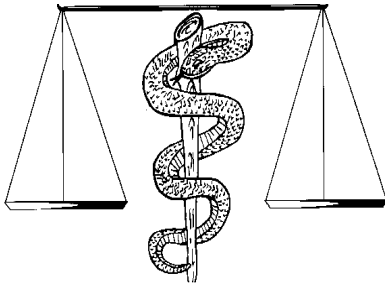


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OUTCOME FOLLOWING PRETERM PREMATURE RUPTURE OF THE MEMBRANES

by **John D. Yeast, M.D., FACOG**

Premature rupture of the membranes (PROM) before 28 weeks gestational age is a relatively uncommon event posing extremely high morbidity and mortality risks for newborns. It occurs in less than 1% of pregnancies and less than 0.5% will experience PROM before viability. The potential complications of prematurity including infection and pulmonary hypoplasia only further complicate management and worsen prognosis.

A series of reports over the past decade have documented the expected clinical course for patients with early-onset PROM. Mortality has been related to gestational age at both PROM and delivery in addition to the severity of oligohydramnios. The latency period from PROM until delivery has been found to be an important variable as well. Longer latency periods translate to more mature gestational ages at delivery but may also increase the dangers of oligohydramnios. Management is still generally expectant until labor, infection or non-reassuring antepartum fetal testing indicates delivery.

Approximately six years ago we reviewed and published over 100 infant outcomes in mothers whose pregnancies were complicated by PROM at less than 29 weeks gestation. No one variable alone predicted the development of lethal pulmonary hypoplasia but PROM before 25 weeks gestational age, severe oligohydramnios and a latency period of less than fourteen days predicted mortality with near 100% accuracy. Severe oligohydramnios as a result of PROM at or before viability was strongly associated with poor outcomes.

Therapy for many patients with early-onset PROM has recently been modified. Prophylactic antepartum maternal antibiotics are more often utilized, antenatal maternal steroids are more often given and pulmonary surfactant combined with aggressive ventilation is now the norm for these newborns in most institutions. Consequently the prognosis for infants born following early-onset PROM may be improving over the past's guarded results.

Last year we prospectively studied outcomes for 81 consecutive infants born following PROM at less than 29 weeks gestation. These mothers and infants had the benefit of the treatment modalities noted above. General management was still expectant unless labor, infection or non-reassuring fetal status was diagnosed.

(Continued on page 23)

THE PRESIDENTIAL BOX

ATTENTION ALL HANDS!

Dan Avery agreed to loan me this space for his last issue as President and what I have to tell you is of the utmost importance. Most people probably read this rag from the front to the back so the "Presidential Box" should be the first thing everyone sees, if they read any of the *Newsletter* at all. In addition to other problems of which you're already aware we are approaching a meltdown with our membership roll. Our bylaws have from the very first welcomed retired physicians as dues exempt honorary members. We still do and expect to always. As a relatively inexpensive way to thank those who write for us sans compensation your editor has offered one year Honorary Memberships to authors upon publication of their work. This has worked fairly well and more than a few have been of a mind to convert to dues paying members the following year. We also have some people whom I will call our angels, from the start providing indispensable advice and assistance to the Society and the *Newsletter* simply because they thought this was a good idea. One even humbled me by insisting on becoming a dues paying member. They will be Honorary Members in perpetuity until they either tell me to stop sending the *Newsletter* or it's returned as undeliverable. We also have one Life Member, Ben Harer, who as last year's "ASFOG Man of the Year" will never have to pay dues again. Over the past year the ACOG Past Presidents Project has been a resounding success judging by comments I've received but it has also blessed us with quite a few retired and actively working Honorary Members, the first of which will be celebrating the one year anniversary of their article's publication next month. More than a few of those participating in the project have already become dues paying members. Over the next year the others will be dropped from the membership roll on their anniversary unless they're entitled to Honorary Membership under the Bylaws.

Here's the rub. I no longer have a clue who among the Honorary Membership is retired and who is not. I don't want to drop anyone who is entitled to Honorary Membership but we can't in all good conscience carry indefinitely those who are working and have a cash flow. If things go according to plan, and they never do, you'll receive the last *Newsletter* included in your 2001 dues January 2002. It will be accompanied by the annual call for dues. If you are fully retired (defined as no longer receiving income from your professional activities as a physician including clinical, academic or administrative practice; teaching; medical case review or testimony; peer review; or industry consulting) please send me a letter to that effect instead of a dues check. Some of our Honorary Members have continued employment in fields completely removed from medicine and should not consider themselves' responsible for the Society's financial support. If you are semi-retired and still work occasionally as a locum tenens physician, medical expert witness or any other profitable endeavor, please consider becoming a dues paying member. If you think the *Newsletter* nothing more than junk mail and deposit it in that tall, round, gray receptacle standing beside the post office exit or use it to line the bottom of your canary's cage, please send me a note so advising and I'll quit sending it. As I was writing that last sentence it suddenly struck me that those who never read their *Newsletter* will not see this. For the rest of you who decide to become or continue as dues paying members for 2002, please feel free to send that \$100.00 check now if you want to get it on your 2001 taxes. As usual the financial cupboard is more than bare by the end of the year and there are always bills to be paid.

One last thing. If you really want to see this sucker fly, talk about what we're doing. Pass around copies of the *Newsletter's* articles. Recommend membership to your friends, partners and colleagues. And like Jimmy Swaggart used to say, keep them cards and letters comin', preferably with a check.

Doug

THE WITNESS BOX

by Doug Daniel, Editor

"You should not trust every book wholeheartedly. You should read them, of course, because it would be impossible to recreate the entire medical experience by yourself, as Hippocrates implied when he wrote: 'The art is long, but life is short.' However, you should remember the less-quoted phrase that Hippocrates added to that aphorism: 'Experience is deceiving.' To believe everything you read with no qualifications is to indulge in the Myth of Infallibility. All physicians make mistakes; the excellent physician is the one who is corrigible."

Jane M. Orient, MD, in Sapira's Art and Science of Bedside Diagnosis, 2000

This month we gain six new Honorary Members. Alvin Langer is Professor Emeritus, Northeastern Ohio Universities College of Medicine; previously Academic Director of Obstetrics and Gynecology for Aultman Hospital in Canton, Ohio, and Chair of the Universities' Department of Obstetrics and Gynecology. He joined after reading fellow new Honorary Member Roy Pitkin's piece in the October 2001 *Newsletter* on ACOG Past President William Mengert. Tom Burke wrote on Robert C. Park (OCTOBER 2001), Frank Ling wrote on George Ryan (OCTOBER 2001), Palmer Evans wrote on Hermann Rhu (OCTOBER 2001) and Weir Horswill wrote on Ralph Campbell (May 2001). Their bios are in those issues' "Witness Box". **Welcome aboard, y'all.**

Your Board of Directors met 11 OCTOBER 2001 via telephone conference call. Election of Vice President-President Elect for 2002 was held with Elliot Levine of Chicago being the sole nominee, elected by acclamation. Accordingly, with regret we will lose Immediate Past President Paul Sinkhorn as a Board member. Paul has been a pillar of strength for the Society during his tenure on the Board as the rest of us tried to just keep up to the example he set. Thanks, Paul, for everything. Kenny Stall, President for 2002, will be setting up our annual ACM membership meeting in Los Angeles.

And now for the latest from www.asfog.com. After our first year on the web monthly activity is fairly stable at about 500 visitors making 1600 visits. The majority visit only briefly, less than a minute, but the rest must see something they like. Most importantly we gained five new members from the web.

So Tell Me Something Else I Didn't Already Know Department: "Desire for Fertility Should Guide Endometriosis Treatment" and "Health Priorities in Congress Shift to Bioterrorism", from *Ob.Gyn.News*, Vol. 36, No. 21, 1 November 2001.

In case you haven't noticed there've been some big changes over at the green journal under its new editor. The most obvious are changes in type font, layout and format but the most interesting is the addition of an editorial section in the front of each month's issue. The ones I've seen have featured big dogs in our specialty commenting on several accompanying articles, either emphasizing their relevance with an additional two cent's worth or advising us more directly of their clinical implications. If an editorial accompanied each article you'd have the *Surrey* or Ralph Hale's *Clinical Review*, but in no way does it seem derivative. Instead the editorials make the green less cut and dried, more personable, looser. As for the other changes, I guess the new sheriff in town had to let everyone know he was his own man.

If you missed it, the November-December 2001 issue of *ACOG Today* (Vol. 45, No. 10) had several articles of more than passing interest. One addressed the increasingly frequent problems of short-staffed nursing services on L&D suites and using untrained, inexperienced nurses there ("You asked/We answered", page 6). Just for the record, this isn't a new problem. It's an old problem that's been around forever and is suddenly getting worse with managed care's ever-tightening money screws. I've always felt badly for our most valuable asset, the well-trained and experienced L&D nurse who was cool and efficient under fire, always there when you needed her, knowledgeable about her special field of practice, and able to leap tall buildings with a single bound. She was however rare as hen's teeth and when found, grossly underappreciated by everyone, most especially her nurse managers. Somehow obstetrical nursing never got the respect it deserved, instead being relegated to the "anybody can do it" category best personified by the jack of all trades, master of none. Imagine the uproar if an inexperienced OR nurse on call came in to run an emergency trauma surgery. What would happen if an agency temp with no ICU experience showed up in the Coronary Care Unit at 11:00 pm to assume care of a ward full of recovering MIs? How many times have you worked with a nurse temporarily assigned to L&D from the med-surg ward and wondered how much she was going to miss when caring for your laboring or delivering patient? How many times have you arrived in the middle of the night to find the youngest, most recently graduated and licensed, last hired nurse alone in L&D with your patient?

Our hospital management culture seems to hold sacred that we overstaff L&D dayshifts Monday through Friday excluding holidays with our best personnel, the ones with the most experience and seniority who want to work days while letting

nights, weekends and holidays fall where they may, usually to the newest and most junior personnel. At night in the small Level I hospital the L&D nurse is often on call outside the hospital and may take an hour or more to come in. Sometimes you're stuck with an inexperienced nurse from another area. The end result is just as bad when the night crew has been working eleven-to-seven forever because they prefer it. They never see the dayshift routines or unusual procedures, miss any chance at formal or informal CME, and more importantly are never directly observed by their managers. If we really want to improve our level of patient care and keep our nursing staff in top form, we need to rotate everyone. That way managers get to see what's happening in the dark hours and night owls get oversight.

There's another facet to this problem. A recent article in *OB.GYN.NEWS* (Breast cancer risk rises with night-shift hours, page 10, 01 DECEMBER 2001) reported on research by two investigators, the first Scott Davis, PhD, of the Fred Hutchinson Cancer Research Center in Seattle, Washington, who found a 60% higher risk of breast cancer among women with a ten year history of nightshift employment compared to those who had never worked the 11 to 7. Risk rose significantly according to the number of night hours worked per week with twice the control group's risk for women working at least 5.2 hours per week on a nightshift. A 14% increased risk for each night per week on the graveyard shift was also found in other women who often didn't sleep during the dark of night. The article didn't elaborate but strippers, bar maids, cocktail waitresses, blackjack dealers, telephone operators and Waffle House waitresses immediately come to mind. The causation was posited to be lack of sleep during darkness when melatonin levels naturally increase and apparently provide a protective effect against breast cancer. There was even slightly increased risk for women who slept at night in brightly lit bedrooms. My biggest concern is what this may portend for the risk of other glandular epithelial carcinomas, even malignancies in general, among obstetricians and others regardless of gender spending major portions of their lives working during the dark of night. On second thought it probably will not affect obstetricians since we never get to sleep the following day after being up all night.

Another investigator, Eva S. Schernhammer from Harvard Medical School and Boston's Brigham and Women's Hospital, reviewed data on 78,562 women from the Nurses Health Study and found that those who had worked 30 years or more on rotating night shifts had 36% greater risk of breast cancer compared with those who had never worked nights. While rotating shifts may not remove all the risk, it does appear to at least halve it. Just two more bricks in the wall of a solid argument for rotating all nursing personnel among all shifts, perhaps even an argument for going to two twelve hour shifts and a 36 hour workweek instead of three eight hour shifts and a 40 hour week. The original articles can be found in the *Journal of the National Cancer Institute*, Vol. 93, No. 20, 2001, pages 1557-62 and 1563-67.

It's high time everyone recognized that obstetrical nursing is an area of expertise requiring specialized training, experience, and skill levels not expected of or found in every nurse. Remember the obstetrician will always be held accountable for the sins of the L&D staff. If we continue as before, only letting the problem worsen, preventable disasters will occur more frequently. There will be no improvement in obstetrical nursing until obstetricians refuse to attend patients in those hospitals without adequate numbers of competent nurses to care for laboring patients. The only alternative is to provide intrapartum nursing care yourself at the bedside or hire a competent L&D nurse, not necessarily a nurse midwife, to care for your patients in labor. When you think about it, that ain't such a bad idea if your practice has enough patient and cash flow to afford it.

