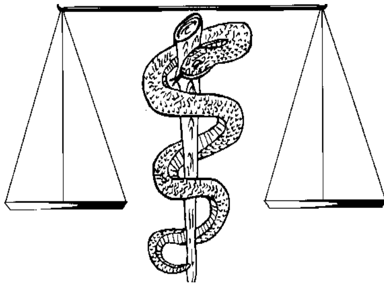
THE MEDICOLEGAL OB/GYN NEWSLETTER



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THE FASTEST MINUTES IN OBSTETRICS

by Shawn P. Stallings, M.D.

Everyone's familiar with the Kentucky Derby, the fastest two minutes in sports. This year's was the 127th running and the second fastest ever, with Monarchos outlasting the pacesetters as the crowd, sensing a challenge to Secretariat's record of 1 minute 59 2/5 seconds, held its collective breath and urged him on. This is an excellent metaphor for shoulder dystocia, one of the most heart-pounding situations obstetricians face.

The reported incidence of shoulder dystocia is 0.2% to 2.1% and can be associated with disastrous outcomes. Few cases demonstrate significant permanent motor or sensory deficits, the majority instead having normal outcomes according to APGAR scores and umbilical cord blood gases.

Sometimes we sit at the delivery table holding our breath until successful completion of a partially delivered child's birth and anxiously cheer him on until crossing some fuzzy finish line, possible permanent neurological damage or even death sometimes waiting there obscured by murky mists. More than the former's specter of brachial plexus injury, we fear central neurological injuries. Problem is, one can determine neither prospectively nor retrospectively with any degree of accuracy when these injuries will or did occur nor why or how they occur, much less how severe they will be or what degree of recovery can be expected.

Much has been written recently about prediction and management of shoulder dystocia but there's little new information on its pathophysiology. The maximum allowable interval from delivery of the head until birth without increased risk of significant fetal neurological injury is unknown. Shoulder dystocia's mechanism of fetal compromise also remains obscure and therefore makes determination of a safe interval even more difficult.

The use of biochemical markers to determine fetal status has become common over the past 30 years. In an early study Wood et al reported the rate of fall of fetal pH during normal delivery of the infant torso to be 0.14 units/min, suggesting fetal acidosis might occur with a delay in delivery as short as two or three minutes.[1.] We recently performed a retrospective study at the University of Florida to examine the relationship between increasing delay in the resolution of shoulder dystocia and declining fetal status as reflected by umbilical artery pH.[2.] Shoulder dystocia cases from 1 January 1994 through 31 December 31 1997 were identified in the Shands Hospital database. Shoulder dystocia was defined as use of ancillary maneuvers to complete delivery regardless of the head-to-body delivery interval, defined as the time period from complete delivery of the head until complete delivery of the feet. Collection of umbilical cord blood for determination of blood gases has been a standard practice at Shands for a number of years. The mean values of umbilical cord blood gases in our general obstetric population have been previously published and were used as case controls.

(Continued on page 18)

THE PRESIDENTIAL BOX

by Dan Avery, President

ET TU, BRUTE?

This month I wish to address a serious, and for me timely, problem: irresponsible and unethical testimony by medical expert witnesses. Recently I was defendant in a medmal trial during which a fellow ACOG Fellow provided testimony for plaintiff. Not in itself an unusual circumstance, but I hope his blatantly unprofessional behavior was.

Eleven years ago I was sitting in the L&D nurses' station while down the hall a fellow Fellow delivered a patient after an uncomplicated pregnancy and labor. Suddenly I heard his desperate cry for help. The uncomplicated delivery had unexpectedly become complicated by severe shoulder dystocia. After first remembering that an immediate summons for assistance was number one on every protocol for managing shoulder dystocia and then trying to remember what came next, I jumped up and ran toward the delivery room. Upon arriving I quickly applied suprapubic pressure and 30 seconds later a depressed baby was delivered. She responded well to my resuscitation and at the age of five minutes after briefly showing her to her mother I hurriedly took her to the nursery, then remained in attendance until the neonatologist and pediatrician arrived to assume her care.

The infant sustained a mild Erb's palsy but gradually improved over the intervening years. When notified the suit had been filed I couldn't understand why. I had responded to another physician's call for assistance, just as I had been taught. I had properly and successfully performed a recognized obstetrical maneuver to resolve a dangerous and unpredictable complication of vaginal delivery, just as I had been taught. I had successfully resuscitated a depressed newborn, just as I had been taught. And upon reflection I would do it all again given the same circumstances, though perhaps now with some hesitation and considerable trepidation.

The plaintiffs went through five teams of lawyers over a decade's pursuit of justice for their daughter, who by the time of trial looked perfectly normal and had no decreased physical ability except when swimming the Australian crawl and shooting from outside the three-point line. The plaintiffs' inability to show significant injury or permanent disability combined with their medical expert witness's inability to provide credible testimony resulted in the jury finding for the defense. This west coast "expert" told them I erred by not cautioning the attending obstetrician against pulling too hard on the infant's head and not advising him to cut an episiotomy. I told them the attending obstetrician was experienced and capable, a mediolateral episiotomy had been cut and the baby was delivered within 30 seconds of my arrival anyway. The expert told them how he had delivered 125 cases of severe shoulder dystocia without even a whiff of medical negligence or malpractice. My lawyers told them about his testimony in prior litigations contradicting his current testimony. I told my wife about the plaintiffs' "hired gun" seeming to make up his testimony as he went. She told me about Oprah's latest book.

Jurors in Alabama may consent to be interviewed by plaintiff and defense attorneys after trial concludes and four of ours did. They thought plaintiffs' medical expert witness was lying. They thought he contradicted testimony he had given in prior cases. My lawyers had shown them blow-ups of his conflicting testimony for almost every allegation. They, as I, thought he was making it up as he went. They also completely disregarded his testimony. I was glad though somewhat surprised the ladies and gentlemen of the jury had so easily seen through his charade, especially when he was paid almost $12,000.00 for it.

My attorneys said as long as fellow physicians continue to testify against colleagues who did their very best clinically and still couldn't reach a satisfactory outcome, our nation's medmal crisis will never be resolved. It saddens me to attend the ACOG ACM each year and see Fellows there, some on prominent display, who make the greater part of their living testifying against colleagues who did their very best. As long as the usual fee for plaintiff medical expert testimony in an obstetrical case remains more than ten times that for global obstetrical care to include 15 to 40 prenatal visits, antepartum fetal testing, laboratory determinations, ultrasound imaging, attendance during labor, delivery, postpartum care and care for all consequent complications for up to 90 days afterward, when will this ever change?

Dan

THE OTHER SIDE OF THE COIN

Dan makes an excellent point; unprofessional medical expert witness testimony is an injustice committed against falsely accused defendants; a rip-off of unsuspecting, medically unsophisticated lawyers and their clients; and an embarrassment to the rest of us. It plagues an already overburdened, clumsy and inefficient medical personal injury compensation system. But I submit the answer is not in prohibiting unfavorable testimony but in establishing a system of nationwide, unbiased peer review of both defense and plaintiff medical expert witness testimony with an eye toward identifying those who provide unprofessional, biased or simply uninformed testimony. The results of this peer review could then be provided to anyone upon request and be admissible at future trials.

I personally have great faith in our jury system. Most jurors seem quite able to smell a rat or see through a con man's new clothes. The answer is not to prohibit those with whom we disagree from testifying. This only opens us to charges of self-protection and censorship of legitimate debate in our courts. Instead we should make it easier for qualified legitimate medical expert witnesses to provide assistance to juries, defendants, and yes, even plaintiffs.

Ad hominum attacks against the opposition's messenger denigrate not only the witness but also the litigant. If all you've got to discredit a medical expert witness's testimony is whether or not he performs elective abortions, he must be telling it like it is. As medical expert witnesses, retired physicians are a mostly untapped source enriched by years of experience and education. You don't have to still be delivering 500 babies a year to spot a negligent, unqualified, uncaring obstetrician or an unsupervised inexperienced L&D nurse. Objective, critical peer review and, when warranted, factual adverse opinion is of more benefit to everyone concerned than whitewashing, lying, or "making it up as you go".

Doug

THE WITNESS BOX

by Doug Daniel, Editor

"At any one time the resources of society are finite, yet the potential demand for those resources is infinite. …Ultimately however the bill has to be paid. Even if at an individual level society wants to pretend that costs are not important, it cannot escape the fact that there is no free lunch."

Michael E. Aubrey, MD
"Canada's Fatal Error - Health Care as a Right (Part II)"
Medical Sentinel 2001;vol. 6, no. 2:57

This month we gain five new members. Honorary Member Steve Ory wrote the ACOG Past Presidents piece on George Malkasian in the last *Newsletter* and his bio is in that issue's "Witness Box". Tim Johnson wrote a similar piece on J. Robert Willson in the March *Newsletter*, bio in that "Witness Box". Tim made an unusual request. When initially offered a year's honorary membership in appreciation for his article, he said, "No, thanks anyway." Upon reconsideration he decided to accept the offer in the name of his department's library. Another milestone: our first institutional honorary member. Needless to say I was more than a little gratified by his holding our fishwrapper in such high esteem as to archive it in his departmental teaching library. David Foley (no, not that David Foley of "Kids in the Hall" and "Newsradio") is a retired gynecologic oncologist writing one of the pieces on ACOG Past Presidents. Dave is a graduate of the Medical College of Wisconsin and completed his internship at Milwaukee County Hospital followed by residency at Loyola University Medical Center and fellowship with the American Cancer Society. He currently lives in Wauwatosa, Wisconsin. Robert Knuppel and Dan Strickland joined via asfog.com. Bob practices maternal-fetal medicine in New Brunswick, New Jersey. He is a graduate of the College of Medicine and Dentistry of New Jersey with internship, residency and fellowship at Tufts University Medical School. Dan practices reproductive endocrinology in Warrensville, North Carolina. He's a graduate of my alma mater, Medical College of Georgia, with residency at Wilford Hall United Air Force Medical Center and fellowship at the University of Texas Southwest Medical School. **Welcome aboard, y'all.**

So Tell Me Something Else I Didn't Already Know Department: From the 1 August 2001 issue of *Ob.Gyn.News*: "Constipation Not Always Easy to Spot".

There was also an interesting article in *Ob.Gyn.News's* 13 October 2001 issue reporting a maternal death related to medical abortion with mifepristone and misoprostol. The patient was Canadian though there was no information regarding on which side of the border her abortionist practiced. The cause of death was clostridium sepsis, said to have been a not uncommon cause of abortion-related maternal mortality in the old days of criminal abortion. This was the first such death in more than a million recorded abortions using the mifepristone and misoprostol protocol. Unfortunately details such as whether the products of conception (POC) were spontaneously passed, incompletely passed, completely or incompletely evacuated were missing, probably for liability reasons. The known incidence of failure to spontaneously pass POC using this protocol is 5% but I've always been concerned about those patients who either don't spontaneously evacuate or evacuate incompletely and never return for suction curettage. This may have been one of those patients.

The same issue raised the question of a mild intellectual impairment syndrome related to retained IUD during pregnancy. Apparently retained Dalkon Shields® are associated with "developmental delays and academic failures in addition to spatial orientation deficits" in four adults born 26 to 29 years ago. Not only that but the guy who came up with this espoused it probably was not just associated with the Dalkon Shield® but any retained IUD. Wow! How's that for your worst medmal nightmare!

We can also thank our Canadian colleagues for the following *Ob.Gyn.News* headline dated 15 August 2001: "Report Says Breast Self-Exam Shows No Benefit". This time they're saying, "Doctors should stop advising women between the ages of 40 and 69 to perform breast self-examination, and education about breast self-examination should be limited to women who specifically ask for it." This came from the Canadian Task Force on Preventive Health Care which instead preferred annual mammography and clinical breast exams. A lack of evidence showing better survivals was used to justify the recommendation. The report also said, "BSE does not improve mortality, and it can cause harm by creating undue stress over benign growths." Yeah, right. And it's free until a patient shows up in your office asking if this lump she found is anything to worry about.

It's probably cheaper to do away with BSE but I'm not sure our patients will be any better off without it. I've always told mine they could examine their breasts better than I since they knew where the usual lumps and bumps were, therefore being more likely to pick-up any changes. Of course this depends on teaching your patients to do BSE properly and being willing to re-examine probably benign lesions in a month before resorting to radiographic or ultrasonic imaging and a surgery consult.

Our United States Preventive Services Task Force is also reviewing the matter following its conclusion in 1996 that there was "insufficient evidence" to either recommend or oppose breast self-examination.

For those searching out relevant CME opportunities, Maurice Druzin is Program Director for an ACOG Postgraduate Course entitled "Intrapartum Management" to be presented 29 November 2001 through 1 December 2001 at the Boca Raton Resort and Club in Florida. Cost is $350.00 to $750.00 depending on your College and practice status plus lodging and travel. Should be quite good with Maurice in charge.

