

THE MEDICOLEGAL OB/GYN NEWS

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WHAT HAPPENS WHEN A PHYSICIAN IS SUSPECTED OF ABUSING DRUGS OR ALCOHOL?

DANIEL M. AVERY, MD AND KATHY T. AVERY, RN, BA, MT (AMT)

Abstract: Physicians suspected of abusing drugs or alcohol are reported by a multiplicity of mechanisms. The vast majority of complaints today are sent to the state impaired physician program. Physician suspected of abusing drugs or alcohol are usually sent for a residential evaluation and assessment by a team of professionals trained in addiction. Most physicians today are treated at state medical society and licensure commission approved residential treatment facilities. There is life and the practice of medicine after successful treatment depending on a compliance contract with the state, a treatment plan and urine drug screens. Most hospitals today are recovery-minded. Relapse of physicians after quality treatment is rare but when it occurs usually results in death or prison.

INTRODUCTION

Physicians suspected of abusing drugs or alcohol are reported many mechanisms. A patient suspect of a physician may register a complaint with a hospital administrator. Many hospitals have physician wellness or physician impairment committees that will then investigate the complaint. Often, a group of colleagues intervene on a physician they are concerned about. A concerned physician, nurse or pharmacist may express concern about a certain physician. Medical students are usually intervened by the medical student affairs office. Residents and fellows in training are usually become involved with the program director. On rare occasion, a patient or concerned party may register a complaint with the licensure board or state medical society. Self reports to state medical societies and physician health programs are few and far between. The physician in trouble is usually the last to know. The thought of his calling the state impaired physician program and expressing concern over himself is usually unheard of. Table 1 lists the possible ways a physician is reported.

TABLE 1: HOW ARE PHYSICIANS REPORTED?

Report to Hospital Administrator
Intervention by colleagues
Complaint to Licensure Board
Complaint to State Medical Society
Self report to Psychiatrist for other reasons
Attempt at “private treatment”
Report by a suspicious Pharmacist
Report by nurse
Report by Fellowship or Residency Director
Report by Medical School Student Affairs Office
Referral from the legal system
Self-reporting by the physician himself is very rare

REPORT TO IMPAIRED PHYSICIAN PROGRAMS

No matter what the point of entry of the concern, ultimately the complaint makes it to the state impaired physician program, usually an agency of the state medical society. Physicians never self report because addiction alters their thinking process; they are the last to know that they are in trouble. In Alabama the appropriate agency is the Alabama Physician's Health Program or "APHP." headed by Dr. Greg Skipper. The program was founded by the late Dr. Gerald Summer as the Physicians Recovery Network or "PRN." Alabama has a very progressive program aimed at rehabilitation, a far cry from the original punitive approach. Records are protected by the Code of Alabama and not discoverable by subpoena. The Program is run by a number of appointed physicians from around the state There are local monitors who are usually psychiatrists or addictionologists who regularly meet with impaired physicians and assist Dr. Skipper with interventions.

The APHP compliance is protective of a physician's medical license unless that physician does not comply and then his license is in jeopardy. Failure to comply with recommendations in Alabama like most states results in licensure revocation.

EVALUATION OF SUSPECTED ADDICTION

The vast majority of complaints about physician addiction are directed sent to the APHP. All reports are anonymous. Dr. Skipper then investigated the complaint and interviews the physician in question. An evaluation by an addictionologist is almost always recommended. A health professional evaluation and assessment consists of a 1-4 day residential assessment by a team of professionals including addictionologist, psychiatrist, psychologist, social worker, neurologist and counselor. A comprehensive history and physical is performed along with urine and blood screens and hair samples for toxicology. The physician-patient is observed in a situation where there is no access to drugs or alcohol. After the assessment is complete, a recommendation is rendered to the state impaired physician program consisting any medical diagnoses, psychiatric diagnoses and opinion about whether the physician is abusing or addicted to drugs or alcohol and if so a recommended course of treatment. A physician may be abusing drugs or alcohol but not yet addicted. A physician may be neither and simply doing things that are "stupid" like going to the hospital with alcohol on his breath. If a diagnosis is not clear, a period of monitoring may be recommended.

DIAGNOSES OF ADDICTION, ABUSE OR NEITHER

For those physicians who are diagnosed with alcohol or drug addiction, almost all states and licensure boards demand residential treatment at an approved treatment facility. In Alabama, diagnosed physicians meet with Dr. Skipper and they usually decide on a treatment facility. The physician is usually given a choice of several possibilities. Compliance with the APHP protects a physician's license. However, non-compliance

means revocation of license, which is not a good choice. Basically, the licensure commission holds a physician's license over his head to get treatment, which in the long run is a good thing.

