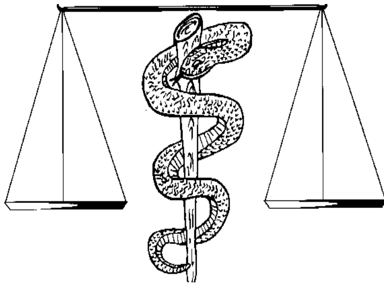
THE MEDICOLEGAL OB/GYN NEWSLETTER



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ACOG AND ROE V. WADE

by Anant R. Bhati, MD, FACOG

It was recently my pleasure to interview Richard T.F. Schmidt, ACOG's 28th President 1977-1978, as background research for a *Newsletter* Past President's Project article. Some say the most valued gifts are those least expected. During the conversation I asked Dick what College action during its first 50 years had in his opinion the greatest effect on medical malpractice or society.

Without hesitation he answered, "Undoubtedly the prominent role we played in the constitutional challenge of *Roe v. Wade*", adding he deeply deplored the predictable deleterious effect it has had upon the nation's most fundamental values. He also disclosed the process, or more accurately lack of process, by which the College became involved. According to Dick the only question ever addressed by the Executive ***Board*** was whether or not the matter should even be discussed. Unbelievably, the ***Board*** apparently never took a formal position on the primary issue.

Within weeks of Dick's becoming Treasurer in 1971 and thus taking a seat on both the Executive ***Board*** and Executive ***Committee***, then-President Clyde Randall convened a meeting of the ***Committee*** via telephone conference call for consideration of an urgent request from the James Madison Constitutional Law Institute to cite ACOG as endorsing an amicus curiae brief to be filed with the Supreme Court of the United States during its deliberation of challenges to the constitutionality of several states' abortion laws. There was no request at the time that the College be the primary amicus. The only College body then empowered to determine policy was the ***Executive Board*** but the response deadline was well before its next scheduled meeting.

During the teleconference the purpose of the litigation was described simply as an effort to bring the various states' inconsistent abortion laws into nationwide agreement. This inconsistency was supposedly posing problems to practicing obstetrician/gynecologists and their patients. Details of the brief were unknown. The question before the ***Executive Committee*** became whether the proposed brief was consistent with several College position statements on abortion previously approved by Fellowship polls.

As late as 1968 the College had officially opposed elective abortion, later to be labeled abortion on demand. After some states began liberalizing their abortion laws this position was altered with statements that elective abortion was ethically acceptable in those jurisdictions where allowed by law, adding that Fellows "should have due regard for local legal statutes and judicial decrees". Nowhere had the College proposed a change in state or federal law!

It was agreed the College's outside counsel should review the proposed brief before any further action was taken. Norman Pritchard, a distinguished and senior corporate law attorney, was to make the judgment and a majority of the ***Executive Committee*** agreed that if Pritchard found the proposed brief to be compatible with existing College positions they would approve ACOG participation. Dick chose to abstain during the vote pending availability of further information. Pritchard was given a copy of an early draft of the brief more than 30 pages long and decided its general thrust was consistent with current policies, after which ACOG's President and Executive Director formally committed the College to support the brief. The deed was done with a mere stroke of the pen.

(Continued on page 14)

THE PRESIDENTIAL BOX

by Dan Avery, President

GOOD INTENTIONS

An unusual occurrence prompted this month's musings. Names and identifying information are purposely omitted to preserve confidentiality. A young sales representative who had performed unusually well during his drug company's training program took his new job quite seriously. One of his new products to be detailed was an antitussive available in narcotic and non-narcotic formulations, both of which had similar though different fruit flavorings. Patterned on the famous "Pepsi™ Challenge", the young man decided to utilize a demonstration in his sales pitch by asking physicians to taste the product, expecting them say it tasted better than the competition. Ergo prescriptions would be written, product moved and sales quotas met or even exceeded.

One of the physicians he called upon happened to be three years into a successful recovery from narcotic addiction and obligated under contract with his physician recovery network to submit to monitoring and routine random drug screening. The previously impaired physician regularly attended his twelve step and support group meetings plus over the preceding five years had always passed his urine screens. He would never do anything to threaten his recovery, or so he thought.

Upon visiting the physician's office late one busy afternoon, the aforementioned drug rep introduced himself, described the new product and suggested the physician taste it, to which he reluctantly agreed. The various product formulations were lined up according to whether they contained the narcotic cough suppressant or not. The detail man opened one he represented as non-narcotic and offered the physician a ten cc dose, which he swallowed without thought or reservation. It was judged to be pleasant tasting, palatable, suitable for prescribing, and samples of the non-narcotic formulation only were requested. Considering his recovery status and solo office practice, the physician specifically requested that no narcotic samples be supplied.

While reading the product's informational materials the physician noticed there was a difference in flavor between the narcotic and non-narcotic formulations, i.e. the non-narcotic was orange but he remembered a cherry taste, that attributed to the narcotic formulation. Catching the rep prior to departure, he was asked if he still had the bottle proffered to the physician. He did and of course it was discovered to be the narcotic formulation. Both the physician and drug rep immediately became concerned but for markedly different reasons.

The next morning, as life would have it, the physician was called upon to provide a random urine sample for drug screening, which he did. Two weeks later he was notified it had tested positive for opiates and the laboratory had notified his licensure board and physician recovery program. He related the above story to his monitoring physician who thought it a bit bizarre but deferred a decision until the drug rep could be contacted and the scenario confirmed.

The newly initiated drug rep's major concerns were that he would be charged with supplying a narcotic substance in violation of state and federal statutes, his well-paying new job would be jeopardized or even lost, and his physician sales target would sue the rep and his company for economic damages suffered as a result of potential disciplinary actions by the licensing board. Upon seeking the counsel of his company's legal department, the rep was advised to deny everything in an effort to avoid criminal charges and civil negligence litigation against himself and the company even though the physician desperately needed corroboration of his explanation regarding the positive urine drug screen.

Physician recovery contracts vary from state to state. In this case it would have been best for the physician to immediately call his monitoring physician regardless of the time day or night, inform him of what had transpired and ask his advice for addressing the problem. By instead sitting on the problem for two weeks and hoping the error would not be caught, an embarrassing mistake became for all practical purposes a train wreck. Of course it would have been wise for the recovering physician to so inform the rep when the subject of controlled substances first came up. As of now this situation involving the federal and state criminal justice systems, the physician's medical licensure, a major drug manufacturer's reputation and the rep's lucrative career remains unresolved.

Another similar problem recently occurred in the physician's office next door. A drug rep called detailing orlistat, a prescription lipase inhibitor indicated for obesity management that works by interfering with absorption of dietary fats. Until the recent past no samples were available. My neighbor was in the operating room when the rep called but all the office employees were given sample starter kits and started taking the drug as part of their incessant efforts to loose weight. Two had past histories of significant bowel disease and therefore the drug was contraindicated.

Who is to blame here? My friend for allowing prescription samples to be left in his office and even given to his employees without his knowledge or approval? The drug rep for supplying prescription drugs? This Gordian knot of a problem also remains unresolved. I would appreciate your thoughts on these matters.

Things sure have changed since I was a kid. Back during college I made the acquaintance of a parttime coed working fulltime at a local general practitioner's office as a receptionist. She had this really neat big apothecary jar filled with brightly colored pills and capsules sitting behind the glass at the check-in window. Every drug detail man dropping by was sure to leave a generous supply of samples and ask if anyone needed prescription items, easily supplied at no cost if Doc would just sign for them. My friend would take the most colorful samples and add them to her jar. The most intriguing capsules in the jar were the timed release capsules or "Spansules" with one half of the capsule clear in order to showcase the multicolored "tiny time pills" inside. I clearly remember the big green ones with little green and white pills inside, great for dropping a few quick pounds or pulling all-nighters before exams. Only years later did I recognize them as Dexamil™, a combination of dextroamphetamine and phenobarbital no longer available in the U.S. I don't know if it was scheduled back then but suspicion it was.

If the DEA, state board of medical licensure, state board of pharmacy or local sheriff became aware of such a stash today, several somebodies would probably lose their licenses and go to jail. As luck would have it the general practitioner had exactly that experience but unrelated to the pill jar. He was indicted and convicted of trying to blackmail the police department's city councilman with an unsuccessful badger game con including compromising in flagranté photos á la Frank Gifford in an effort to extricate his twentysomething son from a major drug bust during which he had been caught with several 35 gallon plastic garbage bags full of marijuana in his apartment. Unquestionably possession and successfully prosecuted as with intent to distribute.

There's another lesson to be learned here. I've always thought a drug sample closet in the office is far more trouble than it's worth. You have to worry about expiration dates, pilferage, diversion, increased risk of breaking and entering, and you never can find what you need when you need it. Maintaining samples of controlled drugs exponentially increases the problems. There are however two exceptions. I keep a sample pack of each of my most frequently prescribed birth control pill formulations in the desk to explain proper dosing to patients. The only controlled drug stocked in my office is injectable Valium™ for office surgical procedures.