In other member news, Ben Harer has been named President of Physicians for Women's Health, the College's political action committee, in addition to receiving an honorary Doctor of Humane Letters degree by California State University-San Bernardino, its first ever awarded. Ben was their commencement speaker but it didn't require a great deal of travel since he lives in San Bernardino. His extensive collection of Egyptian antiquities had previously been placed on long-term loan to the University's art museum.

And finally, Ray Cestero is currently serving a term on the College's Committee on Quality Improvement and Patient Safety. An article on tracking diagnostic testing results in the above referenced *ACOG Today* was credited with his assistance.

You should have already received materials from the College on cystic fibrosis carrier screening for "preconception counseling, infertility evaluation, or prenatal care". The official position is that they expect "during October Fellows will begin offering CF carrier testing in their practices". I don't know about you but to me it sounds like national standard of care. (Quotes from *ACOG Today*, vol. 45, no. 8, September 2001, page 3)

The same issue of *ACOG Today* referenced above contained an item on a recent Committee Opinion regarding fetal pulse oximetry. Now available commercially following FDA approval, the College position is measured skepticism, but it's hard to rationalize routine EFM in labor without also advocating fetal pulse oximetry. At the very least, EFM is purely subjective and pulse oximetry is purely objective. I suppose the biggest concern is accuracy but this question should be easily answered by correlating pulse oximetry determinations with fetal scalp blood gases. Considering our years of touting FSB determination as the gold standard for fetal status, the anesthesiologists' universal reliance on similar technology for their patients and its universal use in every special care unit , it seems difficult to justify a less than positive endorsement. The bottom line is that regardless of cost effectiveness, availability of fetal pulse oximetry in labor will probably become a marketing tool more beneficial to babies than birthing rooms, walking epidurals, postpartum candlelit steak dinners or hot tubs.

My solicited editorial on how we abandon proven methods of medical practice just because patients object was on the front page of Ralph Hale's *Clinical Review* issue of May/June 2001 (Vol. 6, No. 3). Seeing one's byline under such circumstances certainly necessitates an increase of several sizes in one's hat. The Society also got a nice plug and several folks seemed to like it, so maybe we'll get a couple of new members from it. Thanks for asking, Ralph.

In this month's lead article Shawn Stallings examines another aspect of the shoulder dystocia problem: How long do you have to complete a partial delivery before permanent central neurological injury to the fetus will occur? This is really the most important and most expensive question posed by shoulder dystocia and to date there has been no reliable answer. Shawn doesn't pretend to have a dead solid perfect solution to the puzzle but does give you good data and arguments to form your own professional medical opinion.

Shawn's an Honor Graduate in Biology from Transylvania University (No, not that Transylvania. Lexington, Kentucky.) in addition to having a Summa Cum Laude MD from the University of Louisville School of Medicine. Obstetrics and Gynecology residency followed at Shands Hospital at the University of Florida and now Shawn's doing a maternal-fetal medicine fellowship at Wake Forest University School of Medicine. He's already complied an impressive bibliography in the peer reviewed medical literature including articles on plastic and orthopedic surgery of the upper extremities. Don't ask. Whoever gets this guy on their teaching staff will be quite fortunate.

Dan Avery's Presidential Box this month is a Shakespearean tragedy about how it's always easier to tell the truth; otherwise you can get bitten on the butt when you least expect it.

This month's Hot Box relates the train wreck I recently witnessed first-hand while testifying for plaintiff in a medmal case. I felt like a character in one of Franz Kafka's short stories. It was really bizarre, but I'm since told perfectly reasonable. Just don't let this ever happen to you.

Our personal advice column debuts this month under the title "Dear Camilla". It's written by Camilla Buchanan who also wrote the book review of The Lesbian Sex Book in the JANUARY 2001 *Newsletter*. This time she answers a question on how to identify lesbian patients in your practice.

In the Suggestion Box this month I direct your attention to a recent ACOG *Committee Opinion* on obstetrical anesthesia. It seems the College got together with the passers of the gas and agreed if they had to stay in the hospital so did we. As usual the refusal to define critical terms in the opinion leaves it so full of loopholes you can't tell it from a piece of Swiss cheese.

In this month's Litter Box I explain why your *Newsletter* is so tardy and some other things that will change the way we were. Not to worry. We're not dead yet, just doin' poorly.

This issue contains another six articles in our series on ACOG Past Presidents. Roy Pitkin worked closely with "Wild Bill" Mengert while on his junior faculty at the University of Illinois. Mengert, ACOG's 5th President, was a primary force in founding the original American Academy of Obstetrics and Gynecology. He remained a pillar of the subsequent American College of Obstetricians and Gynecologists for the rest of his life and acted as its unofficial historian-archivist. Roy is an author who needs no introduction, but I'm going to try anyway. Best known as the Editor of *Obstetrics and Gynecology* for the past fifteen years, he holds a BA with Highest Distinction and an MD from the University of Iowa. Internship was at King County Hospital in Seattle, Washington, and residency involved a return to the University of Iowa. Two years active duty in the United States Naval Reserve Medical Corps as Chief of Obstetrics and Gynecology, Marine Air Station Hospital, Cherry Point, North Carolina, followed. After assuming Mengert's chair as Head of Iowa's Department of Obstetrics and Gynecology in 1977, Roy moved to UCLA as Chair of its Department of Obstetrics and Gynecology in 1987 and became a Professor Emeritus in 1997. In addition to the "Green Journal", he has edited *Clinical Obstetrics and Gynecology* and *Year Book of Obstetrics and Gynecology.*

Not surprisingly, Roy is a member of AOA and the Institute of Medicine in addition to having served as President of the American Gynecological and Obstetrical Society, the Society of Gynecologic Investigation, and the Society of Perinatal Obstetricians. He has served the American Board of Emergency Medicine as Director and the American Board of Obstetrics and Gynecology as Vice President and Director. Any attempt at summarizing his stellar accomplishments in the published medical literature would be beyond my limited capabilities. In case you're interested, Roy also uses green ink in his fountain pen when editing. P.S.: Thanks for the free grammar and composition lessons.

Keith Edwards first met Frank R. Lock, ACOG's 14th President, in 1951 during in his first year of medical school at Bowman Gray following graduation from the University of South Carolina, Columbia, with a BS in Chemistry. Lock was even then Chairman of Bowman Gray's Department of Obstetrics and Gynecology. After graduating Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, North Carolina, with an MD, Keith returned to Columbia for a rotating internship at Richland County Hospital and then came to West Virginia's Bluefield Sanitarium in Bluefield for his family practice residency. For the next three years he was a medical missionary to Nigeria for the Southern Baptist Convention's Foreign Mission Board, then came home to attend Southeastern Baptist Theological Seminary in Wake Forest, North Carolina, for two years and afterward returned to Nigeria as a medical missionary for another three years. In 1965 he came home to Winston-Salem's North Carolina Baptist Hospital for his first year of obstetrics and gynecology residency in Lock's program, then again returned to Nigeria for another three years as a medical missionary. In 1968 he returned to NCBH to complete his residency under Lock's tutelage. During his ministry in Nigeria he was Medical Superintendent of the Ogbomosho Baptist Medical Center and Medical Secretary for the Nigerian Baptist Convention.

After completing postgraduate training he remained with Lock for a year as an Instructor in Obstetrics and Gynecology, thereby knowing and either working for or with him over a span of nineteen years. Keith then settled in Bluefield where he is a Past President of the Mercer County Medical Society and the West Virginia Obstetrical Society, Past Chairman of the West Virginia State Committee on Maternal Welfare and the Board of Trustees for Bluefield College, and Past Interim President of Bluefield College. He has had numerous book reviews published by the *West Virginia State Medical Journal* and *JAMA* plus reviewing continuing medical education software. While well published in both the popular and peer-reviewed medical literature, Keith is a recognized professional writer for the Southern Baptist Convention's Broadman Press including Sunday School quarterlies and its daily devotional series, Open Windows. Retired from clinical practice, Keith remains active as a Rotarian and supporter of Bluefield College in addition to pursuing his third career as an author.

Wayne Workman tells us about Willis E. Brown, his residency Chairman and ACOG's 18th President. Wayne attended the College of the Ozarks and Arkansas A&M for undergraduate work between 1940 and 1946 including three years off for active duty with the United States Naval Reserve in the Pacific Theater during and immediately after World War II. He holds an MD from Little Rock's University of Arkansas and completed a rotating internship at Edward W. Sparrow Hospital in Lansing, Michigan, then returned to the University of Arkansas Medical Center for residency training under Brown. Following residency he had a private practice in Blytheville, Arkansas, until 1988 when he joined the Department of Obstetrics and Gynecology's faculty at the University of Arkansas School of Medicine as an Associate Professor. In 1975 he was Blytheville Citizen of the year and since has been very active lobbying his state legislators on medical issues. These days he's trying to spend more time gardening, golfing and hunting.

Palmer Evans spent many years in Tucson, Arizona, as a clinical colleague of Hermann S. Rhu, ACOG's 31st President. Palmer holds an AB from Franklin and Marshall College in Lancaster, Pennsylvania, and an MD from Temple University School of Medicine in Philadelphia, Pennsylvania. He completed his internship at Geisinger Medical Center in Danville, Pennsylvania, followed by residency at the Hospital of the University of Pennsylvania also in Philadelphia. He then spent two years as a Medical Officer in the U.S. Public Health Service on the Navajo Reservation as Chief of Obstetrics and Gynecology at Fort Defiance and Chinle, Arizona.

Upon completing his service obligation Palmer settled in Tucson where he has been associated with the Tucson Clinic as Chairman of its Department of Obstetrics and Gynecology, President, and Member of its Board of Directors. He also has served

as Chairman of the Junior Fellows and Arizona Section of ACOG, member of ACOG's Committee on Nominations, and is currently a Clinical Lecturer at the University of Arizona College of Medicine. He has been associated with Tucson Medical Center since 1974, currently serving as Vice President, Quality, for its HealthCare subsidiary and has served as its Chief Medical Officer, Senior Vice President, and Chairman of its Foundation Board of Directors.

Frank Ling was one of 32nd ACOG President George M. Ryan's first residents upon his arrival at the University of Tennessee-Memphis and Frank's subsequent career success bears the indelible imprint of Ryan's guiding touch. Frank holds an AB in psychology from Wabash College in Crawfordsville, Indiana, and an MD from the University of Texas Southwestern Medical School in Dallas. Rotating internship followed at Wilmington Medical Center in Wilmington, Delaware, and then residency at the University of Tennessee's City of Memphis Hospital where Ryan was his Chairman. He is currently a University of Tennessee College of Medicine Group Professor and Chair of its Department of Obstetrics and Gynecology.

Frank is also Medical Director of the Memphis Center for Reproductive Health, active locally and internationally in Planned Parenthood, Incorporated, and consultant to eight major pharmaceutical manufacturers. He is an Examiner for the American Board of Obstetrics and Gynecology in addition to a member of its Board of Directors and Credentials, Oral Examination, Long Range Planning, and Residency Review Committees. Frank is also a Past President of APGO and a member of its Medical Education Foundation Board of Trustees, a Past Chairman of ACOG's Tennessee Section, and a Past President of the Tennessee Obstetrics and Gynecology Society. He currently serves as Vice President of the Central Association of Obstetricians and Gynecologists. He is either on the editorial boards of or a reviewer for *Primary Care Update for Ob/Gyns*, *OBG Management*, *ACOG Update*, *Journal of Gynecologic Techniques*, *Primary Care Companion-Journal of Clinical Psychiatry*, *Obstetrics and Gynecology*, *American Journal of Obstetrics and Gynecology*, *Academic Medicine*, *Journal of Women's Health*, *International Journal of Gynecology and Obstetrics*, *Journal of Pelvic Surgery*, *The New England Journal of Medicine*, *Journal of the American Association of Gynecologic Laparoscopists*, *Obstetrics and Gynecology Clinics of North America*, and Editor-in-Chief of *Contemporary Clinical Obstetrics and Gynecology*. His authored publications are too numerous to even begin to mention.

Tom Burke first met Robert C. Park, ACOG's 39th President, more than twenty years ago and their paths have crossed many times since, sometimes traveling together. Tom is a Summa Cum Laude BS graduate of New Orleans' Tulane University and stayed there for medical school as a Phi Beta Kappa and AOA. He then completed a straight internship and residency at Tripler Army Medical Center in Honolulu followed by a two year tour at Fort Leavenworth's Munson Army Community Hospital including Chief of its Obstetrics and Gynecology Service plus Clinical Instructor in the University of Kansas Medical Center's Department of Obstetrics and Gynecology. He then went to the Washington, DC, area for a fellowship in gynecologic oncology under Park at Walter Reed Army Medical Center and National Naval Medical Center-Naval Hospital Bethesda. Upon completing postgraduate training he was transferred to Brooke Army Medical Center in San Antonio, Texas, as Chief of the Gynecologic Oncology Section, Department of Obstetrics and Gynecology, with simultaneous appointment at the University of Texas Health Science Center at San Antonio as Clinical Assistant Professor. He then moved to the University of Texas' M.D. Anderson Cancer Center in Houston where he today is a Professor of Gynecologic Oncology in its Department of Gynecologic Oncology and Vice President of Medical Affairs.

