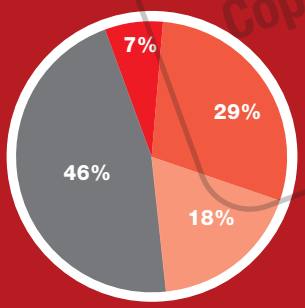
Instant Poll Results

MAY 2008

FAILED HOME BIRTH, NOW IN THE ED

You are at the hospital, caring for your patients in labor, when a 32-year-old G3P2 with two prior cesarean section deliveries is brought to the emergency department in labor after a failed home birth.

"Will you assume care for this woman?" the nursing administrator asks you. Quickly! What would you do?



7% Refuse to accept responsibility for a high-risk patient whom you've never seen

29% Assume her care and recommend cesarean section

46% Assume her care and recommend cesarean section—plus, later, report the responsible midwife to the department of public health and her credentialing organization

18% Agree to assume her care as long as the hospital's attorney and risk management team indemnify you

Comment & Controversy

JULY 2008

"WELCOME TO THE TIPPING POINT IN ORAL CONTRACEPTION PRESCRIBING"
BY ROBERT L. BARBIERI, MD
(EDITORIAL, JULY)

Insurers are the stumbling block in a move to extended-cycle OCs

My thanks to Dr. Barbieri for the useful information and excellent clinical opinion he presented in his discussion of oral contraceptive regimens. I have a different answer, however, to his final question: "Why do we continue to prescribe 21-7 OCs?"

Having been in a private, community-based practice for 27 years, and not in a metropolitan medical center, the answer seems obvious to me: *insurance and money*. Most of my patients have insurance coverage that will not pay for a brand-name OC and do not have the financial wherewithal to pay for these new products out of pocket.

In theory, 24-4 and extended-cycle regimens should work better than what we have. But a patient who cannot afford a prescription for such regimens needs a reliable and fiscally responsible alternative.

Terry R. Brown, MD
Jasper, Ind

›› Dr. Barbieri responds:

Insurers can be slow responders

I appreciate Dr. Brown's identification of insurance rules as a barrier to better prescribing practices for OCs. It will likely take time for insurance rules to catch up with best practices in OC prescribing.

Although cumbersome, and potentially difficult, for patients, an intermediate solution is to prescribe a generic pill and have the patient add 3 estrogen-progestin pills to the standard 21-7 regimen, turning it into a 24-4 regimen.

"MAINTAINING OUR COOL WITH MAINTENANCE OF CERTIFICATION"
BY ROBERT L. BARBIERI, MD
(EDITORIAL, FEBRUARY)
LETTER IN REPLY BY DAVID SHOBIN, MD
(JUNE)

MOC does ask too much of us "workhorses"

I agree with Dr. Shobin that ObGyns are the workhorses of the medical profession, but I disagree with his positive opinion of Maintenance of Certification.

I have been taking the ABC exams for years to retain my board certification. Used to be, that was good enough. In addition, I read multiple journals monthly, view articles from drug company reps, and attend CME meetings and courses.

Now, suddenly, even that isn't sufficient—unless of course, you are old enough to be grandfathered and don't have to do anything to keep your board certification. I find it ironic that those older docs are, in some cases, the ones who should most be required to renew their certificate. (Disclosure: I am 50 years old.)

The new hoops we're supposed to jump through are ridiculous. I predict that many docs will give up their certification as a result of MOC.

Scott Peters, MD
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