RESIDENTIAL TREATMENT

Once a treatment facility is selected, the physician requests a leave of absence from his hospital administrator, training program if he is a fellow or resident or medical school if he is a student. Practicing physicians make arrangements for their practice to be away for a period of time ranging from 13 weeks to a year. As stated above there is no current effect on license with compliance.

Physicians are usually given a choice of several approved treatment programs. Not all states have approved treatment programs. Talbott-Marsh Recovery Campus in Atlanta was one of the first treatment facilities designed primarily for healthcare providers. It is considered the "gold standard" of care and physicians from all over the world come there for treatment. No other program boasts the success rate of Talbott-Marsh which is greater than 90%. In some cases, detoxification may need to be performed first, before actual treatment. This may be performed locally or at a treatment center.

The term residential treatment means in essence that you live there, apart from medicine, family, problems, stresses of life and completely relearn how to live. One lives with 3 to 7 other recovering physicians, varying in length of treatment and recovery. There is a complete restructuring of life with good nutrition, sleep, exercise, group, individual and family therapy, specific counseling, treatment of psychiatric diagnoses, Alcoholic Anonymous, Narcotics Anonymous, Caduceus and Family Week (Table 2). It can be a wonderful experience but it is also life-changing.

TABLE 2: RESIDENTIAL TREATMENT

Detoxification if needed
Living with recovering physicians
Good nutrition
Sleep
Exercise
Group therapy
Individual therapy
Specific counseling
Marital & Couples counseling
Psychological testing
Psychiatric testing
Treatment of psychiatric diagnoses
Alcoholic Anonymous
Narcotics Anonymous
Caduceus

Family Week
Discharge planning

LIFE AFTER TREATMENT

Most physicians complete treatment because the state licensure commission holds their license over their head. Physicians see treatment as a means to a new life and the ability to return to practice. The success rate for quality treatment is greater than 90%. The recidivism rate is low among healthcare professionals. Most physicians do well, regain their practices, their self-esteem and do well professionally. Most serve as a resource of addiction to their patients and colleagues. Most will end up helping others. 99% of patients are understanding, glad to see their physician returned and gladly acknowledge their honesty.

The real work begins after treatment. Treatment provides the tools for the job ahead: recovery. All state medical societies and licensure commissions require at least a 5 year advocacy contract. In reality, *RECOVERY IS FOREVER!* There is no magic pill that keeps one from using drugs and drinking alcohol. As the “Big Book” or Alcoholics Anonymous says: it is simple program but not an easy one. “Don’t drink, don’t do drugs, go to meetings, talk to people in recovery, read the “Big Book.” “Avoid old playmates and playgrounds.” Life after discharge consists of a number of entities outlined in Table 3. They include integration back into family and work, work restrictions of 60 hours per week, proctoring, mentoring, AA, NA, Caduceus, group therapy, After Care, family therapy, urine drug screening, self assessment, relapse prevention and an advocacy contract with state impaired physician program and state medical society. Also essential is a primary care physician and dentist who knows about addiction and treatment center revisits. The physician must also meet with the hospital administrator, physician health committee and malpractice insurance carrier.

TABLE 3:TREATMENT AFTER DISCHARGE

Integration back into family
Integration back into family
Work restrictions (60 hours/week)
Proctoring
Mentoring
Alcoholics Anonymous
Narcotics Anonymous
Caduceus
Group Therapy
After Care
Family Therapy
Urine drug Screening
Self-Assessment

Relapse Prevention
Advocacy Contract with State
Primary care physician
Primary care dentist
Treatment center revisits
Meeting with hospital administrator
Meeting with the physician health committee
Meeting with the malpractice carrier

ADVOCACY CONTRACT WITH STATE

Every state in this country requires that a physician completing treatment sign an advocacy contract with the state impaired physician program and/or state licensure commission. This contract is essential for hospital privileges, malpractice insurance and most practices. While most states only require a contract for 5 years, hospitals, health insurance carriers and malpractice companies require such a contract and advocacy for the duration of a physician's practice life. The contract with the state requires the items listed in Table 3 above. Thereby, most recovering physicians today participate with the state forever. Most malpractice carriers will allow one treatment for addiction but usually consider that physician high risk with higher premium rate.

URINE DRUG SCREENING

Urine drug screening is an integral part of state and licensure contracts and recovery. Most drug screens are random. Initially screens are once a week progressing with time to once a month. After 5 years, most advocacy contracts go to every quarter. Screens may also be used for bad outcomes and any suspicion of drug or alcohol use. Drug screens are observed and follow the "chain of command." They are reviewed by a certified medical review officer or the state director of the physicians' health program. A positive drug screen must be investigated. Urine drug screens can only be performed at an approved collection site.

"CAN I GO BACK TO MY OLD PRACTICE AND HOSPITAL?"

