"THE SGR IS ABOLISHED! WHAT COMES NEXT?"
LUCIA DIVENERE, MA
(PRACTICE MANAGEMENT; JUNE 2015)

Do ACOG guidelines protect us from liability?

I read Ms. DiVenere's June article with interest, but I found this point she quoted confusing:

> The law protects physicians from liability from federal or state standards of care. No health care guideline or other standard developed under federal or state requirements associated with this law may be used as a standard of care or duty of care owed by a health care professional to a patient in a medical liability lawsuit.

I have 2 questions: How do you interpret the use of guidelines by the American College of Obstetricians and Gynecologists (ACOG), since they are developed independently by a specialty society rather than by federal or state "requirements"? Does this only pertain to liability lawsuits concerning billing of fees, or does it pertain to medical malpractice civil lawsuits?

In the Medicare Access and CHIP Reauthorization Act, I find this section that seems to contradict the protection[1]:

> (3) NO PREEMPTION.—Nothing in paragraph (1) or any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et seq.) shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

JULY 2015

What is the bottom line? No law can protect and provide immunity to a physician for true medical malpractice. This federal law says "no preemption."

Arnold D. Wharton, MD
Tyler, Texas

Reference

1. Pub L No. 114-10. Medicare Access and CHIP Reauthorization Act of 2015. 114th Congress. Title 1—SGR repeal and Medicare Provider Payment Modernization. §106. Reducing administrative burden and other provisions. 129 STAT.143. http://www.gpo.gov/fdsys/pkg/PLAW-114publ10/pdf/PLAW-114publ10.pdf. Accessed June 10, 2015.

» Ms. DiVenere responds

I thank Dr. Wharton for his interesting perspective. To answer the first questions, this section of the law only applies to guidelines and standards created by a federal or state entity, not to ACOG guidelines, and is intended to provide one area of protection from medical malpractice lawsuits. Interestingly, legislation has been introduced in the US House by Congressman Andy Barr (R-KY), with ACOG's support, to create liability safe harbors for physicians who follow care guidelines developed by their relevant specialty society.

As for the question about preemption, this section of the law allows stronger state laws to stand; this federal law would not preempt state laws.

"HOW DO YOU DISMISS A PATIENT FROM YOUR PRACTICE'S CARE?"
JOSEPH S. SANFILIPPO, MD, MBA, AND STEVEN R. SMITH, JD
(WHAT'S THE VERDICT?; JUNE 2015)

Statute of limitations still in effect; contact your insurer

While the end result to dismiss the patient was achieved, the statute of limitations for a possible malpractice suit had not fully run. I would suggest that the physician contact his/her insurer so that they can open a file and be alerted for a possible suit. Insurers generally require physicians to notify them of any potential suits.

Lynn Frame, MD, JD
Tulsa, Oklahoma

» Dr. Sanfilippo and Mr. Smith respond

Our thanks to Dr. Frame for the good reminder that physicians should always remember the obligation to inform malpractice insurance carriers when a malpractice claim is being, or may be, filed. Insurance contracts vary somewhat regarding when notice must be given.

In the hypothetical case, there was an angry patient but no formal threat of legal action. Some lawyers take the sensible position that "when in doubt, notify." Others are reluctant to "over notify" carriers. Our view is that this is one of the areas in which it may be beneficial for a physician to have an ongoing professional

CONTINUED ON PAGE 13

CONTINUED FROM PAGE 12

relationship with an attorney to allow for advice on when to provide insurance carrier notification.

I really enjoyed the videos and advice, as always!

Elizabeth Street, MD
Marietta, Georgia

"SURGICAL REMOVAL OF MALPOSITIONED IUDS"
BENJAMIN MARGOLIS, MD; MIREILLE D. TRUONG, MD; JULIA KEARNEY; SARAH SCHECHTER; JEANNIE KIM, MD; AND ARNOLD P. ADVINCULA, MD (VIDEO; JUNE 2015)

Videos show very useful techniques for malpositioned IUDs

I have placed somewhere in the ballpark of 2,000 intrauterine devices (IUDs) and have had 2 perforations that I am aware of (and probably many more malpositioned IUDs that I am unaware of). Some of those were likely the cause of a patient's pain and were either removed or hysteroscopically repositioned. Dr. Advincula's edited video from several cases demonstrates very useful techniques in the surgical management of these problems.

