"AS USES WIDEN FOR INTRAUTERINE CONTRACEPTION, WHY HAVEN'T OBGYNS BECOME ADVOCATES?"
ROBERT L. BARBIERI, MD
(EDITORIAL; NOVEMBER 2009)

Placing IUDs isn't a healthy business decision

I have been in solo practice for almost 10 years. During that time, I have had patient requests for intrauterine contraception. After researching the cost of the devices, and the various reimbursements for placement, I never found it to be a feasible business move. I am dedicated to women's health, but not to the exclusion of my practice's financial health. A high volume of patients allows me to maintain a financially healthy business. Placement of an intrauterine device (IUD) takes more time and yields little—or ends up costing the physician when the price of the device exceeds reimbursement. I send patients who request an IUD to Planned Parenthood, an organization that operates on a different business model than I do. I have done so with full disclosure and explanation.

Ruth Schleifer, MD
South Windsor, Conn

Intrauterine contraception has a long track record

I was very happy to see Dr. Barbieri's editorial about intrauterine contraception and to read of his advocacy for it. I was stationed in Germany 30 years ago during my military service and learned from observation that IUDs are a safe and effective means of contraception in teenagers and nulliparas—contrary to what I was taught during training. I have been encouraging the use of intrauterine contraception for the past 30 years, and I place two to three IUDs per week.

Doug Tolley, MD
Yuba City, Calif

NOVEMBER 2009

›› Dr. Barbieri responds:

Practice patterns are not always conducive to IUD advocacy

In the United States, we are fortunate to have a cadre of highly trained and deeply committed ObGyns, as evidenced by the thoughtful and concise letters from Dr. Schleifer and Dr. Tolley. Their experiences demonstrate how the unique situations of each physician (and patient) influence practice patterns. As we evolve our health system, I hope that financial barriers to patient care will be identified and resolved.

"AFRAID OF GETTING SUED? A PLAINTIFF ATTORNEY OFFERS COUNSEL (BUT NO SYMPATHY)"
JANELLE YATES (OCTOBER 2009)

Plaintiff attorney's statements exemplify courtroom tactics

Plaintiff attorney Lewis Laska's comments are typical for a man who stands to lose a lot if there is any environmental change in the medical malpractice arena. I take great umbrage at many of his statements, and his use of adjectives and subjective coloring to slant the article shows his pedigree in the field of adversarial argument and jury persuasion.

For example, he says, "If ObGyns were more responsive to questions from their patients, and acted more kindly, patients wouldn't be so eager to sue them." I don't know a single ObGyn who isn't kind to his or her patients. We spend countless hours each week consulting and answering questions—at least in my county and practice—and trying to give the patient handouts, brochures, and other educational materials.

Dr. Laska also mentions "928 *needlessly* brain-damaged infants each year." His use of the word "needlessly" colors the larger statement, but he offers no facts to back up his insinuation that physicians are responsible. Many of these so-called "needless" events are beyond the control of reasonable, caring physicians. In our hospital, we perform cesarean delivery immediately if there is any reasonable provocation.

I don't discount the fact that injuries occur and mistakes happen. I once read that, for mankind to be completely free of mistakes, a different species would have to evolve. That said, my personal experience with litigation is that the attorney always finds a way to get paid. I have had to settle a case despite reasonable evidence that I was not responsible for any outcome and could not have changed the nature of the event. Pay an expert witness enough money, and that physician will make any expert statement against anyone. I have had patients tell me they love me and are suing other parties—and yet I ended up on the summons. Whose influence is responsible for that?

At my practice, we have model patients, as well as those who are noncompliant; poorly educated; difficult to reach, teach, and treat; and patients who, through no fault

of mine or their own, have bad outcomes—that is the nature of biological systems.

Doctors are in practice; attorneys are in business. Remember that mantra, "Follow the money"? Therein lies the answer to so many problems in this country.

Jay Sean Rothberg, MD
Langhorne, Pa

Why do patients sue?

