



“STUFF OF NIGHTMARES: CRIMINAL PROSECUTION FOR MALPRACTICE”

BY GARY STEINMAN, MD, PHD (AUGUST)

Standard of care is defined nationally in a majority of cases

The standard of care is defined locally in only a small and declining number of jurisdictions. The national standard is the most common “bright line” used to judge negligence. Furthermore, the variability in the number of malpractice cases initiated against the medical profession is clearly not related to the level at which the standard is set, but by other factors—most notably, the number of lawyers per capita and the presence (or absence) of caps for pain and suffering.

To be sure, the standard for Ob-Gyns in New York is not more stringent than what is found in California or Texas, but there is a greater willingness to sue in New York, where jury awards are much higher than they are in California, Pennsylvania, and Texas. Attorneys will attempt to transfer a case to a more friendly venue for the plaintiff whenever possible. It is called “venue shopping.”

Physicians who have been found guilty of criminal malpractice are usually stripped of their license and denied the opportunity to practice. Dr. Steinman blunts significant differences between a physician being sued for malpractice, being found guilty of negligence, and being found guilty of gross negligence warranting a charge of reckless endangerment.

Theodore Zaleski, MD, JD
Brielle, NJ

» Dr. Steinman responds:
Local factors hold sway more often than you think

Dr. Zaleski is correct: The greater litigious atmosphere in certain geographic areas accounts for the greater frequency



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of civil suits in such areas. However, evidence-based medicine has and will continue to diminish the effect of expert witnesses who base their subjective testimony on the opinions of name physicians rather than objective facts gleaned from actual biomedical observations. (Certain specialty boards are beginning to take a closer look at “experts” who actually fabricate and exaggerate to suit the needs of the plaintiff.) On the other hand, the situations that tend to be prosecuted as examples of criminality vary from locale to locale because of what is perceived to be criminal in each community.

Prosecution for criminal malpractice, in contrast to civil claims, is much more uncommon in the United States than it is in other countries—in Japan, to name one. The monetary motivation probably has much to do with this. Criminal charges are usually brought when the offense is so egregious that the standard of care has little to do with the decision to proceed with a prosecution. The likelihood that a prosecutor will pursue such a complaint depends largely on what the local community considers criminal, a standard that varies considerably, locale to locale.

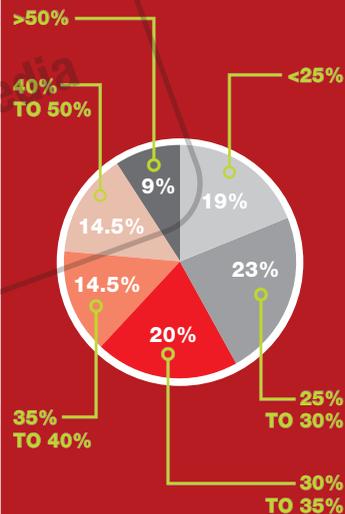
Instant Poll Results



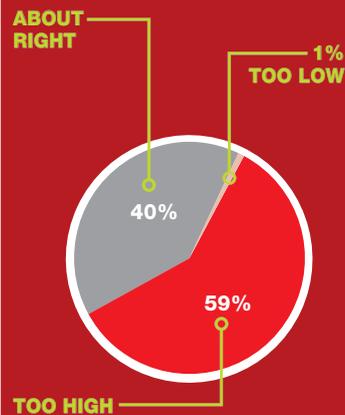
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WHAT IS THE C-SECTION RATE AT YOUR HOSPITAL?

At my hospital, the overall cesarean delivery rate is:



...and I think that this rate is:



Instant Poll → page 15

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“MAJOR VASCULAR INJURY DURING LAPAROSCOPY: PEARLS TO COPE”

BY MAGDY MILAD, MD, MS (APRIL)

Another pearl for laparoscopic entry

I enjoyed Dr. Milad's article and would like to offer the following technique as a way of lowering the probability of major vascular injury during laparoscopy:

1) Make a vertical skin incision about 1 cm long, half of which can be within the umbilicus. This incision heals well and is, cosmetically, essentially invisible in the large majority of my patients.