After all of the above is done, the question remains if a physician can go back to his old job and practice at his old hospital. Most of the time it is possible, but not always. It depends heavily on how much damage was done. Usually 99% of patients are glad to have him back, understand and will use him as a resource; 1% are not and they will go elsewhere. Most hospitals today are very recovery-minded provided the physician does what he is supposed to and is compliant with his contract.

RELAPSE

Despite quality treatment, approximately 1% of physicians will relapse at some point in time, usually early most of the time. Relapse is often disastrous. Recurrent relapse has

very deleterious results on license, privileges and practice. Untreated, the end result of addiction is long term impairment, loss of license, loss of income, loss of family, loss of health, loss of everything and ultimately loss of life or prison.

CONCLUSION

Most physicians do well with treatment, return to a normal life, family and practice and are compliant with advocacy contracts. Most of their patients are understanding and forgiving

HPV VACCINE FOR FEMALES 9 TO 26—WHAT ABOUT EVERYONE ELSE?

DANIEL M. AVERY, MD AND KATHY T. AVERY, RN, BA, MT (AMT)

Abstract: The HPV Vaccine after much publicity became commercially available this past summer. Most patients know about the original study and results. Many have already received the vaccine. Most major insurance carriers reimburse for the vaccine, appreciating the value of its potential for preventive medicine. Many patients have paid cash for the vaccine when their insurance did not cover it. The vaccine is only indicated for females aged 9 to 26. But what about females younger than 9 or older than 26? What about men? What about withholding a vaccine that has the potential to eradicate cervical cancer like the smallpox vaccine did for smallpox?

Since the original paper describing the research on the HPV vaccine, women have been asking when would the HPV vaccine be available. First it was the spring and then finally last summer it became a reality. Most physicians are aware of the details of the original research. Those that received it in the original study did not develop an HPV infection. Those that had abnormal pap smears were cleared of the virus and had normal pap smears. Those of us that read the paper did not appreciate that there may be an age restriction on the vaccine.

Dr. Warner Huh, Gynecologic Oncologist at the University of Alabama in Birmingham Medical Center presented research data last spring at the Alabama Section Meeting of the American College of Obstetricians and Gynecologists. He predicted that the use of the vaccine would be the most off-label use of a vaccine in medical history. He raised questions about who should receive it, what age should it be given and what about giving a vaccine to men that would prevent a malignancy that is limited to opposite sex?

Does it work better if given before one experiences sexual intercourse? Should it be given before one enters elementary school? How long will the immunity last? Will patients need booster shots like tetanus vaccine? Will protection against HPV encourage sexual promiscuity like in the decades before when oral contraceptives became universally available.

But what about the rest of women *and men*? Current research indicates that women older than 26 would probably do well. There is no current reason to think that they should experience side effects that younger women do not. It is proposed that soon it will be available for others. So to eradicate HPV, men need to be treated also. Medicine does not have good data about men and HPV like women. Men do not generally have penile cytology performed. Lesions are rarely seen on men. Modified colposcopic evaluation of men has not been forthcoming. Only a few men tolerated a penile biopsy like a cervical biopsy with Kevorkian Forceps and those few never came back for results.

Personally, I would give it to anyone that would let me. I am constrained by the medical school which is a state institution for whom I work to abide by the FDA guidelines. The time will probably come when anyone can get the vaccine. There is a time when boosters will be also need to be available but it is not known when at this time.

MAINTAINING COMPETENCE IN OBSTETRICAL CARE

DANIEL M. AVERY, MD

Abstract: One of the issues that eventually will come up with physician competence and documentation is how many deliveries are necessary to maintain a physician's competence. Many hospitals have minimum numbers of deliveries and cesarean sections to get initial privileges but not to continue care or to reapply. The American College of Obstetricians and Gynecologists has in the past recommended that an OB/GYN perform 125 deliveries a year. An important consideration is the small rural hospital that does only a 100 deliveries a year but provides access to care and a significant reduction in perinatal morbidity and mortality. The Society of Obstetricians and Gynecologists of Canada surmised that it is not the number of deliveries performed but the competence of the physician and the commitment to life long audit, review and continuing professional development.

Documentation of competency of physicians is an area that the Joint Commission on Accreditation of Hospitals and Organizations plans to look at closely this year and expects hospitals to have a plan in place for evaluating physicians (1). Competency is also an issue with Pay for Performance for physicians (P4P). There has been very little in the literature regarding the number of deliveries to maintain competence. The question is whether a physician who performs only a few deliveries a year can maintain competence. That physician may keep a small hospital alive but more importantly greatly improve access to care reducing perinatal morbidity and mortality.

