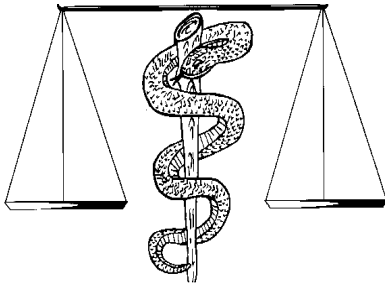


# THE MEDICOLEGAL OB/GYN NEWSLETTER



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## WHY TEACH NEONATAL INTUBATION?

By **John W. Tynes, MD**

Lack of senior resident experience and competence in neonatal intubation and basic resuscitation has long been an area of concern for the Residency Review Committee for Obstetrics-Gynecology (RRC). Between 1995 and 1998 the annual average nationwide of obstetrics and gynecology resident-performed neonatal intubations fell from an already troubling eleven per resident to only nine. At Baylor University Medical Center in Dallas the rate dramatically plummeted from 39 to none. While our program searched for a way to increase resident experience the author conducted a survey on the procedure's relevance, i.e. whether expertise in neonatal intubation and basic resuscitation was necessary in today's clinical practice of obstetrics.

The survey sampled urban and semi-rural obstetricians in private practice and asked yes-or-no and fill-in-the-blank questions. For the urban arm of the study we polled by phone or mail members of the Dallas County Medical Society listing obstetrics or obstetrics and gynecology as their specialty, excluding retirees and academics. For the semi-rural arm we polled by phone similarly defined members of the Taylor-Jones-Haskell County Medical Society in Abilene, Texas. Response rate from Dallas was 78% of contacts (172 of 221) and from Abilene 93% (14 of 15) contacts.

Information on practice demographics was also gathered to ensure accurate comparisons between the two groups. Half the Dallas physicians and 85% of Abilene's described themselves as solo practitioners with the rest group practitioners. Average number of years in practice in both arms was between fifteen and sixteen years. Abilene reported a slightly higher average number of deliveries per obstetrician per year, 185 versus 154 for Dallas, with a few from each at both extremes of a distribution ranging from only a few deliveries per year to one report of 1200. We calculated the median for each area and found it close to the mean.

All obstetricians surveyed in both Dallas and Abilene reported availability of other qualified personnel experienced in neonatal intubation and basic resuscitation. When asked to be specific respondents named a variety of personnel including neonatologists, pediatricians, nurse practitioners, anesthesiologists, certified registered nurse anesthetists, respiratory therapists and residents. Most listed more than one of the above, usually including anesthesia or newborn nursery personnel.

When asked whether they had received formal or on-the-job (OJT) training in neonatal intubation a slight majority of Dallas physicians reported formal training, usually citing the Neonatal Resuscitation Program offered by the American Heart Association. In Abilene the reverse was true with a slight majority reporting OJT only. When asked if they had ever intubated a neonate 16% of Dallas respondents and almost 8% percent of Abilene's replied negatively.

Numbers of intubations performed was tallied in several ways. Respondents were asked how many intubations they had performed in the past year, in the past five years, and how many per year on average. The overwhelming majority of respondents answered none but the calculated mean was much less than one and the median was zero. There was however a single exception. Abilene respondents' neonatal intubations within the preceding five years calculated to a mean of 3.81 and median of 1.5.

(Continued on page 16)

# THE PRESIDENTIAL BOX

by Dan Avery, President

## MEDICAID REIMBURSEMENT FRAUD

Alabama has for years had a Medicaid program covering maternity and newborn care known by the acronym SOBRA (Sixth Omnibus Budget Reconciliation Act). All states had comparable programs funded primarily by federal matching dollars. For years SOBRA paid for maternity and newborn care, albeit with good and bad points. Reimbursements to hospitals and physicians were discounted and often delayed. Each year the state's budget appropriation ran out around October and no payments were made until after the first of the next year. This effectively shifted fourth quarter liabilities to the next year's budget but legislators never provided adequate funding to pay for five quarters. Ergo the money always ran out in October.

In 1998 Alabama stopped providing maternity care through local health departments and took provider reimbursement for obstetrical services out of Medicaid, instead directing Medicaid to funnel payments to hospitals and physicians for these services through third party administrator agencies similar to Medicare intermediaries. Since our state is divided into numerous health regions consisting of four to five counties, competitive bids were taken for each region's intermediary and contracts awarded.

Physicians and hospitals assumed these intermediaries or plan administrators would promptly forward state-supplied funds intended to pay providers' claims but such has not been the case. Every intermediary our hospital has submitted claims to has delayed payment. Medicaid generally pays intermediaries within one month of claims receipt but it takes another two to three months for physicians and hospitals to receive payment. I presume the intermediaries invest the float between Medicaid's payment to them and their payment to us. Every intermediary we deal with is very slow to pay and each has its unique excuses for delays. My office personnel call the intermediary managers almost daily trying to expedite payments, thinking perhaps if we make enough of a nuisance of ourselves they will just break down and send the check.

As I write this on the 22nd of January 2001, one of my fellow obstetricians tells me he still hasn't been paid for September 2000 deliveries. For instance, assume a patient presents for her first prenatal visit in January. As with any insurance coverage no claims for payment can be filed until after delivery, yet like clockwork the bills for prenatal clinical laboratory testing keep coming to my office by the 30th of each month and must be paid by the 15th. Some such as CBCs are inexpensive but many including alpha fetoprotein are not. Diagnostic obstetrical ultrasound is ordered routinely at 18 weeks gestation and before or after as indicated, and these charges too must be promptly paid by my practice. Global obstetrical care usually covers nine months considering registration during the first trimester and a six-weeks postpartum visit, but the Medicaid claim cannot be filed until the patient is discharged following delivery. This results in a nine month delay from initial service to filing of the claim, another month until Medicaid pays the intermediary, and then another three months or more until the intermediary pays us for a total delay of at least 13 months from initial service to receipt of payment, if we're lucky.

Each health region's Medicaid intermediary audits quality of care, recordkeeping, etc. but all these audits are of physicians and hospitals, none of Medicaid or its agents. I have in the past proposed that since Medicaid administrators audit my office and hospital records, I should be able to audit Medicaid's claim and payment records. Needless to say there as yet has been no invitation to visit Medicaid headquarters and go over their books.

None of us ever dreamed there would be such problems with Medicaid intermediaries, instead expecting payments to be about as prompt as when direct from the state treasury. This is worse than Medicaid ever was except between October and January each year. Now it's October through January all year long. It makes me furious to know the intermediaries have been paid money that belongs to me and yet are sitting on it for three months or longer drawing interest on money I had to pay my creditors almost a year ago.

The future of Alabama's Medicaid program is at best uncertain. Its integrity and credibility are forever lost. Hospitals and especially private physicians have learned an expensive lesson. The next round of provider contract negotiations will most likely focus on reimbursement delays and many can be expected to opt out of the system.

## THE WITNESS BOX

by Doug Daniel, Editor

*"Abortion is a unique act, in which a woman's exercise of control over her own body ends, depending on one's view, human life or potential human life. Nothing in our Federal Constitution deprives the people of this country of the right to determine whether the consequences of abortion to the fetus and to society outweigh the burden of an unwanted pregnancy on the mother. Although a State may permit abortion, nothing in the Constitution dictates that a State must do so."*

Associate Supreme Court of the United States Justice Clarence Thomas  
In minority dissenting opinion to Stenberg v. Carhart

This month we gain four new members. Dick Schmidt (Yes, that Dick Schmidt) accepted our offer of an honorary membership while working on an article about the College's history in the abortion controversy. He's a well know and beloved ACOG Past President (1977 - 1978), graduating from the University of Cincinnati's medical school with internship and residency at University Hospitals of Cleveland followed by a fellowship in gynecologic pathology at Case-Western Reserve. Burt Webb found us via the College website. He practices in Scottsdale, Arizona, graduated from Tulane's medical school and was then an intern and resident at Good Samaritan Medical Center in Phoenix. Washington Hill was one of our authors in the January 2001 issue and that Witness Box contains his intro. Another January author, Mike Ross, also became a new member and his intro can be found in the same Witness Box. **Welcome aboard, y'all.**

So how stands the Union? Our total membership increased over the past year but dues income remained essentially unchanged. We lost fourteen members, ten dues paying and four honorary, while one demitted from dues paying to honorary. On the other hand we gained twenty-six new members, twelve honorary and fourteen dues paying. Without the voluntary financial support mentioned below we would have been deeply in the red. The worst news is that we are starting 2001 again with an empty treasury and must somehow pay as we go this year. A continuing supply of new dues paying members who will stick with us is vital.

To date we have received \$1875.00 over dues payable by a combination of deliberate overpayments, gift memberships, contributions both designated and undesignated, and honorary members converting to active status. These generous responses to our treasury's needs have allowed us to dodge the financial bullet so far but new dues paying members are more important now than ever before. Please keep the Society in mind when talking to your colleagues.

As to this year's ACOG ACM in Chicago 28 April through 2 May, the Society will be assisting the American Board of Trial Advocates Foundation (ABOTA) in presenting a mock trial on Sunday, 29 April as a 060 Postgraduate Course. The focus will be on obstetrician liability in early onset group B streptococcal infection of the newborn and its sequelae. This promises to be a dynamite presentation complete with judge, jury and verdict. The Society has been asked to provide the medical expert witnesses and defendant.

The Society's annual membership meeting will be Monday, 30 April at 5:30 pm in Sheraton Ballroom 5 with the program to be presented by Bruce R. Pfaff, Esq., a medmal plaintiff attorney and member of ABOTA. He will be bringing a defense attorney friend, if he can find one, so the evening promises to be exciting and informing. If you are attending the ACM be sure to bring a friend to the membership meeting.

The results are in from last year's membership poll on whether or not to sponsor a yearly "ASFOG Man (Woman) of the Year Award". Of those responding, 63% supported the Award and Ben Harer got three nominations. Your Board of Directors agreed and unanimously named Ben "ASFOG Man of the Year for 2001". Press releases have been sent to multiple popular medical media so expect to see it as a news item. The Society should get some publicity and Ben gets a dues-free Life Membership, so everyone wins. There's a copy of the press release, the formal award notification letter to Ben and his certificate in the back of this issue. Congratulations, Ben!

Congratulations also to Ray Cestero who for the last year of his three-year term on the College's Committee on Quality Assurance, responsible for the Voluntary Review of Quality of Care Program, has been named Vice Chair by President Elect Tom Purdon! It is my personal opinion that no one is more qualified for such a position and I encourage all Society members to actively pursue appointments to ACOG Committees, Task Forces, Councils, Working Groups and liaison organizations plus serving as Section, District and National Officers. Those who do so give the Society a higher profile and thereby honor to all our members.

Elliot Levine has an article in the March 2001 issue of the Green Journal (Levine EM, et al. Mode of delivery and risk of respiratory diseases in newborns. *Obstet Gynecol* 2001;97:439-442). It's a very well done study of the potential neonatal respiratory risks of Caesarean section, relevant to the current brouhaha over Ben Harer's statements on truly elective sections. We've known for years that Caesarean section increased the risks of neonatal RDS and transient tachypnea but these are easily treated and seldom fatal. According to Elliot and his coauthors, Caesarean newborns have about five times the risk of persistent pulmonary hypertension (persistent fetal circulation) as those born vaginally. Persistent fetal circulation has limited effective treatments available and therefore a relatively high mortality rate. Its incidence following Caesarean delivery was fortunately low, only about 1:1000, but the same as newborn Group B Strep infection and we are going nuts over what to do about that one. Apparently there never are easy answers to hard questions.

Dan Avery has a solicited editorial on impaired physicians to be published in the *Obstetrical and Gynecological Survey's* June 2001 issue. I also have a solicited editorial addressing today's lack of attention to principles of asepsis during labor and delivery to be published in the May-June issue of *ACOG Clinical Review*.

