematurely conclude the encounter.

This is not to say that persons exhibiting one or even all these indicators should be refused treatment. It must be remembered that society expects physicians to determine and deliver proper treatment for each of their patients, even if that patient is suspected of seeking scheduled drugs illegally. The key word here is proper.

It is also important that physicians be an active part of the entire community, not just the medical community. It is certainly important to alert colleagues to patients shopping around for a physician with lax prescribing habits. Drug-seeking individuals quickly identify physicians who are easy marks to prescribe controlled substances.

Local pharmacists are an excellent resource since they possess abundant knowledge about patients and drug abusers. Local law enforcement officers as well as your state medical board can be extremely helpful regarding criminal activities such as

obtaining, using and trafficking in drugs. They can also be a source of training and assistance, plus any suspicions related to unfamiliar patients' unreasonable prescribing expectations should always be reported to local law enforcement.

Detailed and accurate recordkeeping is another crucial strategy in protecting your medical and narcotic licenses. Legitimate medical treatment may have been provided but unless corroborating records exist, you could have a problem. It is imperative that patient discussions, physical examinations, diagnostic tests and results, consultations, referrals, and accurate details regarding drugs prescribed, quantities, dosages, refills, patient instructions and professional consultations on drug regimens are fully documented. The patient's medical record, the record you initiate and maintain, is the most important and perhaps only evidence in attempting to retrospectively legitimize your treatment. A good rule of thumb is, "If it isn't written down it didn't happen."

A review of recent cases reveals several problem areas where unsuspecting physicians have quickly found themselves compromised or situations where controlled substance prescribing began for a legitimate medical purpose but over time developed into continued prescribing to maintain patients' addictions. Here's an actual case illustrating the importance of several of the issues discussed including legitimacy of prescribing, valid doctor/patient relationships, and proper documentation.

Obstetrician/gynecologist Dr. A has a close personal friend and golfing buddy, Mr. B, whose chronic back ailment causes extreme pain when they play. Dr. A prescribes Mr. B a few Lorcet™ 7.5mg. (hydrocodone and acetaminophen) tablets which greatly relieve Mr. B's back pain. Dr. A continues the prescribing for several weeks until it becomes routine. Several weeks eventually becomes over a year of regular, consistent prescribing of Lorcet™. It gets to the point Dr. A, as a convenience, leaves prescriptions in Mr. B's locker at the golf club.

One night Mr. B is involved in a motor vehicle accident and a teenage girl in another car is killed. Police officers investigating the accident find pill bottles in Mr. B's car labeled for Lorcet™ and listing Dr. A as the prescribing physician. Mr. B is taken to the local hospital and the Emergency Department physician calls Dr. A to obtain Mr. B's medical history, but Dr. A neither has such records nor can justify his prolonged treatment with narcotics.

In the Emergency Department Mr. B is found to have excessive blood levels of Lorcet™. The dead girl's family learns of this and subsequently files a wrongful death civil suit against Dr. A similar to the Goldmans' against O.J. Mr. B's family files a medical malpractice suit in his behalf against Dr. A.

Dr. A's malpractice carrier then denies liability because his prescribing in this case is considered beyond the usual and ordinary course of legitimate medical practice. Both parties suing Dr. A receive favorable court verdicts with substantial awards. A good physician ignored his professional responsibilities while trying to help a friend, in the process losing control of the situation.

Here are several tips that may help you decide whether prescribing a controlled substance is appropriate in a given circumstance. They have in the past proven beneficial to many physicians and helped them develop practice patterns ensuring legitimate prescribing.

1. Secure all prescription blanks in a safe place where they cannot be stolen.
2. Minimize the number of prescription pads in use at any given time.
3. Write prescriptions for Schedule II drugs in ink or indelible pencil. Each one must be signed by a physician locally and/or federally licensed to prescribe Schedule II narcotics.
4. Record the number of doses prescribed in script *and* Arabic or Roman numerals to discourage alterations.
5. Avoid prescribing large quantities of scheduled drugs unless absolutely necessary.
6. Maintain only a minimum stock of all controlled substances in your office.
7. If you carry a medical bag stock it also with minimum quantities of controlled substances and either keep it in your possession at all times or locked in the trunk of your automobile.
8. Be cautious when another physician has been prescribing controlled substances for your patient. Consult with him, review his inpatient/outpatient records or examine her thoroughly to decide for yourself if treatment with a controlled substance is necessary to legitimate treatment.
9. Prescription pads should only be used for writing prescriptions and not for notes or memos. Drug abusers can easily erase the message and forge a prescription.