Philip Ivey, MD
Casa Grande, Arizona

The IUD might not stay where I put it

For the past several years I have performed the majority (more than 95%) of IUD insertions with ultrasound guidance and have been very thankful at times for the assistance of my sonographer. Despite my knowledge of accurate placement, there are still patients who return months or years later with a malpositioned IUD. I have come to realize that the uterus is a dynamic organ—not a piece of concrete. Just because I put the IUD in the right place does not ensure that it will stay there. Fortunately, I have not yet had a perforation into the abdominal cavity.

"EBOLA IN THE UNITED STATES: MANAGEMENT CONSIDERATIONS DURING PREGNANCY"
STEPHANIE L. BAKAYSA, MD, MPH; JEANNIE C. KELLY, MD; AND ERROL R. NORWITZ, MD, PHD (JUNE 2015)

Improved care for pregnant women during Ebola crisis

The article on Ebola in pregnancy noted how little we actually know about the Ebola virus. The Ebola virus was first documented in 1976 in Sudan and the Democratic Republic of the Congo,[1] not in 1967 as the article stated. The Marburg virus outbreak occurred in 1967. Closely related, both viruses are filo viruses that cause hemorrhagic fever. A significant difference between the 2 is that the natural reservoir for the Marburg virus was identified. The outbreak in Marburg, Germany, which the virus is named for, was linked to African green monkeys imported from Uganda, East Africa.[2] Bats also have been identified as a reservoir for the Marburg virus.[3] However, there is only speculation as to whether the natural reservoir for the Ebola virus is fruit bats. A 3-month research study following the 1995 outbreak of Ebola virus in Kikwit, Democratic Republic of the Congo, tested more than 3,000 vertebrate species and was still unable to identify a natural carrier for the virus.[4]

The Ebola virus was first documented nearly 40 years ago and yet we know so little about it. This demonstrates the ongoing disparity in funding and research devoted to disease conditions that most often affect only third-world nations.

Also, I'd like to point out that the article's comment that pregnant patients are triaged "last" during the current Ebola virus outbreak may not be completely accurate. Yes, pregnant women have a significantly higher rate of mortality with Ebola viral infection. I spoke with a nurse (name and location withheld for confidentiality) who is currently the Clinical Lead at an Ebola Holding Unit for pregnant and lactating women in a West African nation. According to her, improved resources were quickly mobilized by nongovernment organizations and other foreign health care volunteers following the initial reports of disease, a factor that significantly increased access to care for pregnant women and improved outcomes.

Erin Kiser, DNP, FNP-BC, WHNP-BC
Fayetteville, North Carolina

References

1. World Health Organization. Ebola virus disease. Fact sheet No. 103. http://www.who.int/mediacentre/factsheets/fs103/en/. Updated April 2015. Accessed July 6, 2015.
2. World Health Organization. Marburg haemorrhagic fever. Fact sheet. http://www.who.int/mediacentre/factsheets/fs_marburg/en/. Published November 2012. Accessed July 8, 2015.
3. Towner JS, Pourrut X, Albariño CG, et al. Marburg virus infection detected in a common African bat. PLoS One. 2007;2(8):e764. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0000764.
4. Leirs H, Mills JN, Krebs JW, et al. Search for the Ebola virus reservoir in Kikwit, Democratic Republic of the Congo: Reflections on a vertebrate collection. J Infect Dis. 1999;179(suppl 1):S155–S163.

"WHY IS OBSTETRICS AND GYNECOLOGY A POPULAR CAREER CHOICE FOR MEDICAL STUDENTS?"
ROBERT L. BARBIERI, MD (EDITORIAL; MAY 2015)

Had the chance to change my specialty, but didn't

I trained in Mexico, where I was a board certified ObGyn and a maternal-fetal medicine specialist.