Doug

THE WITNESS BOX

by Doug Daniel, Editor

"Do that which thou oughtest to do; let the result be what it will."

Morals and Dogma of the Ancient and Accepted Scottish Rite of Freemasonry
1871

This month we gain two new members. Joe Apuzzio and Chuck Hammond accepted our offer of honorary membership while working on articles for the *Newsletter*'s ACOG Past President's Project. Both their bios are in the last issue's Witness Box. **Welcome aboard, y'all.**

The Society's annual membership meeting during the ACM was less than well attended with Dan Avery, Kenny Stall, John Wachtel, Brent Davidson and myself there. We had several visitors including Weir Horswill (one of the authors on the Past Presidents Project), an attendee interested in membership and Al Strunk. Al stopped by to join the open forum featuring John Stalmack, a defense medmal attorney from the Chicago area, and Nick Motherway, the same for plaintiff. The discussion was wide-ranging and interesting as always and we hope to have John and Nick commit some of their thoughts to paper for future *Newsletter* articles. At least the membership meeting was better attended than the Caduceus meeting we sponsored, for which no one showed up except Dan and I. The lack of adequate publicity continues to plague this aspect of our Impaired Physicians Project.

Most importantly, Sunday's 060 Postgraduate Course mock trial produced jointly by ASFOG and the American Board of Trial Advocates (ABOTA) was an historic occasion indeed as it marked the first time a national physicians' organization had presented a medmal educational program of this caliber. Although also poorly attended with only about 20 in the audience, the program was unbelievably good with probably fifteen of the country's top medmal attorneys both plaintiff and defense demonstrating why they make the big bucks. Dan Avery was the defendant, Elliot Levine the defense medical expert witness, and I the same for plaintiff in a case of preventable neonatal Group B Strep septicemia and meningitis with severe permanent neurological damage. Attendee's comments were consistently positive and even glowing while the course was reportedly the subject of table talk and hallway conversation for the rest of the week. We hope to do another one next year but only time will tell whether we get invited to the prom again.

In the last issue of the *Newsletter* I complained in "The Hot Box" about the imminent restructuring of the Bethesda System's nomenclature. Well, get ready for the other shoe to drop. Apparently the accepted nomenclature for EFM interpretation is about to change again and we haven't completely gotten over its last change fifteen or more years ago. The Gray Journal published the results of an NIH Consensus Conference in 1997 (National Institute of Child Health and Human Development Research Planning Workshop: Electronic fetal heart monitoring: Research guidelines for integration. Am J Obstet Gyn 1997;177:1385). I missed it but heard mention of it at one of the ACM Clinical Seminars. I also purchased the latest (21st) edition of Williams Obstetrics, copyrighted 2001, while at the ACM. The NIH Workshop is mentioned at the beginning of the section on EFM interpretation to establish its nomenclature being used throughout the text. To my reading it is not used consistently and therefore only confuses such interpretation, perhaps not for experienced clinicians when determining intrapartum management but certainly for less experienced clinicians and trainees.

This confusion also poses an unnecessary obstacle to qualified medical expert witnesses' for both plaintiff and defense in maintaining their credibility before juries when they inevitably become confused under cross-examination by very capable attorneys for the opposing side. The last ACOG publication on EFM interpretation was in 1995 (American College of Obstetricians and Gynecologists: Fetal heart rate patterns: Monitoring, interpretation, and management. Technical Bulletin No. 207, JULY 1995). You would think four years was plenty of time to publish accepted changes in the specialty's practice methods, especially since the College is always included in these NIH conferences. But to my reading the most current College publication on EFM is deficient in the definition and gradation of bradycardias and tachycardias, also at variance with the NIH position in several other ways. You can take this to another level entirely by considering the availability for the past three years or more of real-time recorded fetal pulse oxymetry which, if it's as good as it looks, should have already replaced EFM as the intrapartum fetal monitoring mode of choice like it did with anesthesia patients. I suspicion the clinicians, academicians and researchers on the Committee on Obstetrical Practice can't agree on the proposed content of a Committee Opinion or Practice Bulletin but we need now more than ever a clear, concise and simply presented educational monograph on EFM interpretation. According to a source at the College there's no update on intrapartum fetal monitoring in the Practice Guidelines pipeline.

The physiology of fetal heart rate and pO_2 responses to biochemical and mechanical stimuli is the same as it ever was regardless of what you call it. So are the inevitable consequences of ignoring these responses due to a lack of knowledge or concern. While perhaps an attempt to ease medmal pressures, such unnecessary restructuring of interpretative language only confuses the issue and actually presents an increased risk of suits and adverse or unjust verdicts. As long as we accept fellow physicians' ignorance of fetal physiology, ignore our patients in L&D, ignore ominous EFM tracings or pH values, and don't formally teach and test EFM interpretation, the hits are gonna' keep on coming. Intrapartum fetal pulse oxymetry won't solve the problems of to pit or not to pit and when to cut unless we have valid and easily understood criteria to aid decision-making. Even with this new and improved technology and clear direction, we've still got to attend our L&D patients and not neglect that duty by expecting someone else to do it while we see office patients, do surgery in the OR, play golf or sleep-in at home.

There's an excellent article by the College's unofficial philosopher and historian, Warren Pearse, et al, in the May Green Journal which should once and for all lay to rest female obstetrician/gynecologists' recurring complaints about being paid less than they're worth just because they're women (Pearse WH et al. Effect of gender on the obstetric-gynecologic work force. Obstet Gynecol 2001;97:794-97). To wit, "Males on average reported a 15% greater work load overall and reported an average income that was 15% higher (than women's)." So there.

And now for more on www.asfog.com. Caryl, Alan, Paul, Terry, Stratton, Jon, Maurice, Frank and Mike, thanks for dropping by. We are now getting more and more visitors from .edu, .org, .mil and .gov addresses reflecting serious inquiries (or FBI-NSA eavesdropping) instead of surfers via commercial servers (.coms). It seems the activity for the past several months has been fairly stable, so unless there's a change I won't bother you with future stats.

MONTH	VISITORS	INTERNATIONAL	SPIDERS	NEW MEMBERS
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	Ø
JANUARY 2001	400 for 2887 visits	UK (4); Canada, France and Spain 2 each; Taiwan and Peru 1 each	7 for 32 visits	Ø
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
MARCH 2001	411 for 1638 visits	UK (5); Canada (3); France and Australia 2 each; Brazil, Germany, India and Estonia 1 each	10 for 52 visits	Ø
APRIL 2001	475 for 1890 visits	UK (6); Canada (4); Saudi Arabia and Yugoslavia 2 each; France, Norway, Spain, Qatar, Germany, Croatia, South Africa, Australia and Singapore 1 each	10 for 53	Ø

So Tell Me Something Else I Didn't Already Know Department: From the 15 March 2001 issue of *Ob.Gyn.News*: "(Newborn) Circumcision May Prevent Recurrent UTIs".

For those of you who remember our July 1999 dedicated *Newsletter* issue on anti-male gender bias in employment of obstetrician/gynecologists, the front page of the *Ob.Gyn.News* for 1 April 2001 carried an article with photo about David Garfinkel's suit against his previous practice group in Morristown, New Jersey, for firing him and then hiring several female physicians as replacements. Cause for the firing was given as low productivity but Garfinkel says he was delivering more babies that any of the other six physicians in the practice. One member of the practice even told Garfinkel the dismissal was because he was "born the wrong sex". Chances for recovery are considered slim but at least the New Jersey Supreme Court will hear an appeal of two lower courts' decisions requiring Garfinkel to submit all disputes with his employers to arbitration as provided by his employment contract. On the bright side, Garfinkel has opened a solo practice in Morristown directly competing with his previous employers. Hope he kicks their ass.

For those of you seeking the latest news from the front in the abortion wars, the MARCH 2001 issue of CRLP's (Center for Reproductive Law and Policy) *Reproductive Freedom News* carried an article about Dr. Brian L. Finkel of Phoenix, Arizona.

Finkel has for the past 20 years operated an abortion clinic there, reportedly without quality problems. The problem now is that one John J. Jakubczyk, Esq., President of Arizona Right to Life, over the past several years filed six medmal suits against Finkel (all unsuccessful) and seven others against additional Arizona abortionists. You've read in these pages before about Life Dynamics, the antiabortion activist organization dedicated to suing abortionists out of business (Daniel D. "Elective abortions: Are you fer 'um or agin' 'um?" APRIL 1997, Vol. 5, No. 2, pp. 21-22, 26-27), and guess what? Jakubczyk is one of their poster boys! Finkel filed an unsuccessful complaint against Jakubczyk with the Arizona Bar Association over his costs defending baseless medmal litigation; harassment of responding to his state medical licensure board, insurance carrier and hospital; and his inestimable PR damage from the baseless medmal accusations. He then sued his tormentor in state court for abuse of process, the Arizona equivalent of barratry. Finkel lost in circuit court and at the first appeal level but with the help of CRLP et al petitioned the Arizona Supreme Court to hear his appeal on 22 March 2001. Telephone interview with Simon Heller, Esq., a CRLP litigator, revealed that the Court had not as yet rendered their opinion but there will be more to come.