Another article ("Excessive resident work hours get national attention", page 9) resurrected the years-old hand wringing over working residents too hard. Apparently the whole nation is going to be held to the New York State Residency Working Hours and Hospital Code Regulations. Having worked as an attending in this circumstance I can tell you it seriously erodes resident education by decreasing the number of clinical cases they are exposed to and lessening the training experience in responsibly delivering patient care under supervision. If residents want to work nine-to-five Monday-through-Friday they would be best advised to select another specialty or start studying for the bar exam. On the other hand if my prediction is accurate that soon we'll all be punching The Man's clock anyway, perhaps it is best to start paying trainees by the hour based on productivity now and cease paying them for time spent in formal educational activities. Of course these decreased hours per week will require extending the years of training by probably 25% to ensure adequate clinical practice under supervision before graduation. I can almost hear the screams of outrage now.

In case you've been questioning whether to increase your fee schedule in these lean economic times, be assured it's OK to overcharge your patients. I recently was shown a patient's bill for her first visit as a new, uncomplicated gynecology patient. The fee for the office visit was \$185.00 of which her insurer paid \$72.00, the fee for Pap smear was \$40.00 of which her insurer paid \$32.00, and the separately billed fee for rectal examination was \$22.00 of which her insurer paid \$12.80. Those of you who've been reading the *Newsletter* for more than a few years have before heard me bitch about dropping the digital rectal examination from routine bimanual pelvic examination. It now seems to have reappeared, unbundled and at an additional premium of over twenty dollars. But there's more. The physician is a family practitioner, not a gynecologist. Ready for some more? He didn't even see the patient. She was seen by his nurse practitioner. 'Nuff said.

In this month's lead article John Yeast gives us the latest scoop on prolonged PROM in late second trimester pregnancies. John earned a BA and MSPH from the University of Missouri and joined the United States Navy to serve as a Public Health Officer in Norfolk, Virginia, and Staff Epidemiologist in Naples, Italy, before returning to UM for an MD followed by internship and residency at Naval Regional Medical Center San Diego, San Diego, California, where he later served as its Chief of Obstetrics and Gynecology Service for two years. He then moved on to a fellowship in maternal-fetal medicine that included training at Women's Hospital and Memorial Hospital Medical Center in Long Beach plus the University of California-Irving in

Orange, California. He's currently Clinical Director, Vice Chairman and Associate Program Director of Saint Luke's Hospital of Kansas City's (Missouri) Department of Obstetrics and Gynecology; Professor, Department of Obstetrics and Gynecology, University of Missouri-Kansas City; and Medical Director, Obstetrix Medical Group of Kansas and Missouri, PA. John's an ad hoc reviewer for *Obstetrics and Gynecology* and the *American Journal of Obstetrics and Gynecology*, Examiner for the American Board of Obstetrics and Gynecology, and a member of Planned Parenthood of Greater Kansas City's Board of Directors. He's a member of AOA and cultivates an interest in medical and bioethics with involvement in multiple ethics committees, boards, and centers. Research interests include preterm PROM, labor induction, placenta previa and chemical mediators for onset of labor. John's published extensively in the specialty's peer reviewed and popular literature in addition to contributing to multiple medical texts and ACOG CME programs.

Dan Avery let me borrow his "Presidential Box" this month to tell you about a potential problem with the membership rolls. Had I seen it coming there were ways it could have been avoided. As it is, we're facing a bit of a sticky wicket but should be able to solve it with minimal embarrassment if everyone responds.

This month's Hot Box has my heads-up on the latest regarding maternal corticosteroids in threatened premature labor from your friends at the NIH. This topic seems to be in a constant state of flux, telling me we still don't know what we're doing with this stuff.

In this month's Book Box I review Sapira's Art and Science of Bedside Diagnosis by Jane Orient, MD. If you get the *Newsletter* before the holidays, this would make a tremendous gift. If you get it after the holidays, this would still make a tremendous gift.

This month's Suggestion Box by Sid Wilchins gives us his valuable assessment of the current medmal situation and how best to deal with it. Sid's a Founding Member of the Society and its first President, having decided long ago he would come out swinging instead of just bending over, smiling, and asking "Please, sir, may I have more?" Over the years he's taken some pretty good pokes in the *Newsletter* at medmal inequities and abuses in addition to being an unflagging supporter of the Society (*The Medical Expert Witness: A New Mandate*. Vol. VII, No. 1, January 1999, p. 26; *Junkyard Dogs: Galileo's Revenge: Junk Science in the Courtroom*. Vol. VII, No. 2, April 1999, p. 10; *On Diminishing Returns*. Vol. VIII, No. 1, January 2000, p. 14). Ditto this time.

In this month's Litter Box I've got some leads on recent thought-provoking and relevant articles. The internet is a fantastic information resource, especially for our rapidly expanding and changing scientific knowledge and particularly for medical knowledge. Make no mistake, reaching this conclusion took quite a while and admitting it even longer. The Society's corner of the web is a direct result of Ray Cestero and Paul Sinkhorn's unremitting advocacy combined with financial and practical support. I checked the numbers just the other day. In November we had 761 visitors make 1766 visits from the U.S. and nine foreign countries, over 19,000 visits in the past year! And they're all at no cost to the visitor. Anyone can visit our site with unrestricted, free access and read, download or copy anything from the *Newsletter* archives. Initially Paul withheld the most current issue but now he posts it as soon as he gets it. I think this reflects quite well on our Society, especially compared to the archives of much more prestigious journals and their sponsoring organizations.

For this issue I tried to get copies of four peer-reviewed articles. All the publishing journals would sell them to me on a per item basis or for a yearly fee. The *New England Journal of Medicine* had this arrangement for articles published within the past six months but all others could be downloaded for free after providing demographic information and selecting a password. The *British Journal of Obstetrics and Gynaecology* had the same arrangement as *NEJM* except there was no demand for information. The *American Journal of Obstetrics and Gynecology* and the *Australian & New Zealand Journal of Obstetrics and Gynaecology* allowed access to their archives only for a fee, available per item or annually. I don't know what the green journal's policy is but expect to find out on my next visit to the library.

This is ridiculous. Publishers are certainly entitled to financially profit from their business, but professional medical and scientific organizations should not restrict the now potentially unfettered flow of research and clinical information. My local college library maintains a pretty decent collection of medical journals. I can go there and read *NEJM* or copy an article for ten cents a page the same day it is received. But I can't download the same article without paying for the privilege.

Okay, here's the bottom line. If a publisher pays an author for his intellectual property, i.e. John Grisham's latest thriller or the 21st edition of *Williams*, the consumer should pay a reasonable fee to access it via the internet, schlep over to his nearest bookstore (including www.amazon.com) and purchase a hardbound copy at market price, or trudge to the nearest public or medical library to borrow a copy if available. On the other hand if the publisher obtains the author's intellectual property at no cost in the name of advancing scientific knowledge and the author's reputation, there should be no restriction to access and only citation requirements for its further dissemination.

You may ask, "How will scientific publishers survive financially?" The same as they did before the digital revolution, paid advertising. Although the thought is more than just unpleasant, they could sell the same ads from their print publications on their web sites like Yahoo, Ask Jeeves and other public access sites. I don't know. Maybe I'm just getting crotchety in my old age.

The last issue's "President's Box" seems to have sparked more than a passing interest among our readers (Avery DM. *Et Tu, Brute?* Vol. 9, No. 4, October 2001, page 2) as evidenced by this issue's "Mail Box". For those of you who subsequently pondered the vagaries of medical expert witness testimony and shoulder dystocia management, we have a surprise! Check out Dan's article on its clinical management. It's a review of the literature's recommendations with a logical progression for dealing with increasingly difficult situations. Realize that some of the procedures discussed are not recommended or used by the author and are included for scientific interest only. Each individual will have to decide which interventions he is competent to use and judge his response according to the clinical situation he faces. There is no substitute for anticipation combined with physical and mental rehearsal.

This issue contains another four articles in our series on ACOG Past Presidents. Jim Warren and Ming Kao remember Arnie Arneson, ACOG's 15th President, from their long association with him in Saint Louis, Missouri. Jim, a native Oklahoman, earned a magna cum laude AB degree from the University of Wichita and his MD from the University of Kansas. Internship followed at the University of Kansas Medical Center and then two years as a Medical Officer in the United States Navy. After discharge it was on to the University of Nebraska for residency and a PhD in biochemistry. He then returned to the University of Kansas where he simultaneously held Assistant Professor status in the School of Medicine's Obstetrics and Gynecology plus Biochemistry Departments, eventually rising to Professor of both. Two postdoctoral fellowships in biochemistry followed in addition to teaching the subject for a year each at the University of Mexico School of Medicine in Mexico City and the University of Geneva in Switzerland. In 1971 he was named Professor and Head of Saint Louis's Washington University School of Medicine's Department of Obstetrics and Gynecology plus Professor of Biological Chemistry until retirement to emeritus status in 1993. Clinical and research activities included reproductive endocrinology and population control. Over a hundred peer-reviewed scientific articles and textbooks bear his authorship. Not surprisingly, Jim is a member of AOA and has served on multiple NIH committees and study sections. He is a Past President of the Society for Gynecologic Investigation.

A native Taiwanese, Ming earned his MD degree from the National Taiwan University in Taipei and completed his internship at National Taiwan University Hospital. He then spent a required year as an ROTC Medical Officer in the Republic of China Army before general surgery residency, again at National Taiwan University Hospital. He then immigrated to the US for a rotating internship at Methodist Hospital of Central Illinois in Peoria before moving to Saint Louis and coming under Arneson's influence as a resident at Washington University School of Medicine. Another move then took Ming to Queen's Hospital in Kingston, Ontario, Canada, for a gynecology fellowship with subsequent ABOG subspecialty certification in gynecologic oncology. He is currently Professor of Pelvic Surgery, Department of Surgery plus Professor and Deputy Chairman, Department of Obstetrics and Gynecology at Saint Louis University School of Medicine in addition to having served as Acting Chairman of its Department of Obstetrics and Gynecology. He has served his native land as a member of the Scientific Review Committee of the Republic of China's National Health Research Institute and also National Taiwan University's Academic Advisory Committee.

The medical literature is replete with Ming's articles and textbook chapters. A member of the editorial board of *The Journal of the Formosan Medical Association*, he is also a reviewer for the *American Journal of Obstetrics and Gynecology*, *Cancer*, *Gynecologic Oncology*, the *Journal of the American College of Surgeons*, and *Obstetrics and Gynecology* in addition to extensively teaching and lecturing upon invitation at Taiwan's universities, medical schools and professional medical meetings. Perhaps most tellingly, Ming has been the recipient of student-voted teaching awards including Saint Louis University Residents in Obstetrics and Gynecology Award of Excellence in Resident Education; Saint Louis Maternity Hospital Department of Obstetrics and Gynecology Memorial Wall for Outstanding Teachers, Washington University School of Medicine; Barnes Hospital Residents in Obstetrics and Gynecology Chief Resident's Award, Washington University School of Medicine; and Barnes Hospital Residents in Obstetrics and Gynecology Teacher of the Year Award, Washington University School of Medicine.

Dave Foley and Bill Martens give us a glimpse of Fred Hofmeister, ACOG's 25th President. Dave spent his WW II years in the United States Navy and holds a BS from Marquette University, MS from Loyola University Medical School and MD from Marquette University Medical School. Rotating internship was at Milwaukee County General Hospital and residency followed at Loyola with a National Institutes of Health Pelvic Oncology Fellowship under Herbert Schmitz there also. Dave's been on the teaching faculty at Loyola, Marquette and the Medical College of Wisconsin in addition to privately practicing gynecologic oncology. He's currently retired from practice and enjoys spending time with his wife, Jean Francis, traveling, and playing bridge with his friends. Bill was a resident and later practice partner of Hofmeister's.

Bill Martens earned both BS and MD degrees from the University of Wisconsin and then interned at Milwaukee Hospital, serving two years active duty with the United States Army Medical Corps before returning to Milwaukee for residency under Hofmeister at Lutheran Hospital. He is a Past President of the Wisconsin Society of Obstetrics and Gynecology and the Milwaukee Gynecological Society in addition to presenting multiple exhibits, films and papers at ACOG Annual Clinical Meetings. He also served as Hofmeister's co-author on several peer-reviewed articles.