10. ***NEVER SIGN BLANK PRESCRIPTIONS IN ADVANCE.***
11. Maintain an accurate record of controlled substances dispensed in the office or on house calls.
12. Gladly assist pharmacists who call to verify or clarify your prescriptions.
13. Contact your local law enforcement agency or state medical board for assistance and information whenever you suspicion prescribing irregularities.

Your medical license and its privilege to practice are the most valuable assets you possess, excepting perhaps professional integrity and ethics. Remember, the reason you became a physician was to help others and alleviate their suffering. Do not forget to also help yourself by exercising caution whenever controlled substances are prescribed, ensuring valid physician/patient relationships, prescribing only for legitimate medical purposes, plus maintaining detailed medical and dispensing records. First do no harm, neither to your patients nor to yourself.

RISKS AND BENEFITS OF VACUUM-ASSISTED DELIVERY

by Michael G. Ross, MD, MPH, FACOG

In 1829 English surgeon Neill Arnott (1788-1874) wrote: "...a pneumatic tractor...(could be) a substitute for the steel forceps in the hands of men who are deficient in manual dexterity, whether from inexperience or natural ineptitude."

Use of vacuum-assisted delivery devices has increased markedly across the United States over the past decade. The Malmstrom cup vacuum extractor, first introduced in 1954, has undergone several modifications including variations in vacuum hose location and addition of a traction chain. Rapidly utilized in Europe, vacuum was more slowly assimilated into obstetrical practice here.

Until JUNE 2000 the American College of Obstetricians and Gynecologists' (ACOG's) last publication on vacuum-assisted vaginal delivery (Technical Bulletin No. 196, August 1994, "Operative Vaginal Delivery") primarily addressed use of obstetrical forceps. A brief discussion of vacuum extractors noted that soft cup devices required very little time to create an adequate vacuum and therefore were useful in expediting delivery during prolonged fetal bradycardia late in the second stage of labor. Soft cup extractors were mentioned as less likely to cause fetal scalp trauma than those, such as the original Malmstrom, with metal cups. Also emphasized was the lack of consensus regarding maximum allowable number of pulls, cup detachments (pop-offs) and duration of application considered to be safe in addition to the necessity for demonstrable descent of the fetal head and progress toward delivery with each traction attempt. This in many respects was a relaxation of more rigid Technical Bulletin No. 152, February 1991, "Operative Vaginal Delivery" which suggested the fetal head should be delivered within 15 minutes of cup application.

In JUNE 2000 the College published ACOG Practice Bulletin No. 17, "Operative Vaginal Delivery". This current document expands the discussion of vacuum-assisted deliveries but deletes the portion suggesting they are useful in expediting delivery during prolonged fetal bradycardia in the second stage of labor. Soft cups again are noted to be less likely to cause fetal scalp trauma but there are still no guidelines regarding proper technique as to maximum allowable number of pulls, pop-offs and duration of application. Also absent is the necessity of demonstrable descent and progress with each traction attempt.

Over the years here in the US there has been a gradual increase in vacuum-assisted deliveries with a corresponding decrease in forceps-assisted deliveries, perhaps due to the perception that vacuum devices engender fewer clinically significant complications. This increase in vacuum-assisted deliveries has allowed determination of true vacuum-related neonatal morbidity and mortality plus appropriate preventative measures. Although laboratory experiments utilizing physical and mechanical engineering principles have contributed information regarding the traction forces associated with vacuum pop-off, there is no suitable in-vivo model currently available to accurately determine forces applied and consequent neonatal effects. We need to focus our attention on appropriate indications for vacuum-assisted delivery, its correct application and utilization, plus careful monitoring during the newborn period and beyond to identify rare or delayed adverse effects.

Despite manufacturers' recommending cup placement at the median flexing position, many obstetricians apparently simply attach it to the center of whatever portion of the fetal skull is presenting through the cervix. Considering most cups' semi-rigid central handle and diameters between 5.5 and 6.0 cms, placement in the center of a 10 cm vertex presentation may be convenient but not advisable.