And the winner of this month's Dubious Achievement Award is, (May I have the envelope, please?) me! I was quoted, after a phone interview, by a recent issue of *Ob.Gyn.News* (Vol. 36, No. 8, 15 APRIL 2001) in a front-page article on the trend toward credentialing by what I now call Basement Boards, those proliferating "professional" medical organizations similar to the Sears & Roebuck Schools of Ministerial Studies (mail-order entities that will make you a minister in their "church" with the only requirement being that your check doesn't bounce). More and more third-party-payors are encouraging such "gray" medical credentialing by paying those so recognized more than the rest of us, even to the point of refusing to approve procedure fees unless so credentialed.

Ralph Hale was also quoted from his recent editorial in the JANUARY 2001 issue of *ACOG Today* and apparently a personal interview. I mentioned Ralph's editorial in my MARCH 2001 Witness Box. Kathryn Demott, the reporter for *Ob.Gyn.News*, quoted accurately from my phone interview but left out one very important caveat: I emphasized to her that I was in total agreement with the College's position as espoused by Ralph except that neither ACOG, ABOG or any of these Basement Boards could truly attest to a physician's competence beyond a very basic level. There's just no current method of effectively evaluating a physician's technical competence except to take the word of his residency training program director. I also made some surely controversial comments on physicians getting sued for practicing over their heads and behavior modification by their inevitably skyrocketing medmal insurance premiums. If you missed it and want a copy, send me a SASE.

In this month's lead article Anant Bhati relates the story of how the College became embroiled in what has over the years become its most divisive and controversial public position, elective abortion. While at the time there was minimal opposition to becoming involved, dissent was not totally absent within the Executive Committee and Executive Board. Some of the events recounted are less than glorious and smack of smoke-filled hotel rooms and done deals, but over the years history has proven right the College's decision to become an advocate at a time when *Roe v. Wade* was in dire need of public support. Anant is a close, longtime friend of Dick Schmidt, then ACOG Treasurer and later President. He interviewed Dick for one of the *Newsletter's* Past President remembrances and was surprised when an assumedly innocuous question took the interview onto a dark and unexpected sidetrack.

Anant is a native of Jodhpur, India, and a graduate of SMS Medical College in Jaipur, India, afterward receiving postgraduate training at SMS Medical College plus London's Lewishan, Whips Cross, Hackney, Royal North and Saint George Hospitals. Upon his emigration to the U.S. he completed an obstetrics/gynecology residency at Cincinnati's Good Samaritan Hospital where he still maintains a hospital-based practice as Director of Gynecology and is a Clinical Instructor on the University of Cincinnati Medical Center faculty in addition to having a private practice. He is a member of the State Medical Board of Ohio, the Advisory Board of Mutual Assurance of Southwest Ohio and the University of Cincinnati's Board of Trustees. Special expertise includes laser and endoscopic gynecologic surgery with multiple articles and lectures to his credit.

Dan Avery's Presidential Box this month relates two harrowing tales of good intentions gone bad. Dad said many times the road to Hell was paved with such good intentions, and as usual he was right.

This month's Hot Box addresses a recent ACOG Committee Opinion on using your medical office as a retail outlet, surprising only in that this longstanding problem has never before been addressed. There's also some comments on similar direction from the North Carolina Medical Board.

In this month's Litter Box I vent some steam concerning the continued pussyfooting on obstetrician/gynecologist gender issues ranging from medical students to senior attendings. You don't have to agree with me but at least give it some thought and let me know your conclusions.

This issue contains another five articles in our series on ACOG Past Presidents. Weir Horswill's first contact with Ralph Emerson Campbell, ACOG's sixth President, was as a medical student, later as a resident and afterward remaining an obviously close and dear family friend for the rest of Campbell's life. Weir holds a BA in Zoology and an MD, both from the University of Wisconsin-Madison where he completed his residency following internship at Ohio's Toledo Hospital. While in private practice he was a Clinical Associate Professor at the UW Medical School. He has an abiding interest in amateur sports and served as team physician for numerous high school, AAU, UW and other college sports teams. In September 1995 he was a Ringside Physician at the U.S. Boxing Team Final Trials for the Pan Am Games. He served in the US Navy enlisted ranks during World War II as a

Pharmacist Mate 2nd Class and Laboratory Technician. In the 1930s he formally studied art for four years and was an accomplished trumpeter in high school, college and the Navy. Today he pursues a longstanding interest in photography while traveling widely and frequently.

Ed Hill introduces us to R. Glen Craig, ACOG's eighth President. Ed was one of Craig's residents at UCSF during the 1950s and apparently knew him quite well. A graduate of George Washington University's undergraduate school in Washington, DC, Ed also attended its medical school after a respite for a year's work at FBI Headquarters during the Hoover dynasty and then two years as Administrative Assistant to U. S. Senator D. Worth Clark. Armed with his MD, Ed completed internship at King County Hospital in Seattle, Washington, before serving two years as a United States Air Force flight surgeon. Residency was with Craig at the University of California-San Francisco. Unusual at the time, Ed spent 1964-1965 studying gynecologic malignancies with recognized experts in Austria, Sweden, France and England. Another year's study 1982-1983 under similar professors at Harvard and Stanford Universities plus England's Middlesex School of Medicine and the University of Manchester only expanded his knowledge and expertise in gynecologic oncology. Since 1954 he has been on the academic faculty at UCSF where he is now Professor Emeritus.

Ed is a Past President of the San Francisco Gynecological Society and the Pacific Coast Obstetrical and Gynecological Society. He was a member or the Ad Hoc Advisory Committee on DES, State Department of Health Services 1976-1985 and the Editorial Board of JAMA 1980-1989. He has published extensively in the peer reviewed literature, textbooks and popular medical press.

Fredric Frigoletto was a resident at Harvard Medical School-Massachusetts General Hospital-Boston Hospital for Women under Duncan E. Reid, ACOG's 17th President, and probably was closer to Reid than anyone else as they worked together there over the following years. Freddie holds an AB from Brown University and an MA from Boston University, both in psychology, plus an MD also from Boston University. His postgraduate training consisted of two years in surgery at Boston City Hospital and three years in obstetrics/gynecology at Boston Hospital for Women, now The Brigham and Women's Hospital. He has held academic appointments at Harvard and its associated hospitals since completing his training there in 1967 and is currently Charles Montraville Green and Robert Montraville Green Professor of Obstetrics and Gynecology at the Harvard Medical School, Chief of Vincent Memorial Obstetrics Division-Massachusetts General Hospital and Vice Chairman of its Obstetrics and Gynecology Service. Both Reid and Freddie were William Lambert Richardson Professors of Obstetrics at Harvard as well as ACOG Presidents.

Freddie has served the specialty well during his academic career including a term as ACOG's 47th President 1996-1997, Examiner for the American Board of Obstetrics and Gynecology 1981-1997, member of the Association of Professors of Gynecology and Obstetrics' Council 1988-1990, and Chair of an NIH Consensus Development Conference on Diagnostic Ultrasound Imaging in Pregnancy. He has over 200 publications to his credit.

Steve Ory was a resident under 40th ACOG President George D. Malkasian at the Mayo Clinic Graduate School of Medicine in Rochester, Minnesota, still considering him a close friend and advisor. Steve holds a BA from Washington and Lee University in Lexington, Virginia, an MD from Baylor College of Medicine in Houston, a residency certificate from the Mayo's and completed his fellowship in reproductive endocrinology and infertility under Chuck Hammond at Duke. He has been on the faculty at Duke, Northwestern, Mayo's and the University of Miami (Florida) in addition to having a private practice. Currently he is an Associate Clinical Professor at Miami. Steve's been heavily involved with the College's educational programs as a member of the Committee on Technical Bulletins; contributor to Précis IV, V and VI; and member of the Prolog Task Force. He either is or has been a member of the editorial boards of *Obstetrics and Gynecology*, *The American Journal of Obstetrics and Gynecology*, *Advances in Contraception*, *Mayo Clinic Proceedings*, *The International Journal of Gynecology and Obstetrics*, *The New England Journal of Medicine*, *The International Journal of Fertility*, *Adolescent and Pediatric Gynecology*, *The American Family Physician*, *The Journal of Reproductive Medicine* and *Fertility and Sterility* in addition to serving as Assistant Editor of *Fertility and Sterility*. Steve is so widely published and recognized as a medical researcher I won't even try to summarize his achievements.