Living in the same neighborhood, Martens first met Hofmeister while a sixth grader when a donation of basketball uniforms required a personal home visit to express the team's thanks. The summers after freshman and sophomore years of medical school were spent as a surgical extern at Milwaukee Hospital, mostly in the gynecology suite watching Hofmeister and others. He tells of one instance when while scrubbed as the second assistant on a Hofmeister vaginal hysterectomy, a suture broke during tying and Hofmeister's fist inadvertently punched Martens in the nose. This and other experiences during those two

summers led to Bill's choice of residency, and upon completion Hofmeister issued an invitation to join him and his associates in their private practice.

John Boyce has known ACOG 42nd President Richard Schwarz since almost forever, working for him from 1978 until 1990 and then succeeding Schwarz as Chairman of the Department of Obstetrics and Gynecology at the State University of New York Downstate Medical Center in Brooklyn. John is a native of Trinidad, West Indies, and earned his undergraduate degree there from Saint Mary's College followed by an MD from the University of British Columbia in Vancouver, Canada, and an MS in biostatistics from the Columbia University School of Public Health in New York City. Rotating internship, residency and fellowship in gynecologic oncology were at Kings County Hospital Center, also in Brooklyn. He then went to work for Schwarz at SUNY Downstate, eventually replacing him upon retirement.

John's a member of the National Medical Association, an examiner for the American Board of Obstetrics and Gynecology, Past Chairman of ACOG District II, Past President of the New York Obstetrical Society, and served on the Executive Boards of ACOG and the National Cancer Institute's Division of Prevention and Cancer Control. His reputation as a teacher and author in both the peer reviewed and popular medical press is stellar.

Isaac Schiff gives us his portrait of Freddy Frigoletto, 47th ACOG President. Isaac is a native Canadian and naturalized US citizen who graduated from Montreal's McGill University as a University Scholar with a BS, then stayed to earn his MD from its Medical School. Internship followed at Montreal General Hospital and then an internal medicine residency there. Isaac immediately immigrated to Boston for a residency in obstetrics and gynecology at the Boston Hospital for Women and then six months postgraduate training in general surgery at nearby New England Medical Center. After that it was back to the Hospital for Women for a fellowship in reproductive endocrinology. While perhaps appearing redundant or misguided to some younger colleagues, this was the classic method of training for academic medicine until the latter half of the 20th century. Few to none of Isaac's contemporaries are nearly as well trained.

Isaac has been Harvard Medical School's Joe Vincent Meigs Professor of Gynecology since 1988, Chief of its Department of Obstetrics, Gynecology and Reproductive Biology 1996-1998 and Chief of the Massachusetts General Hospital's Vincent Memorial Obstetrics and Gynecology Service since 1993 in addition to being a Past President of the Obstetrical Society of Boston and the North American Menopause Society, the latter of which he also served as a member of its Executive Committee. He is Editor of Clinical Perspectives in Obstetrics and Gynecology, Editor-in-Chief of *Menopause*, and Guest Editor of an *American Journal of Obstetrics and Gynecology* Supplement. He serves on the editorial boards of the American Health and Fitness Association, *Obstetrics and Gynecology Forum*, *Journal of Women's Health*, *Menopause Management*, and *Climacteric*. A listing of his contributions to peer reviewed and popular medical literature plus textbooks runs ad infinitum. And I'll bet his French is letter perfect.

There's a reprint this month from the North Carolina Medical Board's *Forum* on the legal requirements as well as latitude imposed on and provided to physicians caring for minor patients, especially obstetrician-gynecologists. It is of course written to comply with the statutes of North Carolina and you should check with your attorney friends before considering its advice to be the gospel in your jurisdiction, but it probably travels quite well. One aspect that most likely will draw your attention as it did mine is the statement that alleged sexual assault (rape) in minors is not a mandatory reportable crime. This hinges upon the presumption that every pregnant minor is a victim of at the least second degree sexual assault. Closer reading will reveal a mandate for reporting to state social agencies tasked with protection of minors but not necessarily law enforcement agencies. This is a fine distinction but each of us has in the past and must in the future make it. The most important point is to be aware of your jurisdiction's requirements and the judgmental discretion they allow. The author, Anne Dellinger, is a Professor of Public Law and Government at the University of North Carolina and apparently plans a series of five publications covering the legal aspects of female adolescent healthcare relevant to physicians, social workers, public school personnel, parents and finally teenaged patients themselves. The series, funded by a consortium of charitable and public funds, will be distributed to appropriate parties free of charge. If your state doesn't have a similar project, it should. The College hasn't as closely addressed this aspect of clinical practice on a national level because jurisdictional variances are innumerable, but section officers should make it one of their pet projects for their state's Fellows.

As a side note, the *Forum* also saw fit to reprint one of our pieces on commercializing your office into retail sales ("Y'all want fries or a pie with that?", *The Medicolegal Ob/Gyn Newsletter*, vol. 9, no. 3, May 2001, p. 10).

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 audio cassette tapes of the Society's 2000 and 2001 ACOG ACM presentations on impaired physicians and a mock trial 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

21 MAY 2001

Dear Doug,

I got my *Newsletter* today and read it with interest. While reading Anant Bhati's article about Dick Schmidt's "deeply deploring the predictable deleterious effects it (safe, legal, relatively cheap and readily available elective abortion post *Roe v. Wade*) has had upon the nation's most fundamental values", I began to wonder if we might impose upon Dick to clarify exactly which of our most fundamental values he feels have been deleteriously affected.

I have always been proud to be a Fellow of the internationally recognized professional medical association of obstetricians and gynecologists which found the courage to support the *Roe* and *Doe* decisions with amicus curiae briefs before the Supreme Court of the United States when such support was vital to their survival yet slow in forthcoming from other quarters. I'm now even prouder to know that a committed few literally put their reputations on the line by acting independently of and contrary to the obviously strong wishes of others also entrusted with governing the College.

Recently a colleague was asking attendees at a medical meeting what they thought the greatest advance in obstetrics and gynecology was during the last 50 years. He just happened to be an ultrasonographer and, oddly enough, thought the obvious choice was diagnostic ultrasound. In my opinion it was decriminalization of elective abortion, thereby making it a legitimate medical procedure and readily available to our patients. Along with effective and convenient contraception, unfettered access to elective abortion has done more to improve the length and quality of life of women all over the planet than perhaps any other medical, social, technological, religious or political innovation of the past century.

I still can't believe that in the inaugural year of the 21st century these blessings of individual choice are not universally available to all our world's inhabitants. Even more unbelievable, here in the U.S. we face the extreme danger of their becoming unavailable in most states via reversal of *Roe* and/or *Doe* at the hands of a Supreme Court dominated by the current Republican administration's litmus-tested future appointees. I find such a disaster unthinkable and deplorable with even more predictably deleterious effects not only on our fundamental values but also on hundreds of thousands of our most needy and powerless citizens.

Bill Harrison

31 MAY 2001

Dear Bill,

Thanks for your letter. I've been waiting for someone to open a dialog in our membership's *Newsletter* on the abortion issue. Dan Avery and I tried (Daniel D. The great horned dilemma. *The Medicolegal Ob/Gyn Newsletter* 1999. Vol. 7, No. 2; p. 28. Avery DM. A prolife view of abortion. *The Medicolegal Ob/Gyn Newsletter* 2000. Vol. 8, No. 6; p. 10.) but without success.

I've always thought if there were any possibility of reaching an acceptable consensus among those for and against this most divisive issue, it would have to be by sitting down and talking to each other. More importantly, listening to each other. Making an honest effort to try and understand the other's position. Not necessarily agreeing with it or converting to it or accepting it, but at least trying to understand why those on the other side feel they way they do and why they feel so strongly. Strongly enough that some with premeditation and intent gun down physicians, security guards and escorts, thereby facing the consequences of life imprisonment or execution; strongly enough that some physically and psychologically assault women in the midst of making one of the most difficult decisions of their life; strongly enough that some attack and blow-up public buildings during open and covert paramilitary operations; strongly enough that many support and encourage those who actually commit these acts. And strongly enough that many on the other side continue working to provide or assist those who provide this medical and social service in spite of threats and terrorist acts.

I've sent your letter on to Dick and I too hope he will open this Pandora's box more than just a crack. Perhaps by confronting our demons and embracing our differences with rational dialog we can find our way out of this swamp.

Doug

31 OCTOBER 2001

Dear Doug,

Thanks much for the copy of Dr. Bill Harrison's letter and your own comments. Dr. Harrison states his case well, with a ring of nobility and a demonstration of that talent common to the liberal community for expressing mystification, along with a strong current of indignation, that anyone could disagree with them.

Actually there is little in his comments that I could find fault with - if, that is, I bought the premise on which his judgments are based. But unfortunately there is that inconvenient and embarrassing fact of fetal life! The abortion rights case rests entirely on the proposition that fetal life has only the value that somebody - she, you, I, anyone - by a private value judgment declares it to have on any given occasion. Thus it is open season on the fetus right up to the moment of birth. This relative value, rather than respect for human life wherever it exists, is the fundamental value that is being trampled into extinction.

Please note that it was not I but the wise founders of this still unparalleled nation who identified as the *basis for its founding* "self-evident truths", among which they placed first the foundation stone that all men are created equal. That kind of flag-waving statement is apt to set off indignant huffing and puffing about blobs of tissue having rights and the Supreme Court settling that question decades ago. Of course the court didn't settle it. They chose to frame the issue as "when human life begins", a bit of biologic nonsense, rather than face the more direct question of when an existing human life acquires rights. They answered their invented question by punting, with the conclusion that there is no consensus (Pretty obvious!). So anything goes. Well, almost anything, and the almost is rapidly disappearing.

You will recall that the Blackmun majority opinion did allow the states to identify an ascending value with increasing gestational age, to the point that it considered the viable fetus *almost* a human life worth protecting. That quaint thought was neatly disposed of by the successful demand of the abortion rights crowd to have the right to polish off this nearly born creature to protect not only maternal life but also maternal health - and of course a threat to maternal health is whatever we say it is. The result has been a seismic change in centuries of mother and child relations.

Changes in social and governmental policy are heavily influenced by a largely self-appointed intellectual elite drawn from academia and the media. They are largely the product of the crazy sixties, which set for subsequent generations the popular tone of situation ethics, moral relativism and utilitarianism, which had been building for several preceding generations, insofar as moral values are recognized at all in medical decision-making. They are deeply committed to "reproductive freedom", which is one of those correct-speak words that characterize the spin commonly applied to the subject. In reality no one on the planet is prevented from reproducing except perhaps in China! What is really meant, but we dare not say, is *sexual* freedom; which means not having to take responsibility for freely chosen behavior.

An interesting commentary on the current trend of thought among the intellectual elites is the story of Peter Singer, the Australian ethicist who has sought a rational basis for a right to abortion and ultimately found it to his satisfaction. He reasons that human lives are of widely varying value, subjectively as well as objectively, to the point that some forms of life, such as that of a fine horse or cow, should have an equal or greater claim to life. By this measure some human lives do not deserve to be lived and should be ended, while the lives of some animals deserve to be protected! This of course endears him to the animal rights crowd but not the alumni of Princeton University, for it was there that President Harold T. Shapiro recruited Singer to an endowed chair in ethics and vigorously defends his appointment. The significance of this marker of our times and its relevance to our professional activities is greatly enhanced by the fact that Dr. Shapiro is the chairperson of the National Bioethics Advisory Commission.

When each year a million young women decide they deserve to end a fetal life that they created, it has to have some social meaning. In the early months the blob of tissue line obscures any moral consideration for many. But in probably ten thousand of those million occasions, when they are dealing with a viable or near-viable infant, the life that is on the line clearly belongs to what every patient I have ever known considers to be a baby. Can we avoid the conclusion that this has something to do with a couple of New Jersey kids of good family feeling justified in bashing in the head of their secretly-delivered and apparently normal full term child against the dumpster in which it was found? Or with the casual deposit of a similar baby in the waste can of the women's rest room at a suburban high school dance? Can we really believe that the striking increase in infanticide and child murder is not somehow related to the attitude that we have toward these same children when they were developing in utero?

Our colleagues might very well respond, as some have to me, that it is not the business of our profession to form the ethical standards of the nation. We merely apply medical knowledge to the situation in which we find our world. That is a copout! At the very least we are absolutely essential enablers of far-reaching social change. Beyond that, we have become so impressed with what we can accomplish in addressing a mostly social problem with fairly rudimentary surgical and medical skills (which our forebears held at arm's length) that we have virtually abandoned any claim to scientific integrity.