Patients are eager and willing to sue their physician because this is the most litigious civilization in the history of mankind, and it is fueled by self-righteous, rationalizing lawyers.

Albert Tydings, MD, JD
Covington, La

A physician who "wins" a malpractice case is still the loser—just less of one

The interview with plaintiff attorney Lewis Laska was excellent, although I would quibble with two points. First, it is my belief that no physician has ever "won" a malpractice case. When the verdict is in his (or her) favor, he just loses less. He still pays exorbitant—and probably increased—malpractice insurance fees. He still loses time and income from being away from his practice. And he still suffers the mental anguish that accompanies being sued.

Second, Dr. Laska stated that "[i]nsurance companies never settle unless there is provable liability." That brings to mind the old adage, "Never say 'always' or 'never' because there is always an exception." Most insurance companies know that when you parade a deformed infant in front of a jury, facts will take second place to sympathy. As a result, an insurer may well "play the odds" and settle as the lesser of two evils.

Arthur A. Fleisher II, MD
Northridge, Calif

Why are cases settled?

To answer the question—raised during the interview with Dr. Laska—of why cases are settled, I offer the following: If the potential award is large, the doctor may be afraid that his or her personal assets will be attached when the monetary verdict exceeds coverage. In such a situation, settlement is safer even if the allegations are spurious.

Dr. Laska is correct that insurance companies do not like to settle. However, hospitals that self-insure will sometimes settle to avoid the potential financial "bomb" of a large jury verdict. This benefits high-profile attorneys who have won large awards, who use financial fear to settle cases that should have gone to trial.

Steven Klein, MD
Mineola, NY

A strong case isn't the main reason insurance companies settle

I strongly disagree with Dr. Laska about why insurance companies settle cases involving an infant who has brain damage. First, it is very difficult for a lay jury to comprehend the scientific evidence presented. Some of this evidence gets distorted by the theatrics on both sides. Second, and probably more important, is the sympathy factor. It is almost impossible for jurors not to feel sympathy for an impaired infant and the parents. In the absence of overwhelming evidence to the contrary, the tendency is to side with the plaintiff for unreasonably large sums of someone else's money! This, I believe, is what drives insurance companies to settle this type of case—not an overwhelming belief that negligence caused the unfortunate outcome.

William Deschner, MD
Seattle, Wash

Best way to avoid a lawsuit? On L & D, you plan ahead

Labor and Delivery is a problematic specialty that requires a high degree of commitment and close teamwork. Too often, both of those variables are missing, with devastating effects upon both patient and physician.

Given the fact that there is approximately one birth an hour in most L & D rooms, it is easy to understand the challenges in coordinating an ad hoc team. Severely ill patients, in particular, require close coordination among the physicians in charge. The situation requires a high degree of commitment, a goal—like effective teamwork—not that easy to achieve.

The solution to this problem is to have an arrangement worked out and agreed upon beforehand. Such an agreement would require the attending physician to respond as delineated whenever he or she encounters an acute, sudden change in pregnancy that requires critical care, such as:

- chest pain, tachypnea, or pulse oximetry <95% for PO_2
- hypotension, sepsis, diabetic ketoacidosis, respiratory or neurologic emergency, need for cardiopulmonary resuscitation, pulmonary or amniotic embolism, or trauma
- excessive blood loss
- a category 2 or 3 tracing
- risk of breech delivery or shoulder dystocia
- cord prolapse
- metabolic acidosis.

When the attending physician calls this protocol, or has a nurse or resident call it, he or she is immediately joined by two attending members. This team is fully committed to the patient from that moment on. Taking notes, both physicians go through an established and familiar checklist, which includes oxygen level, fluid assessment, measurement

of vitals, measurement of blood gas, electrocardiogram, and appropriate labs. Should it be warranted, they will call for a rapid-response team, anesthesia, or other available equipment and assistance.

