Comment & Controversy

MAJOR VASCULAR INJURY DURING LAPAROSCOPY: PEARLS TO COPE
BY MAGDY MILAD, MD, MS (APRIL)

Scalpel size may also determine vascular injury rate

I suspect the culprit in some vascular injuries is the scalpel used to make the subumbilical skin incision. I have performed laparoscopy since 1973 and am fortunate to have had no vascular injuries. Since we started doing operative laparoscopy and using an assistant, I have noticed that many of my colleagues use a #11 blade for the skin incision, and while my preference is a #15 blade, I am often given a #11. As was noted in the article, in thin women the distance from the skin to the aorta (or right common iliac) where it crosses the vertebrae is not great, and it would be easy for the tip of a #11 blade to nick the vessel—especially while stretching the skin to make the incision.

It would be interesting if there were data collected on the scalpel blade used in laparoscopic surgeries, but I doubt that information is available.

Charles W. Marlowe, MD
Omaha, Neb

›› Dr. Milad responds

Effect of scalpel size isn't clear

Dr. Marlowe brings up an excellent point. In this case, a #15 blade was used for the procedure.

DO YOU FIGHT—OR SETTLE—THAT LAWSUIT?
BY JEFFREY SEGAL, MD (APRIL)

We need cheaper malpractice insurance, not tort reform

Dr. Segal neither answers the question posed in the title of his article nor addresses what really is the common denominator when a doctor is sued: An entire industry has arisen from medical malpractice litigation. Doctors unwittingly finance it because we are scared to death not to. Lawyers and malpractice carriers create that fear.

April 2008

A doctor's lawyer is paid by the carrier, and the doctor pays his or her carrier a substantial portion of gross income. Malpractice insurance is a physician's largest overhead—the largest overhead in health care, as a matter of fact. In return, doctors are required to attend risk-management seminars taught by lawyers. And make no mistake, it is still at the doctor's expense even when a discount is given. Premiums go up every year no matter what.

Dr. Segal's article speaks of consent-to-settle clauses and hammer clauses—which actually work to the benefit of lawyers and insurance companies—but never recommends that a doctor inform the carrier early

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Have a comment to share?
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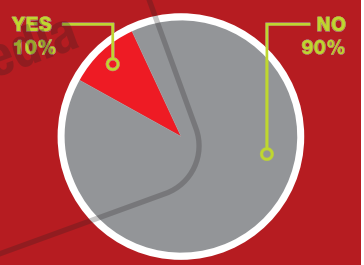
obg@dowdenhealth.com

Instant Poll Results

JULY 2007

Have you been drilled recently to prepare for massive obstetric hemorrhage?

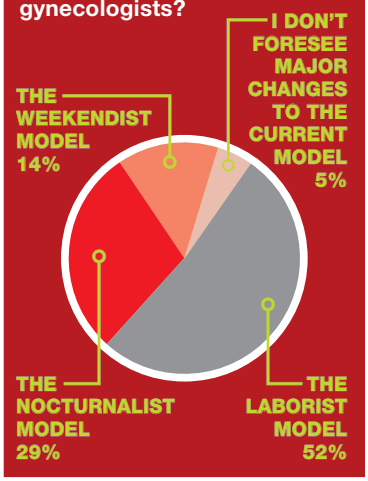
The Joint Commission recommends that labor and delivery services practice responding to common obstetric emergencies by using simulation training. Has your obstetric service had a simulation drill for massive obstetric hemorrhage during the past year?



SEPTEMBER 2007

Can you prognosticate the future of the specialty?

Gazing into the future, which of the following "-ist" models do you think ObGyn practices are most likely to heavily rely on to boost the career satisfaction of practicing obstetrician-gynecologists?



Instant Poll → page 15

in a malpractice case that he or she wants to settle to policy limits if and when a settlement is offered. This notice works to the benefit of a doctor and virtually guarantees that the carrier will be liable if it refuses to settle and a later judgment exceeds policy limits.

The article talks about high-low agreements in cases where damages are clear but causation isn't. These agreements essentially guarantee that no lawyer in a malpractice case loses any money.

It is as though we are party to some social contract that requires us to pay for damages when they are acts of God. We shoulder the economy of this whole industry, yet we are at its mercy.

Why shouldn't we be able to file a counterclaim of malicious prosecution against a plaintiff and his or her attorney and have the carrier pay for it when there is clear and convincing proof that an injury was just a random occurrence and would have happened anyway? To the best of my knowledge, carriers won't pay and no such lawsuit has ever been filed. Why shouldn't we be able to appeal a judgment against us when there is clear and convincing evidence that the injury was an act of God and out of anyone's control? Aren't these standard legal procedures in other torts?

There are forms of scientific inquiry that can show clearly and convincingly that an alleged injury is a random occurrence; I offer the references below as proof.[1–4] These publications also explain when to fight or settle a malpractice lawsuit.

We are the market force, and it is time that we began to act like it. If we don't demand a fair commercial product, there never will be one. The market will respond to our demand, and the company that does so first not only will prosper but will reduce the cost of malpractice insurance for everyone.

Until now, organized medicine has only called for tort reform. It is a lower cost of malpractice insurance—not tort reform—that is in our interest. Let us start by making our demands known. The market will respond or some new organization will form that really meets our needs.

Howard N. Smith, MD, MHA
Washington, DC

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›› Dr. Segal responds

Countersuits are an effective deterrent

I appreciate Dr. Smith's comments. As a point of interest, the topic of the article was provided for me, and space limited what I was able to write. But let me state explicitly: I wholeheartedly agree that many cases have no merit and that physicians should have recourse for being victimized by a process that "gets it wrong" more often than not. To back that assertion, I founded an organization, Medical Justice, which pays expenses to fund viable countersuits. The organization has been in business for over 6 years. More important, the principles work. Medical Justice plan members are sued at a rate of under 2% per year. This is far lower than the frequency for non–plan members.

To read more about this approach, see my article entitled, "Prepare a defense of CP and other malpractice claims—before the lawyers get there," which appeared in the July 2007 issue of OBG MANAGEMENT.

MAINTAINING OUR COOL WITH MAINTENANCE OF CERTIFICATION

BY ROBERT L. BARBIERI, MD (FEBRUARY)

Complaints about MOC reinforce negative view of ObGyns

Recent complaints about Maintenance of Certification (MOC) reinforce negative clichés. To wit:

When I was in med school, the professors and deans generally did not consider students entering our specialty to be standouts. Naturally, there were exceptions. But the best and the brightest were lured into cerebral internal medicine subspecialties such as cardiology, hemeonc, and infectious disease. We who chose obstetrics and gynecology were to become the workhorses of the profession, while the geniuses became the thoroughbreds. The latter could quote any journal article on command and were easily identified by their dog-eared copies of the *New England Journal of Medicine.* They seemed comfortable with lifelong learning and viewed board certification as something to be periodically renewed, like a driver's license. Many fellow ObGyns, on the other hand, considered the Boards to be a rite of passage, after which they were home free. Not so.

Yes, we are overburdened. Yes, we are frustrated. However, numerous studies show that doctors lose clinical competence without ongoing education, including MOC.[1] By resisting recertification, ObGyns not only fall behind the times but risk reinforcing negative intellectual stereotypes.

We are not the stubborn pack mules of yesteryear. We are better, and smarter, than that.

David Shobin, M.D
Smithtown, NY

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1. Choudry NK, Fletcher R. Systematic review: the relationship between clinical experience and the quality of health care. Ann Intern Med. 2005; 142:260–273.