Abortion rights activists do not exclusively represent the interests of women. I am acutely aware that women have historically borne virtually the entire burden of the sexual/reproductive process and are centuries overdue for relief. I

understand that the ability to have effective control over the likelihood of conception is considered basic to any modern concept of equal status for women. I agree our profession has made important and honorable strides in accomplishing this. But the more effective the means of conception control and the more pervasive women's knowledge of it, the more suspect are the justifications given for abortion. Prior to *Roe v. Wade*, and for a good while afterward, the College, even while supporting an abortion right, was careful in its statements to differentiate abortion from birth control. But our current attitude supports the popular view that abortion is simply a necessary additional means of birth control, a concept that is basic to the present function of Planned Parenthood.

I also recognize that early abortion is an easy and attractive solution to difficult problems, far too easy for many young women to set aside for the sake of a principle that is popularly portrayed as not cool. I also recognize that high principles regrettably are not always convertible into public policy. Against this background I do believe that reasonable dialogue is feasible, and could possibly lead to the consensus you seek, or at least a kind of truce. This discourse would be much encouraged by some points of mutual understanding at the outset.

For instance, we defenders of the fetus should face the fact that the proponents of abortion rights claim their own moral high ground, often deeply held. Many believe that denying to women the benefits of this medical intervention is ethically wrong, perhaps even a violation of a physician's moral obligation. That strong moral tone is readily seen, for example, in the writings of David Grimes and can be identified in Dr. Harrison's comments. Thus the conflict is between competing moral positions, not the practice of medicine versus the practice of religion as it is so often presented.

Another ground rule for debate that ought to be obvious, but strangely is not, is the simple agreement that there are issues in this context legitimately and properly debatable. But throughout my long experience in the College any significant discussion was avoided like the plague; and implausibly, this was especially true when important decisions were to be made. It took several decades of progressively broadening support of abortion rights before a major upheaval among the Fellows, which I won't go into here, led to the appointment of a special task force of diverse experience (the first since well before *Roe!*) to examine for the Executive Board the issues involved and recommend a statement of principles to guide future actions. Basic among these was recognition of the fact that there are legitimate differences of broad social significance involved in the questions raised by elective abortion. It also stated that it was not only the obligation but also the right of Fellows and health care institutions to establish their own ethical positions on these questions. It is odd, and also revealing, that it was necessary after all these years to appoint a high level task force to find this out!

My criticism of the way the College has handled these issues in the past is not idle complaining. Rather I hope it will be seen, as indeed it is intended, as a plea for a much more thoughtful and inclusive process in meeting the social challenges as well as the great opportunities of a rapidly escalating body of scientific knowledge and skill. As the most inclusive organization of our specialty in terms of membership and dues it should also provide an equally inclusive forum for the message to be conveyed by its influential public voice.

I hope, Doug, that this contributes some to the dialogue you seek, an effort that deserves support and appreciation. Best wishes!

R.T.F. Schmidt

Editor's Note: This letter was edited for length. Those wishing an unedited copy may send a self-addressed stamped envelope to the *Newsletter*.

01 NOVEMBER 2001

Dear Doug,

Thanks for sending the copy of the *Newsletter*, and I appreciate your offer to continue sending it for a year. I find it interesting. I think a few people will also find the Mengert biography interesting.

Roy Pitkin

05 NOVEMBER 2001

Dear Roy,

Thanks for your letter. I couldn't agree more.

Doug

06 NOVEMBER 2001

Dear Doug,

I have a few comments to make concerning Dan's last "Presidential Box" (Et tu, Brute? *The Ob/Gyn Medicolegal Newsletter*, Vol. 9, No. 4, October 2001, p. 2). For the past fifteen years I have been reviewing alleged medical negligence cases for attorneys. Most of my work has been on behalf of plaintiff attorneys although I would be equally willing to do so for defendant attorneys. It may be that my objectivity gets in their way but I don't know for sure. What I have experienced is the difficulty lawyers encounter when seeking testimony from local experts who fear retribution by their colleagues. This conspiracy of silence is now being broken down by those of us willing to put our neck on the line, tell it like it is, and let the jury decide. Anyone "making it up as he goes" will not last long in our legal system. Most of the defense attorneys I have met possess more than a smattering of medical knowledge and would quickly see through such "experts".

Concerning retired physicians being an untapped medical expert witness source "enriched by years of experience and education", the first question from the opposing attorney is usually "When did you last delivery a baby (perform a hysterectomy), Doctor?" A retiree's honest answer implies to the jury that he is not up on the current means of delivering a baby or removing a uterus. In the nearly 50 years since I graduated medical school the process has not changed that dramatically except for the technology of support systems. You still have to monitor the fetal heart rate during labor and you still have to be certain that the ureter is safe when you clamp the uterine artery. If our colleagues in fact "did their very best clinically" and got a bad outcome, they will be best protected by being honest and forthright with their patients and documenting, documenting, documenting their thought processes and reasoning in the medical record, legibly of course. So many of the cases I have reviewed are filed by angry patients because their physician did not take time to explain what happened or else simply vanished into thin air immediately after things went awry. Most patients seem to recognize us as mortal. We must convince them we recognize it also.

I agree with you on this one. Most jurors in my experience have been able to see through the "con man's new clothes".

Julius Piver

07 NOVEMBER 2001

Dear Julius,

Thanks for your letter. Clear thinkers, defined as those who agree with one, have for me been somewhat rare lately. Good to know you're one. I'm still convinced retired physicians can make some of our best medical expert witnesses. As you pointed out so well, the basics of what we do clinically change but little and the physiology of the human female's reproductive system not at all. When making this argument I have always assumed one caveat: a good medical expert witness never testifies regarding an area of practice with which he is not familiar. If you retired before cystic fibrosis screening became the nationally recognized minimally acceptable standard of care via ACOG's recent recommendation, then you shouldn't testify in defense of a physician who forgot check the results or even order it. On the other hand, you certainly could testify for plaintiff by way of helping the jury understand the ACOG recommendation, why it is important and the consequences of failing to carry it out.

I still say doing your very best is not good enough if it falls below the minimally acceptable and expected national standard of care. Even if I do my very best to fly that 747, it's not going to be good enough. And you're dead on about patients filing suits because they feel lied to, ignored or taken for granted. Unfortunately that's oftentimes what passes for risk management. Many just want someone to say, "This shouldn't have happened, we're sorry it happened to you, and we're doing everything we can to make sure it doesn't happen again." At least then they'll know we take their problem seriously.

Doug

04 NOVEMBER 2001

Dear Doug,

I'm sitting here in my hospital's lounge as the on-call doc for L&D. The day has been quiet so I have a few minutes to write. Upon reading the October 2001 *Newsletter* I would like to address Dan's "President's Box" and your reply on pages two and three relating to the problem of inappropriate medicolegal testimony. Some Florida physicians and myself authored in December 1997 a subsequently adopted AMA resolution defining medicolegal testimony as the practice of medicine and calling for its peer review. Since then the liability problem has only worsened. Here in California premium rates continue upward despite our MICRA tort reform law, watershed legislation that among other things placed a \$250,000 cap on non-economic damages. It has withstood 25 years of vicious assault by trial attorney court challenges and lobbyists, and should serve as a paradigm for national tort reform. But tort reform alone will not suffice; the time has come to take a truly bold action overcoming the timidity with which our specialty has up to now approached the medical expert witness problem.

Despite our natural inclination to blame greedy patients and unscrupulous attorneys, I firmly believe the true crux of the problem is dishonest medical expert witness testimony. I know how hard it is to accept the idea that the problem lies within our own house, but until we recognize that it does we will continue to spin our wheels and keep paying higher and higher insurance premiums. This letter outlines my views on how we can begin to solve this problem; a project potentially able to make a major impact at minimal expense, increase interest in the Society and pump up the membership roll.

Much of the problem lies in dishonest testimony being provided in relative secrecy with experts almost never testifying in their hometown, ergo they carry out their nefarious activities without their local colleagues ever knowing. I doubt most of us are aware of those physicians we pass in the hospital hallways every day who make most of their income by carpetbaggering around the country assaulting their colleagues in the courtroom instead of getting up in the middle of the night to soil their hands with patient care.

Please don't misunderstand; I believe we should all be held accountable for our actions and provide compensation to patients injured by substandard practices. I have provided medical expert witness testimony for both defendants and plaintiffs and have no problem with my colleagues hearing what I have to say because I make it my business to know well what comprises national standards of practice, never varying from them when testifying.

The first step is to simply identify the problem people and then peer review with appropriate sanctions will follow naturally. I therefore propose the Society create a website to which any obstetrician-gynecologist can submit case summaries believed to reflect inappropriate testimony. Summaries would not identify the submitter, defendant, plaintiff or anyone involved with the case except the medical expert witness whose name and practice location would be given. The medical expert witness involved would be notified when a case was received for review and provided the opportunity to respond. Court transcripts, matters of public record, would be utilized to establish the facts of the case.

This proposed website would be open to the general public; publicized with ads in major obstetrics and gynecology publications; and organized by a variety of search parameters including name of the medical expert witness, his locations of practice and testimony, and type of case. Wouldn't you like to search a database to discover who in your community is making a living testifying against colleagues? I even have an acronym, Project EXPOSURE for EXpert Pronouncements, Options, and Statements Under Review and Evaluation.

The major reason we have failed to tackle this issue before is our fear of being sued by angry medical expert witnesses. This proposal could potentially step on some powerful toes and damage some heavily vested interests, and those identified by the project probably would not accept it passively. Litigation could result. The American Neurological Society was recently upheld on appeal for its expulsion of a member for providing poor medical expert witness testimony. The court held that a professional society had the right to determine if, when and how its members would be disciplined. The question now is whether or not we are willing to take some risks to reach a worthy goal. This particular omelet will require breaking some eggs.

I would be pleased to work with other Society members in promoting this project and can be contacted at:

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The time has come for us to stand up for the same integrity and accountability in our courtrooms as in our offices and operating rooms.

Dave Priver

13 NOVEMBER 2001

Dear Dave,

Thanks for your letter. I'm glad someone's thinking about how to improve this situation instead of simply carping about how they're always getting screwed. I have only two problems with your suggestion; nothing major, just some fine tuning. First of all I've always been leery of any accusations made from beneath a cloak of anonymity; if a complainant isn't willing to have his name prominently affixed to his work I ignore it. There's no reason to shield the identity of the one making the charge. My other problem is we shouldn't necessarily concern ourselves with "who in (our) community is making a living testifying against colleagues" but with who is testifying falsely, period. And make no mistake, some of the most outrageous testimony I've ever heard has been given by defense medical expert witnesses and defendants attempting to justify their failures. Of course from a legal perspective the defendant is expected to deliver false testimony if necessary to save himself. I'm not sure but it is my impression that defendants cannot be charged with perjury. From the perspective of medical ethics, should the lying physician defendant be held to the same standard as the medical expert witness? I don't know the answer but the question sure makes for interesting debate.

Practically speaking, your wheel is already up and running to some extent. The College's Grievance Committee has for several years reviewed complaints regarding Fellows' testimony as medical expert witnesses, to my knowledge always being asked to look at plaintiff experts and always finding them within ethical and scientific bounds. Their biggest deviation from your proposal is all deliberations and findings are confidential unless a Fellow is expelled.

Anecdotally, I heard that the leadership of the Medical Society of New York sent word to a member obstetrician-gynecologist that if he continued his opinions-for-hire testimony, he would no longer be a member of their organization. At last report he had not only stopped providing his embarrassing and obviously shoddy testimony, he had totally quit testifying.

The Society's Board of Directors has on several occasions with several memberships discussed what we can do to ensure our members provide valid and ethical testimony, because if some don't we're all tarred with the same brush. We always came to the consensus that if so requested we would objectively review the testimony of a member, realizing that if found lacking he would require some action to get him up to speed or, if especially egregious and/or persistent, removal from membership status. We also agreed that to publicize the availability of such a process would be unwise.

I speak or correspond with many of our members not infrequently and feel as if I know most quite well. While not agreeing with every one every time, our members have consistently impressed me with their collective and individual integrity. If we ever get a complaint about a member's testimony, I'm confident an objective evaluation will prove him within those aforementioned ethical and scientific bounds.

Doug

26 NOVEMBER 2001

Dear Doug,

Thanks for the copy of Dave Priver's letter. I enjoyed it very much. His Project EXPOSURE seems very apropos and I would like to see more information in addition to discussing it with him. He sounds like a good candidate for our Board of Directors.

Dan

05 DECEMBER 2001

Dear Doug,

I visited Australia last month and attended meetings of several committees and the Council of the Royal Australian/New Zealand College of Obstetricians and Gynaecologists. Very interesting. They think we are upside down on a lot of things. Enclosed are some materials on their program certifying Fellows as medical expert witnesses. Obviously our College is not ready for anything like it.

