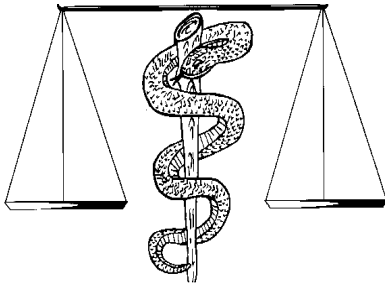


# THE MEDICOLEGAL OB/GYN NEWSLETTER



Published by  
The American Society of Forensic Obstetricians and Gynecologists  
An ACOG Special Interest Group

Post Office Box 536  
Buckhannon, West Virginia 26201-0536

On the web at [www.asfog.com](http://www.asfog.com)

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Vol. 10, No. 1

MARCH 2002

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## HOW MANY PHYSICIANS DO WE REALLY NEED?

by **William D. Daniel, M.D., FACOG**

The question posed in the above title has plagued our healthcare system for almost a century. Inestimable resources of time, money and paper have been expended in the search for its answer by academic, government, media, medical and social prognosticators far more intelligent than your author. Numbers and data have been bandied about as if downloaded from God himself when in reality they were mere guesses, oftentimes poorly made and later proven far from the mark. And now it's happened again.

Recently a reference to an article entitled "Economic and demographic trends signal an impending physician shortage" (Cooper RA et al. *Health Affairs*, January-February 2002) caught my eye. Since it appeared in a relatively arcane publication I could only access it on the web at [www.lexis-nexis.com](http://www.lexis-nexis.com). A university medical library might have provided a hard copy but there wasn't one handy. It was worth the effort. Cooper and his coauthors decided that for the past 20 years Congress has failed, much to our detriment, to accurately divine the country's need for physicians, instead simply sustaining government financial support of medical students and their educational institutions at levels previously thought desirable and encouraging unrestricted immigration of foreign physicians for postgraduate training and practice. All of us over the age of 50 whether patient or physician have seen firsthand this era's sea change in physician staffing, utilization and job responsibility in the name of ruthless cost cutting efficiency and ultimate profit either financial or political. Unfortunately none of the highly touted benefits of this agenda have come to patients or physicians. When they can get it, our patients receive at greater cost worse care than they used to while most of us physicians get a ridiculous fraction of our previous financial and emotional return on investment after obtaining a more expensive medical education and trying to keep the doors open in a high overhead-low profit margin business. Or we work for the man under whatever conditions he dictates at whatever he offers to pay. None of this is good for anybody lower on the food chain than a politician or entrepreneurial robber baron.

An understaffed and underfunded advisory group called the Council on Graduate Medical Education (COGME) and the federal-sounding Graduate Medical Education National Advisory Committee (GMENAC) have for years been telling anyone who would listen that by the turn of the last century the U.S. would have an oversupply of physicians, especially specialists, but a deficit of primary care physicians. This was assumed back in the 1960s but confirmed in the 1980s by GMENAC and in the 1990s by COGME. Few bothered to question these auguries and we saw a rush by government with organized clinical and academic medicine breathlessly tagging along behind to incorporate primary care into specialist training curricula including CME, thought by some to be to the detriment of an already overburdened medical education system. Cooper, ex-dean of an unnamed medical school, collaborated with other doubting Thomases at the Medical College of Wisconsin and Temple University to construct an economic model measuring the adequacy of physician supply based upon demand as evidenced by the growth of our national economy and population. Other factors influencing physician productivity were also considered such as physicians' work effort and the increasing trend to services provided by Non-Physician Clinicians (NPCs) including nurse practitioners, certified nurse midwives, certified registered nurse anesthetists and physician assistants. The study's results indicated we are facing an acute shortage of specialist physicians in the immediate future, if not the present, that our medical education system won't be able to meet for many years nor even then unless current federal funding priorities are markedly changed. Almost all previous predictions had ignored or misinterpreted most of these variables and instead adopted

(Continued on page 21)

# THE PRESIDENTIAL BOX

by **Kenny Stall**

## THE WINDS OF CHANGE

Could any New Year's have seemed more insignificant in view of recent world events? Perhaps not, but the trials, outside pressures and opportunities facing our healthcare system have never been greater. News media coverage of a whole planet in turmoil continues to distract us from the persistent rumblings of change in American healthcare. Many states' physicians face a medical professional liability insurance market with fewer underwriters and less competition while others fear total abandonment by insurers (See page 25). West Virginia continues to see an increasing reluctance of new physicians to practice there plus a migration of its established physicians to bordering states. Saint Paul Fire and Marine Casualty, previously the single largest underwriter of medical professional liability in the U.S., no longer offers medical insurance. Waves of legislation have swept many state legislatures in response to the Institute of Medicine's 1999 report on medical errors and their alleged consequences. Last October Health and Human Services Secretary Tommy Thompson announced a federal commitment of \$50 million toward improving patient safety plus 94 new federal research grants to address the problem. The National Committee for Quality Assurance developed new patient safety standards for managed care organizations. Even the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) expanded its standards to include identification, investigation and analysis of sentinel events followed by actions to prevent their recurrence. Like half a glass, our future can be viewed as frightening or exciting, challenging, ripe with opportunity.

The time may indeed be right for changes benefiting our patients and our practice, a time when each of us should step out of the shadows to take a leadership role on this issue in our community. Any effort to improve patient safety and reporting of medical errors must address their medicolegal implications in order to be effective. We need every available physician and lawyer focusing society's attention on this aspect if it is not to be ignored.

As your incoming Ninth President I intend to continue the pursuit of our Society's stated goals, specifically educating our members and the College Fellowship on the medicolegal aspects of clinical obstetrics and gynecology practice. I sincerely thank those who have preceded me in this office while acknowledging the unfailing loyalty and work of our last President, Dan Avery, and our untiring Editor, Doug Daniel.

Finally I want to thank everyone for your continuing membership and encourage you to invite associates to join our Society. The larger we grow, the greater our voice. If you have someone to whom you wish information on the Society sent or a personal contact made please write, call or fax Doug or myself at:

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# THE WITNESS BOX

by Doug Daniel, Editor

*"It is not our part here to take thought only for a season, or for a few lives of Men, or for a passing age of the world. We should seek a final end of this menace, even if we do not hope to make one."*

Gandalf the Grey

in J.R.R. Tolkien's The Lord of the Rings Part One: The Fellowship of the Ring

This month we gain five new members, two of whom are Honorary Members. Richard Nemiroff is a graduate of Jefferson Medical College with internship and residency at Pennsylvania Hospital. He has a general obstetrics and gynecology practice in Philadelphia. Kenny Stall gave gift memberships to Fred Stehman and Kathryn Zuspan. Fred is Chair of Indiana University's Department of Obstetrics and Gynecology in Indianapolis while Kathryn has an anesthesia practice in Minneapolis. The only other Zuspan I've ever known was Chairman of the Medical College of Georgia's Department of Obstetrics and Gynecology when I was a student there. Related? Haven't a clue but would like to know. Shawn Stallings wrote the lead article on shoulder dystocia in the October 2001 *Newsletter* and his introduction is in that issue's "Witness Box". Isaac Schiff wrote the ACOG Past Presidents piece on Fred Frigoletto in December's *Newsletter* and his is in that issue. **Welcome aboard, y'all.**

Next order of business: **MEMBERSHIP DUES**. A special thank you to Terry and Louis for sending theirs in early, especially with the nice Christmas card. As explained in the December 2001 *Newsletter* yearly dues will remain \$100.00 (\$25.00 for residents in training) payable after receipt of six *Newsletters* instead of at the end of each year. This is your sixth *Newsletter* since 01 January 2001 so 2002 dues are now payable. For the first 25 members who paid their dues last year, a SASE is enclosed for your convenience and as a thank you for prompt payment. For the rest, please remit dues promptly so I won't pester you with phone calls asking whether you'll continue as a member. Then you too will get a SASE next year.

In response to multiple members' requests there is a dues invoice attached to this page. Those holding Honorary Membership under the bylaws by reason of retirement should return their invoice with the box "RETIRED" checked. For those of you who didn't save the December 2001 *Newsletter*, retired is 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. 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 medical endeavor, please consider becoming a dues paying member. If you consider the *Newsletter* junk mail suitable only for lining the bottom of your canary's cage please check "CANCEL MEMBERSHIP" and we with regret won't bother you anymore. Everyone please return their invoice with a dues check or one of the boxes checked. If you don't return your invoice I'll have to call you to ascertain your decision. All with questions or comments should write or call the office.

And now for more on [www.asfog.com](http://www.asfog.com). A disturbing and recurring event has cropped up over the past three months' statistical reports: unidentified visitors accessing the site with a search for "pelvic examination pictures" or "rectal examination pictures" or "gynecology pictures". Since there have been only a very limited number of such hits and we don't post such material anyway, there has been no harm done or photographic images improperly released. The only credible explanation is that some adult pervert who gets off playing doctor or simply a sexually curious adolescent is searching the web for free porn. If this continues I'll contact Mark Graves, the ACOG computer guy, to see if anything else should or could be done. In the meantime Paul Sinkhorn is aware of the situation and keeping an eye on it.

We received a request from Dale Breden at the North Carolina Medical Board's *Forum* to reprint two articles from the December *Newsletter*, Sid Wilchins' on medical professional liability ("Sue 'em all and let the judge sort 'em out") and my book review of Jane Orient's Sapira's Art & Science of Bedside Diagnosis, Second Edition. You Tar Heels look for them later this year and perhaps use them to tout the Society to potential new members.