Several years ago the American College of Obstetricians and Gynecologists (ACOG) recommended that the ideal number of deliveries for an OB/GYN to perform yearly is 125 but no minimum numbers to maintain competency (2). Currently the American

Board of Obstetrics and Gynecology (ABOG) has no specific guidelines on numbers of deliveries to be performed to maintain competence or to take recertification examinations(3).

DCH Regional Medical Center in Tuscaloosa, Alabama requires 200 deliveries over three years of which 35 must be cesarean sections for a family physician to obtain obstetric privileges (1). This averages 67 deliveries a year and 12 cesarean sections. The hospital's Family Medicine Residency Program requires 40 continuity deliveries spread over 3 years of training which averages 12-13 per year. There are no guidelines on maintaining competence or minimum numbers of deliveries

During my own residency training in obstetrics and gynecology in the early 1980's there was the unpublished rule of "a thousand" in which each intern tried to do a thousand deliveries and a thousand epidurals during that year. By the fourth year in training a chief resident would attempt literally anything if he or she were not constrained by the attending physician. Years later after having being seriously ill and going without delivering a baby for a year made me anxious about returning to practice. I later took off a year to do a fellowship and experienced the same anxiety. Three months of supervision of cesarean sections corrected the problem in short order. When I personally perform less than 4 deliveries or less than 2 cesarean sections a month, I have some anxiety about the next one while on call. One of my partners also shares the same feeling; one does not.

A retired OB/GYN re-entered practice after 2 years and both the licensure board and malpractice carrier in the state where he chose to practice required two months of supervised practice to obtain privileges. He had practiced for a number of years and although somewhat anxious about re-entering practice did an excellent job with every procedure he did including operative obstetrics and abdominal and vaginal surgery. Despite being nervous, the skills were very much there and really he only needed encouragement. At the end of the two months with us he re-entered practice and has done well.

Recently a retired chair of OB/GYN of a large medical school and prominent OB/GYN residency program acknowledged that he had quit supervising residents on call because he had done so few cesarean hysterectomies that he longer felt comfortable.

Looking solely at numbers of deliveries to determine competency, raises the question of rural hospitals that provide very important access to care but only perform limited numbers of deliveries. Loss of those obstetric units readily challenges access to maternity and neonatal care in this country. One of the greatest challenges in medicine especially obstetrics is access to care today.

The Society of Obstetricians and Gynecologists of Canada (SOGC) has studied the idea of number of deliveries and has determined that it is not the numbers but other areas of competency (4). There are 576 hospitals in Canada that provide obstetrical care in all of rural Canada. 40% of these hospitals perform less than 20 cesarean sections a year. 1/3 of women in Canada have their children in a rural hospital setting. There are 38

obstetricians and 1384 Family Physicians in rural Canada that perform maternity care. 93% of cesarean sections in rural Canada are performed by Family Physicians. Only 126 Family Physicians providing obstetrical care do not perform cesarean sections (4)

Research shows that Family Physicians who have acquired competence in cesarean section can maintain skills with relatively few annual cases. The range was 5-22 cesarean sections per year. Research suggests that quality of training fits with competence not actual numbers. SOGC does not require an absolute number of deliveries to maintain competence, rather a lifetime commitment to audit, review and continuing professional development. This author recommends the same for advanced maternity skills (4).

Recently I had the pleasure of hearing Dr. Larry Leeman speak at the Swedish Medical Center at the High Risk OB Tools for the Family Physician Conference in Seattle. Dr. Leeman spoke on "Maintaining Rural Maternity Care" and he addressed the issue of number of births to maintain an obstetric unit. He commented that some rural hospitals perform only 100-150 deliveries a year. It is difficult to maintain physicians and staff a unit that does less than 150-200 deliveries a year. But at the same time, 50% of rural hospitals in this country have less than 500 deliveries a year. His study of OB fellowship graduates show that fellows average 31 cesarean sections a year (5). Dr. Leeman reiterated the study by the Society of Obstetricians and Gynecologists of Canada stating that competence in obstetric care is not dependent on number of births attended. There is no data to demonstrate better outcome with more deliveries (5).

Malpractice insurance coverage is also an issue in number of deliveries. There has to be enough deliveries to pay the malpractice premium for coverage unless there is a governmental program with coverage, subsidy or other mitigating circumstances. Normally it would not be practical for a physician to pay \$50,000 in malpractice premiums for \$1,000,000/\$3,000,000 coverage to perform 25 deliveries a year that paid \$1000 per delivery. But if we are comparing the cost of malpractice insurance with the cost of perinatal morbidity and mortality, the picture looks very different because in that light it looks like a bargain. From a Family Medicine Residency standpoint though is that not what we preach to residents: go to a rural area and include obstetrics in your armamentarium of services to the community. Is this not why we teach obstetrics to family medicine residents?