Ben Harer

11 DECEMBER 2001

Dear Ben,

Thanks for your letter. It's a tough job visiting Australia but I guess someone had to do it. Did you perchance meet The Crocodile Hunter or Paul Hogan?

I read the material and you're right, it's most impressive. As you can guess I disagree with their requirement that medical expert witnesses be in active clinical practice at the time of the alleged tort or within the three years preceding their application. There is a proviso for others to serve if "the College consents otherwise" but I expect such consent would be biased against those testifying for plaintiff. At any rate it's certainly better than anything we've done "up over". There's no mention of it but I hope there's some form of either random or complaint-driven peer review of testimony. My other areas of ignorance are whether their medical judicial system is based on fiduciary or contract law, whether plaintiff attorneys work on the contingency system, whether punitive damages are allowable and how often they are awarded, what the median awards are in certain proven allegations, and whether there are caps on awards for pain and suffering or loss of consortium. Anything would be better than what we now have, nothing.

Please contact me if you know someone down there who might be willing to write for the *Newsletter* on their experience. In the meantime those interested in reading the documents can obtain them by sending me a SASE.

Doug

THE HOT BOX

THEY DON'T CHANGE THE QUESTIONS, JUST THE ANSWERS

by Doug Daniel

Back when I was a freshman medical student there were some wise guys who decided to get test questions in advance. They discussed their decision with an upperclassman fraternity brother who told them not to bother. "The profs ask the same questions every year and just change the answers." That's about where we are on maternal corticosteroids in threatened premature labor. It seems the right answer changes about as often as homeless guys change their underwear. The last time I saw anything from an NIH Consensus Conference on this it seemed the only benefit was confined to a very narrow window of about 30 to 32 weeks gestation. The latest Conference has reconsidered and now recommends, "All pregnant women between 24 and 34 weeks gestation who are at risk of preterm delivery within 7 days should be considered candidates for antenatal treatment with a single course of corticosteroids." This comes from the Consensus Statement that was to be mailed to all physicians. If you didn't get one or lost it, try <http://consensus.nih.gov> to download a copy. It's dated August 2000.

Conventional wisdom has in the past had just about everyone administering serial doses of maternal corticosteroids at weekly intervals until delivery or at least 36 weeks gestation. We had an excellent article here in the *Newsletter* advising against repeated dosing and showing why it's not a good idea [Vermillion ST. Repetitive Antenatal Corticosteroids. *The Medicolegal Ob/Gyn Newsletter* 2000;8(5):29]. The Consensus Statement reports, "Because of insufficient scientific data from randomized clinical trials regarding efficacy and safety, repeat courses of corticosteroids should not be used routinely." Somehow I don't think this one will last either.

THE BOOK BOX

THE LEGACY

by Doug Daniel

Sapira's Art & Science of Bedside Diagnosis, Second Edition
Jane M. Orient, MD
682 Pages. Philadelphia: 2000
Lippincott, Williams & Wilkins
Illustrated
\$79.95

"From the day when the first members of councils placed exterior authority higher than interior, that is to say, recognized the decisions of men united in councils as more important and more sacred than reason and conscience; on that day began lies that caused the loss of millions of human beings and which continue their unhappy work to the present day."

Leo Tolstoy

With the above quote, Jane Orient begins her preface to the second edition of a mentor's classic medical textbook. One doesn't have to read between very many lines to quickly see that Orient is a firm advocate of what in religion has been called "the priesthood of the believer", a euphemism for independent thinking. Currently a Clinical Lecturer in Medicine at the University of Arizona College of Medicine in Phoenix, she is also a Past President of and driving force within the Association of American Physicians and Surgeons, the only contemporary medical professional organization totally dedicated to preserving the traditional financial and intellectual independence of the physician and his patient. Attempting to set the desired tone for her work, the preface continues:

"The scarcest item of all appears to be the clinician's time. Thirty seconds may be too long to spend searching for a reference. In some settings, there may be no time to look in the left ear if only the right one hurts, much less to listen to the patient's grief or despair. And when can today's managed provider stop and reflect?

There is much lamentation about the loss of the art of medicine. Alas, the science is being lost as well. 'Evidenced-based' medicine is coming to mean based on the consensus of a committee of experts. Clinical reasoning is replaced by following a practice 'guideline' from one prescribed information bit to another, and diagnosis means a number with five significant digits attached to an appropriate procedure code. The very altar of truth - the autopsy table - is being dismantled.

Medicine is a living thing that will survive and flourish, despite the dinosaurs of 'health-care delivery', and long after inhuman systems fail. There are still students who aspire to be physicians, not providers, gatekeepers, resource managers, or box-checkers. This book is to provide them a compass, a road-map, and perhaps a little entertainment as they embark on an exciting journey of exploration, together with their most important teachers - their patients."

The following quote opened the preface to the first edition, written in 1989 by Joseph D. Sapira, MD:

"As the decay of the Chou Dynasty grew worse, studies were neglected and the scribes became more and more ignorant. When they did not remember the genuine character, they blunderingly invented a false one. These non-genuine characters, copied out again by other ignorant writers, became usual."

L. Weiger, SJ, in *Chinese Characters*

Sapira defined the book's goal somewhat differently than Orient, his then disciple and editor who later assumed authorial responsibility:

"The goal of this book is to help the reader achieve the correct personal, metaphysical, and epistemological perspectives on the artful science of clinical examination. This is not a textbook of medicine. In analogy to football, a textbook of medicine is the playbook. This book is about learning the skills of blocking, tackling, punting, passing, and so forth, so that one may execute the plays with diligence and facility.

The style is intentionally unusual, attempting to capture the excitement of actual rounds with diversions along the way. ... This book is written with a sense of great sadness about American academic medicine, and from a prerevolutionary point of view (the revolution in academic medicine having occurred about 1968, when the intellectual approach to diagnosis and its attendant techniques of clinical examination fell into disrespect, superseded by an inappropriately exclusive reliance on dogma and modern technologic devices). ... (O)ne daily observes patients for whom the history and physical examination could lead one to the correct diagnosis hours, days, and even weeks before it can be achieved by those who rely solely on modern technology. And for some diagnoses (vascular headache, depression, irritable colon, for example) there is no substitutive technology.

The tradition of clinical examination dates back 2500 years or more. ... With sufficient scholarly effort, it would be possible to trace a lineage from any reader back to Laennec, or even to Hippocrates. ... In every hospital and every school that I visit, I meet young persons of the prerevolutionary type. This book is for them."

While these may seem unattainable goals, Orient hits her mark dead center. She sees clinical diagnosis as the currently most neglected tenet of clinical medical practice and uses less than gentle humor to make her point when defining clinical experience as "making the same mistake with increasing confidence for an impressive number of years" or evidence-based medicine as "perpetuating other people's mistakes instead of your own". Conservative in demeanor as well as philosophy, Orient's chapter on interviewing patients establishes somewhat rigid rules of decorum for physician and patient but provides excellent justification for the same. In the chapter on taking the medical history she cites research confirming that 82% of diagnoses are still made by the history, 9% by the physical examination, and 9% by the laboratory. There's also a detailed chapter on management of the patient record and its proper documentation. The final chapter reveals bedside laboratory "tricks" for confirming diagnoses reminiscent of the medical student labs that in the past were a fixture of all teaching hospitals' wards.

Self-described as intended for physicians and not subspecialist technicians, the text uses marginal notations of lustrous pearls, price tags and flying flags to advise students which portions are considered clinical "pearls", what items of diagnostic equipment are advised purchases for the "black bag" if anyone still carries it, and those conditions, situations or findings denoting a real or impending medical emergency. To prevent the visual fatigue so dreaded by readers of medical textbooks, Orient frequently eschews the use of difficult to interpret clinical photographs and instead uses as illustrations classic pieces of sculpture or paintings to serve as examples of physical findings. When photographs are used, many are from classic medical publications. At the end of most chapters are answers to questions posed within the material covered, excellent intellectual and practical exercises to self-evaluate comprehension and understanding. Most impressively, the material is oriented in such a way that the sophomore medical student reading it for the first time is directed along a relatively simple path while the re-reading senior medical student or more sophisticated and experienced resident finds sections with more detailed information. There are even sections written especially with the teaching service's attending physician in mind.

As to production values, this is a superb example of quality printing in medical textbooks. This reviewer could find no typographical errors, almost unheard of in today's world of mindless Spellcheck® software. The paper used is of high quality with a slick finish and crisp, easy to read type, reminiscent of those memorably glossy *Life* magazines. Its size approximates that of the contemporary coffee table book.

Orient's textbook is the perfect gift for that special medical student in your nuclear or expanded family. My only reservation in recommending it is that strict adherence to its precepts will place them in the obvious minority and thereby perhaps draw unwanted attention. On the other hand, never apologize for excellence. While perhaps not relevant in its entirety for residents in other than internal medicine training programs, the chapters on the eye and neurological examinations could stand alone among ophthalmology and neurology texts. The chapter on clinical breast examination is excellent though not nearly as detailed as Bill Hindle's textbook (Hindle WH, Editor. Breast Care: A Clinical Guidebook for Women's Primary Health Care Providers. New York:Springer-Verlag, 1999) and that on the gynecological examination, while adequate for generalist purposes, would be inadequate for the practicing or training obstetrician-gynecologist. It was however of particular interest that Orient's bimanual pelvic examination included a detailed rectovaginal examination.

THE SUGGESTION BOX

SUE 'EM ALL AND LET THE JUDGE SORT 'EM OUT

by Sid Wilchins

According to the American College of Obstetricians and Gynecologists (ACOG) the odds are overwhelming that those of us in practice for 25 to 30 years will have been sued at least one or more times, the number of suits for an individual physician generally being in direct proportion to his years of practice. The longer you practice the more often you'll be sued. The math's actually pretty simple and a function of the laws of chance instead of an indication of increasingly negligent practice patterns as you get older, i.e. the more patients you've seen the more likely you've randomly encountered a medmal case "trigger".

Triggers are those circumstances that initiate medmal actions and in decreasing order of frequency are: (1.) unsatisfactory outcomes, (2.) unsatisfactory interpersonal relationships with patients and/or their families, and (3.) significant deviations from nationally recognized minimally acceptable standards of care which directly or indirectly cause patients injuries. The first two are not necessarily related to the third but may be. When all three exist simultaneously you've got a major problem.

Either alone or in combination these may encourage a patient or third party to seek legal counsel who then must determine whether it is reasonably arguable that all four of the following conditions exist: (1.) the physician/defendant had a contractual obligation to provide medical services to the patient/plaintiff (physician-patient fiduciary relationship), (2.) the physician/defendant deviated from nationally recognized minimally acceptable standards of care in providing those services and thereby failed to meet his obligation (medical negligence), (3.) this deviation or failure injured the patient/plaintiff (medical malpractice), and (4.) the patient/plaintiff injury deserves compensation by the physician/defendant (meritorious claim).

Considering the three triggers it is obvious that medmal suits are provoked and not spontaneous occurrences. Considering the four conditions to be met, it is also obvious that considerable latitude exists in defining them and identifying their existence in a specific case. The most obvious cause of non-meritorious suits is the commonly made and erroneous assumption that unsatisfactory outcomes are inevitably and ultimately secondary to negligence. But recognized medical complications are not in and of themselves associated with deviations from the above standards of care. Just as obvious is the fact that we humans are mortal and the most unsatisfactory outcome, death, will eventually, inevitably, and ultimately come for each and all. Otherwise we could confer immortality upon our patients, a practical impossibility.

All four conditions are eventually considered as to whether factual by a trial jury and whether legal by a trial judge, while in a bench trial a judge determines both without the assistance of a jury. Most claims are settled through financial compromise by both parties to avoid anxiety over which side an unpredictable jury or judge will find for, usually before trial but occasionally even during jury deliberations. Medmal insurers generally have no interest in the ethics or principles of medical practice, instead focusing their concern on profitability issues such as how long can payment of how little be delayed or hopefully avoided while using assets to earn interest on investments. Insurance is intended to be a financially profitable business, not a charitable or altruistic institution.

Medmal defense attorneys work in a constant state of ambivalence by simultaneously serving two masters. They are ethically and legally bound to represent the best interests of their "client", the defendant physician, yet financially dependent upon their employer, the insurance carrier, for reimbursement of expenses and payment of fees, thereby in actuality deriving their livelihood from only one master. Medmal plaintiff attorneys serve one master, their client. Under the contingency fee system the plaintiff attorney gets paid only if and when his client gets paid. Most medmal attorneys are not physical scientists and do not hold undergraduate degrees in the sciences or graduate medical degrees. Physicians must educate the attorneys they work with in medicine while their attorneys educate them in the law.