In 1998 the US Food and Drug Administration (FDA) released a Public Health Advisory urging caution when using vacuum-assisted delivery devices. From 1994 to 1998 they had received unsolicited reports of twelve neonatal deaths and nine serious newborn injuries associated with attempted or successful vacuum-assisted deliveries. It was also noted that between 1983 and 1994 there had been less than one reported complication per year compared to an average of five per year between 1994 and 1998, attributed in part to the two-fold increase in use of vacuum-assisted delivery devices between 1989 and 1995.

This Advisory was intended to alert obstetricians and other healthcare providers that vacuum-assisted delivery devices could be associated with serious neonatal complications including subgaleal and intracranial hemorrhages. It further encouraged voluntary reporting of adverse outcomes to FDA's MedWatch. ACOG responded with Committee Opinion No. 208, September 1998, entitled "Delivery by Vacuum Extraction" which strongly recommended the continued use of vacuum-assisted delivery devices in appropriate clinical settings.

We recently examined voluntarily submitted FDA reports of adverse events associated with vacuum-assisted deliveries prior to and following the FDA Advisory (Ross, Fresquez and El-Haddad, *Journal of Maternal Fetal Medicine*, in press). We searched the FDA's database (MAUDE) prior to the 1998 Advisory and for the six months immediately after. A total of 80 reported

adverse events were identified with 25 prior and 55 subsequent to the Advisory, a twenty-two fold increase from five to 110 per year before and after the Advisory.

During the six months following the Advisory ten neonatal mortalities and 42 morbidities were reported including 30 life-threatening and twelve non life-threatening complications plus three equipment problems. Deaths were due to intracranial or subgaleal hematomas while injuries included fractures and abrasions of the skull plus cephalohematomas.

This surge in reports probably represents heightened awareness within the healthcare system as well as more frequent vacuum-related complications. While increased utilization and a wide range of practice patterns have produced these complications despite vacuum devices' relative safety, reported cases may still represent only a fraction of those actually occurring.

Indications for operative vaginal delivery, including non-reassuring fetal status and failure to deliver spontaneously after a prolonged second stage, are similar for forceps and vacuum. Shortening the second stage of labor with an indicated outlet procedure is always justified. Maternal indications include avoidance of contraindicated voluntary expulsive efforts, exhaustion, lack of cooperation in voluntary expulsive efforts and excessive analgesia. As with forceps, a guarded attempt at vacuum-assisted delivery may be made between 0 and +2 station when indicated, but always coincident with preparations for Caesarean section in the event trial of forceps or vacuum is unsuccessful. With rare exception, vacuum should not be applied to an unengaged head or in the presence of a less than completely dilated cervix.

The obstetrician should beforehand accurately determine station, position and attitude of the fetal head, centering the vacuum cup over the sagittal suture about 3 cms anterior to the posterior fontanel in the median flexion cephalic position and insuring no maternal soft tissue is trapped between the cup and the fetal head. Traction should be applied intermittently and coordinated with voluntary maternal expulsive efforts. Manual torque should not be applied as it predisposes to fetal scalp laceration.

Vacuum-related morbidity is associated with duration of the procedure so caution must be utilized at all times. There was no consensus in ACOG's Bulletins regarding a recommended maximum number of cup detachments but three should generally terminate the procedure. Progress in descent should accompany each traction attempt and the obstetrician should differentiate true cephalic advancement from caput or chignon advancement.

Formation of chignon is an expected though unnecessary precedent to vacuum-assisted traction. Following delivery it can be easily differentiated from caput, subgaleal hematoma and cephalohematoma. Cephalohematoma is a potentially dangerous complication but its occurrence does not *ipso facto* imply negligence. Although many obstetricians reduce vacuum pressure between pulls, e.g. from 500 mmHg to 100 mmHg, there is no evidence of benefit. In general no more than 30 minutes should elapse from initiation of vacuum to delivery, assuming continuous efforts at delivery.