The North Carolina Medical Board's *Forum*, Vol. 5, No. 4, ran an article (A personal view: Medical errors and the IOM - Question the illogical and rely on common sense and personal experience, page 8) cloned from two pieces I wrote for our *Newsletter* on the Institute of Medicine's medical errors report (America's favorite pastime, Vol. 8, No. 5, page 15. The sky isn't really falling, but it could; Vol. 8; No. 6; page 12). As usual they gave the Society an excellent plug. If you want a copy send me a SASE.

Speaking of The North Carolina Medical Board, you may or may not remember a dialog in the *Newsletter* between Dan and myself on the high demands placed upon some licensed physicians by their licensing boards (Caesar's wife, Vol. 8, No. 5, page 36). It revolved around the story of a North Carolina cardiologist who reaped the whirlwind after attending a patient following an evening's dinner with wine and other poor judgments. Lest you think this a rare aberration, it's happened again. An obstetrician/gynecologist living in Georgia but licensed in North Carolina and Virginia attended a wine festival while on call, allegedly consumed six ounces of wine, was called to his hospital to attend a delivery, confronted, required to provide a blood alcohol sample, and found to have a 0.098 BAC. Hard to believe one glass of chardonnay will pop a BAC exceeding the current federal definition (0.08) of DWI. At any rate the Virginia Board reprimanded him and the North Carolina Board suspended his license, indefinitely. National licensing is looking better and better.

Speaking of editorials, Ralph Hale recently had one in *ACOG Today's* January 2001 issue attacking the trend of third party payors requiring physician certification by various medical special interest organizations before approving or reimbursing certain procedures such as diagnostic ultrasound and laparoscopy. His point that we will be nickel-and-dimed to death with this if it continues to expand is well taken. He additionally opines that ABOG certification already attests to current expertise in such areas and anything more is unnecessary and redundant.

All the above being true, there's still a problem. It's my impression that more and more physicians, obstetrician/gynecologists particularly included, are practicing over their heads and out of their leagues by diagnosing and treating conditions or doing procedures they aren't adequately trained, qualified or experienced to do. Most glaring of these are advanced diagnostic obstetrical and gynecologic ultrasound plus laparoscopic and laparoscopic-assisted pelvic surgery. The basis for this opinion is the steady stream of medmal cases from these areas. While ABOG certification and ACOG Fellowship certainly attest to an established *minimum* level of training and expertise, neither qualifies one for more advanced procedures (excepting subspecialty certification).

The answer lies not in discrediting legitimate medical subspecialty organizations but in demanding physicians confine their practice to those areas in which they are qualified. In reality neither the Board nor the College can accurately attest to a Diplomate or Fellow's qualifications but only to his ability to select an approved residency training program, correctly answer questions, attend CME courses and pay dues. Neither to my knowledge ever has nor will take adverse action against a Diplomate or Fellow solely for practicing beyond his limitations and expertise. The medmal litigation and medical licensing systems pose the only potentially effective disincentives to such but both are complaint driven. For the medmal litigation system to have any positive effect on quality of care it must exact financial costs in such amounts as to make continuing the alleged and proven behaviors unacceptably expensive. The only leverage available to the licensing boards is monitoring and restriction or suspension of licensure. Either way, both systems can be effective if properly and fairly utilized.

Speaking of Ralph Hale, *ACOG Clinical Review* looked at an article on the effects of intrapartum epidural analgesia/anesthesia procedures on progress of labor and incidence of operative delivery (Zimmer EZ et al. Adverse effects of epidural analgesia in labor. *Eur J Obstet Gynecol Reprod Biol* 2000;89:153-89). Seems they prolonged labor and increased the incidence of "nonspontaneous vaginal delivery" (I had trouble deciding whether to put this here or under the So Tell Me Something Else I Didn't Already Know Department). Ralph's "Quote of the Month": "It will be a long time before this debate is resolved but, in the meantime, the use of epidural analgesia will continue to be popular and common." Everybody say "Amen, Brother Ralph!"

Here's something you might find of more than passing interest. *Ob.Gyn.News* had a headline in its 1 February 2001 issue proclaiming "Syphilis Rates Reach All-Time Low", introducing an article in which it was stated that rates of primary and

secondary syphilis are now at their lowest ever according to the CDCP. I'm assuming this refers to newly diagnosed cases. The numbers showed that syphilis incidence peaked in 1990 at 20.3 cases/100k population but by 1999 fell to 2.5/100k, almost a ten-fold drop. Now the wise men down in Hotlanta are proposing that syphilis can be eradicated for the United States in our time, same as smallpox worldwide.

I don't know about that. The decrease in reported new cases is probably a direct result of people both gay and straight literally getting the Fear of God instilled in them by the AIDS scare and either keeping to relatively monogamous sexual relationships or double wrapping their genitals in Saran Wrap™ before hitting the bars and sex clubs. There was however a note of concern expressed. Seems the numbers suggest that gay men are abandoning "safe sex" more and more frequently as their private AIDS wildfire more or less burns down to smoldering embers.

If this is indeed the case, get ready for round two. The 1 March 2001 issue proclaimed "Gonorrhea Rates on the Rise After Declining for Two Decades". The CDCP says after 20 years of steadily decreasing incidence, between 1997 and 1999 the rate of new GC infections went from 119 to 130/100k for women and from 125 to 136/100k for men. The percentage of infection in homosexual and bisexual men doubled, from 6% to 13%. You do the math, but remember that over the short haul GC is an acutely symptomatic disease in men and relatively asymptomatic in women whereas syphilis is notoriously asymptomatic in both and not infrequently diagnosed in its more chronic stages.

The 1 February issue also had an excellent editorial by Jerry Weinberg who has graced our own pages on several past occasions. Jerry related his comments made during a recent residents' teaching conference regarding a hysterectomy performed on a 42-year-old patient for metromenorrhagia, implied to have been secondary to an ultrasonically diagnosed and otherwise asymptomatic 5 cm fibroid following proliferative endometrial biopsy. Jerry's point was that small fibroids may cause menorrhagia but not metromenorrhagia, suggesting the residents should look for other causes before getting out the Hyster Heister™. He mentioned some of those other etiologies such as physiologic perimenopausal estrogen/progesterone imbalance and benign endometrial polyps. One he didn't mention and one I have seen more and more frequently is clinical or subclinical hypothyroidism. Classically associated with menorrhagia, it can also cause metromenorrhagia while hyperthyroidism usually causes oligomenorrhea. Often forgotten in the rush to the OR, clinical hypothyroidism can easily be discounted or determined. Most often used is a screening serum TSH but it is not 100% accurate. A better choice is a progressive thyroid screen which performs a battery of serum thyroid function assays in a specific algorithm with the use of more specific, detailed and expensive analyses determined by preceding results. To my knowledge all the commercial clinical laboratories offer it in some form.

The same issue regurgitated the cost-effective question of Pap smear screening frequency, this time in postmenopausal patients, and referred to an unrecognized expert from the left coast who probably works for Kaiser. To quote, "It could be every 2 years, every 3 years, or even never again." The article also cites the College's official party line (ACOG Committee Opinion No. 152, March 1995: Recommendations on frequency of Pap test screening): "After a woman has had three or more consecutive, satisfactory annual examinations with normal findings, the Pap test *may* be performed less frequently in a low risk woman at the discretion of her physician (emphasis mine)." The key word here is may and there's also a problem with the preceding sentence in the policy statement being omitted: "**All** women who are or who have been sexually active or who have reached age 18 **should** undergo an annual Pap test and pelvic examination (emphasis mine)." Pass the Pepto, please. All this cheapskate, harebrained, idiotic blather over something so obvious is jacking up my gastric H<sup>+</sup> concentration.

Another interesting item in the 1 MARCH 2001 issue of *Ob.Gyn.News* reported on a presentation at the recent annual meeting of the American Association of Gynecologic Laparoscopists addressing outpatient supracervical laparoscopic hysterectomy. First of all I hate to see us go back 75 years or more to advocating routine supracervical hysterectomy regardless of its benefit to patients just because it's cheaper for third party payors. Secondly I hate to see us continuing to discharge patients ever more sooner and sicker for the same reason. Transecting and ligating or especially stapling intraabdominal vessels the size of infundibulopelvic ligaments and uterine arteries/veins is never without immediate and more to the point delayed risks, specifically hemoperitoneum, and there's no way to completely eliminate the risk of postoperative infection. Both will almost always become evident to the observant surgeon within 24 to 72 hours following surgery and if hospitalized, such serious complications can be quickly and safely treated. Put me down for at least three days in a room with a view including meals, beverages and gratuities.

And finally, the same issue resurrected that well worn pearl about red wine containing cancer-preventing antioxidants by suggesting regular ingestion of such libations decreased the incidence of colon polyps. Garçon! Another bottle of your finest cabernet sauvignon for my friends and I!

And now for more on [www.asfog.com](http://www.asfog.com). Alan, Mark, Jim, Dan, Sid, Willie, Vic, Brent, Phil, John, Dick, Dick, Frank, Steve, Ben, Gus and Marshall, thanks for dropping by. During the month of December 2000 we had 1940 visits to the site (increase of 3080%) by 314 different visitors (increase of 900%). Bottom line? The site has brought three new members so far. Check it out!

<b>MONTH</b>	<b>VISITORS</b>	<b>INTERNATIONAL</b>	<b>SPIDERS</b>	<b>NEW MEMBERS</b>
NOVEMBER 2000	35 for 47 visits	Japan, France, UK 1 each	4	2
DECEMBER 2000	314 for 1940 visits	UK (4), Saudi Arabia (2), Canada (1)	6 for 70 visits	∅
JANUARY 2001	400 for 2887 visits	UK (4); (Canada (2); France (2); Spain (2); Taiwan and Peru 1 each	7 for 32 visits	∅
FEBRUARY 2001	421 for 1764 visits	UK (7); South Africa, Israel, Canada, Australia, Austria, Ireland, Netherlands and Romania 1 each	10 for 54 visits	1

So Tell Me Something Else I Didn't Already Know Department: For those of you who remember last July's dedicated *Newsletter* on the problems clinical, ethical and philosophical posed by very low birth weight infants, check out the January 2001 issue of the Green Journal, page 49, for an article from your friends at Brigham and Women's and Mass General's level III perinatal service in Boston. Though very limited in number of cases (33), their study of singleton infants born during the 23rd week of gestation (23 completed weeks to 23 completed weeks plus 6 days) confirmed our previously expressed concern that eventually the age of viability (defined as 50% survival) would fall below the judicially established upper limit for elective abortion, i.e. 24 completed weeks gestation. Incidentally, it also showed no neonatal benefit from antepartum maternal steroid administration.

Assuming the Bostonian's dating to be remarkably accurate, survival (defined as live upon discharge) ranged from 0% at 23+0 to 65% at 23+6 weeks, albeit with a very high proportion of transient and possibly permanent complications. Interestingly, the survival rate increased linearly over the seven days and thereby suggests even greater potential survival at 24 completed weeks. Folks, we are finally and firmly hoist upon our own most uncomfortable petard which is of far more import than all the preceding political posturing, pulpit propagandizing, navel contemplation, wool gathering and thumb twiddling over that previously considered most dread evil, "Partial Birth Abortion". I earnestly and sincerely solicit your considered opinions on and solutions to this problem, short of going back to making all elective abortions illegal, for a dialog in our *Newsletter*. (McElrath TF. Neonatal outcome of infants born at 23 weeks' gestation. *Obstet Gynecol* 2001;97:49-52.)

Want some more? There's also an excellent editorial in the February 2001 issue of the Green Journal on repeated maternal doses of antenatal steroids (Goldenberg RL and Wright LL. Repeated courses of antenatal corticosteroids. *Obstet Gynecol* 2001;97:316-317). We addressed this in September 2000 (Vermillion ST. Repetitive antenatal corticosteroids. *The Medicolegal Ob/Gyn Newsletter* 2000;8:29-30). The Green's experts agreed with ours: Don't do it. One comment was especially pertinent.