One of the shibboleths in our system of English justice is the accused's right to trial by a jury of his peers. A judge once told the story of a medmal trial in which the jury was presented conflicting testimony by the chairs of two prestigious medical schools' academic departments. He was asked who finally determined the validity of such distinguished but opposing medical expert witness testimony and replied, "The janitor, for it was he who sat on the jury." This anecdote calls the legitimacy of the National Practitioner Data Bank into question since the mere fact that a demand for money has been successful does not in and of itself indicate or even suggest that medical malpractice occurred.

Another foundation of our legal system is the accuser's requirement to offer facts in proof (more than a 50% chance or more likely than not in medmal cases, sometimes referred to as in all medical probability) of his allegations instead of assuming

the defendant guilty. This is the plaintiff's burden of proof and it assumes the defendant innocent until proven guilty. In reality medical cases often require physicians to prove their innocence before their jury.

The usual initial response upon receiving a medical summons and complaint is that sick, sinking feeling of being kicked in the gut, followed first by guilt and then anger. Just when logical, unemotional strategy and action based on cool, level-headed thinking are called for most of us react instead with the roaring physiology and psychology of the classic fight/flee/freeze/reproduce response. Better to take a deep breath, call your insurance carrier, and make no other notifications or discuss the case with anyone except in confidence with close family and friends. Probably the hardest and most important responsibility for the physician defendant is to recognize and avoid expected feelings of anxiety, anger, depression, guilt, hostility or any combination of these, even to the point of seeking help through experienced counselors, psychologists or psychiatrists.

After notifying your carrier of service of the complaint an attorney will be selected to defend you and very soon initially meet to discuss your case. This is a very important time in your defense; don't try to make yourself unavailable or inconveniently available. Take to the meeting all legal documents as well as patient records in your possession including those medical, financial and business such as correspondence. All these records will be reviewed, legal theories of your case discussed, and questions called interrogatories to the plaintiff proposed. Following the receipt of formal answers to these interrogatories the defendant's deposition is customarily scheduled and taken by plaintiff's counsel. Depositions usually cover the same topics as previous interrogatories to the deponent and are intended to evaluate his appearance, appeal, manner of speaking and style in addition to eliciting unrecognized blunders in testimony for inclusion in the record. A good deponent strategy is to mentally count to three before answering any question under oath, even giving your name and address. This gives your attorney a chance to object to your answering and you a chance to be sure the question is understood while beginning to compose a suitable answer. Volunteer nothing and keep answers short, three sentences or less if possible. Use simple, non-technical terms and similes such as you would in giving a presentation to uninitiated students or laymen. Think jury. Always tell the truth. Never alter medical records or other documents that might be introduced in evidence. Never prompt or try to influence potential witnesses. Always educate your lawyer.

A temporary respite follows deposition while the lawyers depose the plaintiff and other potential witnesses, file motions with the judge, and search for evidence to support their respective cases. During this time attempts to reach a settlement often begin with each side trying to decide whether or not a trial is in their case's best interest, how much and how little can a satisfactory settlement represent, how much and how little could a jury's verdict award, what kind of jury can be impaneled, which judge will be assigned the case and how strict will he be? There's also some consideration of whether the defendant's care deviated from national standards, if so whether it caused injury, and if so what is the injury worth in dollars and cents. This process has in the past been compared to watching a poker game's bluffing, intimidation, odds assessment, and trying to deduce what cards the opponent holds.

Most obstetrical medical suits involve shoulder dystocia deliveries, cerebral or brachial plexus palsies, or electronic fetal monitoring tracings either suggestive of fetal compromise or not reassuring of normal fetal condition. Some involve all three. An extensive medical literature exists on all these and scientific studies have differentiated between expected complications and significant deviations in standards of care. Most gynecological medical suits involve failure to diagnose cancer (breast, cervix or uterus), intraoperative complications (laparoscopy injuries and ureter compromise), or abortion complications (spontaneous or induced, uterine perforations, incomplete evacuations).

Use of citations from the medical literature in support of your case is important. In 1993 the Supreme Court of the United States issued a series of opinions in three cases since known as the Daubert Trilogy. As a result four criteria must be met by all scientific court testimony citing literature references: (1.) testability (reproduced by other investigators), (2.) acceptability (within the discipline's mainstream and generally recognized), (3.) peer reviewed source (other experts reviewed and approved the data and conclusions), and (4.) statistical significance. The best of intentions and valid data do not always help in court but they certainly don't hurt.

I have never observed any physician willfully and knowingly deviate from minimally acceptable standards of care. Quite simply, there are no rewards or incentives to do so. Physicians do inadvertently deviate from these standards and their patients who have been subsequently harmed obviously deserve compensation. The trick is for us to recognize when the plaintiff is right and then work toward resolution of the claim.

It is unlikely our current tort system of resolving claims alleging medical negligence and malpractice will change because there are too many attorneys both for defense and plaintiff plus plaintiffs themselves who are realizing considerable financial gain under the status quo. Defense attorneys are always paid. Plaintiff attorneys consider medical cases games of chance in which they win if they make expenses plus a small profit and on occasion win big. Carriers price their premiums such that they make money on their investments regardless. We physicians may suffer a wound to our pride every now and again but fees can always be adjusted to cover higher premium costs, we can see more patients, and we can relocate our practice to increase cash flow or cut expenses. And don't forget all the legal secretaries, paralegals, court reporters and government employees who make their living servicing the medical machine. It's not very hard to make an argument that medical malpractice is an essential cornerstone of our economy. How ironic that something based upon better than a 50% probability should occupy a position of such financial importance. Adam Smith was right, free markets are driven by self-interest and not altruism.

THE LITTER BOX

TODAY'S WISDOM REPORT: PARTLY CLOUDY

by Doug Daniel

I've said before how today's wisdom is tomorrow's folly, and while this may seem an overstatement of reality sometimes it ain't too far from the truth. Exhibit one is an article from South Africa on prophylactic antibiotics in elective caesarean sections (Bagatee JS, et al. A prospective and blinded randomized controlled trial of antibiotic prophylaxis in elective Caesarean delivery. *British Journal of Obstetrics and Gynaecology* 2001;108:143 and available at www.bjog-elsevier.com). Ralph Hale's *ACOG Clinical Review* brought this one to my attention. The authors are from the Nelson R. Mandela School of Medicine's Department of Obstetrics and Gynaecology at the University of Natal, South Africa, described as a "tertiary teaching hospital in a large urban city". Their patient population is predominately poor black Africans and they prospectively studied 480 elective cesarean section patients randomized for placebo or cefoxitin IV at cord clamping, 10% of whom were HIV positive. After apologizing for the relatively small percentage of HIV patients compared to the existing background rate in the African population obscuring its role in postoperative infections, they found essentially no difference in strictly defined postoperative infections, specifically wound infections. The most common identifiable pathogen for wound infection was Staph aureus, a skin contaminant.

"The infected wounds could be attributed to amongst others surgical preparation of the abdomen and a lapse in surgical technique and haemostasis. The isolation of bacteria that is not present in the genital tract, such as Staphylococcus aureus which is found on the skin and Pseudomonas aeruginosa which is found in the hospital environment, lends support to this iatrogenic aetiology of wound infection. Collection of blood or serous fluid in wounds may be due to lack of proper haemostasis and surgical technique. ... (O)nly an increased body mass predisposed women to a higher infection rate. ... We suggest that prophylactic antibiotics in elective caesarean section be restricted to women who have a high body mass index and where the baseline infectious morbidity is >15%. It should also be noted that use of prophylactic antibiotics for elective caesarean section is not a panacea and should not replace proper pre- and intraoperative preparation and meticulous surgical technique. The proper surgical handling of tissues and meticulous haemostasis is probably of greater importance than prophylactic antibiotics in reducing postoperative infectious morbidity."

This seems to be the same thing I was taught during residency, proven true over subsequent years of practice even though colleagues were dancing to a different tune and pouring on the bug juice.

Exhibit two came from Ralph also and addressed the question of how long is too long before performing urgent caesarean section (Spencer MK et al. How long does it take to deliver a baby by emergency caesarean section? *Australian & New Zealand Journal of Obstetrics and Gynaecology* 2001;41:7-11.). Those who wait more than 30 minutes have always said it was unnecessary and impractical to move faster but the news from down under doesn't agree. Level I, II, and III hospitals were studied retrospectively regarding decision to delivery times of 464 cases. Medians by hospital size were 69 minutes for Level I, 54 for Level II and 42 for Level III. Medians by indication were 25 minutes for cord prolapse or failed assisted delivery, 33 minutes for abnormal fetal scalp blood determination, 44 for antepartum maternal hemorrhage and 49 for abnormal fetal heart rate tracing. The most common cause of delay was unavailable staff at Level I, unavailable operating room at Level II and anesthesia complications due to coexisting serious maternal condition at Level III. Herewith some of Ralph's comments.

"Facilities without onsite obstetricians or anesthesiologists would have great difficulty meeting this standard and perhaps should not accept patients who may need this type of response. ... ACOG has had many questions regarding the 30-minute recommendation and the Obstetric Practice Committee as well as outside consultants have reviewed the relevant information including concerns from those who feel that time is too short. In every instance, the evidence continues to support the ability, if needed, to perform a cesarean delivery within 30 minutes of the decision to proceed. "

And now an article on preeclampsia is submitted for your consideration (Espelin MS et al. Paternal and maternal components of the predisposition to preeclampsia. *New England Journal of Medicine* 2001;344:867-72, available at <http://content.nejm.org/cgi/content/full/344/12/867>). We still don't know much less understand the cause, physiology or progression of preeclampsia but I had always figured it was a genetic predisposition on the part of the mother that was inherited

from her mother. Not necessarily. The good folks at Salt Lake City's University of Utah, a state with unbelievable genealogy resources thanks to the Church of Jesus Christ and Latter Day Saints, identified hospital delivery records of 298 males and 237 females delivered between 1947 and 1957 remarkable for maternal preeclampsia. They then reviewed the delivery records of 947 children of the studied males and 830 of the females to determine the incidence of preeclampsia during their pregnancies. A suitable control group was assembled for comparisons. Wives of men born to preeclamptic mothers were twice as likely (2.7% vs. 1.3%) as controls to develop preeclampsia. Mothers whose mothers had developed preeclampsia were more than twice as likely to become preeclamptic (4.7% vs. 1.9 %). In a British study, women whose mothers had developed preeclampsia were also more than twice as likely as the mothers' daughters-in-law to become preeclamptic (23% vs. 10%). A previous Norwegian study looked at men who fathered children by more than one mother. If one developed preeclampsia the chances were nearly twice as great that another would when compared to men one of whose partners had never become preeclamptic during one of their sired pregnancies. Finally, the authors postulate that since preeclampsia occurs more often in nulliparas or after a change in male sires there is evidence that the causation is an interaction between maternal antibodies and paternally derived fetal antigens. WOW!

There's another article deserving of your attention in the December 2001 green journal (Southwick F. Who was caring for Mary? *Obstetrics and Gynecology* 2001;98:1140). It's the poignant tale of a minor medical problem gone terribly wrong, written by the patient's husband whom I suspect is an academic internist or subspecialist. What should have been a simple, routine outpatient illness became a near-death experience, albeit with the assistance of attending physicians too busy to see their patients or supervise their trainees and trainees unqualified to independently manage patients. It serves as a potent reminder that we cannot ignore our moral and professional obligation to either make ourselves available to care for our patients or in the alternative insure they will be cared for in our absence by someone just as or better qualified.

OUTCOME FOLLOWING PRETERM PROM Continued From Page 1

Statistical analysis suggested that neither maternal age, antepartum maternal administration of corticosteroids, maternal tocolytics, maternal antibiotics, mode of delivery, indication for delivery nor umbilical cord pH values differentiated survivors from non-survivors. Gestational age at PROM, gestational age at delivery and the latency period before delivery seemed to best correlate with outcome. Infants experiencing PROM before 25 weeks gestational age historically would have been assigned the highest risk of mortality, yet in our study the overall survival was 75%. As in the study's entire population, latency period before these infants' delivery and their gestational age at delivery best correlated with outcome.

Advances in neonatal care as well as obstetric management may have jointly contributed to our improved outcomes. Survival now exceeds 50% at 24 weeks gestational age in many large neonatal intensive care units, 80% at 26 weeks. Changes in neonatal management including prophylactic and therapeutic use of surfactants, newer antibiotic regimens and aggressive ventilation techniques have played a major role in improved survival rates. These clinical modalities may now allow very preterm infants, especially those who previously would have succumbed to pulmonary hypoplasia, a better chance for survival. As perinatal and neonatal management become more refined, today's pregnancies complicated by early-onset PROM may have even more hope for survival compared to those delivered only ten years ago. Continued observation and study of perinatal management is expected to produce better treatment options in the near future.