Peter Greenspan has known James P. (Boss, Chief) Youngblood, ACOG's 49th President, since 1984. Reading his loving tribute to Youngblood, one can't help but recognize the close professional and personal relationship they share. Peter holds a BA in Chemistry from the University of Missouri-Kansas City (UMKC) and a DO from the Chicago College of Osteopathic Medicine where he completed his Osteopathic Medicine Fellowship and Rotating Internship. As you will see, his obstetrics and gynecology residency was at UMKC where he and Youngblood first met.

Peter is currently Associate Chairman and Assistant Professor, Department of Obstetrics and Gynecology, UMKC School of Medicine and Director, Obstetrical and Gynecological Consultative Service, Truman Medical Center-Lakewood. He is also an Instructor in Obstetrics and Gynecology, University of Health Sciences-College of Osteopathic Medicine in Kansas City. Peter holds the unique honor of being an Elder and Past Member of the Board of Outreach at Timothy Lutheran Church in addition to being qualified as a High Holidays Lay Cantor for Or Ha Olam Messianic Congregation and a Ritual Circumcisor (mohel) for the Messianic Jewish Community, all in the greater Kansas City area.

There's a reprint from the *Medical Sentinel*, official journal of the Association of American Physicians and Surgeons, by Michael E. Aubrey, MD, a Canadian physician, entitled "Canada's fatal error - Health care as a right (Part I)". While you may

have little interest in things Canadian beyond Molson's Ale or LeBlat Blue, Aubrey clearly shows the error of our ways in having declared healthcare a right to be guaranteed by government and its agencies. While returning to the good old days of the relatively unrestricted, entrepreneurial practice of medicine is about as likely as a *People* cover shot of a balding George Clooney, we can refuse to be the instrument of our own destruction and withhold our participation from socialized healthcare schemes. There's still nothing better for all concerned than the pure, uncluttered, patient-physician therapeutic and fiduciary relationship.

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

19 MARCH 2001

Dear Doug,

I enjoyed reading the March issue of the *Newsletter*. I learned a lot about the "giants" of our field, especially J. Robert Willson, MD. FACOG, my Chairman at Temple when I was a medical student in 1965. Thoughts of Dr. Willson bring fond memories to this old brain. The same can be said for Hal Kaminetzky. It made for pleasant Sunday reading.

Washington Hill

26 MARCH 2001

Dear Washington,

Thanks for your letter. Sometimes I get misty just editing the pieces sent in for the Past Presidents Project. Glad I could contribute to an enjoyable Sunday afternoon.

Doug

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08 APRIL 2001

Dear Doug,

A few observations on the March *Newsletter*. John Tynes' article on lack of expertise in neonatal intubation made me wonder what these colleagues will do when eventually confronted with a depressed newborn in a dark delivery room with only one nurse in attendance while the respiratory therapist is next door sucking out a meconium-clogged airway and the on-call anesthesiologist is just starting an emergency Caesarean section two doors down the hall. Your comments on the conundrum of earlier newborn survivals and late second trimester elective abortion made me think perhaps someone should study why these late elective abortions become necessary in the first place.

As for your "Suggestion Box" on the urologist who opted out of his managed care commitments, why would someone who studied during high school when others were riding around looking for trouble; studied even more during college when the same ones were driving around finding trouble; studied during medical school after giving up all thought of ever getting into any trouble; and worked 36 hours without sleep every other night or so during a residency jump out into the real world and see 80 patients a day just to make those trouble-seekers wealthy beyond belief?

And while we're at it, the article on the new and improved Bethesda System really frosted my pumpkin. If I changed my name to Elizabeth, do you think they'd make me Queen of England? A cytology slide is a cytology slide is a cytology slide. Changing the words or categories used to define it only makes for future department chairmen and confuses everybody else. If we mismanaged abnormal pap smears using the old system, I don't think this new system is going to help much.

A final note on redecorating one's office. Give me a break. Patients will surely know why you raised their office visit charges. And carpets take too long to vacuum, are filthy, and provide a reservoir for moulds and other allergens. Anyway, who's going to water all these new plants? My patients just love my 30-year-old wallpaper.

Jo Hall

13 APRIL 2001

Dear Jo,

Thanks for your letter. Nothing warms the cockles of my cold, cold heart like readers' responding to the *Newsletter*. Keep it up.

Doug

THE HOT BOX

Y'ALL WANT FRIES OR A PIE WITH THAT?

by Doug Daniel

Back when I was just a pimply-faced teenaged clerk working Saturdays and Christmas holidays in the local dry goods store's menswear, boyswear and shoe departments, I had quite a knack for increasing my sales with suggestions. Somebody would come in for a tie and I'd suggest a matching pair of socks. Need a new dress shirt? Take a look at these suits we just got in. Simple, appreciated if done properly, and guaranteed to ring the register. Over the years I've seen many physician colleagues, though thankfully few obstetrician/gynecologists, use their offices as local retail outlets for any number of pseudomedical products such as herbal remedies, nutritional supplements and weight loss aids, even AMWAY™ and NUTRALITE™. Add to this the countless television ads and infomercials featuring what are represented as legitimate physicians urging you not to miss this extraordinary limited time offer and you've got a real problem. This always troubled me because I knew first of all these products were heavily marked up and secondly were probably touted by the occupants of the offices, perhaps even for unproven health claims. Don't get me wrong. I've got nothing against someone making a decent profit or comfortable living in the proper circumstances but it seemed to prostitute our fiduciary patient-physician relationship to suggest patients buy from us probably worthless nostrums at inflated prices, at least presenting the possibility of an unnecessary conflict of interests. It only became worse when we recruited our patients for pyramid and Ponzi schemes such as AMWAY™ and chain letters.

For hundreds of years prescribing physicians were also compounding pharmacists, mixing up various individualized medicines in their offices as patients waited to pay their bill. One of the last to do so lived and practiced until about fifteen years ago in an isolated coal mining town approximately 30 miles from where I currently live. While physician ownership of retail pharmacies, especially locating a retain pharmacy in one's office building, has been verboten by the AMA for years, we all have maintained an office inventory of injectable medications and difficult to find specialty devices such as pessaries and IUD's which were recommended or prescribed to patients when appropriate and added to their bill. And there was a reasonable markup. Never was anything wrong with that and there still isn't, but you should carefully read *ACOG Committee Opinion No. 254, April 2001* entitled "Commercial Enterprises in Medical Practice: Selling and Promoting Products".

> "Sale or promotion of products by physicians to their patients is unethical, with some exceptions, in either clinical sites or other places…whether conducted in person, by telephone, or by written solicitation. The following activities are considered unethical,
>
> - Sale of prescription drugs to be used at home
> - Sale or promotion of nonprescription drugs
> - Sale or promotion of presumptively therapeutic agents that generally are not accepted as part of standard medical practice
> - Sale of non-health-related items, such as household supplies."

There're some others but you need to read the whole Opinion. There're also exceptions such as those noted above and Girl Scout Cookies.

The North Carolina Medical Board thought the subject serious enough to issue a new Position Statement in its *NCMB Forum* , Volume VI, No. 1, 2001 including the following advice:

> "The physician-patient relationship constitutes a fiduciary relationship between the physician and the patient in the strictest sense of the word 'fiduciary'. In this fiduciary capacity, physicians have a duty to place the interests of their patients above their own financial or other interests. Inherent in the in-office sale of products is a perceived conflict of interest with regard to physicians' fiduciary duty. Further, the for profit sale of goods by physicians to patients raises ethical questions that should not intrude on the physician-patient relationship, as does the sale of products that can easily be purchased by patients locally."

There's a warning against having exclusive distributorships and your own name branded products such as "Dr. Daniel's Magic Elixir of Youth, Mammary Enhancer, and Sexual Performance Turbo Boost". Something tells me there's millions to be made at $25.00 a pint by bottling water out of the Buckhannon River and labeling it as such. Licensees are also warned not to sell any non-health-related goods out of their offices or other treatment facilities, with the above exception for Girl Scout Cookies and such.

So if you're one of Amway's Diamond Circle Members, make a choice between selling Pap smears or laundry detergent to your patients and throw out that Nutralite™ display. It may be a nice way to make each month's payment on the Lincoln but you're using your patients for unethical personal financial gain. Copies of the Committee Opinion are available from the College Resource Center at 800.673.8444, ext. 2573 or with a SASE to the ASFOG offices. For copies of the *NCMB Forum*, send us a SASE.

