"'NO-FAULT' INSURANCE THAT COVERS A PREGNANCY AND BIRTH"
PAUL L. OGBURN, JR, MD (JULY)

Many liability cases are result of poor medical care

I just finished reading Dr. Ogburn's thoughts on how to reform the medical malpractice system so that it works for everyone. Here's my problem with his proposal to offer an individual policy for each gestation: As an "in-house" reviewer for a major medical malpractice insurer and a consultant for many defense law firms, I am overwhelmed by the sheer number of med-mal cases out there—and many of them are legitimate.

When I began to review cases, back in 2001, I expected the job to involve mostly frivolous suits and money-hungry lawyers. I was so wrong. Many of the cases I have reviewed are more than justified, and many of them are "bad baby" cases. I can certainly sympathize with the parents of these unfortunate children.

What is needed is better training, with more hours on call to follow the evolution of disease and course of labor. The idea of being off so many nights and working a shorter day in ObGyn just doesn't cut it. Residents are young; they can handle the workload. We need to spend more time with patients and learn more about continuity of care. Then, and only then, will there be fewer mistakes, fewer cases, and lower settlements.

The idea of the patient taking out an individual policy, as with airplane insurance, is not new. It was suggested years ago but never made it to the "big screen." What we need are better, smarter, devoted physicians who care more about their patients and less about time off, vacations, how much they'll make, and how quickly they'll make it.

Barry Kramer, MD
Bay Shore, NY

JULY 2009

›› Dr. Ogburn responds:
We must do better than the current system performs

Dr. Kramer raises some important points:

Medical negligence is happening and harming our patients. *I agree. This sad fact is as true today as it was when we reviewed perinatal closed claims in the mid-1980s.[1] We found that payments were made 50% of the time when there was no negligence; when there was negligence, payments were made 90% of the time. The current system requires someone to have been negligent for the infant to get financial help. This leads to expensive (and wasteful) "discovery" and "expert testimony" designed to convince a jury, not to get at the truth. The one person who is not to blame is the infant. Under the 3MLI system, the infant's needs would be covered without the need to prove fault. This fact alone makes 3MLI superior to the current tort-based system.*

Physicians need to spend more time being trained and more time with their patients. *Again, I agree with Dr. Kramer. The current system of health-care education and practice is not designed for overall efficiency or for the well-being of our patients. Some recent "improvements" are making things worse. Physicians and nurses spend more time trying to document (based on ever increasing rules and regulations) than they can possibly spend at the bedside. Physicians spend more CME time and money to learn the latest "new, improved" coding changes than they spend on any real medical education. The 3MLI will at least require each physician to participate in a detailed review of the case of a poor outcome with a panel of experts so that the case can go into the database of all poor outcomes and the physician can receive specific instructions on practice improvements, if needed (or be removed from 3MLI eligibility, if need be).*

Patients taking out individual policies is not new. *What is new is that, under 3MLI, the physician or provider would pay for the policy, not the patient. I want an insurance policy that will take care of my patient and her infant if they need it, no matter who is or is not at fault. That is what I want; that is what my patients deserve.*

3MLI is designed to help solve some of the problems that Dr. Kramer raises even as it helps our injured patients. It can be instituted without tort-reform legislation. For the sake of our patients, we must do better than the current medical-liability system does.

Reference

1. Ogburn PL Jr, Julian TM, Brooker DC, et al. Perinatal medical negligence closed claims from the St. Paul Company, 1980–1982. J Reprod Med. 1988;33:608–611.

"COLPOCLEISIS: A SIMPLE, EFFECTIVE, AND UNDERUTILIZED PROCEDURE"
OZ HARMANLI, MD (JUNE)

Value of obliterative procedures for POP is their lower failure rate

I commend Dr. Harmanli on highlighting the importance of obliterative procedures for pelvic organ prolapse

(POP). An obliterative procedure should always be offered to women who are certain that they will not be having intercourse in the future.

Dr. Harmanli states that "the fundamental reason for choosing an obliterative procedure…is to treat the prolapse with the least invasive technique in the shortest time." I disagree.

The fundamental reason my patients choose an obliterative procedure is because it has significantly less chance of failure than the alternatives. Dr. Harmanli suggests that hysterectomy in this setting "often adds 30 to 80 minutes to the procedure" and argues that the LeFort procedure is better than hysterectomy followed by colpectomy. Again, my experience is at variance with this position.

There is no evidence that vaginal hysterectomy followed by colpectomy carries more morbidity than a LeFort procedure when a regional anesthetic is used. In addition, if the genital hiatus (levator hiatus) is closed at the time of colpectomy, a separate anti-incontinence procedure is rarely needed because the urethrovesical angle is supported by the approximation of the levator muscle. In a LeFort procedure, the urethrovesical angle is pulled down by the procedure and may increase the risk of stress urinary incontinence postoperatively.