Tom is a peer reviewer or member of the editorial board for *Gynecologic Oncology*, *International Journal of Gynecologic Cancer*, *American Journal of Obstetrics and Gynecology*, *Cancer*, *Clinical and Experimental Metastasis*, *Surgical Oncology*, *Cancer Cytopathology*, *Annals of Surgical Oncology*, *Oncology* and *Lancet*. He also has edited issues of *Clinical Consultation in Obstetrics and Gynecology* and *Operative Techniques in Gynecologic Surgery*. Obviously his publications in the specialty and subspecialty peer-reviewed literature are voluminous.

There're several reprints this month from the *Medical Sentinel*, official journal of the Association of American Physicians and Surgeons. The first is by Michael E. Aubrey, MD, a Canadian physician, entitled "Canada's fatal error - Health care as a right (Part II)". We reprinted Part I in the last *Newsletter* and this continuation is every bit as good. The second is an essay by Jerry Arnett on the risks inherent in the newly proposed, politically correct code of ethics for all physicians called "The Tavistock Principles". It was originally published by the *Sentinel* as an editorial after Jerry presented it in an address before the Ethics Committee of the American College of Chest Physicians. Jerry is a fellow West Virginian practicing pulmonary medicine in nearby Elkins and a member of the *Sentinel*'s Editorial Board. The third is another essay, this one by Miguel Faria who is the *Sentinel*'s Editor-in Chief, on the feds regulation of medical records' "privacy". Only earlier this year the regulations were a hotly debated topic but to my knowledge have yet to be implemented. If in effect they're certainly not being enforced. If there's any possible silver lining to be seen in this ominous cloud hanging low over our country since September 11th, it's that our government now has its hands full just keeping the train running and on the tracks with neither the time nor money to go looking under rocks for new social engineering projects.

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

22 MAY 2001

Dear Doug,

I would like to take you up on the option you gave us of a one year membership in ASFOG. Rather than doing it personally, I would like to enter the membership on behalf of the Department of Obstetrics and Gynecology, University of Michigan if possible. That way the *Newsletter* could come to the departmental library and receive wider circulation. In the future the department could then renew its membership and continue receiving the *Newsletter*. Best wishes.

Tim Johnson

1 JUNE 2001

Dear Tim,

Thanks for your letter. Of course we can have institutional members. Your and John DeLancey's article on J. Robert Willson was worth far more than the paltry year's honorary membership I could offer. I'd have to be a board certified, card-carrying fool to refuse your request. Come to think of it, there are probably quite a few people who would describe me as exactly that.

Doug

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30 MAY 2001

Dear Doug,

Loved your editorial in *ACOG Clinical Review*. I will be interested in the screams of outrage. Life can be tough for those who tell it like it is.

Ben Harer

2 JUNE 2001

Dear Ben,

Thanks as always for your letter. Sometimes you gotta twist a sleeping tiger's tail to get his attention.

Doug

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31 MAY 2001

Dear Doug,

I very much enjoyed your editorial entitled "The Wisdom of our Fathers" (*ACOG Clinical Review* May/June 2001;6:1). You point out, quite rightly, that there is an increasing tendency to disregard basic principles of obstetric asepsis purportedly to achieve a more natural birth process. The observations made in your editorial are very consistent with experiences I have had during my years in clinical practice of obstetrics and gynecology. It's always useful to remind oneself of basic principles, including those of aseptic technique, and it's always worth spending time in explanation to make patients understand that asepsis is not inconsistent with natural childbirth.

Al Strunk

6 JUNE 2001

Dear Al,

Thanks for your letter. Wow! This must be what it feels like to win a Pulitzer Prize! Words of praise from not one but two such highly regarded sources indeed humble me. Even while writing it I knew the editorial was going to be good, but not in my wildest dreams this good. Thanks and glad you enjoyed it.

Doug

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1 JUNE 2001

Dear Doug,

This is a response to your "Witness Box" comments on so-called "basement boards" and the ABOG recertification examinations (vol. 9, no. 3, p. 7). We've both edited the *Newsletter* and served on its Editorial Board since its inception, occasionally seeing things differently and sometimes from opposite extremes. We both also know the days are gone when a physician could go off for a weekend, take a 20 hour course in a new surgical procedure, show up for work Monday morning and perform the procedure in his hospital without any credentialing. Usually the operations went well but sometimes they didn't. Today most hospitals require documentation of medical education and experience, assisting during the procedure and proctoring prior to granting surgical privileges. I spent a year assisting an experienced laparoscopic gynecologic surgeon on laparoscopic abdominal hysterectomies before seeking and obtaining the privilege at my hospital. The Credentials Committee required documentation of that year's experience and proctoring as well as the surgeon coming to my hospital and assisting me with a number of the operations.

It sounds great to learn a new procedure over a weekend but when can it safely be performed on patients? Many medical organizations have risen to the cause and tried to standardize postgraduate training by considering continuing medical education, number of cases performed, outcomes, complications and experience with the hope of providing guidance to credentialing bodies. Obviously they don't personally observe the applicants' operations or technique but this is nothing new; it's always been that way. No one from the ABOG ever watched me do a delivery or hysterectomy as part of my board examinations. Instead they reviewed my experience, asked questions, reviewed my patient lists including complications and made a judgment on my qualifications.

On the other hand I once attended a disability analysis training program in order to become familiar with its applicable guidelines and statutes. I then completed a one page application and mailed it with a check for $300.00, immediately becoming a Fellow of some board of disability analysis. Since then the board has sent me no materials on guidelines nor has it provided any continuing education. The only correspondence received has been a signed certificate suitable for framing. I'm one of their Fellows but how well do you think I could practice disability analysis?

It's absurd to think that obstetrician-gynecologists ABOG certified before the '80s are better trained, equipped or educated than those of us trained since and required to undergo periodic recertification. Some of those more recently trained may be more knowledgeable on current minimum acceptable standards of care and some of those with 30 years of clinical practice may have more expertise, but there's got to be a middle here somewhere. I have no idea how the recertification issue came up but it's a great idea. I've been recertified twice at a cost of $150.00 each. Three times a year I receive three sets of 60 questions on cited articles addressing obstetrics, gynecology and office practice. Now preparing for the third recertification, I find the cited articles current, savant to the profession and representative of the national minimum standard of care. It's fun! There's hours of work but I get an opportunity to read important articles I may have missed when they were first published, all of them very interesting. If you don't have access to a large medical library there're services which, for a nominal fee, will provide the articles. Passing requires correctly answering more than 50% of 120 questions. Extra CME credit may be had by correctly answering all 180 questions. For about $250.00 a year one can have fun, keep current, get CME credits and keep board certification active. There's still the option of sitting the traditional board examination every ten years. The ABOG staff tells me the response for annual recertification has been overwhelming. Apparently no one expected it to be so popular. Multiple choice testing on assigned reading is a very different approach than traditional written and oral examinations. All the questions have been straightforward with only a few obscure or hard to find.

At least I'm doing something to keep current in my profession. I would bet the majority of those like you exempt from recertification don't even try for it. I was impressed when my residency training program director voluntarily took the examination and actually did quite well. Keeping up is the name of the game if you're going to provide competent medical care. Annual recertification is a wonderful way to do just that and I would challenge anyone holding otherwise. How many CME hours do you have? Do you voluntarily participate in recertification?

Dan Avery

12 JUNE 2001

Dear Dan,

Thanks for your letter. I sort of feel like I've been taken out to the woodshed for an attitude adjustment, but we're probably closer together on this than you realize. My comments on "basement" and "gray" boards were directed at exactly what you described in your disability analysis exploits; they're dangerous, worse than useless, and erode the reputation of legitimate medical boards. While I don't feel ABOG certification is the optimal judge of clinical competence, it's the only benchmark we have. The medmal and medical licensing systems are response based and can't attest to competence until one is found to be incompetent.

I would disagree with your portrayal of hospital credentialing. This is certainly the right way to do it and I don't doubt it's the way your hospital grants privileges, but to my experience it's by far the exception and not the rule. I can't begin to tell you how many times I've gone on locums assignments and had to beg for proctoring, almost always denied. That's probably been for the best because, as I painfully discovered, when you foray into the educationally incestuous and specialist deprived medical hinterlands to practice at or above nationally recognized minimal acceptable standards of care, the local status quo is threatened and the hounds of hell loosed.

I don't want to get off on a rant here, but as far as quality of medical education, I've seen it steadily decrease over the years and I'm sure my seniors said the same thing about me as I came along. Medical school and residency curricula have become politically corrected and socially tinkered mishmashes turning out jacks-of-all-trades, masters of none. It used to be that graduates of approved and recognized obstetrics and gynecology residencies were trained to competently and independently practice general obstetrics and gynecology. Today I see young graduates foundering and trying to at least keep their heads above water clinically, with the help and mentoring of an older experienced colleague if they're lucky. All aren't. Most consider anything at variance with what they were taught to be heresy and malpractice, which reflects lack of confidence, limited educational exposure and minimal if any experience in developing independence and responsibility in thought and action. Every night I pray to God that somewhere there is a residency program preparing and then allowing, nay requiring, senior residents to function independently while supervising junior residents with decreasing attending supervision as appropriate. Instead private attendings either cut residents loose to do whatever they want and then berate them when the inevitable consequences occur, micromanage their residents or do the cases themselves because the threat of a malpractice suit or Medicare fraud allegation has them scared witless. Residency is a time for learning, for being exposed to myriad ways of doing things and trying something different after getting approval. It's a time for making mistakes while there's still someone around to first bail your ass out and then chew it out for making such a dumb mistake in the first place don't you dare let it happen ever again. That's the way it used to be and we're the poorer for shucking it.

I can also remember open book tests, although we didn't have very many in college and none in medical school. That's essentially what ABOG recertification has become. When I saw a "correct" answer in direct opposition to the concerned specialty's standard of care, I lost all confidence in recertification. Today's peer reviewed medical literature with its "evidence based medicine" reminds me of a flag waving in the breeze; whichever way the wind blows it follows, easily reversing itself while simply reflecting the current weather conditions and guaranteed to change if you just wait long enough.

The only thing I see is paying a tax of $250.00/year or every ten years submitting to an experience I still equate to a cold turkey root canal at an indeterminable cost. Since I don't have to do it, I won't. To answer your other question, I've received the College's annual CME Award for the past 20 years or more.

Doug

THE HOT BOX

WRECKED 'EM? HELL, SISTER, IT COULD'A KILL EVER ONE OF 'EM!

by Doug Daniel

The title of this installment of "The Hot Box" is the punch line to that classic story about the collision between an express passenger train and an automobile one dark night out in isolated Louisiana Cajun Country. Maurice comes blazing into town driving his pick'um-up truck and screeches to a dusty stop at The Hospital of the Holy Family's emergency entrance. "Sister!! Sister!! Come quick!! They been 'is awful acident out on Gator Creek Bayou! The City o' Nawleens were runnin' wide open and hit a carload of drunks parked on the bridge and one of 'em got the gear shift jam up 'is ass!" "Now Maurice, calm down. Don't you mean rectum?"

I recently found myself in a rural town testifying for plaintiff in a medmal case. Nothing particularly unusual about that, but the outcome of the trial sure was. After working on the case for about three or four years I arrived at the attorney's office early one morning, we briefly discussed the case again, got into his car and drove to the courthouse. By the end of the day the jury had been voir dired and impaneled, the plaintiff had been examined and cross examined, and I had been qualified as a medical expert witness after swearing to tell the whole truth and nothing but the truth so help me God. Court was recessed until the following morning with the judge's strict instruction to the jurors and myself to discuss the case with no one. As soon as we were seated in the attorney's car for the drive back to his office we started discussing what questions he would ask in direct examination the next day and what answers I would give. This strategy session included some research on my part and ended about 9:00 pm to reconvene at the crack of dawn the next morning. When I took the stand he finished his direct examination and the first question under cross examination was, "Doctor, have you discussed this case with anyone?" "No, just Mr. Barrister, Ms. Client's attorney." "When's the last time you and Mr. Barrister discussed your testimony?" "Oh, just this morning before court."

The next thing I knew the jury was taken from the courtroom, both side's lawyers were all huddled up front with the judge and whispering to each other, and I was instructed to go stand in the hall, I guess in a corner. Thirty minutes later the jury walked out of the courtroom and took the elevator, the plaintiff stormed out and took the stairs, and Mr. Barrister came out. "What's going on?" I asked. "Mistrial," he replied. "Why?" "You talked to me about the case after the judge told you not to."

Over the past 20 years of giving sworn testimony in depositions and trials I can't remember when during breaks or recesses the attorney I was working with wasn't prepping me for what was coming next. Maybe once in Indiana during a lunch recess when he parked me in the judge's law library, went to get himself a sandwich and later brought me a Coke™.