There are many ways to improve outcomes in vacuum-assisted deliveries. Careful confirmation of a vertex presentation and its position are necessary before effective placement of the cup, particularly in other than occiput anterior positions. A delivery note should be included in the medical record in which the obstetrician documents his plan to utilize vacuum-assisted delivery, its indications, the position and station of the fetus at the time vacuum was initiated, and informed consent of the patient. There should be demonstrable progress toward delivery with each pull; without it the procedure should be abandoned. It is far easier to halt the attempt at operative delivery if alternatives are immediately available. Excepting uncomplicated outlet procedures, all attempts at vacuum-assisted delivery should be considered only trials. All attempts at vacuum-assisted delivery above +2 station should coincide with preparations for possible Caesarean section and be abandoned in favor of abdominal delivery if there is no demonstrable progress toward delivery, three pop-offs occur or delivery is not imminent within 30 minutes.

It is my opinion that ACOG's 1994 Technical Bulletin overstated the utility of vacuum devices in expediting delivery during prolonged fetal bradycardia in the late second stage of labor. Attempts at forceps-assisted delivery apply traction both during and between uterine contractions, rapidly expediting delivery. By limiting traction to periods of uterine contraction vacuum devices cannot assure expeditious delivery. In all cases of prolonged fetal bradycardia except outlet procedures as above, preparations should be made for Caesarean section in the event either vacuum or forceps fails to rapidly deliver the fetus.

Careful newborn observation is essential considering the association between vacuum-assisted delivery and subgaleal hemorrhage. Most pediatricians have never seen a significant subgaleal hemorrhage so its rarity makes diagnosis difficult. I suggest all newborns delivered with vacuum assistance be carefully observed for the first six to twelve hours postpartum. Hospital nurseries should consider instituting appropriate routine policies/procedures for performing vital signs, serial hematocrits and physical examinations to aid early diagnosis and treatment of the rare though dangerous subgaleal hemorrhage. It should however be remembered that neonatal cephalic hemorrhage following vacuum-assisted delivery does not necessarily indicate obstetrician negligence.

Vacuum-assisted delivery is safe, appropriate and its use will likely continue increasing in the United States. Obstetric residents should ideally be taught competency in using both obstetrical forceps and vacuum devices for operative delivery. Obstetricians contemplating either would be well advised to clearly communicate their intent and the reasons for it to parents and nursing staff as well as document indications and technique plus recommend careful observation of the newborn.

RISKS AND COMPLICATIONS OF TOCOLYSIS

By Washington C. Hill, MD, FACOG

Diagnosis, treatment and prevention of preterm labor plus avoiding the consequences of preterm birth remain significant challenges for today's obstetricians. A variety of agents have been tried to halt uterine activity and prevent preterm birth, but debate continues on their efficacy with some investigators actually arguing that tocolytics are ineffective for both. Others believe these drugs can at the least delay delivery 48 hours and thereby allow maternal administration of corticosteroids to accelerate fetal lung maturation. We currently do not have sound scientific evidence to invoke in this debate, but regardless must be aware of the risks and potential complications tocolytics pose to both our patients for whatever benefit they may gain.

No perfect tocolytic drug exists and all have risks. We must keep in mind the potential problems they can cause for mother, fetus and neonate. All tocolytics, whether used alone or in combination, have potential significant side effects and some can be life threatening. Table 1 lists potential risks for the four most frequently used tocolytics. Betamimetics' (terbutaline) complications primarily occur with intravenous use. This route was used more often in the past but now most obstetricians administer them by mouth or subcutaneous injection. Oral betamimetics have little maternal effect but can cause hyperglycemia, particularly in mothers at risk for gestational diabetes. Subcutaneous terbutaline is also associated with hyperglycemia and glucose intolerance in addition to pulmonary edema.

Today magnesium sulfate ($MgSO_4$) is the most commonly used tocolytic but overdosing can cause respiratory depression. Hypocalcemia, of no clinical significance, is also a common side effect and patients frequently complain of generalized muscle weakness. It decreases Beat-to-beat variability of the fetal heart rate and acoustic stimulation may be necessary to obtain a reactive non-stress test.

Indomethacin, a prostaglandin synthetase inhibitor, is a potent tocolytic agent. Its most significant risk is to the fetus, specifically decreased urinary output with the degree of resultant oligohydramnios dose related. Constriction of the fetal ductus arteriosus has also been reported but appears to be transient in the fetus with no long-term neonatal adverse effects. It should therefore not be used after 32-34 weeks gestation.