THE LITTER BOX

AIN'T SHE SWEET

by Doug Daniel

The March 2001 issue of *ACOG TODAY* was essentially dedicated to the "problem" of gender percentages among physicians in general, more especially obstetrician/gynecologists in practice and training, most specifically the ACOG Fellowship and its leadership. Your *Newsletter* made a detailed examination of this question in its dedicated issue of July 1999 (Vol. 7, No. 3) with a lead article by Michelle Curtis on discrimination against male obstetrician/gynecologists applying for training or employment, a book review by Diane Colgan of Walking Out On the Boys recounting a female neurosurgeon's experiences with gender bias and discrimination both personal and professional as a general surgery and neurosurgery resident and even as an attending/professor, an article by Dave Morrison and Vanessa Goddard on the legal ramifications of gender bias in the workplace including employment and deployment, an article by Jim Nocon and others on gender discrimination against male medical students rotating through a university department of obstetrics and gynecology, and an article by Bob Berkowitz on blatantly and subtly biased gender language in help wanted advertisements for obstetrician/gynecologists.

Yes, I can remember when as a resident we had our first female medical student in the history of Bethesda's Department. Shortly after I left it had its first female resident. I've told you before about the extremely high personal regard and professional respect I had for Diane Colgan as a general surgery resident one year ahead of me there. And yes, I remember taking my written boards in the company of only one or two females, a few middle easterners and no blacks plus taking my orals without seeing any females or blacks for the whole day except the Conrad Hilton's housekeeping and front staff. I was ecstatic when Louella Kline was elected ACOG President, no less so six years later when Ezra Davidson was elected President after serving several years as Secretary.

But I don't like quotas. I don't like somebody or some body arbitrarily deciding what percentage of anything should be male or female, black or white, gay or straight, Christian or Jew, American or Mexican, etc. And I don't like stereotypes. I don't like qualified male nurses being refused training or employment as obstetrical nurses or certified nurse midwives just because some sexually hung-up egocentric prima donnas think these medical professionals can't look at their genitalia without wanting to jump their bones. And I don't like male medical students being discouraged from applying to obstetrics/gynecology residency training programs or male obstetrician/gynecologists being refused employment because some narrow-minded feminist nazis have implied, even blatantly stated, that males aren't genetically capable of delivering women's healthcare as well as females because God didn't grace them with vaginas and uteri. Jesus, Mary and Joseph! I've never had AIDS and desperately hope I never do, yet when working in New York City was judged perfectly capable of caring for many HIV positive patients!

Female obstetrician/gynecologists used to be assumed by their male colleagues to be lazy, whining, complaining, uncommitted, male-bashing lesbian ice queen bitches, and over the years I have worked with a few who would have met maybe one or two of these criteria but never all. Many female obstetrician/gynecologists I've had the pleasure of working with have become close friends and confidants, impressing me with their commitment to give all their patients the best care possible and apparently accepting me as their equal colleague and I them. I've also worked with some males who were egocentric, never satisfied, constantly kvetching, lacked incentive, demonstrated an apparent dislike or at least unconcern for their patients, and preferred their own sex for physical intimacy. Some even displayed most of these traits concurrently.

Bottom line? Barr bodies have absolutely nothing to do with how good a physician, nurse, medical student or resident you can be or are for patients either male or female. These capacities and abilities are developed based upon your humanity, intelligence, experience, educational and training opportunities, role models and mentors, values, and professional ethics. They are also impaired by your ignorance; bias; prejudice; fear; sense of inadequacy or incompetence; abuse by superiors, colleagues or subordinates; and envy. Sex has absolutely nothing to do with most of these and for those that have in the past been gender dependent such as professional opportunities and abuse, changes must be made.

It would be a mistake in my opinion to try socially engineering or manipulating the Fellowship's composition by interfering with medical school career counselors or residency training program candidate selection committees. Let the numbers fall where they may. We didn't reach this imminent female majority of Fellows by playing with numbers and percentages, we got here by recognizing the inherent unfairness of not allowing women the same opportunities as men, instead recognizing ability and encouraging performance regardless of genital anatomy. And that's where we should leave it.

In case you're wondering, the inspiration for this piece came from a quote in one of *ACOG Today*'s articles attributed to Junior Fellow Advisory Council Chair Erin E. Tracy, MD, MPH:

> "We plan to place more emphasis on mentoring and to make sure that mentors know how important it is to try not to discourage males. We also hope to recruit more males through the Medical Student Initiative. Another possibility is approaching CREOG to work on this problem together."

I suspicion Erin is a female but that's unimportant. It is regardless unacceptable not only to condone but to even accept any arguments, decisions, policies or positions based upon physician gender. Political correctness expects us to advocate equal rights for women even if at the expense of equal rights for men. This is not an issue to be lightly addressed by "emphasis on mentoring" or stressing that mentors "try not to discourage males". It demands a policy of zero tolerance without exceptions. To do less will sully our previously hard-won reputation as the leader in eliminating gender bias against women from our area of medical practice.

ACOG AND ROE V. WADE Continued From Page 1

Dick soon discovered the eminent-sounding James Madison Constitutional Law Institute was actually a front organized for the sole purpose of contesting restrictive abortion laws. Its membership consisted of one Roy Lucas, Esq., attorney for both the American Civil Liberties Union (ACLU) and the National Abortion Rights Action League (NARAL). Following the Court's *Roe* decision the "Institute" disappeared forever.

Unable to obtain a copy of the brief from any College source, Dick privately sought the counsel of a Northwestern University professor of constitutional law. The professor rendered an extensive opinion essentially stating that considering existing College policy, allowing use of its name in support of the brief would be a "serious error".

Dick became even more concerned after receiving the professor's opinion and tried to present this additional information at subsequent meetings of both the ***Executive Committee*** and ***Executive Board*** while there was still time to withdraw College participation. At the ***Executive Board*** meeting the only action allowed was voting on a motion to approve the action of the ***Executive Committee*** (and of the President and Executive Director) without discussion. A secret ballot passed this motion thirteen to four, thus effectively blocking any discussion of the basic issue.

In subsequent phone conversations and correspondence Pritchard told Dick it was always his impression that from the beginning the ***Executive Committee*** thought the College should be involved in the case and his only task was to justify this position by finding support for the brief within extant ACOG policy statements. Pritchard made it clear that no one ever asked his advice as to whether the College should allow use of its name as a principal on the amici briefs, adding had he been so asked he probably would have advised against it.

The cover of the *Roe* brief's final version proclaimed in large type that it was the amicus curiae brief ***of*** the American College of Obstetricians and Gynecologists. The College became not only *Roe v. Wade*'s principal amicus but also was similarly identified in *Doe v. Bolton*, the companion case. Together they ran over 150 pages, presenting not only legal arguments but also extensive medical testimony and rather loosely constructed clinical data, much of which could not be substantiated. It was of the greatest concern that no member of the College, no member of its ***Executive Board*** nor any member of its administrative staff saw the medical testimony prior to its publication!

Dick says he is asked even today how he could become ACOG President with his well known and steadfast opposition to the College's actions regarding this critically important women's health issue. It is still his impression that Fellows' opinions on abortion then were much more diverse than the College's consistent advocacy indicated. There was also no motivation to punish colleagues who followed their convictions. Unfortunately he thinks this is no longer necessarily true.

RALPH E. CAMPBELL, MD, 1955-1956
(b. 1898 - d. 1970)

by C. Weir Horswill, MD, FACOG

Ralph Emerson Campbell was a Founding Fellow of the American College of Obstetricians and Gynecologists and served as its sixth President. He was born in Cherry Valley, New York, and held an undergraduate degree from Dartmouth College plus an MD from Northwestern University. Residency training programs during the 1920s were not the prescribed, time-limited continuum they are today. In that era it was necessary to spend a year at several institutions of the highest reputation in order to get the best training. Campbell's specialty training in obstetrics and gynecology was at King's County Hospital, Brooklyn, New York; the Chicago Lying-In Hospital; Johns Hopkins Hospital and the Royal Victoria Hospital in Montreal, Canada. In 1928 he moved to Madison, Wisconsin, to accept a professorship in the University of Wisconsin Medical School's Department of Obstetrics and Gynecology.

Aristotle, Benjamin Franklin and Ralph Waldo Emerson unknowingly though credibly described modern residency training. Aristotle said, "What we have to learn, we learn by doing." This speaks to the Positive Teaching aspects of residency such as learning surgical skills. Benjamin Franklin said, "The things which hurt, instruct." This speaks to Negative Teaching such as learning from one's errors, lapses and blunders as well as those of others. Ralph Waldo Emerson addressed a third and oft ignored aspect of education with, "You send a boy to school but 'tis the school boys who educate him. You send him to Latin class, but much of his tuition comes from the shop-windows." This speaks to the fact that there is much peripheral education in medicine such as the kindnesses, encouragements and reassurances that must be part of successful patient care. Some teachers provide these neither to their patients nor to their students. Campbell, on the other hand, owned many shop-windows.

Our first meeting was in 1950 during his third year medical student lectures as Vice Chairman of the University of Wisconsin's Department of Obstetrics and Gynecology. Our class disliked him as a lecturer and our favorite derision was discussing his lecture entitled "Twenty-Two Reasons For Uterine Bleeding" in which after an hour he would only have covered the first three. We were thus unwittingly forced to read the textbook before taking our examination.