After discussing this with several attorneys it appears that in some jurisdictions all witnesses, even medical expert witnesses, are expected to discuss the case with no one, even the attorneys they're working with, once they take the witness stand and are sworn. Here in West Virginia the members of the Bar apparently agreed years ago with the State Supreme Court when it decided that to deprive an attorney of the ability to continue working with his expert witness during testimony deprived his client of the best representation he could provide.

Bottom line? Whether defendant, plaintiff or medical expert witness for either, ask your attorney in advance if you will be allowed to discuss your testimony with him after your are sworn in at deposition or trial. This is critical since any witness at trial can potentially be recalled unless released by both sides. There's also the concern as to whether depositions given outside a trail court's jurisdiction are subject to the local court's rules or its own. I'm working on an article with ABOTA attorneys Ed Nevin and Herb Underwood to do a postmortem on this particular case and address the problem in general but in the meantime, FOREWARNED IS FOREARMED!

DEAR CAMILLA

by Camilla Buchanan

Dear Camilla,

I really enjoyed your review of The Lesbian Sex Book ("The Book Box", *The Medicolegal Ob/Gyn Newsletter* 2001;9:12) but I don't have any known lesbians in my practice. This is of some concern since I would expect to have more than a few considering the accepted incidence of lesbianism. How can I identify them?

Confused in Cleveland

Dear Confused,

Look at your routine office procedures. Your registration form probably asks for employer, marital status and husband's name. Your office nurse most likely records patients' weight and blood pressure while asking when their last menstrual period began and what contraception they're using. These routine questions implicitly assume heterosexuality and therefore put lesbian patients on notice: We aren't sensitive to the possibility you might be lesbian and if you are, we may not welcome you as a patient.

Taking a sensitive, open-ended sexual history initially establishes trust and communication with all your patients regardless of their sexual orientation. Lesbian patients will be much more likely to disclose their sexual orientation if you don't presume heterosexuality. Such a history includes questions like "Are you currently sexually active? If not now, have you been in the past? Does/did this relationship require contraception?" If any answer is no, ask why. Male infertility or vasectomy is usually the heterosexual's answer for the latter but occasionally you will hear, "Because my partner is a woman."

If a patient answers that her current partner is a woman, inquire if previous partners were exclusively women. More than half of all lesbians have also had sexual relations with men and this must be remembered for purposes of medical diagnosis and treatment. Every patient's history regardless of sexual orientation should also include questions about prior diagnosis and treatment of sexually transmitted diseases and abnormal Pap smears.

What makes someone a lesbian anyway? If more than 50% of lesbians have sex with men as well as women, how do you know who's a lesbian and who's not? Since sexual orientation consists of three different dimensions (desire or attraction, behavior, and identity), the term lesbian can be defined in three different ways. A lesbian may be sexually attracted to other women, may have sex with other women and/or may identify herself as a lesbian. Not surprisingly the percentage of women considered lesbians depends on your definition. Unlike other areas of life, sexual orientation is in the eye of both the beholder and the beholden.

An entire chapter in Lesbian Health, Current Assessment and Directions for the Future, a monograph published by the Institute of Medicine in 1999, is devoted to the difficulty of defining study populations when researching lesbian health issues. According to Laumann's 1994 study in the National Health and Social Life Survey, (Laumann EO, et al. The Social Organization of Sexuality: Sexual Practices in the United States. Chicago:University of Chicago Press, 1994) 7.5% of women reported currently experiencing desire for a female sexual partner but only 1.4% identified themselves as bisexual or homosexual. Obviously the definition of lesbian can vary depending on what particular dimension of sexual orientation is being studied. I let the patient identify her orientation. Over the years several of my patients have discovered their identity as lesbians after living in a heterosexual marriage for many years.

But I digress. Let's get back to your original question. Probably between one and eight percent of your patients are lesbians depending on which dimension of sexual orientation you use. The real question however is how many will actually disclose their sexual orientation to you? Fear of discrimination due to homophobic attitudes and actions is a major barrier to open communication between straight obstetrician/gynecologists and their lesbian patients. A patient may fear her doctor and the office staff will disapprove of her newly disclosed sexual orientation, reacting with personal rejection and subsequently poor medical treatment.

She may also fear breach of confidentiality. Serious social and legal consequences may await lesbians whose sexual orientation becomes public knowledge. Virginia provides homosexuals no protection of constitutionally guaranteed civil rights. Here it is legal to refuse or terminate employment, refuse to sell or rent property, reject application for admission to college or medical school, refuse to lend money and deny custody of children on the basis of an individual's admitted homosexuality. A woman engaging in same sex behavior in the privacy of her home can be charged with a felony under Virginia's Crimes Against

Nature statute. Consequently many patients will keep their lesbian sexual orientation a secret even from open and sensitive persons like yourself.

If lesbian patients sense your office is neutral to sexual orientation, nonjudgmental of their lifestyle, and competent in the diagnosis and treatment of their specific gynecologic disorders, some will share this most personal and intimate part of their social and sexual history but others obviously will not. Regardless, it just makes sense to eliminate potentially discriminatory facets of one's office routine. Every patient should be able to discuss her most intimate concerns and problems with her gynecologist without fear of consequences. All patients, including lesbians, should be assured they will receive the best care possible for their medical problems and this requires the utmost honesty and trust within the patient-physician relationship.

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THE SUGGESTION BOX

SAUCE FOR THE GANDER

by Doug Daniel

ACOG *Committee Opinion* No 256, published in May 2001 and entitled "Optimal Goals for Anesthesia Care in Obstetrics", is simply the latest in a long series of attempts encouraging small Level I hospitals to get out of the business of delivering babies. It's about time, too. The movement to close or consolidate small rural hospitals began back when I was in medical school during the '60s and while it has enjoyed a degree of success, local and state politics has allowed some to perpetuate their brand of crappy care. Even the '80s' pit bull of a medmal insurance crisis didn't stop them although it did push many GPs and FPs out of obstetrics just by making their premiums unaffordable. I'm sure you're all aware of previous tempests in teapots over the College's use of and failure to clearly define "available", "readily available" and "immediately available" as they related to obstetricians and their responsibility for attending patients undergoing VBACs and Pitocin™ inductions of labor, so we won't plow that ground again.

Here's where we are today: "Good obstetric care requires the *availability* of *qualified* personnel and equipment to administer general or regional anesthesia both electively and emergently (emphasis mine)." Those hospitals at the bottom of the healthcare food chain will loudly defend the *qualifications* of their anesthetists without acknowledging the fact that they may live an hour and a half from the hospital and take call at home. Some even simultaneously cover multiple hospitals over widely ranging geographic areas and consequently are not available for hours at a time. This was remarkably well demonstrated by a medmal case I once reviewed in which an obstetrician sat around all day with his first manual digit firmly inserted in the lower portion of his gastrointestinal tract waiting for a CRNA to show up to administer anesthesia for an *emergency* Caesarean section indicated by fetal distress. The baby died. The *Opinion* continues with, "The extent and degree to which anesthesia services are available varies widely among hospitals." That's an indisputable fact, but setting "goals" and "guidelines" ain't gonna' fix it. "Standards" or "requirements" would.

The *Opinion*'s text goes on to describe goals for availability, ready availability and immediate availability of various qualified anesthetists (I guess CRNAs and anesthesiologists), OR crews and physicians "capable of monitoring labor and performing cesarean delivery". (I'm just sitting here thinking: I'm "capable" of flying a 747 but you better hope never to hear my hillbilly accent come over the cabin intercom during an inflight emergency with the words "This is your Captain speaking.") Having additional qualified and experienced personnel to care for distressed newborns without relying on attending obstetricians or anesthesiologists is also covered although the Opinion is strangely silent on the issue of obstetricians acting as anesthesiologists by administering their own saddle or epidural blocks. This has been previously addressed and considered verboten yet family practitioners are not included in the prohibition by the American Academy of Family Practice.

The problem is there's no clear definition of availability, ready or immediate. In fact, there's the usual caveat you could drive a Peterbilt™ through: "The definition of immediately available personnel and facilities remains a local decision based on each institution's available resources and geographic location." There is, for the first time, some pretty tough language included which acknowledges the problem and surprisingly puts some teeth into the *Opinion*.

> "A survey jointly sponsored by the ASA and ACOG found that many hospitals in the United States have not yet achieved the goals mentioned previously. Deficiencies were most evident in smaller delivery units. Some small delivery units are necessary because of geographic considerations. Currently, approximately 50% of hospitals providing obstetric care have fewer than 500 deliveries per year. Providing comprehensive care for obstetric patients in these small units is extremely inefficient, not cost-effective and frequently impossible. Thus, the following recommendations are made:
>
> 1. Whenever possible, small units should consolidate.
> 2. When geographic factors require the existence of smaller units, these units should be part of a well-established regional perinatal system."

I've worked in some very isolated geographic areas and believe me, there's no reason obstetric patients can't be driven, ambulanced or flown the hundred miles or more to a Level II hospital with adequate maternal and fetal care available for routine prenatal and intrapartum services. One Level II hospital in Montana addressed the problem by allowing pregnant mothers to

move into an unused wing of the hospital and care for themselves antepartum for as long as necessary, meals and linens provided for a very reasonable charge.

Here's my advice. Carefully read the Opinion. For purposes of risk management and providing quality obstetrical care in your practice and hospital, consider available to mean a response time no more than 30 minutes; readily available to mean physically present in the hospital and unencumbered by other major responsibilities such as performing surgery or administering anesthesia with a response time no more than five minutes; and immediately available to mean physically present in the Labor and Delivery Suite and unencumbered by other above defined major responsibilities or with back-up of equivalent qualifications present in the suite and with a response time no more than one minute. The predictable response is that the complainant can't be expected to sit on labor and delivery 24/7. While that's certainly true, someone must and they shouldn't be expected to do it for free. A rotating roster for staying in L&D is one option as is hiring others to cover L&D the same as we did for Emergency Departments when we didn't want to take the call anymore. To do nothing and continue business as usual will be very costly indeed.

THE LITTER BOX

GET A JOB!

by Doug Daniel

For those of you too young to remember, that's the title of a classic golden oldie by The Coasters from the '50s and '60s. It's also the dilemma in which I found myself after six years of focusing on promoting the Society to the exclusion of gainful employment. Dan and I originally thought the Society was a fabulous idea just waiting to happen. All it needed was promotion. Why would any obstetrician-gynecologist not be falling all over himself trying to find out how to join a professional organization that would help him keep from getting sued and tell him what to expect if it he did. Why would any qualified, responsible obstetrician-gynecologist medical expert witness not be getting in line to join a professional organization dedicated to improving his forensic skills and reputation while recognizing the professional aspect of and need for his work? We expected to have as many as 1000 dues-paying members within one year and 5000 within two years. The dues income from such a membership and the economies of scale in producing its periodical would have easily paid the Society's expenses plus a living though not extravagant wage for one executive director cum editor.

While still a worthy cause, we're now six years down the pike having without success done everything humanly possible to get this puppy to fly. That's not quite accurate. We have enjoyed some recognition for our *Newsletter* and Impaired Physicians Project plus the opportunity to participate in the College's educational and professional liability functions. And don't forget we have a top notch freely accessible educational web site at asfog.com thanks to Ray, Paul and Blaine. We must've been doing something right to be asked to share our thoughts and opinions in some of the top peer reviewed medical publications.

Point is, I found myself in a position where I could no longer devote the time necessary to manage the Society's operations at the level we were functioning without the cash flow of gainful employment. In retrospect, I really didn't understand just how much time was being taken in membership recruitment, soliciting articles for the *Newsletter*, editing and getting them into production, bird-dogging ACM activities, finding and encouraging authors for the ACOG Past Presidents Project, and liaison with the College. At the same time the membership was on the whole putting in just as much or more effort than I by writing for the *Newsletter*, recruiting new members, promoting and managing the web site, and providing educational programs at the ACM.

The good news is I've found a job. It's interesting work with the federals similar to locum tenens that, though not full time, doesn't allow me the luxury of setting my own schedule; I've got to go when my favorite uncle calls. When mobilized the work involves extended periods away from home, long hours with little time off, no available time during work hours, and the sense you're making a difference by helping folks. It may seem strange, but these are the same demands and rewards I found for years in practicing medicine, at least until the last one got sucked up by managed care.

The bad news is there simply will not be the time previously available to devote to the Society. Phone calls made during mobilizations will have to be made nights if at all, inconvenient for some and impossible for most. If you need to reach me call the Buckhannon number and leave a time and number for returning the call. I'll get back to you, probably during an evening or weekend. Computer time will necessarily be quite limited. It is my hope to find a reasonably priced used laptop to use for editing and possibly e-mail (Yes, Ben, there finally seems to be no other choice.), but this remains only a possibility. Of course, when home there will be more time for the Society but many of our operations are not amenable to being stopped and stared, instead requiring continuous follow-up to be effectively realized. Loss of the ability to obligate myself for ACM activities will be my greatest loss.