When one of my patients opts for an obliterative procedure, I almost always choose to perform a colpectomy.

Michael Valley, MD
St. Louis Park, Minn

›› Dr. Harmanli responds: *For frail elderly, LeFort procedure is best*

I agree with Dr. Valley that one of the advantages of colpocleisis is its lower failure rate. Although the literature lacks a good comparative study, most likely because of the differences between patients who might be candidates for obliterative and reconstructive surgery, the success rate of over 90% reported in all of the colpocleisis case series may be an attractive reason to consider this approach for many elderly patients.

However, I kindly disagree with Dr. Valley about the lack of evidence in favor of LeFort partial colpocleisis. As I stated in my article, the patients who underwent concomitant vaginal hysterectomy with total colpocleisis had a procedure that was 52 minutes longer than those who underwent the LeFort procedure, and 5% of them required laparotomy.[1] No one can dispute that the longer operating time and potential for laparotomy may add to the morbidity of this high-risk surgical population. Therefore, it is incumbent on those who advocate hysterectomy and colpectomy over LeFort colpocleisis to support it with evidence.

I failed to find any data indicating that this more time-consuming and potentially complicated approach improved the success rate. Therefore, for frail single women, I continue to recommend LeFort colpocleisis, which can be performed in less than 1 hour—even with sedation and local anesthesia—by any gynecologist who knows how to do colporrhaphy using the technique described in my article.

Reference

1. Von Pechmann WS, Mutone M, Fyffe J, Hale DS. Total colpocleisis with high levator plication for the treatment of advanced pelvic organ prolapse. Am J Obstet Gynecol. 2003;189:121–126.

"HEALTH CARE, A GORDIAN KNOT OF COST AND ACCESS, FACES REFORM"
ROBERT L. BARBIERI, MD
(EDITORIAL, JUNE)

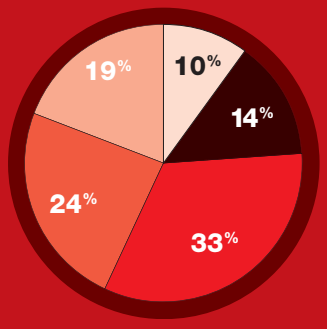
Single-payer system is the only option

Thanks to Dr. Barbieri for pointing out that the Massachusetts insurance plan is not going to work on a nation-

Instant Poll Results

From June 2009

Which strategy would be your top choice to reform health care in this country?



None Reduce use of tobacco and alcohol

None Replace fee-for-service reimbursement with a capitation payment system

10% Reduce capital investments in hospitals and the equipment they use

14% Institute a national electronic health record for all citizens

19% Develop a national effectiveness commission to slow implementation of costly new medicines and equipment that only marginally improve public health

24% Reduce the use of futile end-of-life medical interventions

33% Reduce administrative costs by reforming insurance company practices

al level. With insurance companies as we know them, $400 billion a year are necessary to simply administer the system. (And the average salary of a health-care insurance CEO is $15 million annually.) I say we take all this money and use it to pay for health care so that all of the uninsured can be covered. Simply gather money from taxpayers and pay it out to hospitals and doctors so that they can take care of everyone—especially the 10% of the population that uses 70% of health-care services. Now that's an effective means of insurance!

The single-payer system is the only system that has a chance of rectifying our corrupt system, and a majority of doctors and the American public already recognize that fact.

George C. Denniston, MD, MPH
Seattle, Wash

Seeking clarification

What is the source of the 48 million figure cited in the headline of Dr. Barbieri's editorial? It was given as the number of people who do not have health insurance, but was not referenced in the article.

Does that number include illegal aliens and non-US citizens?

Max Maizels, MD
Richmond, Va

›› Dr. Barbieri responds:

Single-payer system would create a monopoly

I agree with Dr. Denniston that the health-insurance administrative bureaucracy creates unnecessary waste. Many commercial insurance companies have excessively high overhead and pay their executives outsized compensation packages. These wasted resources could be better used to provide health care.

In contrast, Medicare, one of the largest insurers in the United States, has a relatively low administrative overhead and pays physicians quickly after a bill for professional services is submitted. However, in general, Medicare pays physicians at relatively lower rates than commercial insurers.

A single-payer system will create an insurance monopoly. An insurance monopoly will likely result in a reduction in physician reimbursement. If a single-payer system were associated with a 30% reduction in physician reimbursement rates, would US physicians support the new insurance monopoly?

As Dr. Maizels' question suggests, it is very difficult to precisely count the number of people without insurance residing in the United States. The US Census Bureau attempts to provide estimates of various key population statistics, including insured and uninsured US residents, on an annual basis. Its report is available at www.census.gov (click on "Health Insurance"). The report is based on a survey sample with statistical extrapolation to the entire US population.