I've been accused, perhaps not wrongly, of having cold heart cockles but they are greatly warmed by your responses to *Newsletter* articles via "The Witness Box". When it seems all our efforts are no more than tilting at windmills these dialogs suggest the Society is at least serving some useful purpose by encouraging thoughtful consideration of some of the most important concerns we physicians, especially obstetrician-gynecologists, and our patients face today. Looking back over the past year there has been a marked increase in letters to the editor, contributing immensely to the *Newsletter's* credibility and relevance. I'll say it again. "Keep them cards and letters coming!"

In case you missed it the annual report of the ACOG Grievance Committee recently arrived, deserving more than just a casual perusal or less. Five complaints were considered during 2001 with no indication whether any of these were carried over from 2000. One was a Fellow's complaint against another member alleging unethical testimony as a medical expert witness, presumed given for plaintiff in a medical professional liability suit. There's usually about one a year. In its only formal hearing during 2001 the Committee decided to censure the accused who subsequently appealed to the College Executive Board where the action was dismissed. Four other cases were considered involving adverse actions by medical licensing boards. The Committee judged two of the five not actionable and three are still pending with no indication which category includes the disputed medical expert witness testimony.

The Grievance Committee is composed of five voting members: three Fellows from the general membership with one appointed Chair plus two nationally elected officers, the Vice President and Assistant Secretary. The Executive Board is composed of nineteen voting members: all nationally elected officers plus the District Chairs, Chair of the Junior Fellow College Advisory Council and a Public Member. Non-voting members include one representative each of ABOG, APGO, AMA, CREOG and the Society for Maternal-Fetal Medicine plus the Junior Fellow College Advisory Council Vice Chair, and the Editor of *Obstetrics and Gynecology*. Non-voting ACOG administrative staff includes the Executive Vice President, General Counsel and CFO plus the Vice Presidents of Administration, Education, Fellowship Activities, Practice Activities and Women's Health Issues.

I've always been concerned members of the Committee could harbor concealed or even overt prejudice against plaintiff medical expert witnesses and therefore, with limited membership and lack of relatively arcane expertise in this area, perhaps fail to provide them a fair hearing. Without further information this would seem to have been the case last year. Since allegations regarding unethical plaintiff medical expert witness testimony by ACOG members can be expected to continue and probably increase in number, this situation could easily be remedied by appointing someone with the above expertise to the Committee, preferably as a voting member but at least as a non-voting discussant. At the very least the Committee could invite Al Strunk, the College's most qualified administrator in these matters, or a representative of ASFOG, its special interest group devoted to such issues, to attend their formal hearings. Otherwise we may see more of its adverse decisions overturned on appeal. This instance also points up the College membership's need for more detailed information regarding the specifics of complaints considered by the Committee, ultimately necessary if it is to also fill an educational purpose.

An item of more than passing interest appeared in the 15 February 2002 issue of *Ob.Gyn.News*. Easily missed at the bottom of an inside page, a small graph represented through the 1990s our yearly VBAC deliveries per 100 live births in women with previous Caesarean delivery. The data came from the prestigious National Center for Health Statistics and no, I haven't a clue who they are. It formed the classic bell-shaped curve with yearly incidence increasing from about 21% in 1991 to a peak of about 28% in 1996. No surprises there. The clinker was the subsequent decrease by 1999 back to 1992's level. If this trend continues, and there's no reason to think it won't, VBAC essentially will become a thing of the past since I doubt many mothers will voluntarily opt for trial of labor after prior Caesarean if all we know and don't know about it is equitably presented in obtaining prior informed consent. Like I've said before; the more things change, the more they stay the same.

An article in the same issue highlighted a problem I've long been concerned about, elite healthcare for those who can afford it while the rest of us are stuck with shoddy, second-rate goods. It's happening in Boca Raton, Florida, where a company calling itself MDVIP offers its customers, for the yearly fee of \$1500, immediate access to their personal physician, same- or next-day office appointments, comprehensive physical examinations, preventive care, physician filing of insurance claims, physician-arranged consultant appointments and expedited access to their medical records. Of course years ago the private obstetrician-gynecologist provided all these services to his patients at no additional cost.

Insured patients pay their co-payments and deductibles up front and no HMO patients are accepted. Participating physicians agree to provide personal or equivalent physician coverage 24 - 7, limit their practice to MDVIP patients only, and enroll no more than 600. In return they receive reimbursement of mandated services at fair market value. As of the article's writing only five Florida internists had joined but the company expected to expand coverage to the whole east coast and then California. Everyone involved seems to be pleased and satisfied with both patients and physicians receiving value in their return on investment. There is the possibility of government interference on statutory grounds, specifically Medicare, but the company seems to think it is protected from adverse legal action. While this only confirms what I've been saying for years, that we will end up with a two-tiered medical system providing one level of care for the moneyed elite and another for the great unwashed, it at least allows some physicians to practice the way we did years ago when it was financially and personally rewarding.

So Tell Me Something Else I Didn't Already Know Department: From *Ob.Gyn.News*, 15 February 2002; "Genital herpes may raise HIV transmissibility", "Medical arms race' thriving among hospitals" and "Doctors grapple with Medicare payment cuts".

In this month's lead article I discuss a recent study in *Health Affairs* on our country's physician supply and how well it's being met. The problem seems to be that government prognosticators have widely missed the mark in their predictions and the full price of their errors is yet to be paid. The bad news, or perhaps the good news if you never accepted them, is

that efforts to shunt medical specialists such as obstetricians and gynecologists into the primary care provider pool were evidently poorly advised, instead hindering specialist education and practice. Probably the worst news is that a turnaround in our medical education system effectively addressing the authors' newly corrected projections will take at least fifteen years.

Kenny Stall opens his inaugural "Presidential Box" this month to encourage us all to step to the forefront of the controversy over patient safety and reporting of errors in healthcare. Apparently supporting such reforms, he is correct in keeping everyone focused on the necessity for protection against their inevitably increased liability risks.

This month's "Hot Box" presents my eulogy to the now deceased elective vaginal breech delivery. We've lost another of our art's valuable skills. There's also a heads-up on what's coming for Group B Strep prophylaxis.

In this month's Book Box Ben Harer reviews an interesting tale by Jane Orient and Linda Wright about the evil that lurks in medical men's souls, aptly entitled Sutton's Law. Apparently all some of us need to become cocaine-snorting criminal madmen is the scent of a dollar, sort of like Dr. Jeckyll's elixir may have been nothing more than filthy lucre. The book is fiction but its premise unfortunately isn't. In case the lead author's name seems familiar her text on physical diagnosis was reviewed in the last *Newsletter*, soon to be republished in the *Forum* as noted above.

This month's Suggestion Box gives the straight skinny on how we as physicians not directly involved should react to biological terrorism's threat. Frankly it's always been there but we were able to ignore it. No more.

In this month's Litter Box I try to put the last 20 years' demonization of TAH and TVH with or without BSO into perspective. Finally there's now reliable evidence that the hysterical rush to laparoscopy in hysterectomy and the preference for alternative therapies and multiple sequential conservative surgeries in treating menstrual abnormalities has probably been poorly advised. We'll have to wait and see if others agree but in the meantime should reclaim the previously sacred attending physician and patient autonomy regarding healthcare decision-making in these instances. In order to ensure fairness similar considerations should be applied to peer review and medical expert witness testimony. Of course that's only my opinion but I hope you'll agree.

Wayne Sinclair honors us this month with his insightful musings on the latest chapter in the never-ending saga of medical professional liability. Although we haven't heard much out of Wayne recently, he has been an Honorary Member and supporter of the Society for years. One of our first issues critically addressing the medical professional liability insurance problem contained a straightforward commentary by Wayne (Even your own dog will bite you or how I learned to hate the plaintiff attorney, *The Medicolegal Ob/Gyn Newsletter*, July 1997, vol. 5, no. 3, p 24). Over the intervening years it was my pleasure on occasion to work with Wayne in MMI Companies, Incorporated's, claims management program. He taught me a lot. His latest article is no disappointment with its honest assessment of what's happening.

I thought Saint Paul Fire and Marine Casualty's purchase of Wayne's successful company several years ago was part of a nefarious plot to buy up the competition and corner the medical professional liability insurance market *à la* the Brothers Hunt and the silver market. Then when they recently announced a nationwide withdrawal from the marketplace it seemed to be their usual tactic of putting a gun to our collective head in order to rob us of more exorbitant premiums. This play worked in West Virginia about fifteen years ago when the State insurance commissioner was seriously considering tougher regulation only to be told by the legislature and governor to drop it after St. Paul threatened to take his football and go home. Wayne tells me he has no doubts that St. Paul's intentions were honorable and ethical when MMI was purchased but subsequent events and resultant losses forced them to responsibly cut their risks. The worst risk? Medical professional liability. My apologies to the venerable St. Paul.

This issue contains another article in our series on ACOG Past Presidents. Jack Sciarra tells us about Howard C. Taylor, 16th ACOG President. Jack holds a BS from Yale University and an MD from New York City's Columbia University College of Physicians and Surgeons. He returned to Yale-New Haven Medical Center for his internship, then back to Presbyterian Hospital and Sloane Hospital for Women at Columbia-Presbyterian Medical Center for a Taylor-made residency and Josiah Macy, Jr., Fellowship. Along the way he picked-up a PhD in Anatomy from Columbia.

Since 1974 Jack has been Thomas J. Watkins Professor and Chairman of Northwestern University Medical School's Department of Obstetrics and Gynecology in Chicago. Previously he was Professor and Head of the University of Minnesota Medical School's Department of Obstetrics and Gynecology in Minneapolis. He is a Past President of the American Association for Maternal and Neonatal Health, Association of Professors of Gynecology and Obstetrics (APGO), Association of Professors of Gynecology and Obstetrics Medical Education Foundation, Central Association of Obstetricians and Gynecologists, Chicago Gynecological Society, International Federation of Gynecology and Obstetrics (FIGO) and the International Society of Gynecologic Endoscopy. He has been Editor-in-Chief of *Gynecology and Obstetrics* for almost 30 years, Editor of the *International Journal of Gynecology and Obstetrics* for seventeen and a member of the Editorial Board of *Contemporary Clinical Gynecology and Obstetrics* for two. His peer-reviewed scientific literature articles and medical textbooks are far too numerous to even attempt to mention.