The primary side effects of nifedipine, a calcium channel blocker, are all dose related and include maternal headache, transient facial flushing, tachycardia, cutaneous vasodilatation, coronary and peripheral vasodilatation, and hypotension.

The following are important points to be remembered when administering these drugs to prevent preterm labor:

- ❑ Know the side effects, risks and potential complications of your favorite tocolytic drug. Know them well.
- ❑ Remember that tocolytics may be advantageous even in the presence of advanced cervical dilatation if they allow time for initiation of maternal corticosteroids and transport to a perinatal center for delivery.
- ❑ Make sure your patient is in true preterm labor with **both** increased uterine activity **and** cervical change, otherwise the risks of therapy are not justified.
- ❑ Closely monitor all patient's maternal vital signs, intake and output, and fetal heart rate. Pulse oxymetry plus serum electrolytes and glucose should be added for those on betamimetics. Deep tendon reflexes, serum electrolytes plus levels of serum magnesium and calcium should be added for those on $MgSO_4$.
- ❑ Be alert to early signs of pulmonary edema and fluid imbalance when administering betamimetics, $MgSO_4$ and nifedipine. Carefully follow intake and output with limitation of oral and intravenous fluids when indicated. Promptly evaluate complaints of shortness of breath, chest pain or pressure, or other clinical signs of pulmonary edema and reconsider continuation of tocolytics if pulmonary edema is suspected. Evaluation of patients with persistent chest complaints on betamimetics, $MgSO_4$ or nifedipine should include an electrocardiogram.
- ❑ Use detailed targeted obstetrical ultrasound and/or amniocentesis to confirm suspected chronic abruptio placentae, chorioamnionitis or other intrauterine infection when confronted with refractory preterm labor.

- ❑ Do not use oral terbutaline or nifedipine for long-term maintenance tocolytic therapy as both have been shown to be ineffective in these cases.
- ❑ Decrease risks and complications by limiting tocolytics to the minimum dose and time necessary. Intravenous MgSO₄ therapy should usually be stopped after 24-48 hours but can be continued longer if necessary.
- ❑ Don't forget to treat the whole patient by making her antepartum hospitalization as tolerable as possible. Tocolytic therapy usually involves prolonged antepartum hospitalizations with bedrest.

None of us enjoys delivering a preterm baby. We have tried for years to avoid the dangers of prematurity but with limited success. Tocolytic drugs in the meantime have come and gone. Some newer drugs have recently been investigated but did not make it into the therapeutic armamentarium because their maternal and/or fetal risks were unacceptable. In our zeal to treat preterm labor and prevent preterm birth we still must remember to first do no harm, recognizing that these drugs are potent, potentially harmful, and require vigilant care with close maternal and fetal monitoring.

	Maternal	Fetal	Neonatal	Relative Contraindications
Betamimetics	Tachycardia Hypotension Cardiac arrhythmia CNS stimulation Myocardial ischemia Hypocalcemia Hyperglycemia Hyperinsulinemia Hyperlactacidemia Pulmonary edema Fluid retention Glucose intolerance Altered thyroid function Elevated transaminase	Tachycardia Cardiac hypertrophy Peripheral vasodilation Hyperglycemia Hyperinsulinemia Altered uteroplacental blood flow	Tachycardia Hypoglycemia Hypocalcemia Hypotension Hyperbilirubinemia	Poorly-controlled thyroid disease and/or diabetes mellitus
MgSO₄	Respiratory depression Altered cardiac conduction Hypocalcemia Hypothermia Cutaneous vasodilation Generalized muscle weakness Osmotic diuresis	Altered beat-to-beat variability Altered biophysical activity	Hypermagnesemia Respiratory depression Hypotonia Meconium ileus	Myasthenia gravis
Indomethacin	Gastrointestinal irritation Platelet dysfunction Altered renal blood flow Altered immune response Antipyretic effect	Oligohydramnios Constriction of ductus arteriosus Decreased cerebral blood flow	Pulmonary hypertension Oliguria Platelet dysfunction Hyperbilirubinemia Cystic brain lesions Altered immune response	Renal disease Liver disease
Nifedipine	Hypotension Tachycardia Cutaneous vasodilation Fluid retention Altered cardiac conduction	Tachycardia Altered uteroplacental blood flow	Without significant effects to date	Cardiac disease Renal disease Hypotension Liver disease