An evidence-based study of why family physicians should practice obstetrics by the author among other things looks at the financial aspect of rural obstetrical care. In many states including Alabama, the malpractice insurance for a family physician to practice obstetrics is a fraction of the cost for an OB/GYN to see the same patient. The level 1 beginning premium from Alabama's largest malpractice carrier for an OB/GYN is about \$65,000 while a family physician would start at \$12,000 a year for the same coverage, to take care of the same patient. Also in Alabama locally rendered rural obstetrical care carries a much higher reimbursement than the same care in an urban area (6). An OB/GYN attending where I trained after many years in practice, decided to do a family medicine residency at the same institution. He received credit for the first year and

completed years two and three. He changed the name on his nameplate from obstetrics and gynecology to family medicine but cared for the same patients. He experienced an 80% reduction in malpractice insurance premium from his carrier of many years.

The provision of rural obstetric care is really no different from a rural volunteer fire department. The obstetric unit with providers and staff offer maternity care that makes a dramatic effect on perinatal morbidity and mortality that is not replaceable. This is the exact same situation with a rural volunteer fire department. Does it make money? No! Does it even pay for itself? No! Is it worthwhile? Absolutely. Without a rural, volunteer fire department in the time of fire, there is no replacement for it. Everything depends on it. How do the volunteer firemen maintain their skills in the light of only a few fires a year? Preparation, drills, continuing education and maintaining the equipment. Both rural obstetrical care and rural volunteer fire departments spire to the famous Boy Scout motto: "Be Prepared!"

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A TEACHING MODEL FOR NURSE PRACTITIONER OB/GYN EDUCATION IN A UNIVERSITY MEDICAL CENTER CLINIC SETTING

DANIEL M. AVERY, MD; KATHY T. AVERY, RN, BA, MT (AMT)
ANGELA HAMMOND, RN, CNP

Abstract: There are many nurse practitioners in many specialties in this country. Sometimes OB/GYN preceptor sites are hard to find. Nurse practitioner students can be trained in OB/GYN with medical students, residents and fellows in a university medical

center clinic setting with good results. The relationship allows each other to appreciate what the others do and how they can all work together in a health care delivery system.

There are certified nurse practitioners in many specialties in this country. There are also many nurse practitioner students in training who must identify prospective preceptor sites and obtain agreements to precept at those sites. Sufficient sites for primary care including Family Medicine, Internal Medicine and Pediatrics are usually found. OB/GYN training sites are much to the contrary. While private practitioners are comfortable with nurse practitioner students examining children and adult patients, an opportunity to check the cervix with supervision in a pregnant patient or perform a pap smear and pelvic examination on a healthy middle-aged adult woman is very much different due to privacy issues and rights as well as maintaining their comfort with the examination.

Listening to the heart or looking into the ear canals is not intrusive; a pelvic examination and breast examination can be an infringement on privacy. More and more nursing students and nurse practitioner students are male and this further complicates the issue of learning opportunities. The private practice world is not a great source of education endeavors for nurse practitioners to learn, including a female nurse practitioner student's own OB/GYN.

The University of Alabama School of Medicine serves as an OB/GYN preceptor site for 5 nurse practitioner programs from two southern states. Students are selected on a first come basis and only one student is present on the OB/GYN service at a time. Agreements are signed between the nursing school, student and preceptor. Students are given HIPPA training and instruction in electronic medical records on the first day. On day two of the preceptorship, the nursing student follows a medical student or resident seeing patients. The chart is reviewed and the patient is interviewed and examined. Together the student or resident and nursing student develop a diagnosis and plan of treatment which is discussed with the attending physician. All three then see the patient, complete the examination and discuss treatment.

On day three, the nursing student independently selects a patient, reviews the chart, interviews and examines the patient as outlined in Table 1. A plan is formulated and presented to the attending physician. The examination is rechecked by the attending. The plan is discussed with the patient. The nursing student then creates an electronic medical record, orders ancillary tests, writes prescriptions and checks out the patient. The note is reviewed by the attending and signed. The billing and coding is checked.

From a didactic standpoint the nursing student participates in medical student lectures, case presentations and Grand Rounds. For the aggressive nursing student, knot tying and suture classes are available. Ultrasound experience, colposcopy, cryotherapy, LEEP, IUD insertion and removal and endometrial biopsy are also available for advanced students depending on their interest as outlined in Table 2.

The teaching arrangement is a reciprocal one. Nurse practitioners are efficient and usually very quick to learn. Nurse practitioners, medical students, residents and fellows

get the opportunity to work with one another, see what each other does and how they may work together in an integrated health care delivery system. Each is a learning experience for the others.