CONTINUED ON PAGE 14

CONTINUED FROM PAGE 13

When I came to the United States I had the opportunity to change my specialty, and I didn't. As a "free agent" international medical graduate, I had to go through many hurdles. My gate to enter the American medical world was through a family practice residency. After a year, I realized my love was still obstetrics and gynecology. In 1996, I finished an ObGyn residency at Loma Linda University Medical Center in California, and have been board certified since 1998.

There are many things I like about this specialty. Mainly, it's the diversity. A well-rounded ObGyn has to know internal medicine, pediatrics, and surgery and apply this knowledge to the pregnant patient—a feat somehow exclusive to ObGyns.

I have enjoyed a wonderful career and many rewards. I never stop thanking all those professors and colleagues who helped me develop the set of skills that I now possess.

Tomas A. Hernandez, MD
Pasco, Washington

Not again!

I would not go into obstetrics and gynecology again because of many reasons:

- It is a very difficult life, with no family time and calls 24 hours per day.
- The specialty is the bread and butter of malpractice attorneys, causing a lot of stress.
- Insurance companies, health maintenance organizations (HMOs), etc, pay ridiculously low reimbursement for obstetric and gynecologic procedures.
- Malpractice insurance premiums are so high that you can be forced to be without malpractice and therefore more exposed.
- Patients are extremely demanding. Because pregnancy is not a disease but a natural process, they expect perfect results every time (as if congenital malformations, chromosomal abnormalities, and pregnancy complications are your fault).
- There is no patient loyalty, or very little. If a patient changes HMOs she changes obstetricians. If a woman has to wait 20 minutes in the waiting room, she changes doctors—to one who doesn't do obstetrics (too many pregnant women!).

I would like to say that ObGyn is a beautiful specialty, most likely the best of all medical specialties, if it was not for the attorneys' greed and patients' lack of understanding that we are not God. We are only doctors, working within a system that contributes to all of the above.

Manuel S. Mendizabal, MD
Miami, Florida

Are men discouraged from entering the ObGyn field?

Dr. Barbieri asks, "Why is obstetrics and gynecology a popular choice for medical students?" The unaddressed question is why is it unpopular for half of medical students? Ninety-three percent of resident graduates in the field are women, while women account for half of medical student graduates. Men rarely go into the specialty today. Perhaps job advertisements touting physician opportunities in "all female groups" discourage males. Perhaps hospitals' "women's health centers," with "women taking care of women," discourage males. Perhaps receptionists' asking patients whether they prefer a male or female physician discourages male ObGyns. In the United States, two-thirds of outpatient office visits are made by women, and academic centers and hospitals focus on this demographic in their marketing. The business ends justify the unethical means.

The result of discouraging half your medical students from the field is a lower quality field. If male and female medical students are equally qualified for any field, and I believe this is true, then discouraging half the candidates from a field lowers the quality of the resulting field. This has been the product of all discrimination throughout the ages.

Joe Walsh, MD
Philadelphia, Pennsylvania

›› Dr. Barbieri responds

Drs. Hernandez and Mendizabal provide 2 divergent perspectives on our field. Dr. Hernandez cherishes the diversity of the clinical work in the field, and Dr. Mendizabal warns that night call and medical malpractice take a toll on a physician. Both perspectives are valid and important, and medical students entering the field should be alerted to these rewards and challenges.

I agree with Dr. Walsh that the majority of residents in obstetrics and gynecology are women. On December 31, 2013, of the 4,942 residents in obstetrics and gynecology in the United States, 82.5% were women.[1] In the fields of orthopedic surgery, neurosurgery, and urology, male residents dominate the resident complement, constituting 86.3%, 84.1%, and 77.3% of the residents, respectively.[1] It is interesting that the fields of obstetrics and gynecology, orthopedic surgery, neurosurgery, and urology are among the most competitive fields in the resident match. Based on personal observation, medical student clerkship directors and obstetrics and gynecology residency programs encourage both women and men to consider a career in obstetrics and gynecology and warmly welcome male applicants. Medical students select their

CONTINUED ON PAGE 16

CONTINUED FROM PAGE 14

preferred future specialty based on many factors. It is clear that in the past few years the medical students applying to obstetrics and gynecology are extremely capable, and I am confident that the future of women's health is in the hands of excellent clinicians.