Table 1: Potential Risks and Complications of Tocolytics

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CUTTING CORNERS

by Doug Daniel

Every parent has heard this one before: “Why do I have to do that? It doesn’t make any sense. None of the other kids have to.” Now we hear grown-up obstetricians raising the same lament. On page 12 of the 12 OCTOBER 2000 issue of *Ob.Gyn.News* there’s an article covering Dr. Michael Lu’s statements during his presentation at a UCLA-sponsored meeting. Mike’s a Fellow of the College working, I hesitate to say practicing, at UCLA’s School of Public Health’s Department of Community Health. He says we no longer have to do those old fashioned, traditional things that used to be the benchmark of good prenatal care.

First up on Mike’s hit list is measuring uterine height at each prenatal visit. He cites up to a 4 cm variation in fundal height between examiners, blowing out the window any reasonable chance of predicting normal fetal growth. Well, Mike, serial fundal heights are very predictive of IUGR if you do them the way they were originally intended. First of all, every patient empties her bladder immediately before entering the examination room and she’s seen promptly. It always impressed me on locum jobs how every patient could make it onto the table with a full or partially filled bladder. Evidently the folks I replaced never did Leopold’s maneuvers at antepartum visits and paid no attention whatever to fundal heights.

In my residency, military and later private practices, bladders were emptied and fundi carefully measured, the results being reviewed at each visit. Initially this was in the days before obstetrical ultrasound. Later in private practice there never seemed to be the need for an ultrasound machine in the office when fundal height could accurately screen for IUGR. The rare referral to a level III center for serial ultrasound examinations when growth was less than 1 cm/month often showed no evidence of IUGR, but more importantly none were missed. Fundal heights are unbelievably cheap when compared to routine serial ultrasounds, like free when the drug companies provide the disposable paper tapes. I also thought it was reassuring to the patients to have someone objectively measure their baby’s growth at each visit. Of course serial measurements are of no use whatever if you don’t review them at each visit.

Next up was auscultation of FHR. I agree it’s of almost no use except in diagnosing fetal death but once again, it’s really cheap. Before the age of routine obstetrical ultrasound it was a way to confirm gestational age by first audible FHTs, approximately 13 weeks via doptone and 20 weeks via fetoscope. Patients also seemed to like it. If you really want to cut the cost of obstetrical prenatal care try properly using these two almost free screening modalities instead of rolling out the \$10,000 Hitachi color Doppler unit every time a pregnant patient walks through the door. Mike also dissed routine prenatal ultrasounds and here we agree. ‘Nuff said.

Routine multi-vitamin supplementation was another cornerstone of good prenatal care “of no benefit” according to Mike, although he did grudgingly admit folate supplementation was probably a good idea. He’s perhaps right on this one. There’s so much vitamin-added product in our commercial food supply it is inconceivable that someone pregnant today in the United States could be vitamin deficient. But as we all know, pregnant folks can have strange dietary habits. I always worried about adequate nutrition during the first trimester with fetal organogenesis rolling like gangbusters while mom puked her guts out. At least I felt better if she could keep a pill a day down. Oh, by the way. I heard the other day the Canadian manufacturer of the Bendectin™ clone is applying to the FDA for a license to sell it in the lower 48. Can’t wait to see the price.

Multi-vitamin supplements meeting prenatal requirements are also very cheap and do no harm, even giving pregnant patients something to do that might help their baby. To my knowledge everyone recommends or should recommend prenatal supplementation with iron and folic acid, even preceding conception. It just makes good sense to continue while breastfeeding whatever prenatal nutritional supplements were used.

You could have knocked me over with a feather after I read the next one. Mike essentially says we’re idiots to use routine prenatal diabetes screens because they’re not “cost effective”. What? Considering the clinical and medical consequences of missed subclinical diabetes in pregnancy including macrosomia with all its attendant complications, pyelonephritis, chronic UTI, and intrauterine fetal death I don’t think we have any alternative regardless the cost. Maybe we treat some who don’t actually have a significant glucose intolerance but where’s the harm? The majority certainly benefits from better nutrition and, when necessary, insulin control of elevated blood sugars.