"The history of obstetrics (and other medical disciplines) is replete with adoption of interventions before complete evaluation. Many interventions have later turned out to be harmful. Although we have adopted interventions with the intention of doing better, all too often we have done harm. The only way to prevent repeated cycles of too-early adoption (of) interventions followed by documentation of lack of effectiveness or harm, and ultimate abandonment, is to await results of appropriate randomized clinical trials."

Just remember you heard it here first.

And to close out the So Tell Me Something Else I Didn't Already Know Department, from the 1 March 2001 issue of *Ob.Gyn.News*: "(Increasing) Cesarean Rate Portends Rise in Placenta Accreta".

The College's Grievance Committee sent out its yearly report in January and of most prominent interest, there was a complaint filed by a Fellow against a fellow Fellow regarding medical expert witness testimony in a medmal case. A formal hearing was held and the Committee "found no violation of the Code of Professional Ethics and, therefore, the complaint was not sustained." I expected complaints against plaintiff medical expert witnesses to occupy most of the Committee's time but apparently such will be rare occurrences and heard without bias, as they should be.

This month's lead article by John Tynes shares insights gleaned from his study of Texas physicians' newborn intubation frequency and competency. This was an integral part of my residency training and I can remember even when I was a junior medical student working as an obstetrics and gynecology extern in the city-county receiving hospital doing neonatal intubations and basic resuscitations. I taught my junior residents neonatal intubation on stillborns. Somewhere over the years neonatal

intubation and basic resuscitation has obviously fallen off the medical education wagon, much to the detriment of our patients. Of course this is neither the first nor will it be the last such instance.

John is a Junior Fellow of the College with a BA in journalism from Texas A&M (Hook 'em, Horns!) and did postgraduate work at the University of Texas at Austin in radio, TV and film production. He then attended the University of Southern California for premed and earned his MD from the University of Texas Southwestern at Dallas Medical School followed by a residency at Baylor University Medical Center in Dallas. He has a private clinical practice in Crescent City, California, and in his spare time manages his extensive holdings in Texas' oil and gas "bidness" plus freelancing as a writer and photographer.

Dan Avery's Presidential Box this month tells it like it is regarding the continued screwing our government gives this noblest profession of ours. Sometimes you don't know whether to laugh or cry or just blow up something.

This month's Hot Box addresses the confusion generated by capriciously changing diagnostic criteria and language, as in Pap smears and the Bethesda system. Another series of changes are looming on the horizon and if anything like the original implementation, there's trouble ahead.

In the Suggestion Box this month there's a news item from the February 2001 issue of the *AAPS* (Association of American Physicians and Surgeons) *News* relating how a 41 year old solo practicing urologist turned on, tuned in and dropped out by canceling all his managed care obligations. Everyone today is wringing their hands and crying, "Oh, woe is us! Whatever shall we do? The managed care dragon has invaded our castle to kill us, ravage our women and devour our children!" For one thing you can fight back by withholding your labor, a time-proven and effective strategy in collective bargaining which, if enough of us find the courage to do it, will be justly effective in professional bargaining. Think about it.

This month's Tool Box has Liz Woodcock playing Martha Stewart and telling you how to do a makeover on your office, turning it into something out of *House Beautiful*. Your perhaps more relevant questions can be sent to her via email at [ewwoodcock@ppdnet.com](mailto: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.

In this month's Litter Box Jo Hall goes off on a rant about the socialization of healthcare. Jo is a longtime Society member from Glendale, California. Something about last year's membership poll on mandatory universal health insurance must have stuck in her craw because after mulling it over for a year, she has written an excellent piece on the frustration we older physicians feel when caught up in today's mismanaged care tornado while we see another, bigger disaster looming on the horizon. If I didn't know better I'd swear she's been talking to Dad. I don't envy Jo because two of this year's new members, Gillian Esser and Jesse Hall, are her physician children and God-only-knows what they're going to see over their careers.

This issue contains another six articles in our series on ACOG Past Presidents. Charles Hillman was one of Fourth ACOG President F. Bayard (Nick, The Boss) Carter's residents back in the 50's. Charles holds a BS in Biology from Virginia Polytechnic Institute and an MD from Duke University School of Medicine where he completed his internship and residency. Between 1955 and 1957 he served in the United States Air Force Medical Corps and is currently Assistant Professor, Department of Obstetrics and Gynecology, James H. Quillen College of Medicine, East Tennessee State University in Johnson City, Tennessee. He is also a member and Past President of the Bayard Carter Society of Obstetricians and Gynecologists.

Tim Johnson and John DeLancey introduce us to J. Robert Willson, ACOG's 21st President. Tim earned bachelor's and master's degrees with honors from the University of Michigan and his MD from the University of Virginia School of Medicine followed by a return to UM for residency and then fellowship in maternal-fetal medicine at The Johns Hopkins University. He served in the United States Air Force Medical Corps as Chief of Obstetrics and Staff Perinatologist at USAF Medical Center Keesler, Keesler AFB, Mississippi, between 1981 and 1983; then Chief of the Perinatology Section at Malcom Grow USAF Medical Center, Andrews AFB, Washington, DC, between 1983 and 1985 with a simultaneous academic appointment as Assistant Professor of Obstetrics and Gynecology at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. In 1985 he was appointed Assistant Professor of Obstetrics and Gynecology at The Johns Hopkins University, in 1988 Associate Professor and Director of the Division of Maternal-Fetal Medicine, and in 1993 Chair of the Department of Obstetrics and Gynecology back at the University of Michigan Medical Center (UMMC). He has written over 150 professional articles and book chapters plus teaching worldwide including continuing efforts on behalf of training physicians and midwives in Ghana.

John DeLancey is an honors graduate of Oberlin College and earned his MD degree also from the University of Michigan where he completed his residency. He then became an Instructor on the UM faculty at Wayne County General Hospital, later returning to UMMC's faculty where he is now the Norman F. Miller Professor of Gynecology in the Department of Obstetrics and Gynecology. His specific field of expertise is pelvic floor disorders including organ prolapse and incontinence, focusing on the role of maternal birth-related trauma in their development.

Next Phil Eskew shares his memories of Sprague H. Gardner, ACOG's 23rd President. Phil is Medical Director, Women and Infant's Services, Saint Vincent Hospital, Indianapolis, Indiana, where he previously served four years as director of its residency training program. He holds a BA from DePauw University and an MD from Indiana University where he completed his internship and residency. Phil served in the United States Army Reserve Medical Corps between 1971 and 1997 with active

duty for three years as Chief of Professional Services at Fort Benjamin Harrison, Indiana. He is also a Clinical Associate Professor of Obstetrics and Gynecology at Indiana University School of Medicine.

As an ACOG Junior Fellow Phil was Chair of the Indiana Section, Chair of District V and Chair of the Junior Fellow Advisory Council (National). As a Fellow he has been ACOG Vice President (1996-1997), Chair of the Indiana Section, Chair of District V, twice General Chair of District V's Annual Meeting, a John R. McCain Fellow and member of a long list of ACOG committees, task forces, commissions and panels in addition to being the College's recognized expert on coding. He has written extensively in College publications, peer reviewed medical journals and the popular medical press. He is also a longstanding member of APGO and on the editorial boards of *Ob-Gyn Practice Management*, *Ob-Gyn Coding Alert* and *Codelinks*.

Phil has been a Freemason since 1963 and a Shriner since 1964, a Director of the Indiana Basketball Hall of Fame since 1998 and a Kentucky Colonel since 1982. He has received recognition awards as Rotarian of the Year (1984), DePauw University Athletic Hall of Fame (1994 Inductee, Football and Track) and ACOG's Outstanding District Service Award (1995). In his spare time Phil is a member of the Crooked Stick Golf Club and has served as Chair of Medical Coverage for the PGA Championship (1991) and the U.S. Women's Open (1993) in addition to being a Photographer's Assistant for NFL Films covering Super Bowls since 1980 and Indianapolis Colts Home Games since 1984. By comparison, the most important thing on my schedule this week is a haircut.

Charles Hammond remembers his years of close association with Roy T. Parker, ACOG's 26th President. Currently E.C. Hamblen Professor and Chairman of Duke University Medical Center's Department of Obstetrics and Gynecology, Chuck was an undergraduate at The Citadel for three years before transferring to Duke University where he earned a BS in medicine in 1960 and an MD from its School of Medicine in 1961. In 1994 The Citadel's Board of Trustees awarded him its own BS degree. Next came a Duke surgery internship followed by acceptance into its obstetrics and gynecology residency training program to include an endocrinology fellowship. Postgraduate training was interrupted for two years during a stint at the National Institutes of Health in Bethesda, Maryland, as a Clinical Associate in endocrinology while serving as a Medical Officer in the Public Health Service.

Chuck has been President of the American Society of Reproductive Medicine, American Gynecological and Obstetrical Society and the American Gynecologic club. He has additionally been an ABOG Director, a member of CREOG, a member of the Residency Review Committee for Obstetrics and Gynecology, Chairman of ACOG District IV, Nominee for ACOG President 2002-2003, and is a member of the editorial boards of five major medical journals. He is an Honorary Member of the Royal College of Obstetricians and Gynaecologists in addition to recently being elected to the National Academy of Science's prestigious Institute of Medicine.

Not one to rest on his laurels, Chuck has also authored or coauthored over 300 articles and textbook chapters as a recognized expert worldwide on trophoblastic disease, menopause, reproductive endocrinology and infertility, attaining such status by his exhaustive research and stellar clinical practice as Director of Duke's Southeastern Regional Trophoblastic Disease Center since 1966. He is or has been associated with Ayerst Laboratories, Burroughs-Wellcome Laboratories, the Berlex Foundation, Abbott Laboratories, Solvay Laboratories and Syntex Laboratories in various capacities over the past 27 years. In his spare time Chuck works with the Boy Scouts of America.

Joe Apuzzio is a long-standing friend, trainee and colleague of Harold Kaminetzky, ACOG's 29th President. He is also Professor of Obstetrics, Gynecology and Radiology plus Director, Division of Maternal-Fetal Medicine and Administrative Director of Obstetrics, Gynecology and Women's Health at the University of Medicine and Dentistry of New Jersey – New Jersey Medical School (UMDNJ-NJMS), Newark, New Jersey. Joe graduated Phi Beta Kappa from Rutgers University with a BA and AOA from the College of Medicine and Dentistry of New Jersey – New Jersey Medical School (CMDNJ-NJMS) in 1973, followed by internship and residency at Martland Hospital, CMDNJ, and fellowship at University Hospital, NJMS. He's on the Editorial Board of *Infectious Diseases in Obstetrics and Gynecology* and a reviewer for *Obstetrics and Gynecology*, the *American Journal of Obstetrics and Gynecology* and the *Journal of Maternal-Fetal Medicine* in addition to a Past President of the New Jersey Obstetrical and Gynecologic Society. Joe's received multiple teaching awards and wrote or co-wrote innumerable articles for the peer-reviewed medical literature including journals, textbooks and monographs.

André Kasko was a resident under Ben Harer, ACOG's 51st and current President. André currently works for Ben as Associate Chief of Riverside County Regional Medical Center's Department of Obstetrics and Gynecology, also serving as teaching faculty for four different family practice residency training programs with rotations at Arrowhead Regional Medical Center and Riverside. He has undergraduate degrees from Czechoslovakia's State Health School and Pomona's California State Polytechnic University, a DVM from Czechoslovakia's College of Veterinary Medicine, and a DO from Pomona's Western University of Health Sciences - College of Osteopathic Medicine of the Pacific. His internship was in family practice at Riverside where he then completed a family practice residency. A second residency in obstetrics and gynecology followed at San Bernardino County Medical Center with board certifications in both family practice and obstetrics/gynecology.

Jeff Lane again graces these pages with more information on how state medical boards function, focusing on their investigative activities. His introduction is in the January 2001 Witness Box. While Jeff's comments apply only to the Georgia State Medical Board, most other boards operate about the same.

I've got a piece on the attending physician/consultant physician relationship, specifically our responsibility as consultants and the conditions allowing refusal to assume care of referred patients. It was precipitated by the recent revision of a previous ACOG Committee Opinion. There's also another installment in my eternal windmill tilting over the necessity of routine rectovaginal examination.