Your Board of Directors recently met via telephone conference call and I told them every thing I've told you. For the immediate future the Society will continue under the planned leadership with Kenny Stall assuming the Presidency 1 January 2002. I will continue as editor and publish the *Newsletter* when I can. When you've received six issues you'll get a call for dues. Those desiring to continue with our happy band will renew their membership and the rest won't. If any new prospects come aboard they will be heartily welcomed.

As of now Kenny is planning to have a membership meeting at the Los Angeles ACM next spring and your next *Newsletter* will be there when it gets there. My first priority right now is to get the ACOG Past Presidents Project finished. It's about half done. After that we'll see. Call me. We'll talk.

THE FASTEST MINUTES IN OBSTETRICS Continued From Page 1

Of a total 8282 vaginal deliveries during the four-year study period, 138 involved shoulder dystocia for an incidence of 1.7%. Both maternal and newborn medical records were available for 134 case-control pairs with 44 containing head-to-body delivery intervals. These were analyzed for correlations between increasing head-to-body delivery interval and ten minute APGAR score plus umbilical artery pH, pCO_2, pO_2, base deficit and O_2 saturation. Among the 134 cases there were neither infant deaths nor 10-minute APGAR scores below 4. In two infants umbilical artery pH was below 7.00 but neither exhibited signs of hypoxic encephalopathy during hospitalization. Injury rates in our series were similar to those published by other authors.

Comparing our study population's mean umbilical cord blood gas values to the control's, there were statistically significant but clinically insignificant differences in mean umbilical artery pH, pCO_2 and base deficit (Table 1). Mean umbilical artery bicarbonate concentration did not differ between the two groups nor was there significant correlation between increasing head-to-body delivery interval and umbilical artery pH, pCO_2, base deficit, pO_2, bicarbonate or O_2 saturation. Correlations with ten minute APGAR scores could not be determined since very few records contained them.

	STUDY POPULATION		CONTROL POPULATION		SIGNIFICANCE
	Mean	**SD**	**Mean**	**SD**	**p-Value**
pH	7.23	.082	7.27	.069	<.001
pCO_2 (mm Hg)	55.7	11.3	50.3	11.1	<.001
Base Deficit (mEq/l)	5.7	3.2	2.7	2.8	<.001
Bicarbonate (mEq/l)	22.3	2.3	22.0	3.6	.792

Table 1: Comparison of umbilical artery blood gas values between 134 cases of shoulder dystocia and the general obstetric population at Shands Hospital, University of Florida.[2,3]

We also explored whether a nuchal loop of umbilical cord significantly impacted blood gas values by studying a subset of 43 cases with nuchal cord present at delivery. Mean umbilical artery pH was 7.22, pCO_2 was 56 mm Hg and base deficit was 6.1 mEq/l. Only one infant had a five-minute APGAR score less than 3. Differences in umbilical cord blood gas values in venous and arterial samples were similar to cases without nuchal cord.

Some problems are obvious in the study's retrospective design. Head-to-body delivery intervals were absent from most records, and when present had been recorded postpartum by a physician or nurse attending the delivery. It was also difficult to isolate delivery events – acidosis can begin prior to the occurrence of shoulder dystocia or during any stage of labor. Although legitimate controversy remains as to how well umbilical artery pH values reflect the condition of the newborn cerebrum, an umbilical artery pH less than 7.00 has been associated with an increased frequency of low APGAR scores, early neonatal seizures and neonatal death.[4] Umbilical artery pH is also an integral part of attempts to define perinatal asphyxia by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP).[5]

Our data suggests the decrease in umbilical artery pH during management of shoulder dystocia is probably slower than previously thought. There is no clear consensus regarding the time available to safely resolve shoulder dystocia without increasing the newborn's risk of hypoxic neurological injury. Differences of opinion result primarily from scant reliable data regarding neurological injuries in shoulder dystocia and continuing failure to define its physiology.

Several authors have made reference to Wood's study on management of the normal second stage of labor published in the *Journal of Obstetrics and Gynaecology of the British Commonwealth* in 1973.[1] Two groups of eleven patients each constituted cases and controls. Delivery was not expedited in controls. Delivery ***was*** expedited in the study group by encouraging the laboring mothers' expulsive efforts, performing episiotomy and/or Ritgen maneuver, and employing Wrigley's forceps if a subjective delay was present. Exclusion criteria included fetal scalp pH below 7.20 in the second stage of labor and "uncooperative patients". Mean head-to-body delivery times were 37 and 45 seconds in the study and control groups respectively.

Wood's study has unfortunately been cited as demonstrating a decrease in umbilical artery pH of 0.04 units per minute during fetal trunk delivery.[6,7] (See also Bruce A. Harris in *The Medicolegal Ob/Gyn Newsletter*, volume 8, number 3, page 1, May 2000). This interpretation has led to various recommendations regarding the safe interval for shoulder dystocia resolution including a 1996 ACOG publication on the subject.[8] These citations indicate the formation of an incorrect assumption from the original data actually reporting an umbilical artery pH decrease of 0.14 units/minute during torso delivery. But this data may not be accurate. The rates of change in pH were determined from two samplings but applied to multiple midpoints. The results of Wood's study are also of limited value with regard to fetal acidosis in shoulder dystocia because the methodology involves

inappropriate extrapolation from normal deliveries. This normal data cannot be used to determine a "safe interval" in the very different setting of shoulder dystocia. There are other sources for indirect exploration of the safe interval question.

A 1998 report of the United Kingdom's Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) described 56 cases of fatal shoulder dystocia including births in England, Wales and Northern Ireland during 1994-1995.[9.] The advisory board writing this report identified the cases in CESDI's database and then reviewed the relevant patient records. The incidence of fatal shoulder dystocia was estimated to be 1/25,000 births with a median head-to-body interval of five minutes in the 45 cases with available data. Only nine cases had an interval longer than ten minutes. Fetal distress was present prior to delivery of the head in at least fourteen cases. Major criticisms of this report are its very broad definition of shoulder dystocia and its inclusion of deaths likely attributable to sepsis and neonatal pneumonia.

Another piece of the puzzle is Sandberg's 1999 review of Zavanelli deliveries.[10.] Outcomes were generally good if the fetal head was replaced intrauterine within three to four minutes. Good outcomes also occurred in some cases with longer delays in delivery or replacement. Sandberg's review determined an impressive overall success rate of 92% but most exciting from the standpoint of fetal physiology was that once returned to the uterus, the fetus seemed to tolerate remaining there for as long as 30 minutes or more. It may therefore be possible to reverse or relieve deteriorating fetal status during management of shoulder dystocia.

In 1998 Ouzounian presented data from 39 cases of shoulder dystocia studied prospectively.[11.] Analysis included 15 cases with neonatal brain injury and 24 without. The mean head-to-body interval in the injured group was 10.6 minutes compared to 4.3 in the uninjured group. Based on a receiver-operating characteristic curve, the authors stated that a threshold interval greater than or equal to 7 minutes had 67% sensitivity and 74% specificity for predicting subsequent central neurological injury.

Another school of thought suggests a delay of three to four minutes may be benign and recommends waiting until the next uterine contraction further engages the fetal shoulders in an oblique diameter before intervening to expedite delivery.[12.] Similar is the recommendation that shoulder dystocia be strictly defined as failure of shoulder descent during the first contraction subsequent to delivery of the fetal head. This is contradictory to the timing of sequential events during normal vaginal delivery as presented in 1973 by Wood, and more recently by Spong and Beall, who showed a mean head-to-body delivery interval of 24.2 seconds in uncomplicated vaginal deliveries.[13.]

The mechanism of neonatal brain injury in shoulder dystocia is certainly unclear. Speculations in the literature as to its causation have included occult occlusion of the umbilical cord, impaired cerebral blood flow, impaired cerebral venous drainage with subsequent cerebral venous congestion, and reperfusion injury related to these events. For more on how a central neurological injury might occur, we now turn to our ovine friends.

Complete cord occlusion in the fetal sheep model has shown a predictable pattern of hypertension and bradycardia during the initial few minutes followed by marked hypotension and severe respiratory acidosis.[14.] Relieved by release of the occlusion, cardiovascular and metabolic parameters return to normal relatively quickly but significant instability in heart rate, particularly recurrent episodes of spontaneous bradycardia, continues for up to 40 minutes and may play a role in evolving neurological injuries or contribute to reperfusion injuries. The neuronal damage seen in this model is primarily hippocampal, correlated in humans with memory and cognitive defects. A strong correlation between degree of hypotension and extent of neuronal loss in fetal sheep models is similar to that found in human studies.

There are also fetal sheep models showing little neuronal loss with carotid occlusion. It takes a relatively long episode of partial carotid occlusion to achieve the degree of hypoxemia and acidosis we intuitively associate with peripartum neurological injuries. Perhaps none of these fetal sheep models answer our original question regarding the relationship between shoulder dystocia and central neurological injuries but they weren't specifically designed to.

A nuchal loop of umbilical cord can become partially or completely occluded by compression. In our series nuchal cord was not significantly associated with more severe acidemia, greater difference between venous and arterial blood gas values, or lower APGAR scores. The prolonged effects of clamping a nuchal cord in the human fetus are unknown. Iffy reported a series of five infants diagnosed with cerebral palsy whose shoulder dystocias were only recognized after clamping and cutting their nuchal cords.[15.] Delivery delays ranged from three to seven minutes. Based on the animal data and our Shands study, it is my opinion that some cord circulation continues in shoulder dystocias even with nuchal cords. Clamping and cutting the cord apparently contributes to fetal hypoxia and hypotension during attempts to complete the delivery. Therefore it is advisable whenever possible in the management of shoulder dystocia to avoid clamping and cutting nuchal loops of umbilical cord until completion of delivery.

One problem in developing an adequate animal model of human shoulder dystocia is extrapolating the data to humans. Patterns of brain injury in human infants are poorly understood and their clinical manifestations varied. We are only just beginning to understand the significance of early (less than two weeks of age) Magnetic Resonance Imaging (MRI) findings in neurologically damaged children.

Two distinct patterns of injury are seen in animals experiencing hypoxic-ischemic insults to the brain. Prolonged partial ischemia or chronic hypoxia as in severe uteroplacental insufficiency damages both cerebral cortex and white matter, particularly in watershed or parasagittal areas selectively bypassed during prolonged shunting or redistribution of blood supply. Acute total asphyxia as in uterine rupture damages subcortical nuclei in the thalamus and brain stem. A recent study reviewed MRI and computerized tomography imaging studies in eleven term infants who experienced acute intrapartum events associated with terminal fetal bradycardia and early-onset neonatal seizures.[16] Findings were remarkably similar in all cases. Injury was most prominent in the basal ganglia and thalamus with either complete sparing or subtle damage in the cerebral cortex, consistent with the clinical consequences of athetoid cerebral palsy such as abnormal movements and paresis with apparently normal cognitive functioning. The worst cases in this series showed spastic quadriparesis, dysarthrias, and swallowing abnormalities. Damage to other organ systems, considered a hallmark of severe intrapartum hypoxic-anoxic-acidotic perinatal injury, was subtle or even absent in most cases.

The most useful insights gleaned from our study were how ignorant we really are about the physiology of shoulder dystocia and how hard it is to investigate. Inability to clinically predict its occurrence makes scientific prospective studies unbelievably difficult. Objective human physiologic data is difficult to obtain due to its necessitating invasive technology for collection of data. Properly designed fetal animal models hold promise of expanding our knowledge, especially those utilizing total neck occlusion and/or cerebral venous congestion. Human studies can focus on the role of maternal obesity in shoulder dystocia.

The Holy Grail of shoulder dystocia is prediction. Some investigators are currently evaluating prophylactic McRobert's maneuvers and suprapubic pressure. Another exciting area will be innovations in postpartum management. For example, it has recently been shown in fetal sheep that administration of insulin-like growth factor 1 (IGF-1) after a hypoxic-anoxic injury reduces the loss of striatal neurons, those contributing to movement regulation.[17] Neuromodulators like IGF 1 and some neuropeptides will be studied as possible protectors and regulators of neurotransmission following reperfusion.

The fetus in good physiologic condition encountering shoulder dystocia will likely be able to tolerate a prolonged head-to-body delivery interval of four to five minutes, perhaps longer. Obstetricians following a recognized and familiar clinical algorithm in a calm, deliberate manner should eventually deliver an infant with minimum morbidity. An accurate medical record timing events and describing obstetrical maneuvers and interventions is obviously necessary. It is my hope that further studies of shoulder dystocia's pathophysiology will discover more effective interventions.

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Editor's Note: Two additional points should be made in response to Shawn's outstanding article. As regards when to cut the umbilical cord, I've attended untold deliveries with single or multiple loops of nuchal cord running the gamut from very loose to very tight. While never avulsing a cord, I've probably come closer than I realized during the days when I would try to slip a loop or two over the head and complete the delivery. Most of these nuchal cords did not impede delivery since their total length was normal to unusually long. But some with multiple loops, shorter than normal cords and/or high placental implantations did and delivery could not be completed until the cord complication was resolved one way or the other.