How to treat migrant US residents for the purposes of this population survey is controversial. Some authorities recommend counting all US residents, regardless of their status, because they are likely to seek health care in the United States if they become sick. Other authorities would prefer to exclude migrants who are in the United States without proper documents from the estimate of uninsured residents.

Almost everyone agrees that the number of uninsured US residents is very high, whether it is 40 million, 45 million, or 50 million. Interestingly, based on the census surveys performed from 1992 to 2007, the percentage of uninsured US residents has remained steady at about 15% of the population.

Clearly, we have a big problem, and it is going to be very difficult to solve.

"IS OVARIAN CA SCREENING EFFECTIVE IN POSTMENOPAUSAL WOMEN?"
ANDREW M. KAUNITZ, MD
(EXAMINING THE EVIDENCE, JUNE)

Don't rush to adopt UK screening algorithm for ovarian cancer

Dr. Kaunitz posits that ovarian cancer screening *may* be effective in postmenopausal women—but even that equivocation may be too strong an endorsement of the practice. Although the UK study he mentions was large and very well designed, the algorithm it employed is not necessarily applicable to US practice.

The multimodal screening algorithm required the 4,315 women who had an initial abnormal CA-125 level to wait 12 weeks before the screen was repeated. When it was, 1,008 women had abnormal results again and had to wait another 12 weeks for a third screen. This waiting period is critical because it is the constant rise in CA 125, rather than the absolute value of the marker, that is associated with ovarian cancer.

Ninety-six women in the UK trial were deemed to be at intermediate risk of ovarian cancer and underwent ultrasonography 6 weeks later, approximately 7 months after the first abnormal blood test. Of the 97 women in the study who underwent surgery, 42 had ovarian or tubal malignancy, but only 16 were early-stage (I/II). Therefore, six surgeries were performed to detect each case of early ovarian cancer, and early intervention should have made a difference in survival. However, within a year of screening, four additional women developed ovarian cancer (false negatives).

Surgery is not without risk in postmenopausal women; indeed, 3% of women in the UK study suffered major complications, including

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pulmonary embolus, deep venous thrombosis, hemorrhage, wound dehiscence, perforation of a viscus, bowel obstruction, and bowel fistula.

Ovarian cancer is a terrible disease, and we sorely need to find an effective method of early detection. But recent evidence suggests that some serous "ovarian" cancers may originate in the distal tube and are, therefore, at an advanced stage at the outset and undetectable at an early stage using current screening modalities.

The bottom line, as the authors of the UK study and Dr. Kaunitz all acknowledge, is that it is too early to tell whether this screening algorithm will have a significant impact on mortality. In the UK study, the cost-effectiveness of screening and the psychosocial effects on participants during the prolonged waiting periods are still being evaluated, and are likely to be significant issues. Before we rush to reintroduce routine CA-125 testing, which so far has done more harm than good, we should understand that the complex UK study algorithm cannot be abbreviated or we will submit many women to unnecessary surgery. Until the complete analysis is available, avoiding CA-125 screening is prudent.

William H. Parker, MD
John Wayne Cancer Institute at
Saint John's Medical Center
Santa Monica, Calif

"A PRACTICAL APPROACH TO VESTIBULITIS AND VULVODYNIA"
DAVID SOPER, MD (MAY)

Surgery is not the only effective treatment for vestibulitis

I thought Dr. Soper's article represented the typical, surgically oriented approach to vulvar vestibulitis,

MAY 2009

with its emphasis on vestibulectomy and its assumption that interferon provides only moderate relief.

I've treated vulvar vestibulitis for 15 years and have used alpha-interferon (Alferon-N) with excellent results. When I first began managing this disorder, it was poorly understood, and it took me a year or two to determine the best approach. I eventually concluded that vestibulitis is caused by the human papillomavirus (HPV), though that link has not been proved definitively. However, it seems likely to me that a nonpathologic subspecies of HPV causes this condition. Accordingly, I began prescribing alpha-interferon, following the regimen for condyloma. I noticed that each patient began to improve after 5 or 6 weeks of treatment, and was symptom-free by the end of 8 weeks.

Most specialists treat the vestibulitis patient with interferon for 4 weeks. I have always treated the patient for 8 weeks, as it is only after 5 or 6 weeks that her symptoms begin to resolve. This improvement is not dependent on the dosage of interferon, though I prescribe a dosage that is markedly lower than the one that is prescribed for 4 weeks of treatment. Over 15 years, I have treated and essentially cured 55 patients, though I have only followed them for as long as 5 years. It is possible that symptoms may recur after 10 years or longer.