There's a reprint from *Physician's Practice Digest* by Janice C. Simmons on physician burnout, covered in detail by Mark O'Hollaren in the last *Newsletter* (Reclaiming the soul of medicine. The Medicolegal Ob/Gyn Newsletter 2001;9:1). This time the emphasis is on early identification and intervention (think impaired physician) and several web sites are recommended for information and assistance.

On a somewhat sadder personal note, Dad died in February. My apologies for the delay in getting this issue of the *Newsletter* to you but it couldn't be helped. Though dead in body I intend he live in memory by continuing to frequently quote his now priceless aphorisms. Requiescat In Pace.

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 MAIL BOX

10 JANUARY 2001

Dear Doug,

I was quite pleased with the Bob Kimbrough presentation and most pleasantly surprised at the wealth and range of material presented in our fine journal. Best wishes for the New Year!

Karl Rugart

12 JANUARY 2001

Dear Karl,

Thanks for your letter. It's nice to have people saying complimentary things about the *Newsletter*, like having someone compliment your children. You play some small part in their creation but have very little to do with their subsequent accomplishments.

Doug

24 JANUARY 2001

Dear Doug,

I would like to receive the new monograph "The Ninth Commandment: Providing Effective Medical Expert Witness" as noted in the recent *Newsletter*. The enclosed check for \$25.00 should cover the cost plus shipping and handling.

John Wachtel

27 JANUARY 2001

Dear John,

Thanks for your letter. A copy of the monograph, including the dedicated issue on the IUFD case (Smithee A. Cause No. 95-02288-I. *The Medicolegal Ob/Gyn Newsletter*, Vol. 6, No. 3, JULY 1998) with the EFM strips, should be enclosed. If not, let me know. The price is only \$15.00 for members including S&H so I deposited the rest in the copier fund where it was sorely needed. Thanks for your interest and let me know what you think.

Doug

# THE HOT BOX

## REDESIGNING THE LILY

by Doug Daniel

*"Be moderately wise, and not over-prudent."*

The Druid Hava Maal, or Sublime Book of Odin

One of Dad's favorite sayings was "You can't tell the players without a program", referring to the necessity of having some generally accepted and accurate basis of reference in order to determine what the Hell's going on. But we've also got to all be on the same page singing out of the same hymnal, pardon the continuing use of well known and mixed metaphors. You won't be able to follow today's game using last week's program if you're too cheap to buy this week's. The same is true if you're using next week's program because it's got better pictures and stats. While such situations at football games may only result in confusion or one appearing miserly and intellectually challenged, similar situations in medical practice can result in failure to diagnose and treat. If this term sounds familiar, that's because it's the leading allegation in obstetric and gynecologic medical cases, more especially and particularly cancer, i.e. cervical cancer.

Back in 1928 Greek-born George Nikolas Papanicolaou, MD, literally wrote the book (with his talented wife's assistance) on screening cervical cytology based upon three years' investigation of vaginal smears obtained from volunteer female employees of the New York Women's Hospital.<sup>1</sup> One of the early ones incidentally had cervical cancer and demonstrated markedly unusual cellular morphology in her exfoliated cells. Obtaining smears from other women with various gynecologic malignancies confirmed the consistency of these changes in the presence of cancer, establishing a direct relationship between cancer and specific cytologic findings. When in 1928 Papanicolaou reported his investigation and conclusions they made not so much as a ripple on the surface of contemporary medical knowledge and practice.

In 1939 Papanicolaou and Dr. Herbert F. Traut, a gynecologic pathologist, began a clinical trial at the New York Hospital in which Papanicolaou interpreted vaginal smears obtained from every woman admitted to hospital and Traut correlated these cytology findings with subsequent surgical pathology histology slides. Over the next year many asymptomatic and unsuspected gynecologic malignancies were diagnosed, and surprisingly there were some in such early stages as to be invisible to inspection or even missed by conventional biopsy techniques. Their results were presented in March 1941 and published in August 1941.<sup>2</sup>

Proven over the remaining years of the 20th century to be the single most effective development in improving diagnosis and treatment of epithelial malignancies, most especially those of the female reproductive tract, the Pap smear increased women's cancer survival rates by providing a highly accurate, inexpensive and convenient screening method for cervical cancer allowing earlier diagnosis, earlier and less radical treatment, and accurate posttreatment monitoring. Millions of women worldwide have literally owed their lives and/or fertility to the Papanicolaous and Traut.

Papanicolaou devised an interpretation and reporting system of his findings with well-defined cellular changes suggestive or diagnostic of cancer and based on Classes I through V as follows:

Class I	Benign
Class II	Benign, with some atypical cells
Class III	Benign but atypical (mild or moderate dysplasia)
Class IV	Carcinoma in situ (CIS, severe dysplasia)
Class V	Invasive Carcinoma.

This old, established system worked well since clinicians and pathologists alike were familiar with its diagnostic criteria and their clinical implications for therapy. Until the 1970s, that is.

In the early '70s it was decided to gild the lily by adding Class II-B, denoting cervical metaplasia or minimal benign atypia due to infection. This simply bumped up some of the previously interpreted Class I smears to Class II but made essentially no change in the management of Class II smears, i.e. "treat and repeat, biopsy if complete". Class III through V smears still required tissue biopsy for definitive diagnosis and cervical conization for treatment of CIS or staging of invasive malignancies.

By 1988 our cytologic gurus decided Papanicolaou's criteria and classification were at best misguided and proposed a new method termed "The Bethesda System", named for the location of the prestigious National Institutes of Health which sponsored a "Consensus Conference" to change Papanicolaou's proven classification. The reason for the quotations marks is nobody conferred with me for my consensus; if they had I would have said leave well enough alone and if it ain't broke don't fix it.

The resulting new cervical cytology classification threw out the familiar and simple Class I through V and in its stead proposed a complicated narrative description intended to protect pathologists from medical liability in those previously noted failures to diagnose and treat. The new system had some good points such as declaring a smear with no endocervical cells technically unsatisfactory and uninterpretable unless the patient was identified as post TAH/TVH/trachelectomy. Unfortunately it also introduced a plethora of confusing acronyms such as ASCUS (Atypical Squamous Cells of Undetermined Significance), low-grade SIL (Squamous Intraepithelial Lesion), high-grade SIL, HPV (Human Papilloma Virus), CIN 2 (Cervical Intraepithelial Neoplasia) and CIN 3.

Any graduate of the Sears Roebuck Night School of Law could have predicted the results. Pathologists and obstetrician/gynecologists, not to mention nonspecialists, who weren't practicing in the rarified atmosphere of the higher levels of the food chain such as NIH didn't understand the new classification, its terms, its acronyms or their definitions. Subsequently there was a rash of misdiagnosed and/or untreated abnormal Pap smears complete with alleged failures to diagnose and treat cervical cancer.

But you already know all this, so why dredge it up again? Well, get ready for the "New and Improved Bethesda System" coming to a cytology lab near you 30 APRIL 2001 through 2 MAY 2001 courtesy of the friendly folks at NIH. Seems like once again they won't get my conference or consensus since I plan to be in Chicago at the ACOG ACM. To quote Stan Zinberg, ACOG Vice President for Practice Activities, "The outcome of the conference will likely be a revision of how results of cervical cytology testing are done *and reported* (emphasis mine)."

Not to belabor the point but citing the world-renowned Yogi, it's like déjà vu all over again. Is this upheaval going to become a regular event every ten years like the US Census? We're just now recovering from the last one! The best advice is get a copy of the new system ASAP (it's already on the web at <http://bethesda2001.cancer.gov>), familiarize yourself with it, take it to your pathologist and ask if he's familiar with it (assuming you're lucky enough to even know who's reading your smears), and start a file of publications to use in the inevitable future medical actions you may work as a medical expert witness for plaintiff, defense, or even as a defendant yourself. The critical question will be when the new system became known to defendants or should have become known to a prudent clinician. Good Luck!

## REFERENCES

1. Papanicolaou GN. New cancer diagnosis. In: Proceedings of the Third Race Betterment Conference, 1928 2-5 Jan; Battle Creek, Michigan:528-34.
2. Papanicolaou GN and Traut HF. The diagnostic value of vaginal smears in carcinoma of the uterus. Am J Obstet Gynecol 1941;42:193-206.

**Editor's Note:** The historical information on Dr. Papanicolaou and his work was abstracted from Vilos GA, The history of the Papanicolaou smear and the odyssey of George and Andromache Papanicolaou, Obstet Gynecol 1998;91:479-83.

# THE SUGGESTION BOX

## ADMINISTRATIVECTOMY

In 1999, at the age of 41, with six years' experience in private practice, AAPS member Michael Harris, MD, of (Traverse City) Michigan, a solo urologist, had had enough. His patients were brainwashed into a "lotto mentality" and an "entitlement attitude". Instead of complaining, Dr. Harris took out his knife and performed some radical surgery.

In early 1999, Dr. Harris deparicipated from all private insurance plans, and in December 2000 withdrew from his participation agreement with Medicare. Except for Medicare, patients are now provided with all necessary information and submit their own insurance claims. Elective surgery is prepaid by cash, check or credit card. Local banks provide loans with just a phone call for those patients who prefer to finance their surgical charges: "I am not a low/no interest loan agency." The one patient who financed his surgery last year was paid in full by his insurance company within two weeks.

"When we submitted claims electronically" Dr. Harris writes, "patients were isolated from the hassles inflicted on me by their insurance companies.... It took six to eight weeks to complete an uncomplicated insurance claim for companies with whom I did not participate. Companies with whom I did participate questioned my professional judgment and denied payment at will. When medical societies or individual physicians complain about payment hassles, nobody cares.... To my amazement, most patients are paid in full within two weeks of submitting their own claims. I believe that insurance companies are more sensitive to policyholders than to doctors. The patients bought the insurance and the companies have a duty to their insureds. Doctors should never get in the middle of that relationship."

Patients are informed of the billing policy when they call for an appointment. Dr. Harris's rates are low; he cannot afford to hire a collection officer and expects always to be paid for his time. He will care for the downtrodden free of charge but will not waste time or money submitting useless Medicaid claims. Some patients are incensed because he will not "honor" their insurance. That is fine with Dr. Harris: "This is a urology service, not a capitated/number game/healthcare avoidance scheme." Dr. Harris reports that his overhead is down and income is up. He has never been happier practicing medicine.

Other cost-cutting measures have included a simplified electronic medical record and more efficient practice accounting. With a laptop computer in every room Dr. Harris can keep detailed, typewritten notes without paying \$0.12/line for transcription charges. He now does the bookkeeping himself after streamlining it with more user-friendly software and accounting fees have dropped from \$1900.00/month to \$2000/year.

"If you are unsure of the radical approach that I took, then start slowly but with determination. Change for the better against current thinking is not always immediately satisfying. Look at your worst third-party payors and deparicipate. If you lose 20% of your patients but make 20% more on half the remaining patients - and if your billing and collection headaches evaporate - you will have more income and more time. Imagine that! You can go sailing, golfing or fishing. You can spend more time with your family.... You can see more patients who appreciate your time and effort. *Now* is the time to enjoy your practice!"

**Editor's Note:**

This article originally appeared in the *AAPS News*, Vol. 57, No. 2, FEBRUARY 2001 and is reprinted by permission of its Editor.. She may be contacted at: Dr. Jane M. Orient, AAPS, Suite 9, 1601 North Tucson Boulevard, Tucson, Arizona 85716, 1.800.635.1196, on the web at [www.aapsonline.org](http://www.aapsonline.org).