With wisdom born of experience and confidence born of successful technique, I eventually began cutting all but the loosest and most easily resolved of nuchal cords. Wide episiotomy or even episioproctotomy, rotation of the posterior shoulder to an oblique diameter via rotational pressure on its scapula, and judicious traction during voluntary expulsive efforts seemed to always solve the shoulder dystocia problem, albeit with an occasional fractured clavicle or mild Erb's palsy which fortunately resolved without permanent disability. Never was there a known case of permanent central neurological injury related to delay in delivery.

Several caveats should however be mentioned. First, as many patients as could be were monitored with intrauterine pressure catheters and scalp electrodes initiated as early as possible in their labor, and most importantly the tracings were frequently reviewed, even continuously observed during the second stage of labor. Secondly, patients underwent Caesarean section at the first hint of irresolvable hypoxemia due to impaired fetoplacental function or dystocia due to fetopelvic disproportion. Expedited vaginal delivery was used in suspected hypoxemia cases when appropriate. Based upon this experience, I never hesitate to cut the umbilical cord if it will expedite delivery. Of course this obviously removes the Zavanelli option and does burn one's bridges, so to speak.

Then there's the problem of available fetal metabolic reserve prior to a delay in delivery due to shoulder dystocia. If there's already unresolved chronic hypoxia or God forbid significant acidosis, the shoulder dystocia delay in delivery combined with decreased umbilical cord blood flow can be disastrous. This is simply one more reason to personally follow your labor patients closely and not ignore potential EFM evidence of early hypoxia.

Doug

WILLIAM F. MENGERT, MD, 1954-1955
(b. 1899 - d. 1976)

by Roy M. Pitkin, MD, FACOG

Chicago's Mayor Richard Daley (the real one, not the kid currently occupying the office) supposedly once said something to the effect that there's no loyalty like that owed to someone who gave you your first job. William Mengert, ACOG's 5th President, may not have given me my first job but it was the first that paid a living wage, and that counts at least as much. Finishing a stint of military service in 1965, I decided to give academic medicine a try. There were few offers and the most attractive was Assistant Professor of Obstetrics and Gynecology at the University of Illinois College of Medicine in Chicago. For the next three years, Mengert's last before retirement, I worked in his department. The tenure was short but influential.

William Felix Mengert was born November 13, 1899, in Washington, DC. Following graduation from Pennsylvania's Haverford College Mengert taught chemistry and mathematics for two years at DC's then Gallaudet College, today Gallaudet University and still the world's only institution of higher learning dedicated to deaf and hard-of-hearing students. He then entered the Johns Hopkins Medical School where its Dean, the eminent obstetrician J. Whitridge Williams, may have influenced his career choice.

Mengert told two stories about Williams. The first involved application to medical school. Upon visiting the campus he was shown around by an older brother's college classmate, at the time a medical student. They paid a courtesy call on the Dean of the Medical School and, after a few pleasantries and inanities about why Mengert wanted to be a physician, Williams demanded of the medical student, "Is this fellow honest?" The medical student mumbled in reply that he didn't know Mengert very well but had no reason to doubt his character. Williams then whirled in his swivel chair to confront Mengert. "Where did you rank in your college class?" demanded Williams. "At the top of the bottom third," Mengert answered bravely. "Well," snorted Williams, "that sounds honest. We'll take you."

The other Williams anecdote occurred near Mengert's graduation. Deciding he wanted a combined obstetrics and gynecology residency, nonexistent at Hopkins and almost all other US medical centers, he consulted Williams. The Dean noted that E. D. Plass, a former associate, had recently been appointed Chairman of a combined Department of Obstetrics and Gynecology at the University of Iowa College of Medicine. He then added, "I know nothing of Iowa or its university but, wherever Plass is, there will be activity." And so Mengert packed up Ida, his wife of three years, and their child to move from the East Coast to what they regarded as the wilds of Iowa.

Williams proved prophetic, and Mengert found his life's purpose and direction with Plass in Iowa. He served internship and residency there, completing training in 1932 during the depth of the Great Depression. Opportunities were limited, especially in academic medicine. He took a position as research fellow at the University of Pennsylvania where the first year's salary was meager, the second's even less, but the experience good. Two years later a position with Plass at Iowa was offered and he quickly accepted. From 1934 to 1943 he was a faculty member at Iowa under Plass and regarded these the happiest years of his life.

In 1943 he was named Chairman of the Department of Obstetrics and Gynecology at the new Southwestern Medical School and Parkland Memorial Hospital in Dallas, Texas. In 1955 he moved to Chicago and the University of Illinois Medical Center Campus where he served as Chairman of its Department of Obstetrics and Gynecology until his retirement in 1968.

Mengert remained in the Chicago suburb of Riverside after retirement, very busy with a number of writing activities. He completed a history of ACOG's first 20 years which was published and widely distributed by the College in 1971, reprinted in 2001 as a portion of History of the American College of Obstetricians and Gynecologists in celebration of its 50th anniversary. Immediately after retirement he began writing "The Open Line", a regular column in *OB-GYN NEWS* which became so popular he continued it until his death. Believing Plass had not received due recognition, Mengert became his Boswell and wrote a biography ultimately published in abbreviated form as part of a history of the University of Iowa's Department of Obstetrics and Gynecology. It was truly a labor of love.

Mengert strongly advocated what he termed "simplified maternity care", based on the firm conviction that pregnancy and birth (he always used "birth" rather than "delivery") are usually entirely normal and the obstetrician's role is a passive one. He argued forcefully that normal pregnancy is not a disease and to treat it as such leads to nothing but mischief. Complications and abnormalities can of course occur at anytime, demanding immediate and drastic interventions. He once wrote that the obstetrician must "keep hands off the normal woman … but still be able to explode into action on demand." Omitting enemas or shave preps of vulvae and perinea upon parturients' admission to the labor and delivery suite may not seem revolutionary today but it certainly was 40 years ago, even condemned by many of Mengert's colleagues. He was extraordinarily prescient in so many ways.

One of my first assignments on joining the Illinois faculty was to supervise production of a motion picture portraying normal birth to be used in medical student education. I thought the film was pretty good, but when Mengert first viewed it his dissatisfaction was obvious. All he said was, "Roy, anyone watching this movie would be absolutely convinced this woman couldn't possibly have delivered her baby without your ministrations." Needless to say it closed immediately after the premiere, never to be seen again.

His concept of simplified care extended to certain aspects of gynecology. I was astonished to discover women undergoing vaginal surgery without routine bladder catheterization at any time. Upon complaining of the urge to void postoperatively they were helped out of bed to sit in privacy on a bedside commode. While recovery room nurses hated this because it made more work for them, more than half of women undergoing vaginal repair were admitted, operated upon and discharged without catheterizations.

In other ways, however, Mengert was almost reactionary in hanging on to cherished concepts long after nearly everyone else realized their time had passed. He won his spurs scientifically in the 1930s and 1940s with landmark studies on the estimation of pelvic capacity. By the late 1960s the adverse potential of diagnostic radiation was commonly known and most obstetricians agreed x-ray pelvimetry provided little clinically useful information. Even then Mengert still felt most (he really preferred all) gravidas should have x-ray pelvimetry. He also advocated liberal use of blood transfusions, even for relatively mild anemia. This attitude perhaps persisted from an earlier time when he faced a maternal mortality rate of 600 or more per 10,000, most commonly secondary to hemorrhage.

Characterizing Mengert's personality as direct and forceful seriously understates the case. He was frank, sometimes brutally so. He could also be outspoken, opinionated and irascible. In some circles he was called "Wild Bill", though I doubt ever to his face. Under more relaxed conditions he could be gracious and even charming. My wife, who saw him only under such social circumstances, regarded him as a courtly father figure. This transformation seemed to be facilitated by what he called the "social lubricant", alcohol.

Mengert prized integrity above all else, and his disdain for those he considered deficient in this regard was boundless. His most damning insult was, "The truth is not in that man!" Moreover, honesty was absolute and not admitting of degrees; to be less than fully honest, even in the interest of compromise or euphemism, was dishonesty. I better understood his outspoken and uncompromising manner once I finally appreciated this driving force in him. Yet he was not altogether insensitive, and there was even a certain tenderness beneath the gruff exterior. No one to my knowledge ever went to him carrying a problem without finding a sympathetic ear and thoughtful, sound advice.

Mengert regularly consumed alcohol in substantial quantities. He undoubtedly would have agreed with Churchill who, upbraided regarding his alcohol consumption, replied, "I have taken much more from alcohol than alcohol has taken from me." Mengert also loved cigars and nearly always, at least in later life, smoked one after lunch and another after dinner. While going through his ritual of unwrapping, cutting and preparing a fine handmade cigar he would constantly bemoan their increasing cost. "When they get so expensive I can't afford them, I shall have to stop smoking." The option of smoking machine manufactured cigars apparently was not even worth considering.

Mengert like most of his contemporaries followed interests spanning the full range of obstetrics and gynecology. He was the first to recognize and characterize late pregnancy's supine hypotensive syndrome. His description of pelvic anatomy and capacity is still classic. He made original observations on the mechanism of pelvic support and his name is attached to at least one gynecologic operation. But Mengert would undoubtedly consider his most important and lasting legacy to be the indisputably vital role he played in founding, nurturing and chronicling the early history of the American Academy of Obstetrics and Gynecology, later to become the American College of Obstetricians and Gynecologists.

During World War II's insatiable demand for America's physicians Mengert served two terms as Secretary of the Central Association of Obstetricians and Gynecologists. He found himself turning down a growing number of qualified applicants because the Central, a limited membership organization, could not accommodate them. He became uniquely aware of his specialty's rapidly growing number of practitioners and tried to expand the Central into a national organization open to all qualified obstetrician-gynecologists but failed, perhaps for the simple reason that "Wild Bill" was its proponent. He joined forces with a handful of others who shared his vision and in 1951 became one of the original Academy's eleven founding members, and later its President.

Another legacy is the more than 100 obstetrician-gynecologists he trained, first in Dallas and later Chicago. They received sound clinical training with most entering clinical practice, a few academia, to provide and teach the conscientious, conservative care he had provided and taught them to provide.

Mengert certainly represented an important influence on my career. He and the University of Illinois provided a perfect environment for developing research and academic skills. He was helpful, mostly by simply being supportive. There's no way to tell what direction my career would have taken otherwise, but he certainly shaped and directed my professional life during those three years in Chicago.

One specific Mengert imprint is unquestionable. I had written a few papers before moving to Illinois which demonstrated, I thought and was told, a certain flair for writing. Yet there was much to learn and, as is often the case with such education, it was not always pleasant. Mengert's writing style was simple, clear and direct; always technically correct. He preferred short words and short sentences, abhorring euphemism, jargon, circumlocution and grandiloquence. "Never use two words where one will suffice. Never use a three-syllable word if a two-syllable one is appropriate." His words ring in my ear to this day. To paraphrase the same Churchill, it was at Illinois under Mengert that I got into my very bones the structure of the noble English sentence. And I cannot help but believe that experience was a defining one, subsequently affecting the rest of my life.

William F. Mengert was a dominant figure in American obstetrics and gynecology during his century. He chaired departments in two major medical schools, influencing medical students' and obstetric-gynecologic residents' education for generations to come. He was one among a small group of men responsible for today's American College of Obstetricians and Gynecologists, and his role in founding its precedent Academy was as great as any other's. Few who came in contact with him were not affected, one way or the other, by the association.

Ida Gardner Mengert died in 1970 after 49 years of marriage and two children. Dr. Mengert subsequently remarried twice and died suddenly in March 1976, presumably experiencing a catastrophic cardiac event.

FRANK R. LOCK, MD, 1964-1965
(b. 1910 - d. 1979)

by T. Keith Edwards, MD, FACOG

Frank R. Lock, 14th ACOG President, was born in Lake Charles, Louisiana 30 October 1910 and held an AB from Cornell University and an MD from Tulane University School of Medicine. Following graduation from Tulane he traveled to San Francisco where an internship at Southern Pacific Hospital awaited, but returned to his home state for an obstetrics and gynecology residency at New Orleans' Touro Infirmary. He remained in New Orleans to accept an appointment as the C. Jeff Miller Fellow in Obstetrics and Gynecology at his alma mater, Tulane University, and its teaching facility, Charity Hospital.