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

20 DECEMBER 2001

Dear Doug,

I appreciate your cogent observations as regards my project EXPOSURE to create an expert witness testimony registry on a web site ("The Mail Box", Vol. 9, No. 5, DECEMBER 2001). I would add a few additional comments. First, I agree completely with your view that the project should focus upon any form of dishonest testimony, whether for the plaintiff or the defendant. In either event, it reflects poorly upon our profession. I would however disagree about the anonymity issue. I find our colleagues so traumatized by being sued that they would never utilize a system requiring them to be readily identified. Lawsuits are matters of public record and anyone who wished could easily identify the submitter. I also agree that one submitting an opinion should be required to identify himself but the submitter is not expressing an opinion, only reporting an easily verifiable fact.

Although I very strongly support the College's Grievance Committee, I see this project as quite different. I am not primarily interested in expressing an opinion about the submitted testimony, and in fact I think we should carefully avoid that. My goal, as the name implies, is widespread exposure. For this reason confidentiality would work against, in fact destroy, my intention. I spoke with Tom Purdon and Ralph Hale at the recent AMA meeting. It is my understanding that ACOG has been put on notice by several plaintiff attorneys to expect litigation following any disciplinary actions imposed by the College upon its members. We should be much less vulnerable to such threats since we would not be expelling anyone from anything.

Your anecdote about the New York Medical Society warning one of its members about his reckless testimony is intriguing. About a year ago I wrote them advising of a particularly bad actor in their midst and encouraged them to investigate. I had read about a number of outrageous cases emanating from a specific New York City obstetrician-gynecologist. I wonder if this is the same situation. Regardless, it certainly points out how powerful organized medicine can be in this matter if it decides to get involved. I'll await the responses of others before judging whether we have a viable project her.

One more note. The "O" in EXPOSURE is for Opinions, not options.

David Priver  
dpriver@aol.com

27 DECEMBER 2001

Dear Dave,

Thanks for your letter. I wish I had e-mail but it's still pending. The "Big O" snafu was simply another example of my many shortcomings as an editor. Nothing Freudian there, I promise. I'm hung up on some of EXPOSURE's finer points. It still seems ill advised to offer anonymity to the individual submitting the complaint. I know of few more gravid opinions than accusing someone of dishonesty, and simply filing the complaint accomplishes that unless all medical expert witness testimony for plaintiff would be eligible for inclusion. If so, there's already a defense reporting service called IDEX that does exactly that with financial support from the same ACOG to which you send your dues check each year. Access to their information base however isn't free. Even though peer review would supposedly be required before EXPOSURE's reaching the conclusion of dishonesty, it's still a pretty serious charge against someone whose word is supposed to be his bond. I personally would rather see the College's Grievance Committee drop it's cloak of secrecy and issue relatively detailed reports of its proceedings similar to state medical boards but even more complete. This could serve the grander and more noble purpose of educating the fellowship on what's considered Kosher and what's not. Since all complaints to date regarding medical expert witness testimony have been found to be without merit, it would also vindicate those so accused while at the same time serving as a disincentive to knowingly dishonest or unethical testimony. You've not yet convinced me.

Doug

01 JANUARY 2002

Dear Doug,

Thanks to the Board for electing me ASFOG's 2002 Vice President-President Elect. I can't wait until next year when I'll have "The Presidential Box" and now feel compelled to write in response to Dave Priver's letter regarding peer review of medical expert witnesses ("The Mail Box", Vol. 9, No. 5 and above). I wish to go on record as being in complete agreement with and support of the proposed project. I have long pondered this subject and agree that peer review should finally come to medical expert witness testimony, and ASFOG should do whatever necessary to advance the process.

Promoting honesty in plaintiff *and* defense medical expert witness testimony would indeed increase ASFOG's profile and membership. I, too, have testified for both plaintiff and defendant. In my experience, different than yours, plaintiff experts more commonly offer dishonest testimony such as not offering what the majority of practitioners would believe to be the nationally recognized minimum standard of care. Knowingly offering false testimony on behalf of a defendant *is* perjury subject to criminal prosecution if not sanctioned by national medical organizations. I agree however with you that the project may need some fine tuning and propose the following with a commitment to actively participate with others so interested.

First, asfog.com could solicit allegations of potential wrongful testimony with a designated button on the left side of the home page. The accused would not necessarily be a member of ASFOG or any other professional organization and I agree with you that submissions should identify the accuser.

Next, upon receipt of a summary of the facts plus copies of relevant documents and transcripts of the deposition or trial testimony in question, we would notify the accused and request a response. The accuser is in the best position to produce these documents and if indignant enough to request review should willingly bear this responsibility and cost.

Next all submitted materials would be distributed to a standing Testimony Review Committee that would convene via telephone conference call after a designated period of time to discuss the matter and deliver an opinion.

Finally our Board of Directors would review the Committee's opinion and if in agreement that the accused had provided blatantly false testimony, would forward its conclusion to ACOG with supporting documentation. We should not be involved with any disciplinary action against any physician but instead leave that to the College. Our conclusions should be able to stand on their merits and the potential for litigation against ASFOG would be limited.

Interest in ASFOG membership will increase if the College promotes our participation in the process as outlined above.

Elliot Levine

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09 JANUARY 2002

Dear Elliot,

Thanks for your letter. Our Board obviously made a wise choice in your election. It's becoming more and more obvious that we must seriously reconsider this issue of peer-reviewed medical expert witness testimony. In reality we cannot expect the College to be any more involved than they already are. The exception would be if the President of the Society as a Fellow of the College made a formal complaint to its Grievance Committee at the direction of the ASFOG Board of Directors. I do have some responses to your suggestions and the more our membership discusses this matter, preferably through this venue, the better our Board can decide what to do and how to do it.

Although not one to seek epiphanies, I believe I just had one. It has always been my impression that dishonest testimony came primarily from defendants and their medical expert witnesses while others decried the sins of plaintiff medical expert witnesses. There's a simple explanation for this seeming confusion: I've been exposed primarily to defense testimony in triable cases and those like you have seen mostly plaintiff testimony in the same circumstances. I think the best position is that the possibility of tainted testimony exists equally in both and must be recognized as such. This will require the utmost objectivity of those tasked with reviewing the testimony of others and there can absolutely be no preconceived bias.

I still doubt that one can be accused of perjury for testifying to an opinion perhaps not held by others. Heresy perhaps but not perjury. My understanding of perjury involves knowingly false testimony as to fact, not professional medical opinions. If a defense attorney can alter your transcribed deposition testimony, blow it up, and present it to you before the jury with the question "Isn't this your previous testimony?" without professional sanctions, I seriously doubt our legal system

will accuse medical expert witnesses of perjury when providing their opinions. There must be some degree of intellectual freedom allowed in reaching one's opinions. We all know or at least should admit that the nationally recognized minimal acceptable standard of care is a very difficult creature to accurately describe, bringing to mind the fable about the three blind men trying to guess what an elephant was by one feeling its trunk, another feeling its tail and the last feeling its leg. When presented to a jury this standard must be explained and the reasons given for defining it within the circumstances presented by the specific case. Even the Ten Commandments need the reasoning and explanation of the Talmud, which I understand is the source of serious debate among religion scholars.

ASFOG.com has its limitations, as Paul Sinkhorn can tell you better than I. We don't have the capability of direct email and data transfer without a greater financial investment although linking to an individual's email address is probably an option. I also seriously question whether we should review testimony from non-members of ASFOG except upon request of the College. Our expertise is limited to obstetrics and gynecology. I can't see the benefit to reviewing substandard medical expert witness testimony if there is no opportunity for a warning or education to improve its quality, and certainly the power to be disciplined must be a motivation. We have that power for our members and the College has it for Fellows. If this is simply going to be a reporting archive, these already exist.

Our Board of Directors should perform such reviews. Its composition ought to reflect the best of our membership and my experience has only confirmed this. Its composition also changes each year and no individual would be imposed upon for more than three years.

For a step of this magnitude I would think a poll of our membership would be necessary before proceeding beyond the preliminaries. All members are encouraged to write with their suggestions and opinions in order to provide our Board with the most complete information possible.

Doug

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02 JANUARY 2002

Dear Doug,

Responding to Sid Wilchins' "Suggestion Box" (Sue 'em all and let the judge sort 'em out, *Medicolegal Ob/Gyn Newsletter*, Vol. 9, No. 5), *Daubert* was a federal case that made judges gatekeepers in deciding whether a witness could be certified an expert. Prior to *Daubert* another federal precedent, *Frye*, served the same purpose but simply said that expert testimony should be based on methods generally accepted by the scientific community. *Daubert* requires use of the Federal Rules of Evidence to determine reliability and also relevance to the case at hand by answering the following questions in the affirmative.

1. Was published material peer reviewed?
2. Is the methodology in question generally accepted by the scientific community?
3. Can this methodology be tested and was it?
4. Does its potential error rate demonstrate reliability?

In layman's terms *Daubert* asks whether the evidence to be admitted represents good science derived by the scientific method from scientific knowledge.