# THE TOOL BOX

## BUTTONS AND BOWS

**By Elizabeth W. Woodcock, MBA**

A cozy, homelike atmosphere in a physician's office reassures patients and offers a welcome relief for staff from antiseptic environments. Following are some easy ways to add coziness:

- ❑ Hire a landscape architect to build and maintain a garden of native plants and flowers outside the office. Install a picket fence or old-fashioned streetlights for added charm. Inside, hang paintings and photographs by local artists (and change art regularly) to provide a sense of community and aesthetics.
- ❑ Provide seating options. Put some chairs in small groups, some in isolation, some with a view of a window, some in sight of the nurses' station, etc. And consider comfort for everyone: Try a combination of higher, stiffer chairs and lower, softer ones.
- ❑ Use carpeting on the floors and fabrics on the furniture. They are more inviting than bare linoleum and plastic and do not increase the risk of nosocomial infection.
- ❑ Make sure lighting is pleasant and practical. Using only overhead, florescent lights, for example, can create a pallid, harsh atmosphere. Instead employ only one or two overhead fixtures and complement them with floor or table lamps for reading. Supply natural light by adding windows or skylights.
- ❑ Make it clear to patients where they should go once in the office. For instance, make the reception desk an obvious destination. Use big paintings, plants, or patterns on the floor to help patients find and remember the way; such visual cues work better than do text-based signs.
- ❑ Install windows or glass blocks at the entrance to your waiting room so patients can see the space before they enter.
- ❑ And don't forget to have your physicians and staff greet patients with a smile. Nothing clears away anxiety faster than good cheer

# THE LITTER BOX

## A CHICKEN IN EVERY POT

by Jo Hall

I recently spoke with Doug Daniel about last year's membership poll on whether we endorsed the College's position advocating mandatory universal health insurance. That's a hard question because none of the answers are simple. At first glance the obvious answer is a resounding "Yes!" Every patient would get access to healthcare and physicians would get paid for their services. Sounds pretty good, right? Perhaps too good? Maybe not.

Politicians playing on voters' limitless desire for cheap medical care and physicians' desire to make a secure living brought us one of the 60s biggest hits, Medicare. At the time the proposed reimbursement schedules were an insult but reality didn't kick in until they were reduced. Today they're not so much of an insult because reimbursements offered by managed care are even less. We're carrying the HMOs only because we're afraid to cancel their contracts.

My question to those touting the universal healthcare panacea is, "Who's picking up the tab?" Will it be a single-payer government agency like Medicare? These guys already make arbitrary and punitive decisions as to whether our billings are correct, improper or even fraudulent. They also mete out the ever-popular denials of payment. Medicare now threatens fines and even jail time for those found guilty of mistakes or misdeeds. Who would have ever thought physicians would be fined thousands of dollars for expecting to be paid for their labor or wanting to give some of their patients a well-deserved financial break?

There's also that small percentage of bad apple physicians who deliberately recommend unnecessary procedures or diagnostic testing, bill for unprovided services, up-code, unbundle, and even submit bogus claims for services not rendered. Everyone's reputation suffers when tabloid newspapers and TV programs exploit and publicize these sins. MediCal recently uncovered a major fraud operation out here. Media pundits sputtered their outrage over such travesties but what do they expect when the governmental bureaucracy encourages fraud?

In a nation supposedly preaching Democracy, Capitalism, Free Trade, and Entrepreneurial Business, managed healthcare just doesn't ring true. It stands out like the proverbial sore thumb. I can't understand why anyone, patient or physician, would voluntarily relinquish the freedoms of free enterprise for the chains of bureaucratic control. Physicians and patients didn't do so badly before Medicare. Perhaps our knowledge base was by today's standards inaccurate and incomplete but at least care was patient oriented, competent and compassionate nursing was recognized as important to treatment, and hospitals didn't discharge patients until they were on the road to recovery. Everyone took pride in the care delivered.

Patients with limited or no finances received care from municipal hospitals. I don't remember anyone going without healthcare unless they so chose. Certainly there was nothing like the horror stories of refused care we hear today. Fee for service patients got full value for what they paid; some who couldn't pay got an even better deal. When I was a child physicians treated my newly immigrant relatives either for nothing or at a reduced fee. Since opening my private practice I have treated many indigent patients in the office and referred the rest to the county receiving hospital where I volunteer my services. You can't tell me today's MediCal recipients get as good or better care from their "private" physicians as we gave away at the County. Such centralized hospitals should be more cost-effective than private for-profits anyway.

I want to go back to the way we were, small business and capitalism at its best. The threat of taking this unworkable managed care mess and expanding it universally to everyone except the very wealthy and politically powerful scares the very life out of me. It scares me when medical decisions are placed in the hands of high school graduates, CPAs and MBAs. If they want to play doctor they should go to medical school. If they want to make obscenely inflated salaries they should become stockbrokers or NBA all-stars. It's high time the medical profession was closed to business managers, bean counters and golden parachute wannabes. No Vacancies! They simply don't have the credentials necessary for a license to practice medicine.

## **WHY TEACH NEONATAL INTUBATION? Continued From Page 1**

A more relevant interpretation is possible by studying each part of the question separately and expressing respondents who answered zero as a percentage of their entire sample. In Dallas 90% of respondents had not performed a neonatal intubation in the past year, more than 65% in the past five years. In Abilene 85% of respondents reported no neonatal intubations in the past year but almost 70% reported performing at least one in the past five years. Of all comparisons between Dallas and Abilene only this one was statistically significant.

In order to separate obstetricians' actual use of neonatal intubation from their perception of its importance we asked, "Do you think the ability to perform neonatal intubation is an essential skill for today's practicing obstetrician?" Yes answers were 70% in Dallas and 100% in Abilene. Another 9% of Dallas respondents qualified their response by essentially answering, "Yes, but only if practicing in an environment where other qualified personnel are not available." Recall that 100% of all respondents reported they have such personnel available.

A logistic regression equation was used to examine data regarding the single statistically significant difference between Dallas and Abilene respondents. Dallas respondents were less likely to have intubated a neonate in the past five years than those from Abilene ( $p = 0.0859$ ). The more deliveries reported the less likely a respondent was to have intubated a neonate in the last five years ( $p = 0.0122$ ). Respondents with formal neonatal intubation training were more likely to have used it in the last five years ( $p = 0.0015$ ). Apparently this skill is more utilized in the semi-rural setting and by those with formal training. While most don't use it they still consider neonatal intubation a necessary skill.

This study was presented as an oral abstract at the Association of Professors of Gynecology and Obstetrics-Committee on Resident Education in Obstetrics and Gynecology (APGO-CREOG) MAY 2000 Annual Meeting in New Orleans. Several in the audience of residency training program directors plus clinical and academic faculty took the time to personally speak to this author expressing their frustrations concerning the issue. Many seemed to be concerned about how to provide formal training in neonatal intubation, especially since the RRC had made it clear that using animals or infant mannequins was not considered adequate. Many thought it unfair to penalize training programs for deficiencies in this area, especially when the above study seemed to confirm that the ability to perform neonatal intubation in real-world clinical practice is rarely if ever needed.

Perhaps the most interesting aspect of the study is that most practicing obstetricians surveyed virtually never perform neonatal intubations, yet almost all consider it a necessary part of residency training. This may reflect a medmal paranoia. Newborn intubation is relatively simple if one is at least minimally experienced. In the day-to-day pressure cooker of private practice with bad outcomes and medmal suits lying in wait around every corner, it is indeed reassuring to know one can insert an endotracheal tube if necessary.

Everyone agrees residency training programs are faced with demands to be many things to many people. With the push toward training in primary care it's difficult to find time in already crowded curricula for teaching rarely used procedures such as neonatal intubation and basic resuscitation. Our study does provide some justification for its elimination and many at the APGO-CREOG meeting seemed to agree.

Formal residency training in neonatal intubation should probably continue to be available since it is impossible to predict who, few though they may be, will need the skill in their practice. Since most residents apparently won't use it, training should not be required and therefore not subject to RRC noncompliance penalties. Offering formal neonatal intubation and basic resuscitation training as a third or fourth-year elective would be one way to serve residents seeking practice opportunities in more isolated communities where such skills might be useful.

Neonatal intubation and basic resuscitation is admittedly a small facet of obstetric and gynecology residency training, apparently an even smaller part of clinical practice. It is however representative of today's conflicting demands on our residency training programs and the specialty in general. We must preserve traditional concepts of education, training and practice while adapting to the changing demands of a volatile medical marketplace, yet at the same time maintain the quality of care we have always given our patients.

# F. BAYARD CARTER, MD, 1953-1954

(b. 1899 - d. 1976)

by Charles H. Hillman, MD, FACOG

Francis Bayard Carter was born January 20, 1899, in Wilmington, Delaware. He earned a BA from the University of Delaware in 1920; BA and MA degrees as a Rhodes Scholar at Oxford University, Balliol College, Oxford, England, in 1923; MD from Johns Hopkins University Medical School in 1925; and completed an obstetrics and gynecology residency at Yale University School of Medicine in 1928. From 1929 to 1931 Carter was Professor and Acting Chairman of the University of Virginia (Charlottesville) School of Medicine's Department of Obstetrics and Gynecology. From 1931 until retirement in 1964 he was Professor and the first Chairman of the Duke University (Durham, North Carolina) School of Medicine's Department of Obstetrics and Gynecology.

International as well as national peers in obstetrics and gynecology recognized Carter as an outstanding teacher, administrator and researcher. In addition to serving as the fourth ACOG President he was also president of six other national obstetrical and gynecological societies, an Honorary Fellow of the Royal College of Obstetrics and Gynecology, Honorary Member of both the Gynaecological Club of Great Britain and the Society of Obstetricians and Gynecologists of Canada, and additionally served as President and Chairman of the American Board of Obstetrics and Gynecology between 1955 and 1964.

From the outset the academician Carter was a disciplined teacher and astute clinician known for his informal, stimulating and intellectually challenging style with students. He demanded accuracy and detailed observation, loved an argument and was never averse to making courageous diagnoses. When consulting in the public clinic he would say, "Just tell me her age." He believed in truth and honesty, always expecting both from students, residents and attending Staff. In a 1967 videotaped interview he said:

"You don't teach many people. You give them the opportunity to learn. The smart ones will do it. Education goes on every day as long as you live."

Residents dearly loved and respected Carter as their mentor, father figure and trustworthy friend. While known to friends, colleagues and attending staff as "Nick", his residents simply called him "The Boss". He was a demanding taskmaster but his housestaff were part of his family, always supported regardless of the scrapes they got into. In 1991 a former resident, Dr. B.C. West, Jr., edited a compilation of reminiscences entitled "Sincerely, Nick" in which an anonymous resident wrote:

"If you did your job he would back you up against anybody, but if you screwed up, he would sit you down in that red chair in his office, close the door, and tear a strip off your hide. He never embarrassed you in front of anybody else."

The Boss was never at a loss for words. His conversation was always liberally punctuated with descriptive but never profane Carterian expletives, for which he was well known. He was an avid reader of everything from the Greek classics and English novelists to detective stories, westerns and *Sports Illustrated*. He regularly arose at 4:00 am, read two pages of the dictionary to improve his vocabulary, and then perused articles clipped by his secretary from the latest medical journals. He expected no less from his housestaff.

Fifteen of his former residents expressed their loyalty and respect by forming the Nick Carter Travel Club in 1951 for the "promotion of scientific knowledge and the exchange of ideas and practices related to obstetrics and gynecology". This organization, now the F. Bayard Carter Society of Obstetricians and Gynecologists, today has 300 members composed of current or former Duke housestaff and faculty. On the occasion of Carter's retirement in 1964 the Society presented an endowment to the University for the F. Bayard Carter Chair of Obstetrics and Gynecology. Through the continuing efforts of the Society there are now five endowed professorships within the department totaling over \$14.7 million plus a research endowment of nearly \$1 million.

Three of Carter's former residents, Roy T. Parker, George D. Wilbanks and Charles B. Hammond, have been selected to serve as ACOG Presidents and many others have held academic chairs or professorships at prestigious medical institutions across the country. Carter's legacy of excellence in teaching and research continues at Duke, still significantly impacting women's healthcare worldwide well into the 21st century.