Reference

1. Brotherton SE, Etzel SI. Graduate medical education, 2013–2014. JAMA. 2014;312(22):2427–2445.

"IS IT TIME TO REVIVE ROTATIONAL FORCEPS?"
WILLIAM H. BARTH JR, MD
(EXAMINING THE EVIDENCE; APRIL 2015)

Who will teach this dying art to a new generation?

The article on rotational forceps has what I consider one glaring defect—who will teach this dying art to a new generation?

Now retired, I was military-residency trained in the 1970s when you had to do your own regional and conduction anesthesia as well as operative forceps delivery—and that did not mean a silastic cup vacuum extractor, though we had just started using the Malstrom vacuum. Breech forceps, Kielland rotations, occipito-transverse forceps application—you name it and we did it as we had to keep our cesarean delivery rate down. All of us were well skilled in operative vaginal delivery.

When I stopped practicing obstetrics, the fresh-out-of-residency people coming into our practice couldn't do a low forceps delivery. If there is to be a reteaching of rotational forceps, they'd better catch us old codgers fast before we die off (I am 72) and grant us malpractice relief (I no longer have insurance). This is an art, not a science, and can't be taught from a book or a computer model. Set up a crash course to teach this dying art, pay us well, and perhaps we will be able to pass this skill along. Otherwise it will be gone forever.

I have always said that forceps are like a shoehorn—used correctly, they make things so much easier.

Robert Frischer, MD
Wichita Falls, Texas

"IS SUPPLEMENTAL ULTRASONOGRAPHY A VALUABLE ADDITION TO BREAST CANCER SCREENING FOR WOMEN WITH DENSE BREASTS?"
MARK D. PEARLMAN, MD
(EXAMINING THE EVIDENCE; MARCH 2015)

Why I now recommend 3D ultrasonography to my high-risk patients

In 2012, I attended a medical staff meeting where Dr. Ruby Chang spoke about a newly available modality at our hospital: 3D ultrasonography. Her slideshow included some impressive images of cancers that were not seen on mammogram but were unmistakable on sonography.

I decided to have a 3D ultrasound for myself in order to tell my patients what it was like. I also have "heterogeneously dense breasts" on mammogram. For the previous 10 years, my annual screening mammograms had all been negative. The 3D ultrasound showed an 8-mm cancer in my left breast—not palpable to me. A subsequent mammogram was still negative for cancer.

Luckily, the breast cancer was Stage 1 at surgery, and I did not need chemotherapy or radiation, opting for skin- and nipple-sparing double mastectomy. I had a double mastectomy because I believed that I could no longer trust screening mammography for a timely diagnosis.

To this day, I explain breast density to all of my higher-risk patients who have either heterogeneously or extremely dense breasts. I tell them that their mammograms may miss a cancer and that there is another test that might help detect cancer early. It's a good thing to have another way to evaluate the breast, especially when our patients are being sent letters about their "dense breasts." (The majority of my patients do not understand what this means.)

I realize that data may show that this modality isn't the perfect solution and may lead to more testing and procedures, but in my case, it was worth it!

Strangely, to this day, I have not had one patient who had breast cancer diagnosed in this way.

It's a shame that insurance companies don't cover even partial cost for eligible patients.

Bettina Zatuchni, MD
Pleasanton, California

WE WANT TO HEAR FROM YOU!

Share your thoughts on an article you read, or on any topic relevant to ObGyns and women's health practitioners. Tell us which topics you'd like to see covered in future issues, and what challenges you face in daily practice.

We will consider publishing your letter in the "Overheard" column on our Web site, and in a future issue.

Contact us at
rbarbieri@frontlinemedcom.com

Please include the city and state in which you practice.

Stay in touch! Your feedback is important to us!