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SHOULDER DYSTOCIA: A LIFE-THREATENING EMERGENCY

by Dan Avery

Shoulder dystocia is a life-threatening obstetric emergency, defined as impaction of the anterior fetal shoulder behind the maternal symphysis pubis preventing vaginal delivery. It's usually unpredictable with serious potential consequences including severe fetal asphyxia and acidosis, even fetal death.¹ Preventing these fetal complications is not always possible.² Often the attendant must choose between fetal death and the morbidity associated with successful vaginal delivery via sophisticated maneuvers.

Permanent newborn damage remains one of the obstetrician's greatest fears. Erb's palsy is the most common injury associated with shoulder dystocia but fortunately most of these cases do not result in significant permanent disability, instead recovering completely by thirteen months of age.⁴

The occurrence of shoulder dystocia is not in and of itself medical malpractice.³ While excessive traction on the brachial plexus is a recognized etiology of Erb's palsy, it has also been reported following delivery via Caesarean section² and prior to the onset of labor.¹ Additionally, the degree of traction necessary to injure the brachial plexus apparently varies among fetuses.²

Cunningham et al report the incidence of shoulder dystocia to be 0.9% of all vaginal deliveries and apparently increasing with larger newborns.⁴ Multiple factors are said to predispose to shoulder dystocia yet accurate prediction before the fact is almost impossible as these factors are useful neither for forecast of occurrence nor degree or permanence of injury.⁴ Therefore it is imperative that all of us tasked with managing patients' labors and deliveries be well-versed and adept in managing shoulder dystocia. The following are suggested methods for freeing an impacted fetal shoulder.

1. Call For Assistance.
2. Attempt completion of delivery with gentle downward traction assisted by voluntary maternal expulsive efforts.
3. Attempt McRoberts maneuver.
4. Apply suprapubic pressure.
5. Cut a generous episiotomy if not already performed.
6. Attempt to deliver the posterior arm.
7. Attempt Woods corkscrew maneuver.
8. Attempt Rubin maneuvers.
9. Attempt Zavanelli maneuver.
10. Attempt Chavis Horn maneuver.
11. Attempt to rotate the fetal shoulders with Shute's parallel forceps.
12. Perform maternal symphysiotomy.
13. Perform fetal cleidotomy.
14. Fracture the fetal clavicle and/or humerus.
15. Attempt the Hibbard procedure.

1. **Call For Assistance.** The first step in managing shoulder dystocia is to get help immediately by mobilizing qualified technical assistant, anesthesia and newborn pediatric personnel. Drain the maternal bladder if not previously performed.¹
2. **Attempt completion of delivery.** The American College of Obstetricians and Gynecologists recommends an attempt at vaginal delivery via gentle downward traction on the fetal head during voluntary maternal expulsive efforts.¹
3. **Attempt McRoberts maneuver.** In 1983 William A. McRoberts' trainees and associates at the University of Texas Health Center at Houston first described his eponymous maneuver.¹ Extreme flexion of the mother's legs on her abdomen results in straightening of the sacrum relative to lumbar vertebrae and rotation of the symphysis toward her head decreasing the angle of pelvic inclination. The McRoberts position apparently increases both anterior-posterior and transverse diameters of the maternal pelvis, in many cases resolving the dystocia and resulting in spontaneous completion of vaginal delivery. It also reduces the traction forces necessary for fetal shoulder extraction once the shoulder girdle is rotated to an oblique pelvic diameter in addition to increasing the efficiency of maternal voluntary expulsive efforts.

4. **Apply suprapubic pressure.** In 1980 Resnik described an attempt to resolve shoulder dystocia using moderate suprapubic pressure on an impacted anterior fetal shoulder by an assistant while simultaneously exerting downward traction on the partially delivered fetal head.⁴

The preceding interventions focus on relieving the anterior shoulder impaction and seem to be preferred by more recently trained obstetricians. Those longer in the tooth seem to focus on the following maneuvers intended to deliver the posterior shoulder, inherently requiring far more available room in the soft tissues of the lower vagina, often even episiotomy.

5. **Cut a generous episiotomy if not already performed.** Most shoulder dystocias are relieved by the McRoberts maneuver, suprapubic pressure or a combination of both. If they fail a generous episiotomy should be cut if not already performed.
6. **Attempt to deliver the posterior arm.** Delivery of the posterior arm has been described in many textbooks as sweeping it across the anterior fetal chest with subsequent delivery and rotation of the shoulder girdle to an oblique maternal pelvic diameter.
7. **Attempt Woods corkscrew maneuver.** In 1943 Woods recommended progressive rotation of the posterior shoulder through 180° in order to free the anterior shoulder, subsequently referred to as the Woods corkscrew maneuver.¹
8. **Attempt Rubin maneuvers.** In 1974 Rubin recommended two procedures for freeing the impacted anterior fetal shoulder.¹ The first rocked the fetal shoulders from side to side by applying alternating lateral force to the maternal abdomen. The second required the attendant to insert his hand into the vagina, placing his fingers over the posterior aspect of the most easily accessible fetal shoulder and pushing it anteriorly to a more oblique pelvic diameter.² Both maneuvers when successful anteromedially abduct the shoulders (fold them anteriorly) into a narrower bisacromial diameter allowing easier displacement of the impacted anterior shoulder.
9. **Attempt Zavanelli maneuver.** In 1985 Sandberg reported the Zavanelli maneuver, using cephalic flexion and elevation to replace intrauterine the delivered fetal head after rotating it to back to the occiput anterior or posterior position, all performed after 250 µg of subcutaneous terbutaline for uterine relaxation.¹ The delivery is then completed by Caesarean section. In my experience this has been quite difficult to perform yet others describe it as relatively simple with good results even when subsequent Caesarean delivery was up to an hour later.¹ Complications include the maneuver's inherent difficulty, spontaneous vaginal redelivery of the fetal head, maternal uterine rupture, intrauterine fetal distress and fetal demise.
10. **Attempt Chavis Horn maneuver.** In 1979 Chavis developed an instrument similar to a shoehorn to be used in levering the anterior fetal shoulder beneath the maternal symphysis to assist its delivery.⁴ Many obstetricians think a single Luikart-Simpson forceps blade may be used in a similar manner but the difficulty with both these lies in passing the instrument safely past the fetus's head to access its impacted anterior shoulder and then not injuring the maternal pelvis, fetal head or shoulder in the application of force.
11. **Attempt to rotate the fetal shoulders with Shute's parallel forceps.** In 1962 Shute reported using disarticulated obstetrical forceps, one applied to the anterior surface of a shoulder and the other applied to the posterior surface of the contralateral shoulder, to rotate without traction the fetal shoulder girdle into an oblique pelvic diameter.⁵
12. **Perform maternal symphysiotomy.** Maternal symphysiotomy has been utilized worldwide over many years to relieve obstructed labor. Reportedly amenable to performance under local anesthesia, considerable skill is required by the operator lest serious maternal bladder injuries occur. In 1986 Hartfield reported its use in the United States.¹
13. **Perform fetal cleidotomy.** Cleidotomy, cutting the fetal clavicle with scissors or other sharp instrument, was first reported in 1983 as an option for resolving fetal shoulder dystocia but is usually reserved for stillbirths.¹
14. **Fracture the fetal clavicle and/or humerus.** Deliberate fracture of the fetal clavicle and/or humerus has been performed to resolve shoulder dystocia. While always possible, clavicular fractures usually do not injure the underlying neurovascular structures. Deliberate fracture of the fetal clavicle is difficult although it may spontaneously fracture during an otherwise uneventful delivery.
15. **Attempt the Hibbard procedure.** In 1982 Hibbard described application of pressure to the fetal jaw and neck vectored toward the maternal rectum to free the impacted anterior shoulder followed by strong fundal pressure to complete the delivery, albeit with a 77% complication rate.¹ Most experts agree that fundal pressure is contraindicated when trying to resolve shoulder dystocia, instead only making vaginal delivery more difficult.

No doubt shoulder dystocia is a life-threatening obstetrical emergency. Successful management depends upon a well-considered plan of action, knowledge of recognized interventions, and skill in their performance.

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AXEL N. ARNESON, MD, 1965-1966

(b. 1905 - d. 1996)

by James C. Warren, MD, FACOG
and
Ming S. Kao, MD, FACOG

Axel Norman Arneson, ACOG's 15th President, spent the first twenty years of his life in Texas and a later two in New York City as an oncology fellow at Memorial Hospital. The remaining 69 were spent in Saint Louis, Missouri. Though renowned worldwide for his expertise in gynecologic oncology and leadership in various medical organizations, we in Saint Louis knew him best. Indeed, knew him as a man of multiple unique talents, even oenology.

Arnie entered Saint Louis' Washington University School of Medicine in 1925, three years later graduating with its MD degree followed by residency there. He joined its department of obstetrics and gynecology faculty in 1934 and remained a member for 62 years until his death in 1996. For many of these he held a simultaneous appointment on the radiology faculty, enjoying Diplomate status with the American Board of Obstetrics and Gynecology (ABOG) plus the American Board of Radiology. Those of us in Saint Louis had considerable opportunity to observe him first hand and note his accomplishments.

From the outset Arnie had intended to be a gynecologic oncologist, one of the first some forty years before it became an ABOG recognized subspecialty. He pioneered the use of radiation therapy in treatment of gynecologic malignancies and developed considerable expertise in brachytherapy for cervical and endometrial cancer. This was a bonus for the rest of us in town as we got to rub shoulders with the likes of Hans Kottmeyer from the Radiumhemmet, Ben Peckham from Wisconsin and Jim Nolan from California when they visited to see what he was up to. Arnie also studied the risk of secondary malignancy following radiation therapy for cervical cancer and developed pelvic exenteration in cooperation with Eugene Bricker of the University's department of surgery. We certainly knew him to be a pioneer in his field, obviously a man with original ideas.

We also knew him to be an excellent physician, superb educator and meticulous surgeon. His anatomical dissection was at all times precise, careful and sparing of the ureter. Blessed with large hands, he always used the smallest, most delicate instruments and suture. His closures were careful, as cosmetic as possible regardless of whom his patient was while he reminded us it would be the only portion of his work she would ever see. His lecture style was precise as well, initially perhaps a bit dry but less so following a few of his terms as president of various medical organizations. Those of us who knew him well thought these experiences had somewhat diluted his normally serious demeanor with an improved sense of humor. In his later years there was even a twinkle in his eye, though ever the perfect gentleman. A kind and caring teacher, he treated many of his students as if they were his own children.

Arnie was also an outstanding clinician who knew, treated and respected his patients as persons. Those of us privileged to work beside him saw how much time he spent in the office and on the wards discussing patients' personal and family problems with them, rarely donning his white "doctor's coat" during clinics but instead wearing a business suit and tie in order to be less intimidating. After his death those who continued seeing his patients often heard of their high regard for Arnie. Some of us questioned whether or not his frequent and prolonged exposure to live therapeutic radioisotopes may have contributed to his bothersome early cataracts.

He also had a rather unusual hobby that he allowed the rest of us to enjoy with him, winemaking. His winery in central western Missouri's winemaking region was named Peaceful Bend Vineyards, a great source of pride and satisfaction for him. When his busy practice would allow it, weekends were spent working in the vineyard as over the years he studied and developed his wines while defining their genealogy. Ultimately he produced and bottled two good Missouri wines, a red he labeled Courtois and a white he labeled Meramec, both named for local rivers. His greatest pleasure was having his colleagues enjoy the literal fruits of his labor and on many occasions he provided gratis the wines to be served at the dinner meetings of the Saint Louis Gynecologic Society.

Axel Arneson made tremendous contributions to gynecologic practice in the Saint Louis area as well as the world over. He was a pioneering gynecologic oncologist, excellent teacher, splendid physician, impeccable gentleman and a man of the soil deeply interested in the miracle of winemaking. We were all lucky to have him, especially those of us "right here in Saint Louis".

FREDERICK J. HOFMEISTER, MD, 1974-1975

(b. 1909 - d. 1996)

**by David V. Foley, MD, FACOG
and
William E. Martens, MD, FACOG**

Frederick J. Hofmeister, Founding Fellow of the American College of Obstetricians and Gynecologists (ACOG), served as its 25th President. He was born 21 October 1909 in Milwaukee, Wisconsin, and lived there for the rest of his life. In 1932 he earned a BS degree from Marquette University followed in 1935 by an MD from the Marquette School of Medicine (now the Medical College of Wisconsin). A general medicine private practice simultaneous with a preceptorship in general surgery at Milwaukee Hospital followed internship. Pursuing his strong interest in surgery, Fred in 1944 accepted the offer of a year's residency with Heaney at Chicago's Presbyterian Hospital. His consequently extraordinary expertise in vaginal surgery became legendary over the years.