Following internship I was a general practitioner for three years before deciding further training was needed. My choice was obstetrics and gynecology. Wisconsin's former Chairman had died and Campbell was Temporary Acting Chairman. During the application visit to Madison I was impressed by his scribbling my name on a scrap of paper and stuffing it into his billfold, already crammed with previous scribblings. I miraculously was selected for the residency and began 1 July 1956 with the permanent Department Chairman having arrived only four days earlier.

Our new Chairman totally revised the residency training program and for the first time used all three of Madison's hospitals for teaching. I and the other residents immediately recognized him as a superb surgeon in a class by himself. When my mother needed gynecologic surgery I insisted she see our Chairman.

She knew of Campbell from the comments of several close friends who were patients. They frequently mentioned his warm and caring personality while evidencing an obvious, deep appreciation of his care. This impressed my mother. She liked Campbell although she never saw him as a patient. She met him during her subsequent hospitalization and later told me, "Dr. Campbell is a very nice physician, but that other guy I had is a cold fish."

Campbell was a man of only average teaching and surgical skill but a leader in the marathon human race of interpersonal relations. His clinical reputation extended beyond Madison and the jewel in its crown was his warm personality.

Four months into residency a most unusual experience occurred while I assisted Campbell with a primary Caesarean section. Our new Chairman had decreed that no longer would sections be performed in University Hospital's far distant surgical suite; one of our two delivery rooms was to be used instead. For a period of time everyone including nurses, obstetrics and anesthesia residents, and medical students was expected to attend each Caesarean delivery to become familiar with the new milieu. The additional people in attendance would sometimes number as many as twelve or fifteen.

Upon completing surgical scrub I with difficulty made my way through the crowd and walked around the operating table to stand at the patient's left side as this was the only unoccupied space of adequate size to allow gowning and gloving following my surgical preparation of her abdomen. I finished draping the patient shortly before Campbell appeared in the doorway with his hands held up before him dripping water and scrub soap. "Do you plan to stand on this side (patient's left) or that side?" I asked, pointing to her right side. I knew Campbell always performed gynecologic surgery standing at his patient's left but was unaware if he changed sides for Caesarean sections. "I always stand on this side," he answered curtly and pointed to her right, so I remained on her left while completing his sentence in my mind with "… the right side, when doing Caesarean sections."

Anesthesia was induced and Campbell made a vertical lower abdominal incision with uneventful entry into the peritoneal cavity. He palpated the large, term uterus and loudly announced, "It's pocketed! It's pocketed! I've never seen anything like this before!" As an inexperienced four-month-old resident I was sure this would be an invaluable learning experience. He asked me to feel behind the uterus but all I could find was normal gestational uterine anatomy. He then asked, "Did you feel it?", to which I replied, "No." He again asked me to feel the "pocketing" but I was stopped by the Chairman of the Department of Anesthesia, our anesthesiologist, who said, "Gentlemen, let's get moving. This mother and her baby are both getting the anesthetic."

Then Campbell elevated the umbilical apex of the incision with his left hand and gruffly demanded, "Give me some retraction!" I already had my retractor on her symphysis but he repeatedly demanded more retraction. Thinking my tension on the retractor to be inadequate, I pulled even harder, slightly moving the entire patient down the table. Either ignoring or not seeing this Campbell angrily yelled, "Are you going to help me or aren't you?". Resurrecting my old bark from Navy boot camp company commander days, I pointed and said in a very loud, distinct voice: "Dr. Campbell, there is the retractor on the patient's symphysis, there are her feet, and there is the anesthesiologist standing at her head. What further should I do?"

Campbell angrily glared at me eyeball-to-eyeball for what seemed an interminable few seconds. He then backed away from the table and bent over to look at its pedestal visible below the drapes. After another few seconds he straightened up and announced, "I thought I was operating in the other room."

As the section proceeded uneventfully with Campbell operating from the patient's right, a first for him, you could have heard a pin drop. Afterwards he made no comment to me and promptly exited the suite. After completing the usual postoperative responsibilities I searched for him to apologize for my outburst but to no avail.

This represents the acme of Negative Teaching. It permanently imprinted me, but with a positive lesson. Whenever I subsequently have entered an operating room my focus, my only focus, has been to greet and reassure my patient, greet my anesthesiologist, peruse the room and instruments, notice which scrub nurse is on the case and check whether my assistants are scrubbed. I forever appreciated Campbell for his in-depth lesson in operating room procedures and risk management which reverberated for years. Over the next fifteen years total and complete strangers would approach me at state and even national medical meetings, always with the same comment: "Do you recall a Caesarean section with Dr. Campbell back in 1956? I was in the room when …."

Another delivery was also of note. The patient was in stirrups and Campbell, scrubbed, gowned, masked and gloved, was seated between her knees on a stool. I also was scrubbed, gowned, masked and gloved, standing immediately behind him. During a lull between contractions he leaned forward to closely inspect a mole on her perineum. The next contraction suddenly began and she simultaneously gave her greatest expulsive effort, emptying her bladder in a short shot straight onto Campbell's forehead with urine running down both sides of his glasses and mask. I quickly blotted the excess from his face as best I could with a sterile towel and a nurse changed his mask while another dried his eyeglasses. Again, Negative Teaching with a positive denouement.

Ever after I strictly obeyed this rule: Always maintain your chin above the level of the patient's symphysis. This worked well over the years as fusillades of amniotic fluid, urine, postenema feces and postplacental blood were directed at me, but always striking at midsternum or below.

During residency Campbell held frequent semiprivate conversations with me in nurses' stations, hospital corridors and his office. I never questioned why though I later suspected two areas of common ground. We both had served in the military, he in the World War I U.S. Army Infantry and I in the World War II U.S. Navy, and we both had gray hair.

Later during residency I realized mother was right; Campbell was certainly no cold fish. His affable personality carried him far in friendships with contemporary leaders in his specialty, probably one reason he was considered presidential timber for their national organization.

My first year as a resident began during the latter months of Campbell's ACOG Presidency. The next year he told me in one of our private conversations of the following solecism during his Presidential Farewell Address. He was enumerating the highlights of his year as President, the pinnacle being "… the change in our organization's name, from the American Academy of Obstetricians and Gynecologists to the American College of Surgeons". Instead of applause his comment was greeted with a few audible gasps followed by scattered laughter. He had to turn to those seated behind him to ask what he had said that was so funny before he realized the gaffe. Again, Negative Teaching. Best to remain focused on all utterances whether to large audiences of national colleagues, individual patients or even one's own wife.

Dr. Carl P. Huber was Chairman of Indiana University's Department of Obstetrics and Gynecology, also preceding Campbell as second ACOG President and considered one of his closest friends. One day in 1957 I beheld on morning rounds a resplendent Campbell wearing a beautiful red plaid blazer and complimented him on it. He then related its unusual origin. At a recent meeting of ACOG officers Huber was wearing this extraordinary garment which Campbell also admired and complimented Huber on, asking where he had purchased it. Huber suggested he try it on, Campbell did, and it fit quite well.

Huber then said "It's yours", donned Campbell's dull gray tweed number, and said "Thanks for the jacket" as he walked away. Campbell was always very proud of this beautiful coat, particularly its source.

I told my wife, Jane, the story of Campbell's coat of many colors. Shortly afterward she found an attractive bolt of red plaid wool in a Madison shop-window. Despite the tight finances of raising three children on a resident's salary of $175.00/month, she scraped up enough to purchase the necessary fabric and essentials to run-up my very own beautiful, red plaid blazer on her sewing machine.

Some time later the Campbells invited us and two other resident couples to their home for an evening of dinner and pleasant conversation. I was proudly wearing my new jacket especially for the occasion when Mrs. Campbell greeted us at the door. Dr. Campbell was dressed in a dark green sport jacket, rather dull by comparison, and in another room talking with my fellow residents and their wives. Upon my entrance he immediately excused himself and disappeared for the next 45 minutes, delaying dinner. When he returned he had made a complete change of clothing, wearing his own beautiful red plaid jacket and not one to be topped by a mere resident. It's difficult to find a lesson here other than to accept life's jokes at one's expense graciously. Regardless, considerable laughter rang throughout the Campbell household that evening.

Campbell retired in 1967 and died in 1970 at the age of 73. A week later his wife, Mariel, asked me to come by for a visit. She said she wanted to give me some of Ralph's old textbooks, written in the 1920s by such as DeLee, Kelly, Williams and Eastman. Campbell's name was written inside the front cover of his copy of Williams' Obstetrics along with the inscription "July 20, 1927, The Johns Hopkins Hospital, The Night of Nights" followed by the signatures of Jerold K. (Jack) Horner, C.H. Peckham, M.J. Glass, A.H. Labenam (sic), E.E. Duncan, H.C. Alward, John L. McKelvey and A.J. Schaffer. A wonderful treasure for my library.