One could argue that since all civil cases except strict liability require a preponderance of the evidence, like medical malpractice all civil cases are financially driven. But isn't it true that our whole society is financially driven? Why would someone devote so much time, effort and lifespan to the practice of medicine if there were only the reward of helping others? That's certainly a great satisfaction but why do so many physicians live in big houses, send their children to private schools and drive expensive automobiles if there is no financial benefit? I cannot believe that physicians' financial gain is only a secondary motivation.

Richard Litt

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19 JANUARY 2002

Dear Rich,

Thanks for your letter. Glad you liked Sid's piece. It was chosen for republication by the North Carolina Medical Board's *Forum*. I think everyone agrees *Daubert* is preferable by far to *Frye* and apparently well accepted in the state courts also, but according to Herb Underwood there are still some jurisdictions where the trial lawyers have been able to hang on to *Frye*. At least the federal courts should now be protected from another class action verdict like the Dow-Corning silicone implant travesty.

Doug

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08 JANUARY 2002

Dear Doug,

I am enclosing for your interest copies of letters I have sent to two of the more popular "throw away journals" stressing the importance of doing away with the term "malpractice". As you are well aware we are about to face another medical professional liability insurance crisis in this country with serious hot spots in Pennsylvania, West Virginia and Florida just to name three. ACOG will be devoting a significant amount of time and effort to this problem but one thing we all can do immediately is delete the word malpractice from our vocabularies. I believe it creates a wrong impression in the minds of laymen as well as litigating attorneys.

I hope you can help get the word out in the *Newsletter*, which I incidentally look forward to receiving each month. We will be looking for solutions to the various elements of this recurring problem but this is something everyone can do right away to help people understand that bad outcomes do not necessarily mean someone made a mistake.

Tom Purdon

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17 JANUARY 2002

Dear Tom,

Thanks for your letter and the enclosed copies of your correspondence with *OBG Management* and *Contemporary Ob/Gyn*. Those favorably inclined toward physicians will probably exert every effort to make the adjustment and the *Newsletter* certainly will. Others such as plaintiff attorneys, popular news media and patient rights advocates probably won't because they covet the emotional impact of specific words. On the other hand, medical and some other terms of art will survive forever in personal conversations among physicians and attorneys. I also doubt the legal textbooks will change since they have already painstakingly defined medical malpractice. Since our readership is very narrowly based I expect medical will continue to be used informally but for everything else we'll try to go with medical professional liability. Keep up the good work.

Doug

# THE HOT BOX

## PART 1: DUST IN THE WIND

by Doug Daniel

It's now official. Vaginal breech delivery is a lost art never to be recovered and we are the poorer for it. Years from now when the evidence-based wisdom of the future advocates vaginal breech delivery, it will be too late. *ACOG Committee Opinion No. 265*, December 2001, wrote its final epitaph.

“Recently, researchers conducted a large, international multicenter randomized clinical trial comparing a policy of planned cesarean birth with planned vaginal birth. Given the results of this exceptionally large and well-controlled clinical trial, ... planned vaginal delivery of a term singleton breech may no longer be appropriate. In those instances in which breech vaginal deliveries are pursued, great caution should be exercised. ... (P)atients presenting in advanced labor with a fetus in the breech presentation in whom delivery is likely to be imminent or patients whose second twin is in a nonvertex presentation (are excepted).”

If you still even consider performing or teaching vaginal breech deliveries, don't.

I used to take pride in being able to successfully and safely manage an assisted vaginal breech delivery with Piper forceps to the aftercoming head, even to the point of never trying to become adept at external version as it seemed first of all usually unsuccessful or at best temporary, secondly fraught with unnecessary danger to mother and infant, and finally simply a way to bill for another procedure. Too many times I closely watched the EFM tracing and progress of labor for any legitimate obstetrical indication for Caesarean section, enduring the scorn of inexperienced and ignorant nurses or physicians who had never seen a vaginal breech delivery. When delivery was completed and a healthy child produced they seemed to credit the outcome more to the blind luck of an idiot than to technical expertise and experience. None were ever delivered with known serious impairments other than those preceding labor.

Not all my colleagues were so fortunate. Some on occasion delivered severely depressed or injured infants, usually due in my mind to their failure to attend their patients, recognize the signs of impending problems or simply not perform obstetrical maneuvers properly. When eventually the only one still willing to perform and teach elective vaginal breech delivery, I became a perceived threat to their professional integrity.

I am still convinced the problem was not with breech presentation per se. As a resident I was taught a respect for breech presentations plus how to properly manage and deliver them at a time when an acceptable Caesarean section rate was 10% to 12%. As the wizards of the East in Boston, Baltimore and New Haven preached the salvation of Caesarean section rates reaching 50% or greater there was no longer any reason to teach, learn and practice what was certainly a difficult and, if not properly performed, dangerous obstetrical technique. Far easier to section all breeches before labor than stand closely by a labor bed alert and on the watch for lurking danger.

While *ACOG Committee Opinion No. 265* may relax many obstetricians' coronary spasms and increase their average hours of sleep per night (AHSPN), I fear the Piper will still demand payment when presenting the admittedly rare emergency admission of a mother laboring with a breech presentation near delivery, the breech second twin or the breech delivery encountered beyond the confines of L&D and the OR. I still occasionally have dreams but not nightmares about the young mother Dave O'Patry and I found screaming on the floor of our hospital's women's toilet with two legs and a pair of buttocks squirming outside her vagina. Mother and baby did fine but for a while it was touch and go. Thank God we both knew how to safely deliver a breech vaginally and had done so many times before.

Although the Committee apparently endorses vaginal breech delivery of the second twin no one will know how to do it and instead we'll botch the job or just passively watch while mother and baby do the best they can on their own. We'd be better off to section all twins and forget about learning the hard stuff. Hell, let's just section everybody.

## PART 2: DUST IN MY EYES

In case you've thought your author's previously discussed and less than laudable opinion of today's evidence-based medicine to be poorly advised, here's another brick in the wall. Last year's mock trial at the Chicago ACM convinced all those in attendance of the medical and clinical dangers inherent in forever fine-tuning standards of clinical practice vis-à-vis Group B Strep (GBS) prophylaxis. Constantly changing recommendations have gone from do nothing to culture everyone to culture those at risk to treat those at risk to either of the latter two. If you need more convincing consider the similar situation with Pap smear interpretation: from a simple I through V classification easily understood by pathologists and clinicians to sub-classifications to Carcinoma-In-Situ (CIS) to Cervical Intraepithelial Neoplasia (CIN) I, II and III to Atypical Squamous Cells of Unknown Significance (ASCUS) to a one page single-spaced Bethesda System to finally an even more complicated "modified" Bethesda System. In the case of GBS, apparently it's going to change again. The current ACOG recommendations for managing GBS can be found in ACOG Committee Opinion No. 173, June 1996, entitled "Prevention of early-onset group B streptococcal disease in newborns".

According to a recent front-page article in *Ob.Gyn.News* ("CDC seeks to expand Group B strep testing", Vol. 37, No. 3, 1 FEBRUARY 2002) the Centers for Disease Control and Prevention has decided to change back to recommending screening everyone based on their study of GBS cases in 1998 and 1999, only two years after their last finagling. The evidence-based recommendation and its study data will be forwarded to ACOG, the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), AARP, AAA and God-only-knows who else for their review, read rubber stamp, before officially making the change. If you want to avoid future liability problems I would advise making the change now since it is already one of the two options currently recommended. Here's the short course.

1. Add a box to your prenatal record's first page for recording the date of GBS urine and anogenital cultures with their results.
2. Properly culture all obstetrical patients for group B strep at 35 to 37 weeks gestation. The key word here is "properly". Most do a cervical culture but that's not the best. Since the sought after organism is normal gastrointestinal flora the highest recovery rate is from rectal culture, next highest from the surface of the posterior fourchette and next highest from the lower vagina. An acceptable method would be to either use three separate swabs submitted in one tube or take one sterile swab and sample the lower vagina, withdraw it and sample the fourchette, then insert the same swab into the rectal ampulla (as with proper rectal culture technique for gonorrhea). Then only one culture need be sent since the location testing positive is irrelevant. You would also be well advised to simultaneously submit either a catheterized or clean-catch urine for culture. Any culture positive for group B Strep indicates penicillin prophylaxis in labor. Forget about colony counts.
3. Patients with group B strep in either urine or anogenital culture should be treated during labor with intravenous aqueous penicillin G. The current recommended dose is 5 million units initially and 2.5 million units q 4h. An easier alternative is the way we ran penicillin in labor when I was a resident: ten million units/1 D<sub>5</sub>W to run the first 500 ccs ASAP and then 125 ccs/hr until after delivery, minimum dose 1 liter. I've heard some theoretical musings about decreasing potency at room temperature and the solute adhering to the walls of plastic IV bags but it's the same material used for the smaller IV infusion medication administration bags so go figure. It worked well plus being simple and easy. Penicillin is now preferable to ampicillin since ampicillin has a wider spectrum and is more useful in therapeutic treatment of other infections. Penicillin seems to still have the best sensitivity against almost all strep organisms. At least for now.
4. Penicillin allergic patients should no longer be treated with clindamycin or erythromycin since the organism has developed significant resistance. Unfortunately no effective alternative antibiotics are available and there are no current CDC recommendations regarding prophylaxis for penicillin allergic patients. Somebody a lot smarter than me needs to address this immediately for both clinical and liability reasons.
5. Patients with negative cultures but presenting in labor with previously determined risk factors should not be treated with prophylactic penicillin. Therapeutic antibiotic treatment should not however be withheld for other legitimate obstetrical indications. ***THE EXCEPTION IS ALL PATIENTS DELIVERING A PREVIOUS INFANT WITH NEWBORN GBS DISEASE SHOULD BE TREATED WITH PROPHYLACTIC PENICILLIN IN LABOR UNLESS DETERMINED TO HAVE A VALID HISTORY OF PENICILLIN ANAPHYLAXIS!***

While the above may not identically coincide with ultimately agreed upon recommendations a year or more down the road it is compatible with current recommendations, excepting the problem of what to do with penicillin allergic patients. Instituting this protocol into your practice now will decrease your chances of future liability. Medical expert witnesses and peer reviewers must however continue to recognize ACOG recommendations currently in effect. I still say the best and safest preventative for GBS is aseptic surgical preparation of the perineum at the onset of labor, minimal vaginal examinations after rupture of the membranes, and the use of sterile technique with iodophore antiseptic solution when performing all vaginal examinations after 36 weeks or when labor or rupture of membranes is suspected. But what do I know? To quote the universally recognized medical authority Johnny Cochran, Esq., "If they grow the bug you must give the drug."