It is also a great opportunity for nurse practitioner students to develop relationships with physicians that they may refer to when they are in practice. It gives the physician referred to an opportunity to know the capability of a certified nurse practitioner. It gives the nurse practitioner the opportunity to learn what they can treat and what they need to refer. Sometimes all that needed is a question about a patient. Already having developed a relationship helps knowing what physician is willing to help them. Developing collegial relationships with physicians while in training assists the nurse practitioner in identifying mentor physicians in their future professional practice.

Table 1: Student Nurse Practitioner Program at University Medical Center

Students are interviewed by department chair and selected on a first come basis; only 1 student is present in clinic at a time

Agreement is signed between nursing school, student and preceptor

**Day 1 HIPPA Compliance & Privacy Course and Certification
Electronic Medical Record Introduction and Education**

**Day 2 Nurse Practitioner Student follows a medical student or resident
and is under the supervision of an attending faculty member**

**Day 3+ Student works independently in clinic seeing patients on their own
reviewing the chart, interviewing the patient, examining the patient,
creating a note, developing a working diagnosis and establishing a
plan, presenting the patient to an attending faculty member. The
faculty member sees the patient with the student and completes the
visit. Effort is made for the student to have both follow up and
continuity of care with subsequent visits. Coding & billing follow.**

Table 2: Advanced Student Nurse Practitioner Program Procedures

Ultrasound

Colposcopy with Cervical Biopsy & Endocervical Curettage

Vulvar & Vaginal Biopsy

Intrauterine Device Placement, Maintenance & Removal

High Risk Obstetrics

Non Stress Testing

Cryotherapy

Endometrial Biopsy

LEEP

Suturing & Knot tying

THE LEGAL ASPECTS OF APPLYING TO MEDICAL SCHOOL

DANIEL M. AVERY, JR, MD; DANIEL M. AVERY, III; JUSTIN G. MILLER

Abstract: Interviewing applicants for medical school is a very important function of the medical school education system. However, there are many questions that are not appropriate to ask applicants. While some would be useful to know, there are many one cannot ask.

In 1973, very few women applied to medical school and even professional schools as a whole. The following is a true story about a friend that applied to medical school.

CASE STUDY

A young woman in graduate school applied to medical school. During the interview, the woman was asked if she was married and she responded "Yes." She was then asked her age. But then the interviewer asked; "what if you were on call and you and your husband were having sex and the hospital called for you to come to the emergency room to attend

one of your patients in cardiac arrest. What would you do?" The young woman responded, "I would go to the hospital like any physician." The young woman kept her cool. When the interview was over, the interviewer asked her how she felt about the interview. She replied, "Good, my uncle is the Dean of the Dental School and President of the University."

DISCUSSION

Today in 2007, one cannot ask those questions when interviewing prospective medical students. Table 1 lists the things that cannot be asked in a medical school interview today. Some seem very benign like how old are you which is usually found on most applications. It used to be traditional and *very honest* to ask how an applicant was planning to pay for medical school. This lead into a discussion about loans, scholarships and rural areas needing physicians who were willing to pay stipends for a graduate to return to their area to practice medicine. Debts, credit and difficulties thereof are not important.

Some medical schools have established age limits on medical school based on the premise that as one completes medical school and residency, if older, has less time to practice and serve society. In the old days, age did not matter. One of the authors had many in his medical school class in their thirties, ten in their forties and several in their fifties, one of whom was the class president. One is uncertain if age really matters.

Marital status used to be an important question to ask because married students were thought to be more stable and more mature. Their marital responsibilities mandated that they do well in school and not fail. Single students were thought to party more, although that is of doubtful importance. One cannot ask about children. However, if brought up by the applicant, it could be discussed by the interviewer. "Are you pregnant or plan to get pregnant or have you ever had an abortion?" are not appropriate now or in the past. Along with the above, an individual's method of contraception should not be asked and certainly not whether they are sexually active. Today, that would be considered sexual abuse or at least sexual misconduct.

Table 1: Things Not To Ask in a Medical School Application Interview

How old are you?

Are you married?

Do you have children?

Are you pregnant or plan to get pregnant during medical school

Where you do go to church?

What nationality are you?

How do you plan to pay for medical school?

Do you plan to get married in medical school?

Are you sexually active?

What is your religious preference?

Where are you from?
Are you gay?
Are you living with someone?
Have you ever been married?
Have you ever had an abortion?
Are you on birth control pills?
How old were you when you got married?
Are you sexually active?
Do you have AIDS or any other STD?
Do you believe in God?
What political party do you belong to?
Why is your hair so long?
Always had the ring in your nose?
Do you have any tattoos?
Do you have any learning disabilities?
Do you do drugs?
How much do you drink?
Ever had sex with someone of your own sex?
How much money do you have in the bank?
Ever declared bankruptcy?
Ever defaulted on a loan?
Method of contraception?