Because too many planes have been crashing on carriers and airfields, two air-traffic controllers are now required to be on deck to launch a plane or stop a landing. Why not have two attending physicians working together to prevent a catastrophic event or call in the rapid-response team? Residents are not all equal, and neither are attendings. A call for help takes too much thought, and so does committing to another attending. If everything is arranged beforehand, this hesitancy and doubt can be eliminated.

When the response to the protocol is complete, the checklist can then be used with facility until the patient is tucked in and labs are scheduled at 6-hour intervals.

Properly applied and administered, the jeopardy protocol should help us provide each patient with the best possible care.

Theodore M. Hale, MD, MA
Assistant Professor of Obstetrics and Gynecology
Weill Cornell University
New York City

"UPDATE ON CONTRACEPTION"
AILEEN GARIEPY, MD, AND MITCHELL D. CREININ, MD (AUGUST 2009)

Mirena-related spotting is a challenge in some patients

I found this article to be pertinent to the clinician in the trenches. I am very much concerned about breakthrough bleeding in my patients who are using the levonorgestrel-releasing intrauterine system (Mirena). I believe that most patients who have persistent brown spotting following the insertion of Mirena have some degree of adenomyosis and would benefit from continuation of this contraceptive method.

The addition of estrogen by means of a combination oral contraceptive appears to be a good solution for some types of dysfunctional bleeding not related to the progestin IUD, but it may be a poor suggestion in this scenario. It would take an extremely high dosage of oral estrogen—much higher than the dosage contained in a combined hormonal contraceptive—to have an effect on the endometrium. To be effective, the dosage of estrogen would need to be high enough to overcome the progestin effect of the Mirena on the lining of the uterus. The addition of this level of estrogen may compromise the main contraceptive effect of Mirena—namely, the production of viscous cervical mucus.

Other suggestions might be use of cyclic progestins for a few months, one course of depot medroxyprogesterone acetate (Depo-Provera), or the use of depot leuprolide acetate (Lupron Depot) until amenorrhea is achieved. I have used these regimens with motivated patients and have been most gratified with the results.

John Lewis, MD
Waterbury, Conn

›› Drs. Gariepy and Creinin respond:

Adenomyosis is unlikely in so large a percentage of Mirena users

Although Dr. Lewis' hypothesis that most women who have persistent spotting with Mirena have adenomyosis is interesting, it is statistically highly unlikely to be true. At 6 months of use, as many as 25% of women using Mirena report continued episodes of bleeding or spotting. Because adenomyosis affects approximately 5% of women, the numbers just don't add up.

Just as important to understand is that Mirena causes significant changes in the endometrium, including atrophy of the glandular and surface epithelium, extensive decidualization of the endometrial stromal cells, and increased fragility of the endometrial vasculature. These effects lead to the breakthrough bleeding that is common among users of Mirena and other progestin-only methods.

Interestingly, some studies of the Norplant System suggested small, potential improvement of breakthrough bleeding after treatment with progestin; however, these effects were weaker than those seen with use of nonsteroidal anti-inflammatory drugs (NSAIDs). Because the local level of progestin is very high with Mirena, addition of a systemic progestin is unlikely to alter the local environment to any relative degree. Use of additional progestin, therefore, is not advisable for Mirena users.

In our clinical practice, we have had variable success with short courses of low-dose combined hormonal contraceptives (in women who do not have a contraindication to estrogen) to treat nuisance, breakthrough bleeding. Although high levels of estrogen alone could theoretically alter the mucus-thickening effect that prevents pregnancy with progestin-only methods, use of a combination hormonal contraceptive would not do so.

As we stated in our article, researchers continue to explore antiprogestins, NSAIDs, and antifibrinolytic drugs such as tranexamic acid as possible treatments for nuisance bleeding associated with progestin-only methods. In Mirena users, irregular bleeding improves with time. Therefore, any treatment could appear to be beneficial without there being any true effect. Accordingly, anecdotal reports of success are not definitive evidence that a given intervention is effective. That level of evidence requires a placebo-controlled study.