The last of Mike’s targets is the frequency of prenatal visits. He says seeing uncomplicated prenatal patients more frequently after 28 and 36 weeks is unnecessary and again not “cost effective”. Maybe so, but when charges and reimbursements are based on global obstetrical fees this makes no sense unless you’re an HMO trying to cut its staff. The problem here is that more frequent visits later in gestation are the means to diagnosing complications; if you don’t see ‘um you won’t find ‘um. We all know the costs of missed complications, especially during pregnancy. So once again, thanks but no thanks, Mike.

Bottom line? Go with what you know. Your patients will do better in the delivery room and you’ll do better in the jury room.

HANGING BY A THREAD

By Doug Daniel

The Supreme Court of the United States' ruling last June in *Stenberg v. Carhart* made only one thing perfectly clear: Women's right in the United States to choose to safely terminate their unwanted pregnancies is literally hanging by a slender, very frayed thread. While many of the Court's abortion rulings over the years have been split five-to-four either for or against, *Stenberg* seems to herald a new era. The majority, dissenting and concurring opinions written by every Justice except Souter speak volumes on this most divisive and seemingly insolvable problem. As with Special Prosecutor Kenneth Starr's report on l'affaire Lewinsky, every citizen and more especially women's physicians should read these documents in their entirety. They're available on the web at www.findlaw.com or the Society's office has available to members at no cost an unabridged highlighted version with 44 pages of small type.

At the time of this writing the Court consists of 76-year-old Chief Justice William H. Rehnquist (first appointed Associate Justice in 1972 by President Richard Nixon and then promoted to Chief Justice in 1986 by President Ronald Reagan) and Associate Justices 80-year-old John Paul Stevens (the Court's oldest Justice, appointed in 1975 by President Gerald Ford), 70-year-old Sandra Day O'Connor (the Court's first female Justice, appointed in 1981 by Reagan), 64-year-old Antonin Scalia (appointed in 1986 by Reagan), 64-year-old Anthony M. Kennedy (appointed in 1988 by Reagan), 61-year-old David H. Souter (appointed in 1990 by President George H. Bush), 52-year-old Clarence Thomas (the Court's youngest Justice, appointed in 1991 by G.H. Bush), 67-year-old Ruth Bader Ginsburg (appointed in 1993 by President Bill Clinton) and 62-year-old Stephen G. Breyer (appointed in 1994 by Clinton).

Franklin Delano Roosevelt is famous for making more Court appointments, eight, during his three-plus term Presidency than any other President except Washington and thereby influenced its political character for decades following his death. Washington appointed eleven Justices during his two-term Presidency by appointing all six of the first Court's Justices plus four replacements and reappointing John Rutledge as Chief Justice following his resignation as an Associate Justice. All members of Washington's Court were gone within 22 years of John Jay's appointment, the first. The last of Roosevelt's appointees, Justice William O. Douglas, remained on the Court until 1975 or 38 years after Justice Hugo L. Black's appointment, FDR's first. Other Roosevelt appointees served until 1971, 1962 and 1957.

Within the current Court Nixon appointed one Justice, Ford one, Reagan three, G.H. Bush and Clinton two each. Reagan is well-known for his staunch opposition to abortion and his three appointees (O'Connor, Scalia and Kennedy) would be expected to heavily weight Court opinions against abortion.

Dad always said you couldn't judge a book by its cover and apparently you can't judge a Supreme Court Nominee by his political affiliations, which is of course as it should be. Surprisingly, among Reagan's appointees O'Connor has increasingly and Kennedy occasionally supported abortion. As expected, Scalia never misses a chance to attack *Roe v. Wade* and with rare exception Rehnquist (Nixon) is at his side.

The same situation exists with G.H. Bush's appointees. Appointed by an anti-abortion President only somewhat to the left of Reagan, Souter usually sides with O'Connor (Reagan) and Thomas with Scalia (Reagan). But as expected, Justices Ginsburg and Breyer consistently man the barricades in defending abortion rights against all challengers. Justice Stevens (Ford), appointed by a conservative Republican President but before abortion became a litmus test for appointees, seems to be committed to protecting the Court's *Roe v. Wade* precedent.