# THE BOOK BOX

## WHODUNNIT?

by Ben Harer

Sutton's Law

Jane M. Orient, MD, and Linda J. Wright

299 Pages. Macon, GA: 1997

Hacienda Publishing

\$21.95

What a great fast read! Jane Orient and Linda Wright's reader-friendly mystery will be especially resonant to those physicians both in training and in practice still striving to secure for their patients the best medical care possible in spite of the ever-present restraints and obstacles imposed by contemporary medicine's "managed care", "cost containment" and "quality of care" juggernauts. A coincident murder mystery adds even more appeal for fans of the genre.

Heroine Maggie Altman, a naive intern returning to Texas University Regional Preventive Health Center (TURPH) after several years in medical research, finds her alma mater no longer the typical charity/teaching hospital she remembers. TURPH is now wedded to EquaCare, an archetypical computer-controlled cost-containing profit-generating paradigm of modern medicine. EquaCare and TURPH wave the banner of preventive medicine and trumpet the virtue of resource allocation while ruthlessly withholding services and resources from uninsured sick patients and those insured but with unprofitable diagnoses. Profitable patients on the other hand have their care padded, sometimes even becoming paper admissions from the emergency department post mortem. Profits are maximized by sinister, dangerous characters who generate, manipulate and falsify medical records in addition to occasionally hastening the demise of patients and pesky interns threatening to adversely effect their cash cow. The same villains massage the case mix software and ultimately skim the tainted cash flow via a mysterious consulting company in an operation neatly described as "a system designed by thieves for thieves".

As in real life it is not always obvious who profits and who unwittingly facilitates, the vast majority of us simply trying to do our best to treat whatever disease our patients have wherever and however they present. Today's charity hospital patients still have the same mixed experiences I observed over the last forty years. The big difference here is that the outrageous degree of potential financial gain to be had is such that greed more than occasionally pushes profiteers beyond mere unconscionable restriction of medical services to outright fraud, even murder. Maggie, a continual drain on TURPH's bottom line by refusing to ignore her patients' various and costly medical needs, soon literally becomes a target. Initially her nemeses try to figuratively kill her with work, then later resort to overt violence.

To paraphrase H.L. Mencken, in managed care organizations as in cesspools, the really big ones rise to the top. Such is the case at TURPH. Continuing the above analogy, Maggie Altman proves to be one of those little ones so difficult to flush away. She is surrounded by peers with the varying degrees of skill and acumen typical of any teaching program. The daily grind of patient care is realistically presented as is TURPH's less than perfect house and teaching staffs.

A notable character is Maggie's former medical school professor, the bitter and disillusioned Dr. Milton Silber. After being passed over for chair of TURPH's department of medicine Silber retired from clinical medicine and pursued an interest in the stock market. He eventually became a highly successful investor and author of the "Silber Report", a financial newsletter specializing in analysis of medical-related stocks. Orient gently introduces this enigmatic figure who easily abandoned medicine for money, almost. Silber's cynical insights are eventually found to play a critical role in the plot's development but his relationship with Keynes, a feline pet, more accurately defines him as a kindly curmudgeon.

Maggie's penchant for research leads her to record observations deemed unimportant by her colleagues as they all struggle daily to care for patient after patient. Sound familiar? After her curiosity naturally leads to questions, she consequently becomes more and more a threat to the profiteers and their scheme.

Orient and Wright artfully craft their tale with interlocking subplots, including a bit of romance and a dash of cocaine hydrochloride, which keep the story moving along nicely. Orient is a clinically practicing physician with experience

in academia, currently specializing in internal medicine in Tucson, Arizona. She has written a number of pieces for both lay and scientific audiences including works scholarly, philosophical and fictional in addition to being a driving force within the Association of American Physicians and Surgeons. Wright, previously collaborating with Orient on other projects, is the award-winning author of some ten mystery novels, obviously a master at drafting characters and plots to present plausible ambiguity with steadily increasing tension.

I highly recommend their book. Its medical aspects remain believable at all times. I personally cannot stand to watch television shows or read books whose writers use inaccurate medical information to advance their plots, a particular hazard in murder mysteries. No such worries here. All the puzzle's pieces come together nicely in the end. Not to give away the plot, but the good guys sort of win while, as in real life, justice's ultimate triumph leaves much to be desired. Like I said, it's a great fast read!

## THE SUGGESTION BOX

### STICK 'EM UP!

by Doug Daniel

The above title refers to the classic mugger's command before taking whatever valuable possessions you at the time possess. That's about the way I'm starting to look at the post-911 world situation where it seems a relatively few criminally insane individuals are trying to empty our pockets while holding us hostage to their threats of extreme violence. An integral part of every terrorist's agenda foreign or domestic is and always has been bioterrorism. Nobody working for the Federal Emergency Management Agency (FEMA) can for long remain naive about the very real threat posed by the natural, accidental or terrorist-engineered release of hazardous materials. These materials include biological agents such as anthrax, smallpox, hemorrhagic fevers (i.e. Ebola and hanta viruses), plague, botulism, tularemia and all the other usual suspects you read about in medical school freshman microbiology and senior infectious diseases. Don't feel bad, I don't remember most of them either. Too many world governments, some hostile or highly unstable politically, openly or covertly maintain supplies both scientific and military of these deadly pathogens.

Another class of biohazards are those emitters of high energy electromagnetic radiation such as naturally occurring and enriched weapons grade uranium, plutonium, strontium, radium, radon and a list of radioactive isotopes as long as your arm, many of which for now at least reside under man's control in numerous nuclear reactors and storage sites the world over, again too often in hostile or unstable political conditions. Some have lifespans of nanoseconds while others hang around for thousands of years before even reaching their half-life. Still another class includes chemical weapon agents capable of inducing almost instantaneous death or permanent disability (i.e. sarin nerve gas, nitrogen mustard gas and phosgene gas) with no beneficial use to mankind. Not to be forgotten are the infinitely numerous toxic chemical compounds so necessary to our contemporary way of life such as chlorine, sulfuric acid and the ever ubiquitous petroleum products. Finally there are the old standbys of gunpowder, trinitrotoluene (TNT), nitroglycerine and plastique explosives. All the above are potential terrorist weapons. All are stored and on occasion, some everyday, moved across the United States of America and the world by every conceivable means of transportation, in the process presenting untold opportunities for accidental or intentional release, hijacking and diversion into irresponsible hands.

Most of these agents have been present in our environment since the beginning of time, some have naturally evolved, and a most dangerous few we have ourselves created. Terrorism has been a fact of human existence since prehistoric Cro-Magnon cavemen tried to influence their fellows' behavior with clubs and stones. History has refined our methods of attitude adjustment from weapons of wood and stone to those of iron and bronze, then chemical explosives, bacteriologic pathogens and most recently nuclear devices. Terrorism is nothing new, we've just advanced it to a remarkably efficient level. Who knows what new terror scientific discovery will next bring or may already be portending?

But I digress. The point here is that physicians, some more than others, have an obligation to familiarize themselves to some extent with all dangers facing their patients. Emergency medicine physicians, infectious disease specialists and epidemiologists have the gravest responsibility in the case at hand but we all should be able to intelligently and accurately answer our patients' and acquaintances' questions or correct their misunderstandings about biohazards, more specifically terrorist biohazards 12 September 2001 and after. We should be able to recognize cutaneous anthrax when it walks into our office. We should know when a patient presenting with expected symptoms of their usual "common cold" (a misnomer if ever there was one), influenza, or gastroenteritis may instead be demonstrating early symptoms of a terrorist's deadly and highly contagious mayhem.

So what do we do? Should we all be required by our state's medical licensing authority to take X hours of expensive state medical association-sponsored CME on terrorist biohazards? There have already been too many wasted hours and dollars stolen from us in the sacrosanct names of AIDS and child abuse. Instead I propose it is the individual physician's responsibility to develop the degree of expertise in these matters he deems warranted. In the case of bioterrorism a realm of information ranging from adequate to extensive is available free of charge on the web at [www.bioterrorism.uab.edu](http://www.bioterrorism.uab.edu) through the University of Alabama. They even offer an hour's CME credit. While not extensive their information is far beyond basic, relevant to and accessible by the level of knowledge possessed by healthcare professionals. In those instances where inadequate information is available on UAB's website there are efficient links to other sites maintained by such educational institutions as Johns Hopkins University and federal government agencies such as FEMA and the Centers for Disease Control and Prevention.

UAB should be congratulated for an unusually prescient solution to a problem most didn't even recognize; they opened their site in August 2001. The most recent postings were mid-October 2001 and will probably be updated as necessary. Before you next log-on to check your e-mail or place a J. Crew order, check-out UAB's site. It's a good thing.