Religious beliefs should not be an issue applying to medical school. What difference should it make? One's nationality begs the same question. However, many primary care residency and fellowship programs that are funded on state funds with a commitment to practice in that state. Where one is from may well be an issue in where they plan to practice. Students from rural areas are more apt to return to rural areas. So, in this context along with the tremendous need for care in those areas, it may prudent to know where a student is from. Rural programs for medical clerkships like the TERM Program (Tuscaloosa Experience in Rural Medicine) requires the applicant come from a rural area.

Sexual preference and experience have no place in determining if an applicant would be a good medical student. Partying is not a question to ask. To the contrary, it would be useful to know if there was a drug or alcohol problem. With random and cause-and-effect drug screening for physicians and soon to be urine drug screens as a part of the application for hospital privileges, drug screening will eventually make its way to the medical school application process as well.

There are however, issues of professionalism with how medical students present themselves to patients and are an issue with the LCME too. Tattoos, inappropriate rings and modern hair designs are to be discussed. Patient perception and appreciation of students and their learning to meet patients are important. Medical students, shadowing students and premed students are required to meet patients in a professional appearance at the University of Alabama School of Medicine in Tuscaloosa, Alabama. To participate in

the OB/GYN Clerkship there, there is no long hair or beards and no obvious rings or tattoos. Students that do not comb or brush their hair are asked to do so. The current trend of males to wet their hair, apply mousse or oil and leave it standing up or unkempt is not appropriate.

WHAT CAN YOU ASK ?

Traditional important questions to ask an applicant for medical school include why does that individual want to be a physician, what medical experiences have they had that have stimulated their interest in medicine and how have their academic performances been? Many of the above topics can be discussed if the applicant brings them up such as marriage, children and the church they go to. It is also appropriate to ask at what point in their life did they decide they wanted to go to medical school.

After my first orientation to interviewing applicants, I wondered if I should do any more than just introduce myself to be on the safe side. My experience has found applicants that really did not want to medical school. One young woman really wanted to get married and have children, not go to medical school. There are some that felt that it was the right thing to do but uncertain if it was right for them. But there are many that have worked very hard to get to this point in the process and will make wonderful physicians.

DOCUMENTATION OF PHYSICIAN COMPETENCY IN THE HOSPITAL SETTING

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Abstract: Documentation of physician competency in the hospital setting is a new area of interest for the Joint Commission on Accreditation of Hospitals and Organizations. Physician competency documentation also preempts Pay for Performance (P4P) by insurance companies, Medicaid and Medicare. This paper looks at procedures and complications selected for review. Some complications have nothing to do with patient care such as spontaneous abortion and placental abruption. More appropriate categories are suggested. Concern over admonishing a physician for complications despite excellent detection and management are discussed along with the long term results of this evaluation system on patient care and physician reimbursement.

The Joint Commission on Accreditation of Hospitals and Organizations has announced that it will soon look at physician competency in the hospital setting. Insurance companies, Medicare and Medicaid plan on paying based on quality performance as well. Insurance companies, Medicare and Medicaid have all announced that they will reimburse physicians based on quality of care called Pay for Performance (P4P). Procedures have been selected by hospitals in anticipation of JCAHO site visits. Standard

complications of both gynecology and obstetrics have been selected. Unfortunately, the selected complications of pregnancy have nothing to do with physician care. Whether a patient spontaneously aborts or develops an abruption usually has very little to do with a patient's obstetrician. So, why penalize a physician for a complication he had nothing to do with? This paper looks at reasonable obstetric complications that could be used to evaluate physician competency.

The procedures selected for evaluation include endometrial ablation with Novasure, suction dilatation and curettage, laparoscopically assisted vaginal hysterectomy with bilateral salpingoophorectomy, total abdominal hysterectomy, total abdominal hysterectomy with bilateral salpingoophorectomy and cesarean section as outlined in Table 1 below.

TABLE 1: PROCEDURES SELECTED FOR PHYSICIAN EVALUATION

Endometrial Ablation with Novasure
Suction Dilatation & Curettage
Laparoscopically Assisted Vaginal Hysterectomy with Bilateral Salpingoophorectomy
Total Abdominal Hysterectomy
Total Abdominal Hysterectomy with Bilateral Salpingoophorectomy
Cesarean Section

TABLE 2: CATEGORIES OF PHYSICIAN EVALUATION BY COMPLICATION CODES IN GYNECOLOGY

996.3 Mechanical complication of genitourinary device, implant and graft
996.30 Unspecified device, implant and graft
996.31 Due to urethral (indwelling catheter)
996.32 Due to intrauterine device
996.6 Infection and inflammatory reaction due to internal prosthetic device, implant and graft
996.65 Due to other genitourinary device, implant and graft
996.7 Other complications on internal (biological)(synthetic)prosthetic device, implant and graft
996.76 Due to genitourinary device, implant and graft
997.3 Respiratory Complications
997.4 Digestive system complications
997.5 Urinary complications
998 Other complications of procedures, not elsewhere classified
998.0 Postoperative shock
998.1 Hemorrhage or hematoma or seroma complicating a procedure
998.11 Hemorrhage complicating a procedure
998.12 Hematoma complicating a procedure

