COMMENT & CONTROVERSY

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"Until we clean up our own house, we can hardly combat a medicolegal system weighted against the doctor"

"Vaginal hysterectomy: 6 challenges, an arsenal of solutions," by Barbara S. Levy, MD (October)

Tip for difficult colpotomy at vaginal hysterectomy

Dr. Levy's enjoyable article inspired me to offer this solution to another common challenge. Vaginal hysterectomy traditionally begins with an anterior colpotomy followed by a posterior one. When the latter is difficult, I instill 200 to 300 mL of sterile normal saline through the opening of the anterior colpotomy, which causes the posterior cul-de-sac to bulge. This swelling of Douglas' cul-de-sac facilitates entry into the cavity, as the incision initiates the escape of instilled saline.

The technique is also useful for anterior and posterior colpotomies during laparoscopically assisted vaginal hysterectomy.

Reza Mohajer, MD
Los Angeles

Dr. Levy responds:

I prefer to start with posterior colpotomy

I appreciate Dr. Mohajer's technical trick! I'm sure some readers will find it useful.

In my procedures, I routinely start with the posterior colpotomy. I find that postponing the anterior colpotomy until the peritoneal fold is clearly visible helps me to perform vaginal hysterectomy safely for women with large myomas, especially in women with previous cesarean sections.

There is little doubt that each anatomical situation is unique and that Dr. Mohajer's approach will be useful at times.

"Membrane sweeping and GBS: A litigious combination?" by Arnold W. Cohen, MD, and Jay Goldberg, MD, MSCP (September)

We need to penalize "experts" who give unsupported testimony

I appreciated the article on the medicolegal aspects of membrane stripping. My only disappointment is that you did not identify the plaintiff's "expert" perinatologist. Too often, as a defense expert, I've read testimony from pompous "experts" that was not supported by the literature. It would be helpful if we as physicians had a site where we could identify doctors who have given unsupported testimony. If they are in our practice area, we could certainly limit referrals to such unscrupulous physicians.

Until we clean up our own house, so to speak, we can hardly make strides in combating a medicolegal system weighted against the doctor. Remember, a suit cannot be filed without expert testimony.

Thomas J. Meyer, MD
Barrington, Ill

Drs. Cohen and Goldberg respond:

Reluctance to "name names" is part of the problem

We appreciate Dr. Meyer's letter about our article on the litigious consequences of membrane sweeping. His concerns are absolutely in sync with ours.

One author (Cohen) has, on several occasions, approached the editors of this and other journals to identify the experts for both the defense and plaintiff, but the

lawyers for the publications have not approved. All of the cases in question are closed, and the documents are held in the public record. We do not understand the reluctance to publish the names.

As you know, the Ethics Committee of the American College of Obstetricians and Gynecologists (ACOG) will not divulge the names of Fellows who have been sanctioned or who have withdrawn from the college after the Grievance Committee has found against them. In the case discussed in OBG MANAGEMENT, the plaintiff's expert opinion was submitted to the ACOG Grievance Committee for review. The plaintiff's expert then withdrew his membership from ACOG. As a result, the Grievance Committee could no longer consider the case because the expert was no longer a Fellow of the college.

The reluctance to "name names" of Fellows who provide expert testimony that is "personal opinion" and not consistent with evidence-based medicine only promulgates the injustices of the medicolegal tort system under which we function. Until our journals and official organizations are willing to "expose" those of us who provide unethical testimony, we will continue to see the medicolegal problems within the specialty worsen, resulting in fewer practitioners of our specialty and poorer quality of health care for women.

Hopefully, people like Dr. Meyer will keep on asking these difficult questions of our journals and leaders and we will see changes that result in a more equitable and honest system. This will improve access to, and quality of, care for American women.

"Shoulder dystocia: What is the legal standard of care?" by Henry M. Lerner, MD (August)

Force is a 2-way street

I have practiced obstetrics for 25 years and sometimes serve as an expert witness in the defense of physicians and nurses accused of below-standard care. In my experience, "excessive force" has no concrete definition and therefore very little defense. Moreover, force is not always applied by a health-care provider moving the fetal head away from the perineum to effect delivery. In some cases, the health-care provider is simply holding the infant's head still, and it is the mother who is pulling back. These cases often involve a lack of good pain control or regional anesthesia. The mother often panics, pulling upward or closing her legs, obstructing further delivery of the fetus.

As for shoulder dystocia, when it occurs, I use my own variation of the Woods screw maneuver. Once the dystocia is diagnosed, I have the mother hyperflex her thighs, as with the McRoberts maneuver, and ask her to take a deep breath and push. At the same time, I rotate the fetal head clockwise or counterclockwise, depending on the position of the fetus in relation to the "y" axis. This creates the dynamics of a screw technique. The force applied is lateral, and the forward movement of the vertex is effected by the patient's pushing.

I have yet to see this maneuver fail.

Jeffrey H. Kotzen, MD
West Palm Beach, Fla

"Excessive force during delivery has no concrete definition and therefore little defense"

Dr. Lerner responds:

Woods articulated a similar principle

It is of interest that in Dr. Woods' original 1943 article, he describes the use of fundal pressure along with intravaginal posterior shoulder rotation. He said that this screw-like action (force from above, rotation below) duplicates the principle of multiplication of force found in the simple "machine" of the screw. Dr. Kotzen's technique applies a similar principle.

We want to hear from you!

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