## THE LITTER BOX

### “I DON’T CARE, JUST PLEASE GET IT ALL OUT”

by Doug Daniel

If you don’t immediately recognize the above title think back to the last time you broached the topic of elective hysterectomy to someone with a long history of chronic pelvic pain, dysmenorrhea on deep penetration or metromenorrhagia. In my experience that’s the most common response. Many times I have listened to tales of other gynecologists dragging reluctant patients through prolonged morasses of potent and potentially complicated temporary hormonal therapies, unsuccessful destructive surgical procedures and piecemeal removal of offending, no longer useful reproductive organ systems followed by the above plea.

My philosophy has always been to offer solutions with the best chance of permanent success at the least global cost to the payor, whether patient or other, and risk to the patient. When dealing with most symptomatic disorders of the uterus, fallopian tubes and ovaries in patients with no desire for future childbearing this usually meant removal of the uterus, its cervix, the fallopian tubes and oftentimes both ovaries. Lest we lose sight of a most important consideration these comments are made assuming progression through an organized therapeutic plan including detailed history and physical examination with periodic reassessments, brief observation, a brief unsuccessful trial of individually selected birth control pills or relatively innocuous hormonal therapy which could be continued long-term if successful, total endometrial sampling by inexpensive and safe outpatient technique when indicated for both diagnosis and therapy, and necessary diagnostic studies both imaging and clinical. In more than a few patients noxious symptoms were relieved or ameliorated, spontaneously resolved, or deemed tolerable for the near future by this plan. Others were offered definitive surgery as above. Over the past 20 years we have heard more and more encouragement for avoiding surgery if at all possible, delaying as long as allowable if not, and when unavoidable performing the most conservative and inexpensive of surgical procedures conceivable.

The point of this exercise is a recent article in *Obstetrics and Gynecology* addressing hysterectomy (Farquhar CM and Steiner CA. Hysterectomy rates in the United States 1990-1997. Vol. 99, No. 2, February 2002, p. 229-34). About 600,000 hysterectomies are performed yearly in this country and it is now our most commonly performed nonpregnancy related surgical procedure. Up to about 1970 routine childhood tonsillectomy held this distinction but discovery of its supposed lack of universally beneficial results and therefore unacceptable complication rate doomed it to obscurity. Today tonsillectomy, especially in childhood, is almost unheard of. Our risk of a woman having undergone hysterectomy by age 60 years remains about one in three and we have the highest hysterectomy rate in the world at 5.6 per thousand women over the age of 16 years, estimated to be three to four times higher than Australia’s, New Zealand’s or most European countries’. Considering we are one of the last remaining bastions of even limited patient and physician autonomy in choosing and providing costly elective healthcare, some observers would consider this an accolade rather than indictment.

Advocacy of laparoscopy and laparoscopy assisted hysterectomy over the past 20 years has come from many quarters but mostly those with a vested financial interest such as surgical equipment manufacturers and retailers, managed healthcare and medical insurance schemes, hospitals, and for unknown reasons leaders of some medical professional organizations. The implication has been that those not incorporating laparoscopy into their hysterectomy surgical technique were unskilled and outdated. Many managed care schemes and hospitals have pressured gynecologic surgeons to increasingly utilize laparoscopy in hysterectomy in order to realize promised financial windfalls and increased cash flows occasioned by remarkably shorter lengths-of-stay and operating times plus decreased intraoperative and postoperative complications, reduced hospital charges, and improved patient satisfaction when compared to abdominal hysterectomy. A similar situation has developed regarding subtotal laparotomy or laparoscopy hysterectomy with the same sources increasingly advocating supracervical hysterectomy for the same reasons. Not all investigators have confirmed these expectations (Richardson RE, et al. Is laparoscopic hysterectomy a waste of time? *Lancet* 1995;345:36-41). Some have found attempted vaginal hysterectomy often successful in cases traditionally deemed beyond its technical limitations (Kovac SR. Hysterectomy outcomes in patients with similar indications. *Obstet Gynecol* 2000;95:787-93). Others have found laparoscopy hysterectomy to have a higher rate of bladder injury and longer duration of surgery when compared to other hysterectomies (Meikle SF, et al. Complications and recovery from laparoscopy-assisted vaginal hysterectomy compared with abdominal and vaginal hysterectomy. *Obstet Gynecol* 1997;89:304-11). As a result many gynecologic surgeons have performed laparoscopy procedures beyond their capabilities or unnecessarily prolonged unwanted symptoms by delaying definitive surgical therapy. I’ve heard more than a few colleagues tell of starting every abdominal hysterectomy with laparoscopy but then converting to laparotomy when “unexpected” complicating conditions were encountered, thereby satisfying their masters. For years evidence-based

medicine confirmed the benefits of laparoscopy in hysterectomy based upon almost exclusively favorable peer-reviewed studies. When attending medical meetings or discussing clinical topics with colleagues it seemed “everybody’s doing it, doing it, doing it”. Coincidentally, innumerable allegations of medical professional liability with regard to operative laparoscopy were made during this same time and many were deemed meritorious as demonstrated by settlements and awards.

But as is too often the case in the medical arts and energy companies, it now appears we’ve been had by the greed of others and perhaps ourselves. The initially mentioned article details a study by statistical researchers of discharges over a recent seven-year period from a representatively sampled 20% of U.S. community hospitals in 22 states. ICD-9-CM diagnostic codes comprised the database for an undetermined number of cases, estimated to be 120,000. A potential problem exists with the data since prior to 1996 there was no specific diagnostic code for laparoscopy hysterectomy so the investigators simply designated as such all discharges coded for laparoscopy and vaginal hysterectomy, subtotal, or other hysterectomy. For discharges after 1996 they considered cases coded for laparoscopy and any other hysterectomy except abdominal or radical as Laparoscopy Assisted Vaginal Hysterectomies (LAVHs). Obviously this may question the accuracy of their data and its extrapolation across the years of their study.

The following are some of the more startling findings.

- ❑ Abdominal (laparotomy) hysterectomy continued to be the most frequently used approach for removal of the uterus in the United States, decreasing slightly in frequency over approximately the past 20 years accompanied by an equivalent limited increase in laparoscopy hysterectomy until 1993, since which time it has remained essentially stable at 63% of all hysterectomies.
- ❑ Over two thirds of women with a primary preoperative diagnosis of leiomyomata uteri, endometriosis, cancer or salpingo-oophoritis underwent abdominal hysterectomy.
- ❑ In 1997 less than 25% of U.S. hysterectomies were vaginal as opposed to France and Australia where almost 50% were.
- ❑ Introduction of and advocacy for alternative therapies to control abnormal uterine bleeding have not markedly decreased the overall rate of hysterectomy in the United States nor greatly increased the utilization of laparoscopy in hysterectomy.
- ❑ The incidence of subtotal hysterectomy tripled during the study period, progressively increasing after 1992 to a high of 2% of all hysterectomies in 1997.
- ❑ The incidence of laparoscopy hysterectomy gradually increased during the study period to a high of 9.9% of all hysterectomies in 1997.
- ❑ For all years studied vaginal hysterectomy had the lowest median total hospital charges of all hysterectomy procedures.
- ❑ Median total hospital charges for laparoscopy hysterectomy almost doubled during the study period from \$5132 to \$9385.
- ❑ Median length of stay following abdominal hysterectomy was consistently only one day longer than following laparoscopy hysterectomy.
- ❑ Median total hospital charges for abdominal hysterectomy were \$827 greater than for laparoscopy hysterectomy in 1990, \$1115 less in 1994 and \$735 less in 1997.

Although the authors give us no practical advice on utilizing their findings in our clinical and medical expert witness practices, some conclusions are obvious.

1. There is no longer conclusive evidence that laparoscopy or laparoscopy assisted hysterectomy offers financial or clinical advantages over laparotomy or simple vaginal hysterectomy. Indeed, Farquhar and others suggest there are serious disadvantages.
2. The long-term financial and clinical benefits of alternative therapies and conservative surgical therapies in controlling abnormal uterine bleeding compared to definitive surgical treatment are now questionable and should no longer be considered preferable.

3. Therefore, third party payors and peer reviewers should for now consider all the above procedures to be equally preferable. Specifically, laparoscopy and laparoscopy assisted hysterectomies should be equally reimbursed to all providers as compared to traditional abdominal and vaginal hysterectomy.
4. Ergo, decisions regarding technique, extent and approach of these surgical procedures should be left entirely to attending physicians and their patients with evidence of truly informed consent documented in the medical record. Specifically there should be no prior interference in these decisions by payors and considerable latitude allowed by *post facto* reviewers.

## **HOW MANY PHYSICIANS DO WE REALLY NEED? Continued From Page 1**

“...a social planning perspective that centered on what ought to occur, rather than an analytic approach that sought to define what most likely would occur. ... (T)he surpluses predicted by these studies gained wide acceptance, and they formed the theoretical basis for subsequent actions, including the termination of federal support for undergraduate medical education and a progressive decrease in support for graduate medical education.”

Cooper et al avoided previous biases by analyzing macroeconomic parameters instead of getting whipsawed by short-term fluctuations inherent in microeconomic analysis of minute-by-minute physician productivity such as the ever-familiar Full Time Equivalent (FTE) physician. Keeping It Simple, Stupid. They also analyzed long-term instead of short-term economic and demographic changes for the same reason. Trends that in brief snapshots of time seem to be erratic and unpredictable tend to smooth out over the long haul. Just compare a one month plot of the stock market's daily value to a 30 year plot of its annual value. They also assumed past trends in physician supply reflect past trends in physician demand, again keeping it simple. Perhaps most importantly they only made assumptions regarding what was most likely to occur instead of what ought to occur. Lest you think Cooper and Company the only voices crying in the wilderness, another researcher named William Schwartz and his colleagues used a similar economic model over ten years ago to determine that the GMENAC and COGME predictions were fatally flawed. Instead they predicted the dreaded 2000 physician surplus and generalist deficit would never come.