- 998.13 Seroma complicating a procedure**
 - 998.2 Accidental puncture or laceration during a procedure**
 - 998.3 Disruption or operation wound**
 - 998.4 Foreign body accidentally left during a procedure**
 - 998.5 Postoperative infection**
 - 998.51 Infected postoperative seroma**
 - 998.59 Other postoperative infection**
 - 998.6 Persistent postoperative fistula**
 - 998.83 Non-healing surgical wound**
-

Physician complications of gynecologic procedures are listed in Table 2. These are the usual gynecologic complications discussed in OB/GYN Department meetings in hospitals such as postoperative hematomas, seromas, abscesses, wound separations, cellulitis, foreign bodies left inside the patient and fistulas. They also include complications in other body systems such pneumonia, small bowel obstruction and inadvertent cystotomies. Many of these depend on the patient. A morbidly obese patient weighing 400 pounds has more risk of a seroma than a 130 pound patient. Bladder injuries are more at risk when the patient has had 4 previous cesarean sections. So my question is still, why is the physician at risk for taking on the challenge? Why reimburse the physician for taking on the challenge? Reward the physician---don't punish him.

**TABLE 3: CATEGORIES OF PHYSICIAN EVALUATION BY
COMPLICATION CODES IN OBSTETRICS**

- 640 Hemorrhage in early pregnancy**
 - 641 Antepartum Hemorrhage, abruption placentae and placenta previa**
 - 642 Hypertension complicating pregnancy, childbirth and the puerperium**
 - 643 Excessive vomiting in pregnancy**
 - 644 Early or threatened labor**
 - 645 Late pregnancy**
 - 646 Other complications of pregnancy, not elsewhere classified**
 - 647 Infectious and parasitic conditions in the mother classifiable elsewhere but complicating pregnancy, childbirth or the puerperium**
 - 648 Other current conditions in the mother classifiable elsewhere but complicating pregnancy, childbirth or the puerperium**
-

**TABLE 4: PROPOSED CATEGORIES OF PHYSICIAN EVALUATION BY
BY COMPLICATIONS IN OBSTETRICS**

APGARS less than 3 at 10 minutes

Cephalohematoma
Excessive Blood Loss
Broken Clavicle
Erb's Palsy
Other Birth Injury
Facial Laceration
Fetal Skull Fracture
Uterine Perforation at Dilatation & Curettage

Evaluation of physician performance and payment based on that has a number of failings. Perceived decreased payment for high risk, complicated patients will destroy the healthcare for those patients. In other words, if a patient already has risk factors or complications before surgery with decreased payment up front why should a physician tackle such a patient knowing that most likely there will also be complications postoperatively further reducing reimbursement, not to mention documentation of complications for both the hospital and JCAHO.

A colleague of mine in practice told me that years ago his group had a “fat charge” for overweight patients who of course were more likely to have complications and for sure had more difficult operations. Now, medical society is proposing paying less for those patients and acknowledging that one is not as good a surgeon because of the complications. So, what will happen? Very simply put those patients just will not get elective operations. Of course they will get emergency operations, such as appendectomies. Do you think that they have a chance with an elective total abdominal hysterectomy for bleeding when they are morbidly obese with diabetes, hypertension and had deep venous thrombosis last year. I think not!

Physicians will look for the slender, healthy patient with dysfunctional bleeding to operate on. The 400 pound patient with bleeding will be out of luck.

The charity patient that received care pro bono is out of luck. There will be no compensation and only a hit on competency that affects care on other patients

Imagine a system that punishes the physician for caring for sicker patients. In the past, discovery, correction and management of a complication for the standard of care because complications do occur. Now, the rules have changed. Even if the complication is discovered in a timely fashion and managed appropriately and the patients does well two things happen. Number one, the physician gets paid less because he had a complication, despite the fact that the patient did well. Number two, he gets dinged by the hospital for having a complication, reported and it affects his reimbursement with subsequent patients. It makes no sense, whatsoever.

This is a system that has absolutely nothing to do with patient care. It is only another mechanism to keep from paying physicians and hospitals for the care that they render.

This saves the insurance company and hurts patient care. But has this ever stopped anything in the past detrimental to patient care and physician reimbursement?

Older, more venerated physicians that have now retired once speculated that things would deteriorate to the position that healthcare providers would gladly welcome socialized medicine. We are getting closer to that each day.