Life's education is a staircase, each step a training for one's next needs. Ultimately two retirements occur. First, the professional retirement from medicine and surgery. Second, life's final retirement. For the time between the two, from whence comes that education? It is provided by the many shop-windows along life's road, the best windows displaying the fundamentals of self worth, an active soul, independent thought and human kindness - the windows of which Ralph Waldo Emerson spoke.

Campbell provided such shop-windows for his residents, patients and many friends. Ralph Waldo Emerson's standards for humankind were truly displayed in the life of Ralph Emerson Campbell.

R. GLEN CRAIG, MD, 1958-1959
(b. 1897 - d. 1970)

by Edward C. Hill, MD, FACOG

Robert Glen Craig, eighth ACOG President and a true southerner, was born 29 September 1897 in Cuthbert, Georgia. He graduated from Gainesville, Georgia's, Riverside Military Academy and then attended Washington and Lee University, graduating in 1917. After a year as an Instructor at the Marion Institute in Marion, Alabama, he enrolled at the Johns Hopkins University Medical School in Baltimore, Maryland, graduating in 1922 and remaining there through his internship and gynecology residency.

Following a year's study in Europe Craig settled in San Francisco, California, to open a private gynecology practice. Initially associated with the Stanford University School of Medicine, he resigned this affiliation in 1946 to accept an appointment in the University of California - San Francisco's Department of Obstetrics and Gynecology under the Chairmanship of Dr. Herbert F. Traut of Papanicolaou-Traut fame. Craig and Traut had been schoolmates at Hopkins (Traut graduated in 1923) and were colleagues on its housestaff. Both were also graduates of military academies, sons of Presbyterian ministers, and well acquainted.

Craig was an Associate Clinical Professor, Department of Obstetrics and Gynecology, University of California - San Francisco during my residency there 1950 to 1954. By then he had been a solo San Francisco gynecologist with an office "downtown" for many years. His hospital practice was based primarily at Saint Luke's Hospital, at that time affiliated with UCSF. Our contact however was rather casual while we were both members of the San Francisco Gynecological and Pacific Coast Obstetrical and Gynecological Societies. His skill as a gynecologic surgeon was legendary, which when combined with his courtly manner, handsome physical appearance and beautifully coifed head of white hair, led to his affectionately being referred to as "The Silver Fox".

Craig, a lifelong confirmed bachelor living in a high-rise penthouse atop Nob Hill, was the envy of his peers. This apartment with terraces on two sides occupied the entire top floor of his building and provided breathtaking vistas of the whole Bay Area. From one terrace could be seen the magnificent Grace Cathedral; from the other the ornate Fairmont Hotel. Craig often dined at the Fairmont and rumor had it he purloined two large silver spoons from its dining room, modifying them to serve as vaginal retractors. He must have known that J. Marion Simms, father of American gynecology, had a century before used the same as retractors in his pioneering efforts at vesicovaginal fistula repair.

Years ahead of his time, Craig was especially remembered by fellow medical staff members at Saint Luke's for insisting his patients have steak and potatoes for their evening meal the day of surgery. For many years he contributed the leiomyomata uteri chapter to Davis' Obstetrics and Gynecology. He retired from active practice following a stroke and died 20 February 1970 in San Francisco.

DUNCAN E. REID, MD, 1967-1968
(b. 1905 - d. 1973)

by Fredric D. Frigoletto, Jr., MD, FACOG

Duncan Earl Reid, 17th ACOG President, was born in Burr Oak, Iowa, on 22 December 1905, to a mother who died during his infancy, his father dying twelve years later. Left an orphan, his grandmother and paternal aunt raised him and played a major role in his character development which he forever acknowledged. Premedical studies were at Ripon College and he earned his MD from Northwestern University Medical School in 1931. After surgical and gynecological training at St. Luke's Hospital in Chicago he finished his postgraduate education at the prestigious Boston Lying–In Hospital, the first non-Harvard resident to do so, and remained there for the rest of his professional career until retirement in 1971.

Upon rising to senior staff status following World War II he succeeded Dr. Fritz Irving as Lying-In's Chief of Staff. In 1947 he became Harvard Medical School's William Lambert Richardson Professor of Obstetrics and Gynecology and in 1948 established a three-year obstetrics and gynecology residency training program in cooperation with the Free Hospital for Women. He foresaw even then that obstetrician/gynecologists of the future would be expected to assume a greater role in global women's healthcare. Therefore, in contrast to contemporary postgraduate training programs, two years surgical and medical experience were necessary prior to acceptance into his program.

In 1959 Reid was instrumental in combining Harvard's separate Departments of Obstetrics and Gynecology into one combined Department of Obstetrics and Gynecology. In 1966 he spearheaded the merger of Harvard's two women's teaching hospitals into the Boston Hospital for Women, simultaneously becoming its Chief of Staff and heading the Medical School's newly created unified Department. Thirty of his trainees had entered academic medicine by 1970 through the financial assistance of the Josiah Macy, Jr., Foundation, including nine university professors. This was a source of great pride because he considered development of the discipline's teachers and leaders his major responsibility. As a result of these educational achievements the Macy Foundation endowed Harvard Medical School's Kate Macy Ladd Chair in Obstetrics and Gynecology and Duncan Reid quite appropriately became its first incumbent.

More than 25 years' clinical and academic experience bore fruit in 1962 with publication of his A Textbook of Obstetrics, later revised with Dr. Kenneth J. Ryan as coauthor and retitled Principles and Management of Human Reproduction. Its dedication to "those who work together toward achievement of the initial right of man to be born without handicap and the privilege of women to bear without injury" is a statement of Reid's professional credo. He authored or co-authored over 140 other outstanding scientific publications including studies on toxemia, pituitary extract therapy, mechanism of pregnancy-related coagulopathies, and diagnosis and management of septic shock.

Reid was a man of strong principles and deep conscience, his concern for the underprivileged frequently reflected in lectures and writings. He was undoubtedly influenced by criminal abortion's disproportionate number of maternal deaths among the disadvantaged, determining that most post-criminal abortion deaths were due to infection and its associated septic shock. He also urged considering other etiologies, especially patient-induced chemical abortifacients popular at the time such as Lysol™ and soap. These cases probably inspired him to lead the fight for liberalized laws allowing physicians to dispense contraceptive devices, counseling and treatment. He was an early advocate of women's right to control their reproduction and one cannot but note the similar issues involved in the half-century's controversy over safety of oral contraceptives and our current debate over RU486; the names may have changed but the line-ups are remarkably similar. Not surprisingly he was among the earliest to advocate availability of elective abortion upon consideration of patients' present and future medical and social situations.

Reid's activities in national medical organizations were legion, a member of at least a dozen of the most prestigious professional medical societies and serving many as their president. During his ACOG Presidency he strengthened its academic functions and focused attention on global women's healthcare. He actively urged providing adequate maternity care regardless of patients' economic status. Skilled in his specialty's art and practice, Duncan Reid was liked and respected by his students, his staff and most of all his patients. I am only one among his many admirers.

GEORGE D. MALKASIAN, JR., MD, 1989-1990
(b. 1927 - d. ____)

by Steven J. Ory, MD, FACOG

Fortieth ACOG President George Malkasian's window of opportunity for joining "The Greatest Generation" was quite small. In the closing days of World War II he joined the United States Navy at the age of eighteen, thereby delaying college for a year. Following separation to the Fleet Reserve he enrolled at Yale University as a young, focused ex-GI and after graduation enrolled in Boston University's medical school. He then went to Worchester, Mass., for internship and on to Rochester, Minnesota's, Mayo Graduate School of Medicine for residency. Uncle Sam then had need of George's services again and following residency recalled him to active duty as a Medical Officer in the United States Naval Reserve. After a second separation to the Fleet Reserve George found his way back to Mayo's and remained there for the rest of his professional career, rising through the ranks to eventually serve as Chairman of its Department of Obstetrics and Gynecology for ten years.

During this time he pursued a research interest in medical gynecologic oncology, especially ovarian malignancies. Numerous offices in local, regional and national medical societies or committees occupied his spare time. In addition to being ACOG President he has also been President of the Central Association of Obstetricians and Gynecologists, currently serving as Executive Director of the four-county Zumbro Valley Medical Society where he has championed its vaccination and smoke-free environment campaigns.

I was a first year obstetrics and gynecology resident at Mayo's when I met George 25 years ago. His foghorn voice, level gaze and totally unflappable demeanor created as strong a first impression then as they do now. My most vivid recollection of him comes from an experience early in my first year obstetrics rotation. After three months my customary first year resident's smug confidence rapidly dissipated one evening upon being called to evaluate a young woman presenting at term in active labor accompanied by her husband. A not unusual situation except that she had a history of poliomyelitis with consequent flaccid quadriparesis and respiratory paralysis, and therefore was totally encased in an iron lung. Not only was I unsure how to examine her but the very thought of possibly imminent delivery brought visions of disaster. Fortunately for us all she was one of George's private patients and after a quick phone call he appeared almost immediately. His cool, matter-of-fact approach to management of her labor and delivery made it seem business as usual.