Following this exceptional training Lock remained for a year at Tulane as an Instructor in Obstetrics and Gynecology before traveling to Baltimore's Johns Hopkins where he studied gynecologic pathology under Dr. Emil Novak. In 1941 he again moved, this time to a permanent home at Wake Forest College's Bowman Gray School of Medicine in Winston-Salem, North Carolina, as an Assistant Professor of Obstetrics and Gynecology. Although Bowman Gray had only become a fully accredited four year medical school in 1939, Lock joined a faculty of other bright, energetic young men and women excited by what the future might hold for their newborn institution sitting atop Hawthorn Hill and blessed with the financial support of such wealthy local families as the Reynolds and the Grays. Lock became Chairman of Bowman Gray's Department of Obstetrics and Gynecology in 1946 after a year's preparation spent in Chicago, Boston and other cities recognized as leading centers of medical education.

I first met Lock in 1951 as a Bowman Gray freshman medical student. After assuming the Department Chair he had quickly developed quite a reputation among the state's physicians. Dr. Robert A. Ross, Chairman of the University of North Carolina's Department of Obstetrics and Gynecology at Chapel Hill and fondly known by everyone as "Daddy Ross", warmly welcomed Lock to the state and its obstetrician/gynecologist community.

For several years Lock reviewed North Carolina's maternal death registry and absorbed the knowledge gained into his outstanding teaching. As a teacher he earned a mixture of awe and appreciation from those of us who studied under him. Our resident staff was initially quite small with only two residents at each year level, requiring each to be present in the hospital about 100 hours a week. The most difficult shift was from 8:00 am Saturday to 5:00 pm Monday, and to make matters worse the chief resident on call for the weekend was responsible for presenting a literature review on a topic of his choice between 4:00 pm and 5:00 pm Monday afternoon. This dreaded hour became known as "Dr. Lock's Conference" because he was always there, freely giving the presenter the benefit of his special insights into the material.

One of our chief residents, Robert Bowden, was a large, muscular fellow who filled out an extra large scrub suit quite well. His nickname was inevitably "The Jolly Green Giant". One Monday afternoon The Jolly Green Giant was trying to quickly wrap up a rough weekend on call but Lock repeatedly interrupted with questions whose answers he thought his residents should be familiar with. The Giant began to falter in his answers and eventually resorted to simply trying to guess what Lock was thinking. Finally he stopped, totally frustrated, and firmly gripped the edges of the lectern. "Dr. Lock," he said, "I'm obviously not very good at playing obstetrical charades or twenty questions, so why don't we just stop and you tell us what you want us to know." You could have heard a pin drop!

Lock rose from his chair and, not the least bit affronted, picked up the lecture narrative on this particular disease as if he had been preparing for several weeks. As he spoke he mentioned several journal articles, even giving the months published. Sitting there, I got the impression he was visualizing the very pages being discussed and could probably have told us the page number and paragraph containing the information cited.

While Chairman, Lock also maintained an active private practice. His reputation rapidly spread far and wide with women traveling considerable distances seeking his care. A patient from one of the finest families of Virginia came to him during her second pregnancy after experiencing problems with her first. Following one of her prenatal visits she told Lock how pleased she was to have him for her obstetrician, but she had one reservation: she wanted her child born on Virginia soil and so could he please come to her hometown hospital for the delivery. Lock of course said that would be impossible for a number of reasons but suggested an acceptable alternative.

I was covering L&D when she presented in labor carrying a bucket of dirt. When asked what the dirt was for, she replied Dr. Lock had asked her to bring it and no more questions were asked. He arrived for the delivery shortly after I called him, ordered the bucket of dirt wrapped in a sterile drape, and placed it on the floor under the delivery table, allowing the mother to say her child was born over Virginia soil.

It was not unusual for Lock to appear on the wards at 9:00 pm or 10:00 pm at night and ask to have the charity ward patients presented. He expected his residents to know every patient by name and provide a concise review of her history and hospitalization including pertinent laboratory values. He would then pose questions assessing your knowledge of the relevant disease processes. Finally he would offer suggestions on treatment.

In 1954 during senior medical student obstetrics rotation my wife went into labor. She was head nurse on the gynecologic surgery ward and knew Lock very well. As was his custom, he attended this medical student wife's pregnancy and delivery as a professional courtesy. Alice was having contractions Friday night but went to work anyway. She delivered about 9:00 am Saturday while I was attending a lecture 40 feet down the hall. In the midst of her begging and pleading that I be allowed to be present for the delivery she was finally told, "Hush, Alice. Keith is in class and he is not coming for this delivery."

At delivery it appeared my term son had experienced some degree of intrauterine growth retardation, weighing only 4 lbs 13 oz. Our pediatrician told us he seemed to be miniature instead of premature. Alice was wide awake since Lock did the delivery under saddle block anesthesia. He lifted the child by his feet, presented him to his mother, and exclaimed, "Damn, Alice, you've had a rabbit!" Today such comments would be considered grossly inappropriate and even offensive, but back then we knew he deeply cared for us and gave the very best he had to offer. Rather than become offended we simply loved him all the more and appreciated his eccentricities.

In the early 1950's Lock performed a definitive study on the fetal effects of maternal rubella after an epidemic swept North Carolina. The wife of one of my medical student friends a year behind me became pregnant and contracted rubella at 17 weeks gestation. He came to me and asked what he should do. I took them to see Lock and he offered to take care of her himself. After the first prenatal visit confirmed her estimated length of gestation, he assured them the pregnancy would be uneventful and the baby would be absolutely normal. Several months later at the delivery he was proven right.

Some years later when I became chief resident I questioned him about this. He told me his studies had shown that by 17 weeks gestation the risk of fetal deformities secondary to maternally acquired rubella had passed. "That's true, Dr. Lock," I said. "But there was still the random possibility of a deformity."

He looked me squarely in the eye and replied, "Are you going to tell all your patients there is a one to two percent chance of deformity? If you do they will worry needlessly for nine months about something they cannot change. The percentages were on my side and I chose to take the risk of being proven wrong in order to reassure my patient."

As the years passed Lock sought the very best faculty he could find for his Department. Dr. Richard Burt did significant work on diabetes in pregnancy. Dr. Frank Greiss laboriously performed meticulous investigations on placental blood flow using an ovine model. Both later succeeded Lock as Chairmen of his Department.

In May of 1964 Lock became President of the American College of Obstetricians and Gynecologists, also serving as President of the American Association of Obstetrics and Gynecology in 1966 and President of the American Gynecological Society in 1969.

Shortly after installing his successor as ACOG President Lock was enjoying some well-deserved time off at his home when he had his first myocardial infarction. Word of this frightening event spread through the medical center like a fast-moving storm cloud. I rushed to the Emergency Room and found several hospital personnel already in attendance holding the ambulance entryway doors open as his stretcher barreled through. Richard Burt was appointed Acting Chairman of the Department and Lock returned to work after a six weeks recovery, but the vigor of his earlier years had painfully forsaken him.

My last recollection of Lock has me sitting beside him in one of our departmental meetings. Richard is presiding and Lock appears tired and listless, barely paying attention. Mention is made as an information item of instructions Richard has received from Dr. Eben Alexander, Chief of Staff. Suddenly Lock rouses himself like a sleeping dragon awakened by a perceived threat to her children. He fixes Burt in his steady gaze and says with steely resolve, "Now Richard, you be sure he understands that he does ***not*** run this Department."

Editor's Note: Upon arriving in 1970 for my internship at Naval Hospital Bethesda in Bethesda, Maryland, just inside the Washington, DC, beltway, a similar story was recounted regarding the birth of President Lyndon Baines Johnson's first grandchild. Johnson's son-in-law was a naval officer on active duty and for various reasons the parents chose Bethesda for prenatal care and delivery. Not to be denied his Texas bragging rights, Johnson ordered that a can of dirt from his farm in Texas be shipped to the White House for the sole purpose of being placed under his daughter's delivery table, and it was.

WILLIS E. BROWN, MD, 1968-1969
(b. 1909 – d. 1969)

by W. Wayne Workman, MD, FACOG

Willis Ellsworth Brown, 18th ACOG President, was born in 1909 in Danville, Illinois, and grew up with his medical missionary parents in China, graduating from Shanghai American School in 1927. As a teenager he sometimes administered anesthesia to the Chinese patients during his father's surgeries. Young Willis then returned to the United States, graduating from Albion College in Albion, Michigan, in 1931 with a BS degree and receiving his MD degree from the University of Michigan in 1934. He completed his residency in obstetrics and gynecology there in 1937 and remained on its faculty until he accepted an academic appointment at Omaha's University of Nebraska in 1940. Six months later he accepted a position with the Children's Bureau in Washington, DC. In 1943 he moved to the University of Iowa as an Associate Professor and in 1949 was named Chairman of the University of Arkansas' Department of Obstetrics and Gynecology where he remained until his death in l969.

Before 1948 when Dr. Eugene T. Ellison was appointed Chairman at the University of Arkansas and established a combined Department of Obstetrics and Gynecology, an independent Department of Obstetrics had been staffed by volunteer private practitioners from the local community. The next year Ellison resigned his Chairmanship and began private practice in Texarkana, Arkansas, leaving his department without a residency training program. Soon after Brown's arrival he established a residency with four positions at each year level which quickly became very active and was nationally recognized for its outstanding quality. One of his first residents, Dr. Hart Baker, went to the Kaiser Permanente Foundation Hospital in California as its residency program director. Not associated with a university, Kaiser quickly became a very highly respected academic residency.

When Brown came to Arkansas 30% of all deliveries were performed by lay midwives with no obstetrical training other than observation of other midwives. With the cooperation of Dr. Eva Dodge and the Arkansas Department of Health he developed a system of rules and permits for lay midwives. There was no legal requirement for such permits or enforcement of the rules but together they effectively reduced maternal and infant mortality, quite high in 1949 at 169.5 mothers per 100,000 live births and 31.2 infants per 1,000 live births. By 1969 they had dropped to 32.9 per 100,000 and 19.9 per 1000 live births respectively. The permit system essentially required midwives to follow an established program of cleanliness in their work as well as refer complicated maternity patients to a physician. Dodge and the Arkansas Department of Health monitored permit renewals.

Maternity facilities at the University when Brown arrived were extremely overcrowded and totally inadequate with no air conditioning in the surgery or labor and delivery suites. He became one of many advocates for passage of a two cent soft drink tax to build a new medical center. His intense interest in the hospital's design and construction was innovative for the early 1950s. The opportunity to participate in hospital design and construction was actually a major factor in his decision to come to the University of Arkansas.

Brown religiously attended church every Sunday. He would just as religiously take his family from church out to the hillside construction site each week. Initially he would pace about and observe the architects' surveys. Later he would gaze into the depths of their excavations and ponder whether they were going to build a new hospital or simply try to uncover a buried one. Toward the end he would walk among the floors checking doorways, widths of halls and various other details from his design. He was very proud of his facility's innovative provision for mother and baby "rooming in", a philosophy which gradually extended to many hospitals.

Brown worked diligently to make his lectures relevant whether presented to nurses, lay persons, students, residents or ACOG Fellows. He was also avidly interested in teaching medical students. Arkansas' medical students rotated through obstetrics and gynecology twice, first as juniors in the outpatient clinics and then as seniors in the labor and delivery suite, operating suite and on the wards. The senior rotation was virtually an obstetrics internship with a great deal of hands-on experience in operative and spontaneous deliveries, administration of regional anesthetics and other minor procedures. Brown was responsible for instructing approximately 1610 students of obstetrics during his tenure as Chairman.

A stern but loving father to his students and residents, Brown also took a very personal interest in their lives as well as their families' and was responsible for salvaging more than one marriage. He considered his residents professional sons and grandsons of his mentoring.

Brown recruited a small but bright faculty although funding was always a problem. Chief residents doubled as instructors. Faculty members over the years included Drs. Eva Dodge, Clarence Sutherland, John Nettles, Kermit Krantz, Stewart Fish, Byron Hawks, Stacy Stephens and, in anesthesia, Richard Clark. Brown was a very warm and caring person always interested in promoting the advancement of his faculty. Three of them, Krantz, Fish and Nettles, rose from Assistant Professors

at Arkansas to Professors and/or Chairman elsewhere: Krantz at Kansas, Fish at Tennessee and Nettles at Tulsa. Hart remained director of obstetrical and gynecological resident training at Kaiser.

A founding member of the American College of Obstetricians and Gynecologists in 1951, Brown remained strongly interested in other of the specialty's organizations. He served as President of the American Society for the Study of Sterility in 1962; senior examiner for the American Board of Obstetrics and Gynecology; and member of the Advisory Committee of the Children's Bureau of the Department of Health, Education and Welfare. He was active in medical journalism and served on the editorial boards of four professional periodicals, publishing over 125 articles in scientific journals.

Through these involvements he came to know all the specialty's leaders, utilizing these friendships to invite them to visit Arkansas and expose his residents to other teachers. Many would stay overnight and some as long as two weeks. Among those who visited were Drs. Leon Israel, Robert A. "Daddy" Ross, Isidore Dyer, Hans Kottmeir, Russell de Alvarez, Phil Schreier and Bill Mengert, his very close friend.

Brown did original research on pelvic cancer chemotherapy and was an accomplished oncological surgeon who taught his interested residents to perform radical hysterectomy plus total and partial pelvic exenteration. Byron Hawks once said, "I really believe Dr. Brown has a genuine hatred for cancer in women."