2) Use Metzenbaum scissors to dissect subcutaneous fat and tissue apart until the fascia is visible. Ribbon retractors are helpful in visualizing the fascia.

3) Grasp the fascia with Allis clamps, and then regrasp it with a second pair of Allis clamps. Elevate the fascia as much as is reasonable without detaching the Allis clamps. The fascia usually can be elevated until it is very close to the skin.

4) Have your assistant grasp the skin of the abdomen in the midline, about 3 to 4 cm inferior to the umbilicus, and elevate this skin.

5) Place a disposable needle so that it just touches the fascia, make a note of how long the needle is (by clicking up and then down on the Veress needle indicator system), and insert it through the fascia. Do not insert the needle too rapidly, and be sure to point it at the uterus.

6) Observe how far the Veress needle seems to have been inserted. In general, more than 3 or 4 cm is too far. When you believe the Veress needle has entered the peritoneum, use the “hanging drop” test. (Place a drop of water on the open end of the Veress needle with the abdominal wall elevated; if the needle is positioned

correctly, the water should disappear down the shaft.) Keep in mind, however, that this test can sometimes be falsely positive or falsely negative.

7) Insufflate the gas at a rate of 1 L/min. If the pressure of insufflation rises above about 4 to 6 mm Hg, stop and restart. Pay close attention. It is my experience that insufflation pressures (at least initially) above 4 to 6 mm Hg are never associated with proper intraperitoneal placement, with the exception of extremely obese patients, and they usually (initially) remain below 6 to 8 mm Hg.

8) Limit yourself to three or four reruns of this approach before moving to the steps described below.

If you fail to achieve proper entry

1) Evaluate the length of your skin incision. It is remarkable how just a minor extension will offer greater visualization of the fascia and make it easier to tent up and determine when the Veress needle has passed into the peritoneum.

2) If you still have no success, separate the Allis clamps and place one on the fascia near the superior limit of what you can see of the fascia, and place the other about 1 cm inferior to this. Use the Metzenbaum scissors to make a transverse division of the fascial fibers between the Allis clamps. Then place the scissor tips in this division and widen it to about 1 cm. You will see the remaining fascial fibers beneath this transverse division, or (if your division is deep enough) you will see the peritoneum.

3) Place the Veress needle through this division and again reinsert it into the peritoneum. If your flow rates are still inadequate, use the scissors to ensure that you are through the fascia, elevate the fascia with the ribbon retractors, remove the Allis clamps, and use the Allis clamps to grasp and elevate the peritoneum.

4) Place the Veress needle tip on the peritoneum and insert it. At this point, you should need to insert the Veress needle only about 1 to 2 cm. It has been my experience that, even with this magnitude of dissection of the fascial fibers, successful access at this point will allow insufflation of the peritoneal cavity, and pneumoperitoneum will be maintained even after insertion of a laparoscopic access port once insufflation is completed.

5) If these steps do not ensure success, divide the peritoneum with scissors, ensure entry into the peritoneum (the ribbon retractors make nice manipulators to visualize bowel edges), and convert the approach to open laparoscopic entry.

Patrick Gray, MD
Dunn, NC

>> Dr. Milad responds:

Complications of open entry technique remain unknown

I thank Dr. Gray for his interest in my article. His modification of the open entry technique is interesting but has not been studied in regard to complications. As discussed in my article, open entry techniques may lower but do not eliminate the risk of major vascular injury.

His use of a needle to determine the distance to the peritoneum was previously described using a somewhat different methodology¹ and was outlined in my article. Dr. Gray is correct that the distance from skin to peritoneum is rarely more than 1 or 2 cm in the average adult woman.

Ultimately, being aware of the risk, taking logical steps to avoid injury, and knowing how to initially recognize and manage any injury that does occur will lower the overall morbidity of this potentially fatal complication.

Reference

1. Milad MP, Terkildsen MF. The spinal needle test effectively measures abdominal wall thickness before cannula placement at laparoscopy. *J Am Assoc Gynecol Laparosc.* 2002;9:514-518.