### **The Economy Factor**

It's the economy, stupid. According to Cooper's group the major factor affecting worldwide demand for physician services is its economy and history confirms this.

“In developed countries throughout the world, health care spending has been closely tied to levels of economic development, as reflected by a country's real (inflation-adjusted) Gross Domestic Product (GDP) or national income. Since labor is the principle health care expense component, it is not surprising that growth of GDP has also correlated with growth of the health care labor force. However, most of this growth in the workforce has involved ancillary personnel, so physicians have become a proportionately smaller component. ...Physician supply [in the U.S.] correlated with state per capita income. ...The medical specialties (including both general and subspecialty internal medicine and pediatrics) were most responsive to income effects, while the surgical specialties were less affected, and family/general practice displayed a slightly negative relationship with per capita income. ...[G]eographic differences in physician supply are likely to persist as long as regional differences in income exist. ...[These] macro trends only apply to physicians in the aggregate over broad periods. While micro turbulence, such as changes in payment schemes, governmental regulation, or the structure of health plans, may induce deviations from the trend lasting as long as five to ten years, such factors do not influence the slope of the trend, which is affected by macroeconomic dynamics. ...[I]ncreases in GDP, which (with a lag of several years) induce further demand for health services, thereby caus[e] health care spending to rise. This leads to growth of the health care labor force, of which physicians are an important component.

“[T]he perceived triumphs of technology contribute to a culture that is willing to devote more resources to health care. Similarly, although population aging does not itself cause health care spending to rise above its established trends, the elderly constitute a political force that can influence the allocation of societal resources. In each instance, efforts to push health care use higher are balanced by public and private 'reforms' that work to constrain spending and limit access. The striking observation is that the net of these counterbalancing factors yields such stable results, infrequently allowing physician supply to deviate by more than 10% from its long-term relationship with GDP.”

### **The Population Factor**

Population growth is the next most important factor determining physician demand. The U.S. Census is the universal source of population estimates and forecasts used by all the above models, councils and committees but its raw data can be at best deceiving and at worst simply wrong for the purpose to which it's utilized.

“Unfortunately, most previous workforce analyses used unmodified population forecasts from the Census Bureau, which have proved to be low, and, therefore, the resulting projections of physicians per capita were excessively high. Indeed, this error accounts for approximately 25% of the physician surpluses that were previously predicted. ...Using a modification of Census Bureau estimates, we have forecasted that the U.S. population will grow from 285 million in 2000 to 325 million in 2010 and that it will reach 345 million in 2020. These values are similar to those that both we and the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) have used previously. Although 6-8% higher than current Census Bureau forecasts, they are within 2% of the projections that can be derived using data from the year 2000 census.”

If you doubt there is currently a dearth of specialists, ask your patients or receptionist how long it takes to get appointments to see your consultants. All indicators point to the beginning of a current physician shortage that will worsen, most critical among specialists. The solution seems to be a reorganizing of medical education to increase specialist physician training, especially in recently emerging areas of practice.

## The Supply Factor

Every workforce prediction study must first determine its subject's current size. Cooper's model avoided the confusion inherent in previous studies' complicated and subjectively ambiguous FTE physicians by considering all currently active physicians, regardless of their level of activity and including residents, to be the physician workforce. Again, KISS. With this definition our physician supply increased fivefold over the past 70 years from 144k in 1929 to 772k in 2000, a more than doubling of physicians per capita from 119 to 270 per 100k population. But is this enough?

“Recent surveys of physicians and the public, combined with information on physician recruitment, yield a picture of marginal sufficiency, with a strong demand for specialists, lengthening of waiting times in many specialties, and sporadic reports of physician shortages. ...[W]e project that the “head count” of active physicians will increase from 772,000 in 2000 to a peak level of 887,300 (283 per 100,000 of population) in 2010. Thereafter, the total number will continue to grow, reaching 964,700 in 2020, but the population will grow even faster, and the number of physicians per capita will actually decrease slightly, to 280 per 100,000 of population. ”

## The Productivity Factor

We all know physician work effort has changed. Today's residents don't work nearly the hours we used to nor did we our predecessors'. New York State's stringent regulations governing workdays and workweeks of physicians-in-training are about to be imposed upon all U.S. training programs in response to simultaneous cries for humane treatment of residents and decreased errors in medicine, ringing somewhat hollow since I know of no similar rush to improve the working conditions of attending physicians for the same reasons. The average age and female composition of the physician workforce is increasing. Both older and female physicians statistically tend to work fewer hours. More and more physicians are working for the man and everyone knows employees don't work nearly as hard as owners. Young physicians place more emphasis on personal and family time than we did whether that's an improvement or not. Older physicians are retiring earlier or leaving clinical practice for other vocations. All these factors decrease physician productivity but Cooper only considered increasing age and female composition by assuming productivity reductions of 10% in physicians age 55 to 65 years, 20% in physicians over 65, and 20% in females.

“This resulted in a decrease in the ‘effective supply’ of physicians by 5% in 2010 and 7% in 2020. Because these adjustments do not include consideration of other factors that also reduce work effort, they probably overstate the amount of physician effort that will actually be available in the future.”

## The Hamburger Helper™ Factor

For years this proprietary product has been marketed as a meat extender to cut the cost of a family meal by adding relatively cheap carbohydrates to more expensive ground beef, serving twice as many diners as before at only a fraction more

cost. The result may not taste, smell or look as good as a grilled hamburger and certainly doesn't have equivalent nutritional value, but it's cheaper and therefore literally flies off the grocery shelves at Sam Walton's Supercenters. When Cooper et al addressed physician extenders they spoke far more eloquently than I ever could.

“Until recently NPC's ability to substitute for physicians was limited by their licensed prerogatives and by their total numbers, but both of these limitations are diminishing. Most NPCs now provide not only adjunctive services but also services that broadly overlap those provided by physicians, and their potential for substitution is substantial. And their numbers are growing. By 2015 there are likely to be as many as 275,000 nurse practitioners, physician assistants, and nurse midwives; 150,000 chiropractors and acupuncturists; and 100,000 other NPCs engaged in specific specialties, such as psychology, anesthesia, and optometry. Their combined output will be equivalent to the services of approximately 65 physicians per 100,000 of population. More than a third of this output is in place already. Therefore, the incremental growth of NPCs over the next fifteen years was taken to be equivalent to 40 physicians per 100,000 of population, which is equal to approximately 15% of the physician workforce. Paradoxically, most of this growth will be concentrated in primary care, which has shown relatively stable needs, whereas the greatest growth of demand for physician services is in the non-primary care specialties, to which NPCs can be expected to contribute proportionately less.”

## The Bottom Line

“[A] growth in the demand for physician services of approximately 1.1% to 1.5% annually [is projected], a rate of increase that is similar to the job opportunities for physicians that have been projected by the Bureau of Labor Statistics. Comparing this growth in the demand for physician services with the number of active physicians that has been projected reveals a shortfall of substantial magnitude. This shortfall widens further when work effort is considered and demand is compared, instead, with the ‘effective supply’ of physicians, but the incremental contributions of NPCs more than compensate for changes due to physician work effort, leaving a projected deficit in 2010 of only 50,000 physicians, less than 6% of the projected demand. Some of this is within the margin of error of the trends that were analyzed, and much of it could be accommodated by the elasticity of the health care labor force. However, by 2020 the deficit is projected to exceed 200,000 physicians, an amount that represents more than 20% of the projected demand. In percentage terms, this is greater than shortages that existed during the 1960s.

“These projections are made against a background of concern that health care spending is excessive and that physicians may exacerbate the problem, either by actually inducing demand or by facilitating utilization in a system in which they exert control over most expenditures, a conclusion that is not supported by contemporary data. Among those who hold this perspective, constraining the growth of physician supply is seen as a means of limiting spending. Canada followed such a policy throughout the 1990s. Physician supply in the United States has remained lower relative to GDP than in most Organization for Economic Cooperation and Development countries, and managed care has been used to further limit access. However, as revealed both by the backlash against managed care in the United States and by the recent recognition in both Canada and California that physician shortages are looming, such constraints inevitably conflict with long-term economic trends and with the perceptions of need that flow from them.

“Thus, physicians are at the nexus of a health care system that is shaped in large measure by exogenous trends. Their role is broad. It bridges an expanding universe of medical science and a long tradition of compassion and healing. But are the trends consistent with the continuation of this duality? ...[I]t seems more likely that physicians will be drawn to those complex areas of specialty medicine that demand their attention most and that they will find it increasingly difficult to lavishly dispense time, sympathy and understanding... Patients desire the most advanced treatments, but they also seek a caring physician. Ironically, attempts to impede patients' access to the former have had the unintended consequence of squeezing out the latter.

“The socialist Andrew Abbott has observed that... ‘when a powerful profession ignores a potential clientele, paraprofessionals appear to provide the needed services’. ...[Physicians'] ability to increase their productivity is limited by their declining work effort. Their ability to grow their numbers is hostage to the belief that surpluses exist.

“The last debate about physician shortages continued well into the 1960s. Ultimately, the Health Professions Education Assistance Act of 1963 led to a doubling of medical school slots, but it was another

fifteen years before appreciably more physicians were available to the public. It is doubtful that this process could occur any more rapidly today. While the recruitment of additional international medical graduates (IMGs) could shorten the response time, the wisdom of even our current dependency on IMGs has been questioned. If, instead, the infrastructure of medical education were expanded to alleviate just one third of the projected shortages, more than 25 additional medical schools would be required over the next decade, a formidable undertaking. But to do nothing invites public discontent and forces the profession of medicine to redefine itself in an ever more narrow scientific and technological sphere while other disciplines evolve to fill important gaps. Although the path is uncertain, the choices are clear. We believe that a dialogue regarding these choices is imperative.”