Multiple facets reflected the Hofmeister professional reputation. He was most of all a clinician and educator at Milwaukee Hospital (today known as Milwaukee Lutheran Hospital), chairing its obstetrics and gynecology residency training program from the early 1950s until it closed in the early 1970s. Although providing an excellent training experience, the program did not meet the Residency Review Committee's revised requirements based upon university medical school residencies. Fred realized this and voluntarily turned his program over to the Medical College of Wisconsin, in the process closing the city's finest vaginal surgery training experience and losing 300 teaching deliveries a year.

Fred continued his educational career as a Clinical Professor at the Medical College where he encouraged and enabled residents to attend specialty meetings including those of the Chicago and Milwaukee Gynecological Society, the Central Association of Obstetricians and Gynecologists, plus ACOG's district and national meetings by founding the Fred Hofmeister Travel Club. He also wrote over 81 professional articles and was first to report long term follow-up of 13,000 endometrial biopsies over fifteen years with no missed diagnoses of malignancy. All his life Fred decried the perceived deficits in vaginal surgery training during residency. His extensive reporting of anterior colporrhaphy results far superior to others' following suprapubic urethropexy and cystopexy apparently fell on deaf ears. He was often heard to ask, "Where are the vaginal surgeons?"

Another facet was his strong commitment to community service via the Salvation Army. Residents and former residents staffed the Army's Booth Memorial Hospital in Wauwatosa, delivering between 200 and 300 cases a year. Every Christmas season he took a daily turn ringing the bell at Army donation kettles in addition to serving as Chairman of its Milwaukee Advisory Board. He was similarly committed to pro-life organizations such as Lutherans for Life and the American Association of Pro-Life Obstetricians and Gynecologists.

Commitment to professional organizations other than ACOG included: serving as President of the Central Association of Obstetricians and Gynecologists, Wisconsin Society of Obstetrics and Gynecology, and the Milwaukee Gynecological Society; member of the American College of Surgeons plus Honorary Member and Senior Member of the Milwaukee Surgical Society. ACOG Founding Fellow Hofmeister was also the first recipient of its Distinguished Service Award recognizing his critical role in establishing the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG). Sensing that many colleagues failed to continue their professional education post residency, Fred advocated continuing medical education for young obstetrician-gynecologists, creating a sound basis for peer review, and establishing American Board of Obstetrics and Gynecology periodic reexaminations. The Sixth World Congress of Obstetrics and Gynecology greatly benefited from his enthusiasm and leadership as did the University of Wisconsin and ACOG. Fred served as ACOG's Wisconsin Section Chair, District VI Vice Chair and Chair, plus College Second and First Vice President in addition to appointment to numerous commissions, committees and councils.

Fred insisted residents attend local and national specialty meetings at which he introduced us to its leaders while ensuring we also met them socially, often inviting us to dinner with some of his many friends. He always emphasized caring for our patients, our specialty, our community and our church. Despite his busy clinical practice he made time to serve as President of the American College and the Central Association of Obstetricians and Gynecologists in addition to his church, serve on the hospital ship HOPE, and ring the Salvation Army Christmas Kettle bell.

Fred and his beloved wife, Vi, were inseparable with one seldom seen without the other. Rarely would he attend even medical professional functions without her at his side. In his last years Fred developed Alzheimer's disease with its inevitable progressive mental deterioration, becoming confined to home and requiring constant attention. Vi willingly became his caregiver. On occasion she would tell others how fortunate she was to have the opportunity and ability to care for him and share so much time together, yet how difficult it was to watch his brilliant mind becoming increasingly unresponsive. The last year of Fred's life

he and Vi lived with their daughter, Jane, and her husband Robert Stanhope in Rochester, Minnesota, where Bob practiced gynecologic surgery as a member of the Mayo Clinic.

Fred Hofmeister probably has friends the world over who miss him still today, but none more than those of us in Milwaukee. For those who knew him, he enhanced our specialty and our lives. Though gone in life, his extraordinary example will remain with us always.

RICHARD H. SCHWARZ, MD, 1991-1992

(b. 1931 - d. ____)

by John G. Boyce, MD, FACOG

I have known Richard Schwarz for 23 years, a witness to the development and meteoric rise of his outstanding career in obstetrics and gynecology. He is a master teacher and lecturer as well as an intelligent, conscientious and hardworking academician who has consistently demonstrated an exemplary administrative leadership combined with academic and clinical excellence.

Richard attended Pennsylvania's Lafayette College where he was a member of Phi Beta Kappa and then earned an MD degree from Jefferson Medical College in Philadelphia, Pennsylvania. Internship and residency followed at Philadelphia General Hospital and then a four year tour with the United States Air Force at Keesler Air Force Base in Biloxi, Mississippi. In 1967 he was appointed an Assistant Professor by the University of Pennsylvania School of Medicine, promoted in 1970 to Associate Professor and elevated to Professor in 1972. Selected an Associate Examiner by the American Board of Obstetrics and Gynecology in 1977, he served them well for the next eighteen years.

In 1978 he moved to the State University of New York-Health Science Center at Brooklyn (SUNY-Brooklyn) to become Professor and Chairman of its Department of Obstetrics and Gynecology for the next twelve years in addition to Chief of Service of Obstetrics and Gynecology at State University Hospital of Brooklyn and Kings County Hospital Center. In 1983 he served a year as Interim Dean of the College of Medicine and Vice President for Academic Affairs, then was appointed to fill the position for the next five years. In 1988 he was named Provost and Vice President for Clinical Affairs by SUNY-Brooklyn, serving for the next six years including one year as Interim President.

In 1985 he was appointed to a four-year term as a Member of the Council of the Association of Professors of Gynecology and Obstetrics (APGO), then served as a Board Member 1989-1993. From 1985 through 1987 he was Vice President of the Associated Medical Schools of New York, appointed President in 1987 for a two-year term. Between 1994 and 1995 he was a consultant to the Vice Provost for Health Sciences and Hospitals at SUNY-Albany.

Richard was an active medical researcher primarily interested in infectious diseases and authoring or co-authoring over 180 publications demonstrating a profound knowledge of his subject, but he was also personally involved in the education and training of medical students, residents, fellows and faculty. He lectured frequently and the door to his office was always open to student interruptions at any time. He was committed to recruiting the best people into his department and always provided them sound counsel plus stimulating research opportunities. Some of those who worked under his guidance early in their careers include Howard Minkoff, William Crombleholme, Ron Gibbs and Mike Mennuti, all now distinguished educators and obstetrician/gynecologists in their own right. His professional accomplishments were formally recognized in 1996 when SUNY-Brooklyn named him an Emeritus Distinguished Service Professor.

In 1996 he became Chairman of Methodist Hospital's Department of Obstetrics and Gynecology in Brooklyn and still holds that position in addition to Professor of Obstetrics and Gynecology at Cornell University Medical College plus Program Director and Professor of Obstetrics and Gynecology at Saint George's University Medical School.

FREDRIC D. FRIGOLETTO, MD, 1996-1997

(b. 1933 - d. ____)

by Isaac Schiff, MD, FACOG

Ha Wa Ya? That infectiously accented New England greeting could well serve as the middle moniker of a unique individual who has touched so many lives, each for the better. Fred Frigoletto – 47th ACOG President and world-renown physician, researcher, and journal contributor; mentor, friend, husband and father nonpareil; weathered son of the sea.

Fred grew up in Fitchburg, Massachusetts, one of two children in a first generation Italian- American dentist father and homemaker mother's family. He attended Lawrence Academy in Groton, Massachusetts, then on to Brown University where he earned its BA degree. He returned home to study medicine at Boston University Medical School where he met his wife of 35 years, Martha McKay. During residency at the Boston Lying-In Hospital Fred became a protégé of Duncan Reid, then a Past President of the American College of Obstetricians and Gynecologists. Reid put him in charge of Lying-In's residency training program and that's how I later came under Fred's brilliant tutelage.

It was clear early on that Fred had set a standard for obstetrics and gynecology residency training programs that others could only hope to achieve. By my arrival his legendary reputation was already well established. There was a perpetual line of medical school faculty, students, residents and private practitioners snaking down the hall from his office, all eagerly seeking his wise counsel. In spite of this Fred remained a truly modest person who always had time and a smile for everyone, even those with neither position nor power. His advice, humbly offered, was always both creative and practical. Recipients sometimes felt foolish for not having thought of it themselves, but that was Fred's way of making you feel you could have found the solution yourself with just a little more concentration. Many times callers would ask Fred to attend a wife, daughter or close friend, the physician's ultimate compliment.

When Kenneth Ryan became the new chief of service at the Boston Hospital for Women, he chose Fred as his alter ego and confidante. They realized that isolated women's hospitals were quickly becoming anachronistic and arranged the merger of Boston Hospital for Women with Peter Bent Brigham and Robert Breck Brigham Hospitals to form Brigham and Women's Hospital. Together Ryan and Fred made their department one of the best in the country. Fred not only fulfilled his extensive mentoring and teaching responsibilities toward his medical students and residents but also pursued a productive research career as well.

On a trip to Ireland Fred became interested in Dublin's results with active management of labor. He obtained a National Institutes of Health grant and instituted the Irish protocol at Brigham and Women's Hospital, reporting that it did not significantly impact their Caesarean section rate. He's also introduced many important, novel ideas to obstetrical practice both locally in Boston and at the national level. In the 1960's he was responsible for Boston's first intrauterine fetal transfusion and thus paved the way for saving untold numbers of babies with intrauterine Rh isoimmunization, rarely seen since Rh hyperimmune globulin became commonly available.

Fred also worked closely with Beryl Benacerraf on developing diagnostic ultrasound imaging technology for obstetrics and gynecology. He learned the basics from researchers at Yale and mastered diagnostic sonography long before many physicians even knew it existed. Fred and Beryl changed obstetrics forever by mapping a previously unknown area that today is an essential aspect of its practice. Diagnostic ultrasound is now an integral part of pregnancy management, yet Beryl and Fred were objective in their later reevaluation of Doppler imaging's role and came to the controversial conclusion that it could be unnecessary in normal pregnancies.

A common thread runs through Fred's professional achievements whether in clinical practice, academic instruction, investigative research or national political and organizational roles representing his specialty; a compassion for women and their children that has made childbearing safer for both. Small wonder then that whenever you encounter one of his colleagues, whether a senior attending or former resident, and mention you're from Boston, inevitably they reply, "You must know Fred Frigoletto! Give him my regards."

Fred is always young at heart; both Sinatra's "Young at Heart" and Bob Dylan's "Forever Young" well apply in his case. At an age when most people retire he accepted the challenge of establishing and then managing the Vincent Obstetrics Program at the Massachusetts General Hospital (MGH), subsequently being appointed Harvard Medical School's Charles and Robert Montraville Green Professor of Obstetrics and Gynecology. Unfortunately his plan for measured, steady growth went quickly awry. In less than five years Vincent had outgrown its facilities by delivering over 3300 babies a year. But the true measure of Fred's success isn't only volume and cash flow; it's also the obvious satisfaction of his patients and camaraderie among his faculty.

Fred is additionally committed to establishing nurse midwifery as a vital aspect of modern obstetrical care. He has developed an incredibly successful group of obstetrics and gynecology generalists at the MGH. Fulltime faculty and midwives attend all deliveries with the assistance of residents and students. Boston's wealthiest and poorest women receive the same care. No wonder Fred is known around Boston as "Mr. Obstetrics". He is equally comfortable among society's powerbrokers and its disadvantaged with both appreciating his genuine concern.

Fred's major focus as ACOG President was promoting the benefits of the electronic medical record in obstetrical care. He recognized the advantages of applying modern information technology to a form of medical care that is fundamentally information management. One of Fred's former students, Michael Greene, even developed a state-of-the-art electronic medical record for the new Vincent department at the MGH.

Yet with all the hats, caps and other assorted headgear Fred wears, he is very much a family man first. Wife Martha and daughters Susan and Laurie always know they are the objects of his total love and devotion. Without neglecting his patients, everything stops for Fred whenever one of them phones or visits the hospital. During the winter he finds deserved respite at his winter retreat in Naples, Florida, and during the summer at another home in Rockport, Massachusetts, where he contemplates the sea he loves so much.

Hail to thee, Dr. Fredric Frigoletto, my esteemed colleague, devoted friend, and physician extraordinaire.

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