# **J. ROBERT WILLSON, MD, 1970-1971**

## **(b. 1912 – d. 1993)**

**by Timothy R.B. Johnson, MD, FACOG**  
**John O.L. DeLancey, MD, FACOG**

J. Robert Willson, one of the twentieth century's most influential obstetrician/gynecologists, was born in Flint, Michigan, in 1912. He completed his undergraduate education at the University of Michigan and graduated from the University of Michigan Medical School in 1937, subsequently serving his residency in obstetrics and gynecology there between 1937 and 1941. Dr. Willson served as Temple University's Chairman of Obstetrics and Gynecology from 1947 to 1963 and the University of Michigan's between 1964 and 1978, remaining on the Michigan faculty until his retirement in 1983. He then moved to Albuquerque, New Mexico, where he was a University of New Mexico Adjunct Professor. In addition to serving as President of ACOG he also served as President of the Association of Professors of Gynecology and Obstetrics (APGO) and the American Gynecological Society. Dr. Willson died in Albuquerque on December 16, 1993, at the age of 81 following a motor vehicle accident.

As the young firebrand Chairman of Temple's Department of Obstetrics and Gynecology, Willson made major changes that revitalized Philadelphia's practice of obstetrics and gynecology. On his later return to the University of Michigan he became Chairman of a department that over the years provided his specialty's national leaders and influenced its clinical practice. He trained, mentored and developed many faculty members including Robert Jaffe, Bill Ledger, Jan Behrman, George Morley, Rick Sweet, Jim Roberts, Bob Hayashi and others who have since had meteoric academic careers.

Like Norman F. Miller, his predecessor at Michigan, Willson published important papers on obstetrician/gynecologists as primary care providers, defining this important role for generalist obstetrician/gynecologists. After retirement as Chairman he was actively involved in resident education, especially vaginal surgery, at both Michigan and New Mexico.

Willson was always an important influence on the training and practice of obstetrics and gynecology in the US. His uncompromisingly high standards affected all those coming in contact with him. When evaluating new developments in the specialty he would ignore personal convenience, popularity and politics in favor of precise critical analyses regarding whether or not they would truly prove beneficial to women. His focus on truth was unflinching, augmented by an ability to see what the future held while others remained confused. He saw the importance of primary care teaching in obstetrics and gynecology long before others recognized its importance, arguing we should provide training for future physician practice styles.

While it is difficult to accurately define wisdom, all who knew Dr Willson could point to him as its ideal example. He was a visionary but stern leader. During our residencies we never saw him smile; riding with him in an elevator or passing him in a corridor was torture. Rather than responding to remarks like "How are you today?" or "Isn't it a nice day?", he would silently direct a penetrating look toward the questioner. These were long and painful moments. Many years later one of your authors was at a meeting in New Mexico and became very uncomfortable because there seemed to be something wrong with Dr. Willson. He quickly realized it was the first time he had ever seen him smile, demonstrating a previously unknown facet of his personality. He had a sense of humor!

Another famous story concerns precision with the English language. A stickler for appropriate use of language, his textbook Obstetrics and Gynecology was tightly edited and clearly written. Perhaps his demand of proper spelling from his sons was prescient. He hated people using laparoscope as a verb and enjoyed the term laparotomy. One of your authors will always remember a Grand Rounds presented by Dr. George Morley, subsequently ACOG President, on the surgical approach to pelvic infections in patients with bilateral tubo-ovarian abscesses and extensive pelvic infection. In response to a question about definitive treatment Morley said, "Well, I think I would have to clean her out." Dr. Willson's voice came from the back of the room, "And what would you use, George, soap and water?"

Willson's legacy to obstetrics and gynecology is a cadre of contemporary leaders demonstrating his uncompromising drive for excellence, dedicated focus and clear thinking, collectively thankful to truly have stood on a giant's shoulders.

# **SPRAGUE H. GARDINER, MD, 1972-1973**

## **(b. 1910 - d. 1993)**

**by Philip N. Eskew, MD, FACOG**

Sprague Herman Gardiner was born in Toledo, Ohio, 20 OCTOBER 1910. He earned AB, MS and MD degrees from the University of Michigan in addition to completing his internship and residency there, afterward becoming an Instructor in Obstetrics and Gynecology at its School of Medicine. A Rockefeller Neuropsychiatry Fellowship at the Johns Hopkins School of Medicine in Baltimore, Maryland, followed and he then served 1942-1946 as a Major in the United States Army Medical Corps.

Gardiner arrived in Indianapolis, Indiana, in 1946 as an Indiana University School of Medicine's Department of Obstetrics and Gynecology Professor and remained there until his retirement in 1981. An ACOG Founding Fellow, his election as its 23rd President was preceded by terms as Assistant Secretary and Treasurer, later followed by its Distinguished Fellow Award.

Gardiner was also active in other national medical organizations and appointments in addition to being board certified in both obstetrics and gynecology plus psychiatry. For many years he served the American Medical Association as a Delegate plus member of its Maternal and Child Health, Human Reproduction, and Health Care for the Poor Committees. He also served nine years as an AMA Commissioner of the Joint Commission on Accreditation of Hospitals. A member of the American College of Surgeons, he served as Chairman of its National Task Force on Perinatal Care for developing guidelines on prenatal care of high-risk mothers and newborns. His contribution to this important work was recognized with awards from the American Academy of Pediatrics and the National Foundation, March of Dimes. In 1974 President Richard M. Nixon appointed Gardiner Vice Chairman of the National Observance of World Population Year.

As a junior medical student in the fall of 1968 I was among those assigned to meet with Gardiner every Tuesday afternoon. He would informally talk with us about obstetrics and gynecology in general, the psychological aspects of women's healthcare and its need for compassion and skill. Under his influence three of the six members of this group became obstetrician/gynecologists. He continued to be a mentor to me, advising, prodding and suggesting I become involved with ACOG's Indiana Section. No other single physician had a greater impact upon my career than Gardiner, yet I am but one of many this great physician so influenced.

# **ROY T. PARKER, MD, 1975-1976**

## **(b. 1920 - d. \_\_\_\_\_)**

**by Charles B. Hammond, MD, FACOG**

Roy Turnage Parker, M.D., FACOG, FRCOG (Fellow of the Royal College of Obstetricians and Gynaecologists) is presently the F. Bayard Carter Professor Emeritus and Chairman Emeritus of Duke University Medical Center's Department of Obstetrics and Gynecology in Durham, North Carolina, where he is regarded as a true Son of the South. He was born September 7, 1920, in Pinetops, a small town in rural Edgecombe County, North Carolina. He grew up in a southern Presbyterian home and graduated from South Edgecombe High School in 1937, then attended the University of North Carolina in Chapel Hill to earn an AB with distinction. He next moved to Richmond, Virginia, where he attended the Medical College of Virginia and received his MD in 1944 with AOA honors.

Having served in the United States Naval Reserve 1942-1944, Ensign Parker answered his country's call to active military duty and was assigned to an internship 1944-1945 at Naval Hospital Bethesda, Bethesda, Maryland. He then continued serving in World War II's Pacific Theater until 1946.

After World War II the civilian Doctor Parker returned to North Carolina to pursue his life's work in obstetrics and gynecology by joining Duke's Department of Obstetrics and Gynecology as a resident of F. Bayard Carter, the Department's first Chairman. During this time Parker also scheduled brief fellowships in pathology and reproductive endocrinology. After a year as Resident Instructor in Obstetrics and Gynecology he entered private practice in Kinston, North Carolina, with his brother, Sam, and several other physicians. A year later the Korean War recalled him to active duty until 1955 as Chief of Obstetrics and Gynecology, Camp Lejeune, North Carolina.

By this time Parker had decided to become an academic obstetrician/gynecologist and so returned to Carter's Department at Duke, rapidly rising to Associate Professor within two years, Professor within six more and finally Chairman by 1964. In 1970 he was promoted to the academic rank of F. Bayard Carter Professor of Obstetrics and Gynecology, a title he enjoyed until his retirement in 1990. He served as Chairman until I succeeded him in 1980.

Our relationship began during my studies at Duke University School of Medicine. Afterward I served a Duke surgery internship but decided on a residency in obstetrics and gynecology. By then Parker had essentially assumed the role of Department Chairman and Carter was expected to soon step down. Halfway through my residency Parker helped secure a position for me as a Clinical Associate at the National Institutes of Health in Bethesda, Maryland. The Selective Service System was trying to draft me into the Viet Nam War and serving as a commissioned officer in the Public Health Service certainly was more appealing than a Southeast Asia vacation. Since I already aspired to an academic career, subspecialty training in reproductive endocrinology and gynecologic cancer would eventually be necessary anyway.

The decision whether to leave Duke in mid-residency was difficult. Over breakfast one morning Parker and I discussed my disrupted training and whether a position would be available upon my return two years later, but I was bargaining with a man who was not yet Department Chairman; the search process had not even begun and nothing was certain. I'll never forget what he said: "Son, you'll have a residency training position to return to. By then I'm going to either be Chairman here or somewhere else."

Parker was eventually appointed Chairman and upon my return honored every commitment he had made to me and more. It was always obvious he would someday be a Chairman of Obstetrics and Gynecology, if not at Duke then at some equally prestigious institution. Over these years he became my mentor and helped me accomplish many things.

There were no formal subspecialty fellowships at this time but the NIH training prepared me even as a resident to attend private gynecologic oncology patients with choriocarcinoma and related diseases plus certain reproductive endocrinopathies. This made for an interesting day of seeing my private patients, being called to admit and workup faculty private patients, and attending teaching service patients who were my responsibility as a relatively junior resident. Through it all Parker steadfastly remained mentor, teacher, friend and colleague. He actually ran the training program for at least five years before my residency began while Carter remained the titular but often absent Chairman.

Parker was above all a physician who cared for his patients in every sense of the word. He knew everything about them including residential address area, hospital room number, spouse employer and family situation. He was a fair but stern taskmaster, demonstrating excellence in the care of his patients and demanding no less of his housestaff. He made three or four hour teaching rounds every Saturday morning. Woe be unto residents not as knowledgeable in their service or private patients. Despite being vigorous these were wonderful learning opportunities. He had a broad, deep medical knowledge allowing him to

practice and teach as a generalist plus as a gynecologic oncologist and pelvic surgeon. He was as good a gynecologic surgeon as I have ever seen.

I have previously referred to Parker as my mentor because it describes someone dedicated to developing a younger professional through example, emotional support, encouragement, intellectual challenge, and even financial assistance when necessary. I will be eternally grateful for his helping me enter the national obstetrics/gynecology academic and political arenas with priceless introductions, constant support and unflinching encouragement, but he also helped many others he trained or hired at Duke.

Throughout his career Parker was active in national medical politics, heavily committed to the American College of Obstetricians and Gynecologists from 1961 when he served as Assistant Annual Program Chairman until 1975 when he was its President. During the intervening years he served as Annual Clinical Meeting Program Chair, Assistant Secretary, District IV Chairman and President-Elect. He devoted himself to the College as well as many other medical societies and groups such as the American Gynecologic Club, American Association of Obstetricians and Gynecologists (President of its Foundation in 1978), and American Gynecologic Society (Council Member in 1972). The last two merged into the American Gynecologic and Obstetrical Society, of which he was a proud member.

He was also a member of the American Medical Association, American Society for the Study of Sterility (today's American Society of Reproductive Medicine), Medical Society of the State of North Carolina, North Carolina Obstetrical and Gynecological Society, Society of Gynecologic Oncologists, Society of Pelvic Surgeons, Southern Medical Association, and South Atlantic Association of Obstetricians and Gynecologists (President in 1980). He was a Founding Member of the Association of Professors of Gynecology and Obstetrics (APGO) and its President in 1969. Roy T. Parker has clearly left his mark on our discipline locally, regionally and nationally, even internationally by being made a Fellow (*ad eundem*) of the Royal College of Obstetricians and Gynaecologists. He has represented Duke University Medical Center with aplomb by serving in many roles during his career.