Over the years George remained a valued and trusted advisor as my challenges became more complex, instrumental in my decision five years after residency to return to Mayo's as head of its Division of Reproductive Endocrinology. He retired from clinical practice almost ten years ago but I continue to enjoy his company socially at medical meetings and through our mutual memberships in travel clubs, still seeking his advice several times a year.

JAMES P. YOUNGBLOOD, MD, 1998-1999
(b. 1932 – d. ____)

by Peter B. Greenspan, DO, FACOG

James Peter Youngblood, ACOG's 49th President, was born in Detroit, Michigan, where his father, Frank, worked for Chrysler and his mother, Catherine, was a housewife. His only sibling, Mary Ann, is today a housewife. Education and rearing were Catholic through La Salle High School where he was active in football, rowing and Scouting. Youngblood then attended the University of Michigan (M Go Blue!) and after graduating its School of Medicine cum laude stayed for his residency in obstetrics and gynecology with the renowned Dr. Norman Miller as his Chairman.

One of Youngblood's resident comrades, Dr. Robert Kretzschmar, preceded him as Chairman of the Department of Obstetrics and Gynecology at University of Missouri-Kansas City (UMKC) School of Medicine. Dr. George Morley, a mentor, is a fellow ACOG Past President and many fellow residents achieved distinction in their own right.

Following residency Youngblood served in the United States Air Force at Schilling Air Force Base in Salina, Kansas, and afterward came to Kansas City, Missouri, in 1965 to join a very prestigious group practice. In no time at all he became one of the busiest and most popular obstetricians in the region. Over the years he was involved in many professional activities both while in private practice and during his tenure as the Chairman at Truman Medical Center including Chair of the Western Missouri Maternal Mortality Committee, President of the Kansas City Gynecological Society, Chair of ACOG's Missouri Section, President of the Central Association of Obstetricians and Gynecologists and Chair of the Council on Resident Education in Obstetrics and Gynecology (CREOG). In the interim he fathered seven children and has numerous grandchildren.

An avid outdoorsman who loves to fish, hunt and travel, Youngblood much prefers telling good hunting and fishing stories to discussing rare diseases and interesting patients. On the wall of his office suite at UMKC's Truman Medical Center hangs an unusually large sailfish he caught in the Caribbean. He's a strong supporter of his alma mater with a lithograph of a wolverine signed by Bo Schembechler hanging in his private consultation room. He also enjoys the good life, well versed in wines and frequently asked to select the appropriate libations at social gatherings.

In June 1984 the obstetrics and gynecology chief residents graduating the UMKC program didn't really concern themselves with the arrival of Dr. James P. Youngblood as the new Department Chair. They would not actually work with, for or under him but third year residents Brenda Lofton, Linda Khademol-Reza, Eugene Vanden Boom and myself were excited about finally having a leader for our Department after three years of administrative turmoil.

Since we had entered the program in July 1981 Youngblood's predecessor had resigned and Dr. Harry S. Jonas, Dean of the UMKC School of Medicine and soon to also be ACOG President, had been Interim Chair for eighteen months. Jonas did a great job but was very busy with the med school and wasn't always available. We had adjusted to the lack of leadership and awaited Youngblood's arrival with anticipation.

We really didn't know much about him other than his reputation as a very successful obstetrician/gynecologist with a busy Kansas City private practice. Jonas informed me that Youngblood had always been an excellent student of the specialty, staying current and quite well read in its literature. We residents had seen him at local professional meetings and knew he was respected by his colleagues, revered by his employees and adored by his patients.

He certainly looked the part of a Department Chair, tall and exquisitely dressed with a warm, paternal face and full head of snow-white hair. His amicability was reassuring since none of us wanted a stern autocrat or dictator in the front office. Rumors circulated about his plans to recruit faculty and pursue research grants. I wasn't concerned about research because there probably wouldn't be available time and it was only a year before I would leave for private practice.

Plans for our new faculty began even before he became Chair. Three months prior to taking over he recruited a clinically and academically outstanding perinatologist. Dr. Dev Maulik signed on and shortly thereafter a recent graduate from a large eastern program, Dr. Susan Mou, did the same.

After officially becoming Chairman a few days before the departmental New Year on 1 July 1984, he came by several times to spend a few hours getting to know the place and acquaint himself with staff and personnel. He asked each incoming chief resident to come by his office for a personal visit. The four of us individually went to see him for our private audience. He sat in a huge leather chair behind a gigantic desk, looking quite the perfectly dressed and appointed Chairman. Upon each resident's arrival he immediately rose, warmly greeted his visitor and sat with them on a couch opposite his desk to conduct the meeting more informally.

After comparing notes with my running mates we all concurred that our experiences had been largely the same. First he asked us about ourselves, then our opinions about the program's strong points, weaknesses and what we thought would improve the Department. He had a lot to learn about how to handle residents but was sincere and forthright, so we felt comfortable speaking our minds. As each meeting drew to a close he reassured us there was no longer cause for our concern because he was there to take the helm and captain the ship. He told us we would no longer be responsible for day-to-day Department operations and would be relieved of clinical and administrative managerial responsibility, emphasizing how much he appreciated our help and how well we had kept things running. All we needed to do now was be the best chief residents we could, not concerning ourselves with the distractions of Departmental management as we had without a full-time Chairman.

Each of us told him we were so relieved to have these burdens lifted, repeatedly assuring him we would gladly relinquish these responsibilities and were glad to be rid of them. Of course each of us left the office and immediately went right back to running the Department by making up schedules, putting out fires between residents, managing nursing conflicts, setting up lectures, etc., etc., etc. Luckily for all parties concerned and to their relief it took only a few weeks for him to effectively take control of his Department.

During our meeting he asked that I, as the new chief resident on obstetrics, bring him up to date on what was currently on L&D. As far as I was concerned it was a normal day at Truman, nothing at all unusual. I got out my peripheral brain, in those pre-palm pilot days a handwritten notebook, and went down the list.

We had an eclamptic patient at 28 weeks gestation with HELLP syndrome and huge uterine fibroids who was postictal from her first seizure and awaiting platelet transfusion prior to Caesarean section. There was also a patient at 34 weeks gestation in sickle cell crisis in addition to the usual number of patients in various stages of labor with or without adequate progress. Pitocin™ was flowing like the Missouri River in Spring flood. The clinic was its usual madhouse but under control. Wrapping-up and about to leave, I turned to my new boss and matter-of-factly mentioned that I had almost forgotten the patient admitted the night before with a fever. "Oh, yeah," I said, "she's from the Sudan and has falciparum malaria."

I was the only human being on the planet privileged to see the resultant priceless expression on our new leader's face, wondering what he was thinking. Could he have briefly thought taking this new position was perhaps a mistake? Was he concerned I might ask him about treating malaria in pregnant Sudanese immigrants recently relocated to the American Midwest. Maybe he was reviewing in his mind the life cycles of various malaria organisms from med school parasitology. I don't know what he was thinking and never will, but I also will never forget that expression.

He recovered from that short meeting and went on to take charge of a Department sorely needing his strong hand on the wheel. Not only did he bring it up to date, surpassing the requirements for an approved obstetrics and gynecology residency training program, he also recruited an exceptional faculty. Serious research began. Within a year our department was among the best in the University's medical and postgraduate schools.

I finished residency 30 June 1985, and the next day joined the practice of a wonderful group of physicians in Independence, Kansas City's sister city. I would never have been considered for that position without Jim's intervention. I remained involved with the Department as a Clinical Assistant Professor, mostly teaching the second year medical students in UMKC's six-year program.

During the next thirteen years we developed an even closer bond as he continued to inspire and encourage me. During the summer of 1998 I asked to take some attending call at our satellite hospital, Truman Medical Center-Lakewood. It would have been easy since I literally lived right across the street. He knew I had kids starting college and a little moonlighting wouldn't hurt me. He called three weeks later with the bad news that the budget wouldn't allow me to take call at Lakewood. He also said he was about to shock me, and he did. He offered me Associate Chair with fulltime responsibility for that Division of the Department!

After serious deliberation and prayer I accepted his offer. Once again he had given my career a boost. First private practice with the finest group in KC, then an academic appointment at a hospital with a family practice residency. I owe my entire professional life to Jim Youngblood. Not only did he set me on the right course as a chief resident, he also guided me into a wonderful private practice and then, in mid-career, brought me back to academic medicine, something he knew I had wanted all along. You may think I adore Jim Youngblood but that's an understatement. When we meet professionally I always have and will call him Boss or Chief; at social gatherings he's Dad. I even send him a card every Father's Day.

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