The numbers stack up like this. On the far right, staunchly opposed to abortion in general and most especially abortion on demand, is Thomas with Rehnquist and Scalia only slightly to the left. Kennedy stands more to the left and toward the center. On the far left, just as staunchly defending abortion on all fronts, are Ginsburg and Breyer with Stevens somewhat to the right. O'Connor and Souter stand more to the right and toward the center. Like a sixth grade arithmetic problem, Thomas and Rehnquist cancel Ginsburg and Breyer while Scalia cancels Stevens, Kennedy cancels Souter, and O'Connor is the swing vote. It's actually a bit more complicated since O'Connor, Kennedy and Souter are all possible swing votes.

Surprisingly only two appointments were made by a Democratic Pro-Abortion President, Clinton. Carter made none during his term as President and probably would have been less inclined than Clinton to nominate strong supporters of abortion rights.

The President of these United States' most important jobs are committing our military assets to overt and clandestine hostile operations plus nominating federal judges to the District, Appeals and Supreme Courts. These two responsibilities are his alone with the first usually supported by even an opposition-controlled Congress and, as we all know from the last century's history, ricocheting repercussions around the world for many years afterward. Until abortion became a confirmation determinant

for both conservatives and liberals, the second was also relatively routine unless the nominee was a partisan judicial extremist. Just about everything else that goes on in the Oval Office down to employee and intern relations is filtered through Congress.

There is no mandatory retirement age for Supreme Court Justices and they seem to cling to their perches until almost dead and buried, so the next four years could produce pivotal changes in the Court's composition. On the right Rehnquist is 76, has had health problems in the past, and sometimes looks a little peaked; Scalia looks like he plays three sets of tennis every day; and Thomas brings to mind the Eveready Bunny. On the left Stevens is 80 (think William O. Douglas), Ginsburg is a colon cancer survivor in apparently good health, and Breyer could be Scalia's doubles partner. In the middle Souter probably runs in each year's Boston and New York Marathons, Kennedy seems to have no immediate concerns about collecting on his life insurance policy, and O'Connor at 70 is a breast cancer survivor with some court watchers concerned about her current health but no word on her medical condition.

Three members of the Court (Rehnquist, Scalia and Thomas) have publicly declared their desire to overturn *Roe v. Wade*, so appointing two more like-minded Justices throws us back to the hypocrisy, injustice and clinical horrors of illegal abortion. It's anybody's guess but probably two or even three Justices will be appointed over the next four, perhaps two, years. All but one of those most likely to retire are to the left on abortion. You do the math.

With the 2001-2002 Senate and House already so evenly split as to obviously be totally ineffective and unpredictable, any President whether Republican or Democrat would have had an almost impossible task in trying to get Supreme Court nominees past Senate confirmation if their legal and moral philosophy on abortion could in any way be divined. There's just no way to gaze into our smoke-choked crystal ball and see what's going to happen. Even assuming G.W. Bush is inaugurated there is still no way in Hell to predict with any accuracy what will happen with regard to the abortion question over the next two years, but one must assume most of Clinton's pro-abortion Executive Orders will be reversed and his legislative vetoes become history. The whole mess including the 2000 election should definitely be a hot issue in the 2002 Senate and Congressional elections.

Many years ago there was a brief final segment on each broadcast of CBS's "Sixty Minutes" consisting of Jack Alexander, a red-white-and-blue-to-the-bone conservative, debating a specific issue with Shana Alexander, radical liberal. Called "Point/Counterpoint", it made for good television and good political debate. Its entertainment value came from the talent's restrained hostility and not so restrained sarcasm.

NBC's "Saturday Night Live", ever one to pick-up on social satire, subsequently had an outstanding recurring skit ending its Weekend Update news satire featuring Dan Ackroyd as the ram-rod straight, tightly wrapped, bespectacled conservative and Jane Curtin as the yuppie bleeding-heart liberal. The funniest line was Ackroyd always beginning his rebuttals with "Jane, you ignorant slut." The Court has fallen to the level of broad burlesque comedy skits and petty partisan politics with Justice Thomas' dissenting opinion to Justice O'Connor's majority concurrence all but beginning with "Sandra, you ignorant slut." Personalities have no place in these proceedings.

Editor's Note: This article was compiled from various sources including www.findlaw.com, www.naral.org, www.plannedparenthood.org, and www.crlp.org. The author wishes to thank Simon Heller, Esq. and his staff at The Center for Reproductive Law and Policy (CRLP) offices in New York and Washington for their assistance.

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