Parker was an investigator. In his era the bulk of medical publishing was clinical treatises and he published nearly a hundred peer-reviewed scientific articles dealing with gynecologic oncology in general, surgical treatment of gynecologic malignancies, and the use and reliability of screening Papanicolaou cervical cytology. As coauthor with many colleagues including myself he wrote superb papers on the important problems within our discipline, probably best known for his articles on anaerobic pelvic infections and gynecologic oncology. He was a gynecologic oncologist even before there was such an animal but continued to work and publish in obstetrics as well including articles on diabetes in pregnancy, uterine rupture, and hyperbaric oxygenation in the treatment of pelvic infections. After my NIH stint we published at least a dozen papers on trophoblastic malignancy, hydatidiform mole, endometriosis and its management, hormonally secreting ovarian malignancies, and menopausal management.

Parker had a strong interest in academics, publishing many articles on medical student and resident education within our discipline. He was integral to APGO's founding and development as our primary educational arm plus a driving force in the development of subspecialty fellowships. He was also a respected teacher, twice selected from among 600-700 faculty physicians by Duke's medical students to receive their coveted annual Golden Apple Teaching Award plus several similar awards from our residents. He was always a strong teacher and mentor for residents and fellows. Even after stepping down as Chairman he served as Duke's Director of Continuing Medical Education for four years. He was always well read and could lead superb teaching discussions, weaving them around the individual patient being seen.

Many of my fondest memories are of our personal relationship. Roy always had an ability to bond closely with his trainees, participating fully in their education as well as their lives. His wife, Georgia, never met a stranger. When obstetrician/gynecologists visited Duke they usually wound up staying with Roy and Georgia. She cared deeply for those within our department and could always be relied upon in moments of need. Roy also had an extraordinary way with everyone's children, a wonderful surrogate grandfather.

When my wife and I returned from NIH we decided to purchase a house in Durham. I wanted Roy and Georgia to see it before we signed the contract. We went by one evening but unfortunately I had misplaced the door key. Between Roy peering in the windows and Georgia searching my pockets for the key, their enthusiasm was infectious. I also remember the day I was appointed Chairman of Duke's Department. The Dean called my home to offer the position and within three minutes Roy ran through the front door offering his congratulations. He may have had better lines of communication than I, but he certainly was enthusiastic about the appointment.

Parker retired from our Department in 1990 and while he continued for some years to occasionally participate in rounds and teaching conferences, this finally ceased over the past few years as his health deteriorated. I never see him without his asking about the Medical Center, our Department, its faculty and his many friends. He and Georgia now live at a retirement facility in Durham. Their address is The Forest at Duke, #4049, 2701 Pickett Road, Durham, North Carolina 27705.

I hope this will help preserve the memories I and others have of Roy T. Parker, MD. Perhaps those who never knew him may in this way remember him also. He will forever be my teacher and mentor as well as my friend. I wish each of you could have someone like Roy Parker in your life.

# HAROLD A. KAMINETZKY, MD, 1978-1979

## (b. 1923 – d. \_\_\_\_\_)

by Joseph J. Apuzzio, MD, FACOG

Harold Kaminetzky received his undergraduate education at Northwestern University, afterward enrolling in the University of Illinois's College of Medicine, completing his internship at Cook County Hospital and his residency at the Research and Educational Hospitals of the University of Illinois, all in Chicago. After four years in private practice following his residency he was appointed to the University of Illinois's College of Medicine faculty, rapidly progressing to Professor of Obstetrics and Gynecology. In 1968 he was recruited by the College of Medicine and Dentistry of New Jersey, New Jersey Medical School, for Professor and Chairman of Obstetrics and Gynecology, remaining in that position until December 1984. During this time Kaminetzky also was Acting Dean of the Medical School for one year and Dean for another. In January 1985 he became The American College of Obstetricians and Gynecologists' (ACOG) Director of Practice Activities and Government Relations, remaining there until his retirement in January 1994. He has served New Jersey colleagues well as a member of the ACOG District III Advisory Council and the ACOG New Jersey Section since 1994.

Many other prestigious posts have been held such as Editor of *The International Journal of Obstetrics and Gynecology* (1968-1985) and member of the Editorial Advisory Committee of *Excerpta Medica*. He served as a member and Chairman of the Committee on In-Training Examination of the Council of Resident Education in Obstetrics and Gynecology (CREOG). He also worked on maternal nutrition for the National Research Council in Washington, D.C., and its Liaison Committee for Obstetrics and Gynecology. He is or has been a member of many other medical organizations including the International Federation of Gynecology and Obstetrics (FIGO). He has edited four textbooks and been author or co-author of over 50 articles published in the medical literature.

In 1968 when Kaminetzky first came to what was then Martland Hospital in Newark, New Jersey, as Chairman of its Department of Obstetrics and Gynecology, he headed a very small department with few fulltime attendings. Through his unflagging work and dedication quality residents as well as young attendings were recruited into the program. After the 1979 move from Martland Hospital to a new University Hospital Kaminetzky developed various subspecialty divisions within his department including an American Board of Obstetrics and Gynecology (ABOG) approved Fellowship in Maternal-Fetal Medicine. I was one of those accepted into New Jersey's first such program. The quality of obstetrical care among Newark's socioeconomically deprived population vastly improved during Kaminetzky's chairmanship as evidenced by our marked decrease in stillbirths.

I first met Dr. Kaminetzky as a third year clerk in obstetrics and gynecology at the New Jersey Medical School. One of the clerkship's highlights was attending lectures and grand rounds where he demonstrated an extraordinary ability to communicate and teach. After his lectures I had almost total recall of everything said. This was particularly true of his lecture on cervical cancer. His careful explanation and manner of presentation allowed us to understand a topic many found difficult. Dr. Kaminetzky was one of the reasons I elected to stay at Martland Hospital for my residency. His clinical expertise, national prominence, remarkable education and communication skills, plus constant encouragement and support made the possibility of working with him and his staff thrilling. After being asked to join his faculty I accepted for the same reasons. With his leadership and consent a Maternal-Fetal Medicine Fellowship followed, a tremendous learning experience with excellent teachers and clinical material.

During the 1984 ACOG Annual Clinical Meeting in San Francisco Kaminetzky called my room and asked to meet with me. When we sat down he said he was leaving as Department Chair to become ACOG's Director of Practice Activities and Government Relations. This saddened me because I had worked for or with him since the mid 1970s. Today as Vice Chair of ACOG's New Jersey Section I am fortunate indeed he is still my mentor and advisor.

# W. BENSON HARER, MD, 2000-2001 (b. 1930 - d. \_\_\_\_\_)

by André M. Kasko, DO, ACOOG, AOAFP

William Benson Harer, Jr., MD, has a record of exceptional service to the American College of Obstetricians and Gynecologists including District IX Chair, six years as national Secretary and as a member at one time or another of almost every one of its committees, task forces, commissions and panels. He is a Founder and Past President of the California Association of Obstetricians and Gynecologists, Tel-Med Corporation, and The American Society of Forensic Obstetricians and Gynecologists. I first met Ben Harer in 1994 during my obstetrics and gynecology residency at San Bernardino County Medical Center in San Bernardino, California. He was an attending there whom I soon found to be not only an extraordinary physician and educator but also an extraordinary man.

Ben was born into a family of Pennsylvania physicians and in the early 1940s his father, W. Benson Harer, Sr., MD, was Assistant Professor of Obstetrics and Gynecology at the University of Pennsylvania Medical School in Philadelphia. Ben's father wrote the University's "Manual of Operative Obstetrics", first published in 1946 with a 1963 second edition co-authored with Ben *filis*. Ben earned his undergraduate degree at Princeton University in Princeton, New Jersey, in 1952 followed by an MD degree from the University of Philadelphia in 1956, internship at Fitzgerald Mercy Hospital in Darby, Pennsylvania, and residency at The Hospital of the University of Pennsylvania while a Captain in the US Air Force Reserve, Medical Corps. Active duty followed residency including assignment to Norton Air Force Base Hospital in California as Chief of Obstetrics and Gynecology. After separation from the Air Force came private practice in San Bernardino for approximately 30 years before he joined the Medical Center's fulltime teaching faculty in 1996.

Ben's academic accomplishments alone are quite impressive. He was a Special Fellow in Pharmacology at the National Institutes of Health during 1964-65, Clinical Instructor at the University of California-Los Angeles School of Medicine from 1974 to 1976, and is an Adjunct Professor of Egyptology in the Department of Humanities at California State University, San Bernardino, in addition to co-authoring two books plus 37 peer reviewed articles including "The First Scientific Autopsy of a Mummy in 1821 and Reautopsy in 1995" (British Museum Press, London). In 1963 he co-presented a scientific exhibit entitled "Long Acting Single Shot Caudal Anesthesia of Obstetrics" at the Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in New York City.

I have from the start been tremendously impressed by Ben's accumulated knowledge, experience and expertise in all areas of women's health which he eagerly shares with residents, staff and medical students alike. He brought not only clinical experience to our program but also prestige and a nationally recognized reputation. I remember him teaching us both the basic and the complex, starting with the art of physical examination and culminating later with practical operating room instruction on total pelvic reconstruction.

Ben always stressed the importance of physical examination, personally examining every patient before approving our surgeries. He taught us how to diagnose a pregnant uterus early in gestation before ordering confirmatory diagnostic tests. Ben was a master of the colposcope as both clinician and teacher. Residents would fight to get him into their examining rooms because once there he would review their colposcopic findings and then predict the histologic diagnosis. Preoperative conferences were enriched by his presence as he explained in detail the evaluation and preparation of patients for surgery. Operations were approved only after all other therapies had been exhausted.

Operating with Ben is an unforgettable experience as he is a master of pelvic reconstruction. His influence developed whatever surgical skills I possess today and I will never forget the lessons he taught me, but his expertise is not confined to the examining room, operating suite and labor and delivery suite. His nationally recognized academic achievement is equally admired. To this day he continues to assist residents as well as staff with research activities. He frequently suggests research topics and shares specific guidelines on study design. He travels to national medical meetings almost monthly if not weekly and on his return shares all the latest clinical and technologic information. He provides copies of the latest articles on relevant cases. His administrative skills and experience are limitless while his knowledge of coding and billing abounds. He frequently advises graduating residents on employment interviews and contract negotiations.

One would be remiss not to mention Ben's longstanding interest in Egyptology. He has performed significant historical research on various subjects including mummies and donated a significant portion of his personal collection of Egyptian art to the Museum of the University of San Bernardino. He has also published articles on ancient Egyptian obstetrics such as "A Glimpse into Obstetrical Practice in A Rural Egyptian Village" (NARCE, 111, 1983) and "A Spirit of Women's Liberation, Rural Egyptian Style" (NARCE, 123, 1983). I'm one of many fortunate people taught and trained by W. Benson Harer not only in how to practice exemplary obstetrics and gynecology but also how to enjoy life.

# THE GEORGIA STATE MEDICAL BOARD

by Jeffrey D. Lane

The Georgia Composite State Board of Medical Examiners, commonly known as the State Medical Board, has undergone recent change. In 1999 the Georgia General Assembly passed legislation effective July 1, 1999, separating the Medical Board from the Secretary of State's Office.

Since the 1930s the Medical Board plus 34 other professional and occupational licensing boards operated under the Examining Boards Division of the Secretary of State's Office, sharing administrative and investigative resources with its sister boards. Now the Medical Board is an independent agency administratively attached to the Georgia Department of Community Health and has created its own force of state law enforcement agents charged exclusively with investigating the licensed as well as unlicensed practice of medicine.

The Medical Board is charged with a two-fold mission: (1) Accurately and prudently license physicians, physician assistants, respiratory care professionals, paramedics and cardiac technicians to practice in the State of Georgia and; (2) Enforce and investigate alleged violations of state laws pertaining to medical practice such as the Medical Practice Act (OCGA Title 43), the Criminal Code (OCGA Title 16) and other Georgia statutes and regulations.

A major change involves investigation and enforcement. Medical Board agents are now able to focus on the intricacies of medical practice investigation thereby increasing investigative expertise and consistency. Medical practice investigations require a broad knowledge of basic medical procedures, medical terminology, office/billing procedures, pharmacology, addiction, prescribing practices and the fundamentals of physician/patient relationships. The reorganization focused more on specialized investigation and training rather than broad, generalized operations.