Brown's first myocardial infarction came in 1950. After another in 1962 he complained to his cardiologist that his residents needed him back at work. The cardiologist's response was that "the cemetery is full of indispensable people". Brown relented and recuperated for a short time.

In 1968 Brown became President of the American College of Obstetricians and Gynecologists. He was honored with a dinner hosted by all his former residents at which time they presented him a new Cadillac with Arkansas license plate "ACOG 1". This was done in appreciation of his excellent preparation of each of them to practice state-of-the-art women's healthcare. In his presidential inaugural address he advocated College members being women's primary care physicians, and today we have finally reached his goal of providing total obstetrical and gynecological care.

While serving as ACOG's 18th President, Brown died on January 9, 1969, at the University of Arkansas Hospital following another myocardial infarction. The remainder of his term was filled by then First Vice President Keith P. Russell, becoming ACOG's 19th President and later elected to serve a full term as ACOG's 24th President. Brown was survived by his wife, Dorothy Anderson Brown, and his two sons, Dr. Willis E. Brown, Jr., a neurosurgeon, and Dr. Robert M. Brown, a theoretical physicist. His legacy is his unsurpassed obstetrical and gynecological teaching to the many students, residents and practitioners whom he inspired and influenced.

HERMANN S. RHU, MD, 1980-1981
(b. 1914 - d. ____)

by Palmer C. Evans, MD, FACOG

As ACOG's 31st President, Hermann Rhu was particularly pleased to be representing the women he served and felt it important that clinically practicing obstetrician/gynecologists participate in governing the College. Hermann was always a consummate clinician, a bridge between privately practicing obstetrician/gynecologists and those in academia while getting along well with both. He graduated from Case Western Reserve Medical School and completed his residency at Syracuse University, going on to a fellowship at Boston Lying-In.

Practice years were spent as Senior Chief of Obstetrics and Gynecology at the Thomas Davis Clinic in Tucson, Arizona. All who worked with him including physicians such as myself and nurses were impressed with his consistently excellent judgment and confidence born of wisdom and knowledge. But Hermann also had a wonderful way with younger physicians, respecting their opinions and learning from them while he taught. Operating beside him was pure joy with his teaching style involving lots of give-and-take and not a hint of degrading or patronizing comments. Not surprisingly, he was unusually receptive to new ideas and always expanding his knowledge base in order to remain current. He was one of the few in his generation to take the time to learn laparoscopic surgery.

An ACOG Founding Fellow and at one time its Assistant Secretary, Hermann was also a member of the Committee on Future Development, Chairman of the Committee on Insurance and a member of the Committee on Professional Liability. He served as Chairman of ACOG District VIII and remained involved in other organized medical groups. He is a Past President of the Pima County Medical Society and the Pima County Chapter of the American Cancer Society, also serving on the Board of the Arizona Medical Association for seven years.

The College has been the one true love of Hermann's professional life. He and first wife Ruth, tragically lost to breast cancer, were gracious hosts to many of us privileged over the years to work or serve with him. He told everyone he met about the advantages of College membership, encouraging those in training to become Junior Fellows. Believing these young men and women to be ACOG's very lifeblood and future, he spared no effort to bring them into the fold.

Retired in Tucson with second wife Pat, Hermann was recently honored by the Pima County Medical Society with the Year 2000 Foundation Award for Excellence in Medical Education. This was a fitting tribute to a great teacher, an example and inspiration to all of us who had the privilege and pleasure of working with him.

GEORGE M. RYAN, MD, 1981-1982
(b. 1929 - d. ____)

by Frank W. Ling, MD, FACOG

Dr. George M. Ryan's 1977 arrival in Memphis, Tennessee, engendered among those who knew him a sense of progress and at the same time a return to the good old days. Seemingly paradoxical, this sense of simultaneously going forward and backward actually benefited Memphis medicine.

Although recruited from the north by the University of Tennessee's Department of Obstetrics and Gynecology Chairman, Preston V. Dilts, Jr., MD, none of us residents realized that George was actually coming home. By no means was this "Harvard Man" a Yankee. Growing up in Bay Springs, Mississippi, he was a graduate of the University of Mississippi (Ole Miss) located just a few miles south of Memphis in Oxford. It was no wonder he could so easily work and live within our distinctly Southern institutions and traditions.

Not only a return to his geographic roots, Ryan's move to Memphis was emblematic of his return to the roots of medicine. The fundamental concept of medicine, the patient-physician relationship, again became our greatest priority with his implementation of efforts to recapture the true spirit of the office visit. Along with Drs. Patrick Sweeney and Abiodun Solola, he encouraged quality patient care and quality physician education in office and clinic settings. Nurses and physicians alike were taught that an office visit was the critical foundation upon which to build quality patient care. Residents and even on occasion staff physicians were sent back to the L&D locker room or home with instructions to dress in attire more appropriate than scrubs when seeing patients in our office facility. This traditional respect for patients taught us how to better care for women outside the hospital environment.

Ryan returned geographically, took clinical care back to its roots, and also returned to his cultural roots through his lifelong avocation - jazz. His band became well known on the jazz festival circuit, a previously undiscovered art form for many of us younger in years. It was fascinating to see the consummate physician with his patients one moment and the next watch as he seamlessly made the transition to musical performer and stage personality.

In taking us back Ryan also helped us move forward. Technology and medical advances weren't ignored but rather implemented with the future in mind, recognizing that expertise in outpatient medicine would be vital to future generations of physicians. When outpatient surgery became a novel idea resources were quickly allocated for this type of facility. Realizing traditional respect for patients would have to be a part of this new practice paradigm, our Ambulatory Care Division was instrumental in preparing a generation of physicians and pivotal in caring for a generation of patients.

Ryan served as a mentor to many. He invited me as a senior resident to represent the Tennessee Section in the American College of Obstetricians and Gynecologists. A few years later I had the unique pleasure and honor of Chairing the National Junior Fellow College Advisory Council, coincidentally during his Presidency. Somewhat ironic but also demonstrating a sort of cosmic symmetry at an organizational level!

When George Ryan's life is tallied one recalls magnificent white hair, extraordinary leadership, a hot jazz trumpet, a ready smile, a warm handshake and a remarkable vision for the future of women's healthcare. There are many others who could add their warm recollections of his contributions to their professional development. He's just that kind of a guy.

ROBERT C. PARK, COL., MC USA, 1988-1989
(b. 1932 - d. ____)

by Thomas W. Burke, MD, FACOG

COL Robert C. Park became the 39th President of the American College of Obstetricians and Gynecologists in 1988 at the height of a distinguished medical and military career. True to character, his Presidential Agenda focused on the ethics of obstetric and gynecologic practice. But Bob started small, obtaining his undergraduate degree from Franklin and Marshall College in Lancaster, Pennsylvania, followed by an MD from Hahnemann Medical College in Philadelphia (now MCP Hahnemann University) and rotating internship at Lower Bucks County Hospital in Bristol, Pennsylvania. A dual lifelong dedication to his chosen specialty and the United States Army Medical Corps began in Silver Springs, Maryland, in 1962 upon his acceptance to its Walter Reed General Hospital residency training program.

For the next four decades Bob managed to intertwine the rigorous demands of military service with an advancing medical career dedicated to treating women with pelvic cancers. His military assignments ran the gamut of opportunities for Medical Officers. From Captain to Colonel, Bob served in an impressive number of leadership positions: Seoul Military Hospital [1959]; Taegue Korea Dispensary [1960]; Assistant Chief, Obstetrics & Gynecology, Fort Carson MEDDAC [1965]; Commanding Officer, 74th Medical Battalion, Chu Lai [1968]; Chief, Gynecologic Oncology, Walter Reed Army Medical Center [1971]; Chief, Obstetrics & Gynecology, Walter Reed Army Medical Center [1978]; Consultant to the Surgeon General of the Army [1979]; Chief, Clinical Policy Consultants Division, Surgeon General of the Army [1983]; and Deputy Director of Professional Services, Surgeon General of the Army [1987].

His many simultaneous contributions to obstetrics and gynecology received similar recognition: Director, Gynecologic Fellowship Program, Walter Reed Army Medical Center [1971]; Chairman, Ovarian Tumor Committee, Gynecologic Oncology Group [1973]; Professor and Vice-Chairman, Department of Obstetrics & Gynecology, Uniformed Services University of the Health Sciences [1978]; Chairman, ACOG Armed Forces District [1980]; President, Society of Gynecologic Oncologists [1986]; President, American College of Obstetricians and Gynecologists [1988]; Chairman, Gynecologic Oncology Group [1989]; and President, Society of Gynecologic Surgeons [1990]. In his_remaining time Bob managed to write or contribute to over 100 scientific publications and book chapters, trained fellows and residents, and cared for patients.

An unlikely product of the 60s and 70s, my medical education was financed by a U.S. Army scholarship. I first met COL Park in 1980 while a resident interested in gynecologic oncology at Honolulu's Tripler Army Medical Center. He was visiting as the Army's senior gynecologic oncologist and its Office of the Surgeon General representative tasked with future assignment of Army obstetrician/gynecologists. I specifically sought him out to express a desire to move directly from residency to fellowship, but Bob countered with the comment that some "seasoning" prior to subspecialty training would be best.

Consequently I spent two years practicing general obstetrics and gynecology in a small Army hospital at Fort Leavenworth, Kansas. Bob was right. The Army's smaller medical units were never overstaffed and junior physicians were expected to assume leadership roles at an early point in their careers. I used this time to better develop diagnostic talents, surgical techniques, people skills and administrative abilities. Eventual gynecologic oncology fellowship with Bob at Walter Reed was well founded on practical experience in obstetrics and gynecology as well as military medicine, a distinct contrast to the oncology fellows I now train directly out of residency.

During the fellowship Bob truly became my mentor. We had a superlative group of residents, fellows and faculty. Bob, Bill Hoskins and Paul Heller started a monthly journal club that consisted of dinner followed by presentation and discussion of a controversial topic by one of the fellows. Hosting the dinner rotated and liquid refreshments were expected. When his turn came Bob would always leave work early to fire up the grill and precook his special hamburgers, fondly referred to as "Park Pucks" because by the time we finished rounds and arrived at his house_they would be well past rare.

We were always anxious to analyze clinical data and publish patient care results. In that precomputer age the entire fifteen years' experience of the Walter Reed Gynecologic Oncology Service was recorded in ***The Robert C. Park 3x5 Card File***. This early database consisted of drawers containing hundreds of file cards on which Bob had painstakingly written patient information, staging and prognostic data, treatment plans, and follow-up information storing amazingly vast quantities of medical and research data in very small spaces. If only it had been legible! I probably spent as many hours deciphering Bob's handwriting as I did filling out data sheets.

Bob integrally involved himself in every treatment decision made on his service by presiding over weekly tumor board meetings. These educational patient care conferences exemplified the original multidisciplinary model by including gynecologic oncologists, pathologists and radiation oncologists plus gynecology residents and nurses. Bob never abandoned his model of

patient care, continuing to attend and contribute to these conferences while ever more senior positions placed increasing demands on his time.

As a senior fellow I greatly appreciated Bob's willingness to remain in the shadows while allowing me to manage patients in the clinic, on the ward and in the operating room. This probably would not have been possible without the "seasoning" he had insisted upon and a junior fellow year under Bill Hoskin's tutelage. Bob showed me how to trust trainees and manage from a distance without compromising patient care. I honestly believe this philosophy and our program's camaraderie inspired eight or nine of us to subsequently become gynecologic oncologists, with Bob Park always acting as our role model.

I didn't want to leave Washington upon completing my fellowship and tried to convince Bob I was the ideal candidate for his gynecologic oncology faculty. Again Bob thought I needed a few years "seasoning", this time at Brooke Army Medical Center in San Antonio, Texas. My residency training program director was now Chief in San Antonio and had specifically requested I be assigned to his service. Captains never outrank colonels so off I went to the land of longhorns and longnecks. I learned a lot in Texas - writing papers, training residents, caring for patients and fulfilling my military service obligation. After two years the opportunity to return to Walter Reed as gynecologic oncology faculty arose and while tempting, a number of other offers also surfaced. I ultimately chose the University of Texas M. D. Anderson Cancer Center in Houston. Bob graciously wrote the letter of reference securing my assistant professorship.

Over the past 15 years Bob has always been available. When I needed a letter recommending promotion or tenure, he wrote it. When I needed a sponsor to join our specialty society, he was it. When considered for a national committee or society assignment, he recommended it. Each of my contemporaries could recount a similar litany of instances when Bob Park has promoted their careers. Many of the principles I currently advocate for my fellows are liberally borrowed from my own training, including maintaining a "big picture" focus, multidisciplinary teamwork, personal integrity, clinical judgment and the key role of research. I was fortunate to encounter Bob Park at a critical juncture in my life and am very grateful for our long friendship.

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