My concern now is that the company that has produced Alferon-N no longer does so. I'm looking into a similar interferon known as Intron, which is also used for condyloma, as well as for various types of cancer and hepatitis. I'm not sure whether I want to try a new medication, especially at dosages that may not be equivalent, but I would like to continue treating this problem. Why? Because it is rewarding to offer the patient a pain-free life, with complete resolution of her symptoms.

Richard G. Hofmann, MD
Carthage, NY

"INSIDE THE STIMULUS PACKAGE: CASH FOR USING ELECTRONIC HEALTH RECORDS"
G. WILLIAM BATES, MD, MBA (MAY)

Electronic health records can pay for themselves

I agree completely with Dr. Bates' argument for electronic health records (EHR). I am a software developer and provider of billing services, using my own PMS software, and I know a good deal about "real-world" experience. Dr. Bates is right: With an EHR in place, two important things can and should happen:

1. You can see one or two more patients each day.

2. If you will upgrade 20% of your 99213 codes to 99214, based on what you did for the patient—and documented—you can generate more than enough "brand-new" revenue to pay for virtually any EHR system.

J.S. McMillan
St. Louis, Mo

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Does the stimulus offer extend to practices with existing EHR?

The article on the stimulus package prompts a question. Does this cash allotment for using electronic health records extend to practices that are already fully functional and using a Certification Commission for Health-care Information Technology (CCHIT) certification? We have been using electronic records for 6 years. Is there a form or application we should be completing?

Shelly Murphy
Carson City, Mich

›› Dr. Bates responds:

Some aspects of stimulus are still being determined

I thank Mr. McMillan for his affirmation of the value of electronic health records—independent of any external stimulus funds. Physicians should expect a three-time return on investment within 12 to 15 months of implementing an EHR.

Ms. Murphy asks if the stimulus package (American Recovery and Reinvestment Act) money will be available to practices that began using EHR before 2010. I don't have an answer, but it would seem unfair for practices that took the initial plunge to be penalized because they were early adopters.

I do know that current vendor CCHIT certification (2008) is not sufficient to qualify a practice for stimulus funds. Despite the marketing hype of several vendors, none is certified today with the "meaningful-use criteria" designated in the legislation. CCHIT suspended certification for 2009, awaiting definition of the term. Vendors expect the certification process that qualifies a practice to receive stimulus funds to begin in early 2010.

"PREECLAMPSIA AND ECLAMPSIA: 7 MANAGEMENT CHALLENGES (AND ZERO SHORTCUTS)"
JOHN T. REPKE, MD, AND
BAHA M. SIBAI, MD (APRIL)

Don't overlook the importance of patient education in preeclampsia

It was great to read such a thorough article on preeclampsia and eclampsia. This subject is often relegated to the "we don't know much about it so why bother discussing it" category, which is clearly a problem considering preeclampsia's relatively high prevalence and sometimes disastrous outcomes.

Dr. Repke and Dr. Sibai (who are both members of our Medical Board) did an excellent job of offering a thorough evaluation of some of the key challenges and underscoring the unpredictability of these disorders. The one critical piece missing from their recommendations is patient education, which is especially important because diagnosis is sometimes difficult and maternal and fetal health can go south so quickly. Our research—and that of others—has shown that most patients are not routinely and consistently informed about the signs and symptoms—information that is critical to their understanding of when to call or see their health-care providers. Prompt presentation can alleviate the 11th-hour crisis that often leads to disastrous outcomes.

Once preeclampsia is diagnosed—or indications are that the case is moving in that direction—patient education becomes more critical. In fact, it is often requested by the patient and her family. The Preeclampsia Foundation can help physicians bridge the gap in knowledge; we provide not only credible information in print and online, but also comfort and support during an often anxious and trying time.

Eleni Tsigas
Executive Director
Preeclampsia Foundation
www.preeclampsia.org

›› Dr. Repke and Dr. Sibai respond:

Signs and symptoms of preeclampsia may be protean

We are pleased to acknowledge Ms. Tsigas' important point about patient education. Although our article was written for a physician audience, patient (and physician) education about the sometimes-subtle signs of preeclampsia is extremely important, especially in very high-risk individuals.

We also agree that patient education is a very important part of post-diagnosis management, as patients are often confused by how well they feel (in mild cases). A better understanding of the potential severity and swift progression of this disease can aid in maintaining compliance with a management strategy and elicit earlier reporting of signs or symptoms that might suggest worsening of disease.

We want to hear from you!

Please take a moment to share your opinion! Have a comment? Drop us a line and let us know what you think. You can send a letter any of 3 ways.

1 **E-mail** obg@dowdenhealth.com
2 **Fax** 201-391-2778
3 **Mail** OBG Management, 110 Summit Ave., Montvale, NJ 07645

Letters should be addressed to the Editor, OBG MANAGEMENT, and be 200 words or less. They may be edited prior to publication.