When examining the Board's overall mission as stated above it is necessary to define investigation and enforcement. The Board views its investigatory mission from two perspectives, public safety and education/training. The Investigative Division of the Board considers public safety its first priority in protecting Georgia's citizens from unscrupulous, incompetent or otherwise impaired medical practitioners. It must be emphasized that the vast majority of the Board's licensees demonstrate the highest degree of competence, professionalism and compassion toward their patients, but the remaining few present potentially serious public safety concerns and can wreak havoc in patients' lives. Examples are excessive and/or criminal prescribing of controlled substances, technical incompetence, ignorance, fraud, sexual misconduct including violation of professional relationship boundaries and assault of patients, and physician addiction.

Another important investigative mission is educating and training those interested in licensees including government, non-government and public safety agencies such as local and state law enforcement officers, medical associations, healthcare entities and other physicians. It is important that law enforcement officers recognize healthcare problems within their jurisdiction early and properly address them, with outside assistance if necessary. By doing so their own investigations are enhanced as are subsequent Board investigations. Professional relationships between law enforcement agencies are vital to proper investigation. By providing education and training the Board enables its investigative staff as well as local law enforcement officers to identify and address problems before patients are injured.

Interagency cooperation and education allows a "big picture" view of cases. Given the otherwise unusual situations common to medical practice it is important that investigations differentiate an isolated incident of poor physician judgment from a criminal, incompetent or unprofessional act.

An extremely important area for education and training is physician impairment by either abuse or illegal use of substances, chemical addiction or addictive behavior. The physician, his patients and the public in general are all in great danger when he becomes addicted to or under the influence of legal substances such as alcohol, illegal substances such as cannabis, controlled substances such as narcotics, or abnormal behaviors such as obsessive gambling; injury is inevitable when judgment and/or manual dexterity are impaired. Public safety concerns demand he be removed from practice before injury occurs.

The Board helps impaired physicians by first requiring treatment and then rehabilitation. In order to return to practice it is necessary that regular and favorable progress reports be received from one's treating, monitoring and clinically supervising physicians. Many outstanding careers have been salvaged through this process while protecting unsuspecting patients. The Board makes every reasonable effort to not only identify but also assist impaired licensees, at the same time never losing sight of its public safety mandate.

The Georgia Medical Board's Executive Director manages the entire organization. The Board's members, appointed by the Governor subject to Senate approval, appoint the Executive Director who supervises the Medical Director and Director of Investigations. The first is a licensed physician acting as liaison to Georgia's medical community plus technical advisor to Board

investigations. He provides essential medical expertise and critically reviews all complaints filed with the Board plus subsequent investigative reports. He also supervises peer reviews whereby practicing physicians not affiliated with the Board or the reviewed licensees carefully examine available documents to determine whether or not alleged behaviors are consistent with or below minimum acceptable standards of care, similar to medical expert witnesses' function in allegations of medical malpractice. The Medical Director also works closely with impaired physicians in treatment and recovery.

The Board charges the Director of Investigations with the responsibility of overseeing all aspects of the investigative process from case assignment to final action. Case management, review/implementation of policy and procedure, guidance on investigative procedures and techniques, supervision of six agents, and training are among the Director's duties. He must also maintain effective communication and positive professional relationships with sister law enforcement, regulatory and healthcare agencies to facilitate effective and efficient investigations.

Investigative staff members come from varied backgrounds such as law enforcement, nursing and the military. All six agents are certified by the Peace Officer Standards and Training (POST) Council of Georgia and three are certified POST instructors. Agents have always provided seminars and training to numerous law enforcement agencies, medical associations and healthcare facilities to strengthen professional relationships. The investigative staff has an average thirteen years of experience in medical practice investigation. Their level of education coupled with their experience and diverse background creates a strong, effective team.

Though for the most part complaint driven, the board can initiate investigations based upon information of possible licensee offenses regardless of its source or method of disclosure. Complaints and information are received from a variety of sources but primarily from patients complaining of substandard care. Patients' disgruntled family members also file complaints. Law enforcement agencies across the state routinely inform the Board of suspected illegal activity by licensees and seek guidance as needed. Complaints and information also come from other licensees.

Categorization of complaints/cases is based upon alleged violations or suspected activity. The basic categories are quality of care, prescribing, sexual misconduct, impairment, malpractice settlements reported by insurance carriers, out of state disciplinary actions and fraud. The Medical Director and on occasion the Director of Investigations evaluate all complaints to determine proper jurisdiction, priority and the most expedient way to address the allegations. Upon deciding an investigation is warranted the case is referred to the Investigative Division and its Director determines proper assignment.

The case is assigned to an agent afterward responsible for complete and thorough investigation of the matter including interviewing all pertinent witnesses, collecting all necessary and pertinent evidence, and preparing a comprehensive investigation report. After investigation is complete the entire case file is submitted to the Director of Investigations for review. The Medical Director then reviews cases demonstrating possibly substandard quality of care. After the case file is fully reviewed at all levels it is presented to the Board at its next meeting.

The Board determines what action if any should be taken. The case can be closed at this time or referred for an investigative interview. An investigative interview consists of the subject of investigation (respondent) meeting with two Board members to discuss the matters of the case. Many times the case is resolved at this point. It may also be referred to the Attorney General's Office for official disciplinary action. Assistant Attorneys General in that office then draft a Notice of Hearing to be served to the respondent, initiating formal consideration of the complaint and appropriate disciplinary action if found warranted. They later serve as the state's prosecutors if criminal charges result. The hearing is convened before an administrative law judge who ultimately renders a decision after both parties, the Board and respondent, have presented their respective cases. Another effective method in resolution of complaints is issuing a consent order or consent agreement. The Board and respondent both agree to certain facts about the case and the respondent agrees to abide by specified conditions enumerated in the order. Many cases are resolved via consent orders.

Over 500 investigations are conducted each year so the Board remains extremely busy evaluating each case on its merits and seeking the best solution for all concerned. The Board meets once per month for two days. During these meetings an average of 50 cases are presented and evaluated, policies and rules deliberated, legal matters dispensed with, and a host of other important activities addressed while the Board remains constantly focused on its primary mission, public safety.

# PLAYING WELL WITH OTHERS

by Doug Daniel

I recently received ACOG Committee Opinion No. 233, April 2000 (don't ask) entitled "Ethical Dimensions of Seeking and Giving Consultation". I couldn't find much new here except I never remember previously seeing the following in any College publication or statement:

"[A]t times a consultant may be called on unexpectedly, inconveniently, and sometimes inappropriately to be involved in or to assume the care of a patient. In these situations, a physician is only obligated to provide consultation or assume the care of the patient if there is a contractual agreement or a preexisting patient-physician relationship or if there is a severe medical emergency in which there is no reasonably available alternative caregiver."

This seemed more than a little strange since I had always thought we had almost no wiggle room on refusing consultations. Certainly if a patient calls your office, requests an appointment and for any reason is refused then there is no patient-physician relationship or responsibility. I know that in some jurisdictions the relationship is considered legally established as soon as you agree to see the patient and give her an appointment. In some other jurisdictions the relationship is not recognized until you have actually seen the patient in your office. States with "Good Samaritan" laws allow patients to be treated outside the bounds of office, clinic or hospital without establishing the therapeutic relationship if an emergency poses risk of disability or loss of life. The relationship is however considered to be established if the same or later treatment is provided within one or another such healthcare facility whether or not you work there.

The same is true of consultations. Once you schedule an appointment for or see a patient in consultation, with the above mentioned caveats, they are your patient. When on call either at my hospital or under employment by another, the issues of convenience and expectation have never been an issue: if you're on call you're expected to be available. Inappropriate calls are another matter entirely. The most frequent have been instances going all the way back to residency of general surgeons being called by emergency room or attending physicians to see patients with abdominal pain suspected to be appendicitis. Too numerous to count have been the instances when the general surgeons so summoned would insist upon a gynecology consult or "screen" or "clearance" before evaluating the patient.

This attitude is understandable though not excusable since also too numerous to count have been the instances of patients with abdominal pain who were followed and treated as outpatients or admitted and treated as inpatients by non-gynecologists for "PID", only to eventually be diagnosed with a ruptured ectopic pregnancy, obvious hemoperitoneum and hypovolemic shock or ruptured chronic periappendiceal abscess, peritonitis and bacteremic shock. It's certainly easy to see how a general surgeon could get paranoid about women and their belly aches.

All of which comes to the point of this exercise: relating an anecdotal incident which perhaps could have been better managed in retrospect yet didn't necessarily reflect unethical or negligent care. Shortly after starting private practice I was called about 3:00 am one morning by the emergency room physician in my local hospital. I had already become fairly well acquainted with him and was impressed by his abilities and competence. A patient had presented to the emergency room complaining of non-specific right lower quadrant abdominal pain for the past several days with increasing intensity. Upon evaluating her via general physical examination, pelvic examination and appropriate laboratory studies the emergency physician's diagnosis was chronic appendicitis. He had contacted the general surgeon on call who listened to the history, physical findings and lab data only to inform his caller that it could also be PID. He would come in to evaluate the patient only after she had been seen by the gynecologist on call and determined not to have a gynecologic problem.

So my friend the ER physician called me, related the same information including the general surgeon's refusal to evaluate the patient, and asked that I come evaluate the patient. Upon my asking whether he thought she had acute salpingo-oophoritis or appendicitis he reaffirmed his original diagnosis. I then said, "Well, tell Don I won't come see the patient until he evaluates her and decides she doesn't have a general surgical problem." Around seven o'clock that morning the general surgeon called to inform me he had just finished performing an exploratory laparotomy upon the patient and she indeed had obvious PID as he originally contended. "Then why did you open her up?" I asked and offered to accept her in transfer for further treatment. He of course didn't have an answer for the question and wasn't interested in the offer.

# THROWING YOUR DOG A BONE

by Doug Daniel

I've written before in these pages about my strong advocacy for rectovaginal examination as a routine part of bimanual pelvic examination (See "Routine Rectovaginal Examination: Good Economics vs. Good Medicine", *The Medicolegal OB/GYN Newsletter*, Vol. III, No. 2, November 1995). ACOG Committee Opinion No. 229, DECEMBER 1999, entitled "Primary and Preventive Care: Periodic Assessments" agreed with all College guidelines and publications since 1995 in that it recommended rectal examination only for women age 50 years and older. Two more recent Opinions have changed the rules again while at the same time covering those of us who still adhere to the philosophy that bimanual pelvic examination is not complete without a rectovaginal component.

ACOG Committee Opinion No. 246, DECEMBER 2000, entitled "Primary and Preventive Care: Periodic Assessments" completely ignores annual routine digital rectal examination except for advising "digital rectal examination (be) performed at the time of each screening sigmoidoscopy, colonoscopy, or DCBE (Double Contrast Barium Enema) (beginning at age 50 years)". Flexible sigmoidoscopy is to be performed every five years or colonoscopy every ten years or DCBE every five to ten years, essentially making the minimum acceptable standard of care for digital rectal examination as infrequent as once every ten years.

But here's the bone we get thrown. The very next one, ACOG Committee Opinion No. 247, DECEMBER 2000, entitled "Routine Cancer Screening", states:

"The Committee on Gynecologic Practice recommends that every woman undergo examination of the pelvis and breast annually, beginning at age 18 years or earlier if she is sexually active. The examination also may include the skin, lymph nodes, thyroid gland, oral cavity, anus, and rectum to detect signs of premalignant or malignant conditions."

While this may seem like splitting pubic hairs, to me it is indeed heartening but at the same time disappointing. Heartening because the College is recognizing the importance some of us still place on rectovaginal examination and thereby legitimizing it. Disappointing because this importance is not recognized universally and included in the nationally applicable minimum acceptable standard of care.

Oh, by the way. This same *Opinion* also unapologetically states that "the guidelines recommending annual cervical cytology screening for most women are prudent and warranted if early precursors to cervical cancer are to be detected and successfully treated." Put that in your pipe and smoke it, American Cancer Society!









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