## Afterthoughts

Cooper and Company may not hear hearty huzzahs and accolades of acceptance for their work but to those of us on the factory floor it has the ring of truth. If their summarization sounds familiar it's because the same situation regarding our supplies of petroleum and qualified teachers, i.e. inadequate domestic production with reliance on a combination of cheap substitutes and foreign resources, has existed for almost half of the last century with no more than Band-Aid treatment and not surprisingly continues to exist. While the thought is bone-chilling I suspect the hard though right choices in all three problems will be avoided in favor of the politically advantageous cheap trick and quick fix, passing the consequences on to our progeny. On the other hand if these dire predictions come true it may just be enough of a disaster to in the long run salvage something of what we had before medicine's fall into this abyss of partisan political tampering, governmental meddling, social engineering, and Enron-like big business profiteering.

# What's Goin' On?

by Wayne Sinclair

My apologies to Marvin Gaye, but I believe this question is on the minds of just about every healthcare provider in the United States whether private, institutional or corporate. It's a little difficult to sort through but permit me a few observations. As former Senior Vice President and General Counsel of MMI Companies, Inc., I'm frequently in touch with many colleagues still in the medical professional liability insurance industry.

First, the situation on the civil litigation side continues to deteriorate. The average medical professional liability verdict has doubled in the past two years to over \$1,000,000. Severity of loss is up but frequency has been stable for a number of years. Plaintiff's attorneys are more aggressive than ever, largely because they now have huge financial resources provided by their tobacco settlement fund fees.

Second, for the past fourteen or so years healthcare professionals enjoyed the longest "soft" insurance market in history. The capacity of companies to write insurance was enormous. Recently this market hardened considerably due to increasing medical professional liability payouts, inadequate premium rates, lessened capacity, and more disasters both natural and man-made. My German reinsurance friends tell me their product will be priced 30-90% higher this year with another increase to come in 2003, of course passed on to their U.S. insurance company customers.

Third, the U.S. medical professional liability market is in disarray. All are aware of its insolvencies, bankruptcies, liquidations and so on. PHICO, Frontier, Reliance and others' failures have left a large hole in U.S. capacity. MMIX announced the third week in February that earnings would be delayed because of losses. Its stock fell 33% the next day. St. Paul is attempting to sell its present book of business since announcing its exit from medical professional liability. Can it accomplish that sale? Probably not. Losses last year were \$960,000,000 on \$540,000,000 in premium. Why buy a bad book of business when one may simply start anew?

Some of our best medical professional liability companies are the PIAA (Physician Insurers Association of America) companies. PIAA has excellent leadership in Larry Smarr. Member companies insure about 300,000 U.S. physicians and for the most part are well run, but all are at or near their regulated capacity to write new policies.

What's a physician to do? Many industry publications suggest the future will see formation of many new risk retention groups (RRGs) and rent-a-captives. The Cayman Islands has a new segregated cell captive law that is a very good vehicle. Ignore Congressional rhetoric about Enron and the "evil Cayman captive". These viable business options serve a valuable purpose.

It is predicted that many physicians will go their own way and form RRGs with obstetrician-gynecologists, radiologists, emergency medicine physicians and other specialists finding each other, raising some capital and self-insuring. These schemes will work if they are adequately capitalized, charge an adequate premium rate, have excellent risk management and claims handling programs, and police their own.

While the money hurdle comes first, it may not be difficult to overcome; the most serious problem will be adequate rates. Excuse the remark, but physicians are whiners when it comes to paying adequate premiums. Let's take the Pennsylvania Patients' Compensation Fund for an example. While payouts are high, every attempt by the State to charge adequate premiums has confronted heavy physician lobbying for low rates; thus a \$3 billion shortfall. If an RRG doesn't charge an adequate rate it will collapse very quickly.

The State of West Virginia just passed legislation allowing the formation of a physicians mutual insurance company with state money capitalizing the venture. To sound like a broken record, the above elements are essential to its success, particularly adequate rates.

Fourteen years at MMI taught me aggressive risk management works, even with physicians fighting you every inch of the way in both their hospital and office. If you do not want someone taking an interest in your medical practice and trying to help, stay out of medical professional liability insurance plans with good risk management. Conscientious physicians welcome quality risk assessments of their office and hospital practices.

I have worked on, read and settled thousands of claims during my 32-year career. Good, intelligent, experienced claims handling is the single biggest reason cases go well for the defense. This means cooperative physicians, great defense attorneys and knowledgeable claims consultants. When coupled with a corporate philosophy of not just sitting back and letting claims play themselves out, this is the formula for a successful medical professional liability insurance company.

Policing your own. Is it possible? “But I went to school with him..., But we trained together..., But it will ruin her...” and so on ad nauseam. Studies have shown that “claims predict claims”. There are incompetent physicians; there are incapacitated physicians. Either help them or get rid of them. The most difficult argument to counter when dealing with plaintiffs’ attorneys is, “You don’t get rid of the bad ones.” The reason it’s the most difficult? It’s true.

So, the bad news is it’s going to get tougher and physicians are going to have to get creative. They’re going to have to get involved. They’re going to have to find alternative mechanisms of insurance coverage. Otherwise they’re going to have to get out of the healthcare business. There is no good news.

In future articles I will discuss some of these issues in more detail, perhaps delve a little into the question of civil justice reform. Questions, remarks and criticisms are encouraged and can be directed to me through the ASFOG editorial offices.

# HOWARD C. TAYLOR, Jr., MD, 1966-1967 (b. 1900- d. 1985)

by John J. Sciarra, MD, FACOG

Howard Canning Taylor, Jr., 16<sup>th</sup> ACOG President, was born in New York City 17 February 1900. His father, a prominent local physician specializing in diseases of women, was later a founder of the American Cancer Society. Howard earned a PhB degree summa cum laude from the Yale Sheffield Scientific School and an MD from his hometown Columbia University College of Physicians and Surgeons. Five years of internship and residency in general surgery, obstetrics and gynecology followed at Roosevelt and New York Lying-In Hospitals. A stint of foreign study with Ludwig Aschoff, prominent German physiologist and Director of the Pathological Institute of Freiburg, preceded joining in 1928 his father's private practice in New York City. During this time Dr. Taylor held clinical and academic appointments at Roosevelt, Memorial and Bellevue Hospitals, New York University College of Medicine, and the University of Pennsylvania.

In 1946 Dr. Taylor was appointed Director of Columbia's Sloan Hospital for Women as well as Professor and Chairman of its College of Physicians and Surgeons' Department of Obstetrics and Gynecology, posts he held for the next nineteen years. During his tenure clinical and basic research became a major priority and he greatly expanded existing investigative laboratory facilities, often at his own expense. Consequently the number, quality and diversity of scientific publications from his faculty and residents in steroid chemistry and metabolism, gynecologic endocrinology, uterine dynamics, graphic analysis of labor, fluid balance during pregnancy, transplacental maternal-fetal interaction, fetal and neonatal physiology, human embryology, sperm morphology, hemocoagulation, cytogenetics, hemolytic disease of the newborn and gynecologic oncology became renowned. He also was responsible for initiating publication of the quarterly *Bulletin of The Sloan Hospital for Women* in 1955.

An innovative educator, Dr. Taylor expanded and strengthened Sloan's residency program with an emphasis on producing academic physicians. He extended its duration from eighteen months to three years with optional fourth and fifth years offered to selected graduates for clinical research or advanced studies in surgery or obstetrics. Consequently he could choose his residents from among those best qualified. As a result over four foreign and 21 U.S. university department chairs trained under him. He thrived on inquiry, enjoyed intellectual pursuits and admired investigation, encouraging these qualities his trainees. In 1975 the Howard C. Taylor, Jr., Society was established by his residents to recognize his influence in their lives.

Dr. Taylor also found time for other interests. Beginning in 1953 he served sixteen years as Editor-in-Chief of *The American Journal of Obstetrics and Gynecology*. He also served as President of the American Cancer Society, International Federation of Gynecology and Obstetrics (FIGO), New York Obstetrical Society, American Public Health Association and the American Association of Planned Parenthood Physicians. In addition to holding the ACOG Presidency he chaired six of its standing committees and served on numerous others.

In 1965 Dr. Taylor retired as Department Chairman to become the first Director of Columbia's International Institute for the Study of Human Reproduction, the culmination of his efforts over the preceding fifteen years to focus the world's attention on the dangers posed by its burgeoning population. The Institute was to coordinate scientific inquiries into reproduction plus disseminate information to healthcare specialists and family planners worldwide by focusing on biology, medicine, social science, public health, adolescent contraception and population control programs in all countries. Again retiring after seven years in this post, he served seven more as a senior consultant to the Population Council on the now standard implementation of contraception as an integral part of postpartum care.

Dr. Taylor was obviously a role model for his residents. He encouraged us all to be involved in research and publication. For me his urging to become involved in international affairs persisted throughout my career and culminated in my election to a term as FIGO President in 1991, almost 20 years following his Presidency.

On 22 March 1985 Dr. Taylor died at his home in Manhattan. He was recognized across the country as a skilled surgeon, talented researcher and devoted teacher of unique vision able to perceive mid-20<sup>th</sup> century the unprecedented opportunities for the development of obstetrics and gynecology as a medical specialty. His achievements were remarkable and have drawn well-deserved accolades. Many have said his greatest contribution was in reproductive health by focusing attention on the threat the world population explosion of the 1950s posed. A lasting effect upon women's healthcare and its academic disciplines will continue for generations to come through the continuing efforts of those he nurtured. He was an absolutely unique individual in our specialty with ideas far ahead of his time.