ean sections among women who have recurrent genital herpes by diminishing the frequency of recurrences at term, and many specialists recommend such treatment. The guidelines do not recommend routine antiviral prophylaxis near term for women with recurrent genital herpes. The American College of Obstetricians and Gynecologists Practice Bulletin of October 1999 states, “For women at or beyond 36 weeks of gestation with a first episode of HSV during the current pregnancy, antiviral therapy should be considered” (level B recommendation based on limited or inconsistent scientific evidence) and “For women at or beyond 36 weeks of gestation who are at risk for recurrent HSV, antiviral therapy also may be considered, although such therapy may not reduce the likelihood of cesarean delivery” (level C recommendation based on consensus and expert opinion).

In the current era, evidence-based medicine guides individual practice and the recommendations of professional organizations and public health agencies. Given the concerns and controversy about lack of sufficient data to recommend antiviral suppression in late pregnancy, we believe our study was both needed and properly designed. We thank Drs. Caughey, Urato, and Lurie for focusing clinicians’ and patients’ attention to the continued need for research in this area. We support their contentions about the proper conduct of studies in accordance with the principles laid down in the Declaration of Helsinki. We did so, balancing the interests of both of our patients: the mother and the fetus.

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The information released in this letter is not endorsed by the United States Army or by Womack Army Medical Center.

REFERENCES


Characteristics of Physicians Who Frequently Act as Expert Witnesses in Neurologic Birth Injury Litigation

To the Editor:

Although the collection of data on expert witnesses in the Kesselheim and Studdert study1 was reasonably unbiased, the discussion contained innuendo and implications that were quite the opposite.

The study period was 1990–2005. During this period there were approximately 70 million deliveries and 11,200 cerebral palsy cases (at 1.6 cases per 10,000 deliveries). The 732 litigated cases represent 6.6% of all cerebral palsy cases, meaning 93.4% were not attributed to malpractice. Some cerebral palsy is certainly caused by poor antepartum and intrapartum care, yet no data are presented to indicate that 732 of 70 million deliveries is an inappropriate number of cases to litigate.

The statement that witnesses “establish themselves as plaintiff or defense experts” is misleading. Experts do not choose attorneys; rather, lawyers choose experts. Any lawyer may send any case to any expert. That attorneys choose experts “is misleading. Experts do not establish themselves as plaintiff or defense experts” is misleading. Experts do not choose attorneys; rather, lawyers choose experts. Any lawyer may send any case to any expert. That attorneys choose experts otherwise is the lawyer’s doing—not the expert’s.

The finding that 40% of plaintive experts come from outside the state surely reflects that local physicians are far more likely to defend their friends and colleagues than to testify against them. There is no surprise here.

The notion that subspecialty boards constitute “superior credentials” and that “lack of subspecialty boards certification diminish the likelihood that
they [plaintive experts] represent the highest level of current expertise." is unsupported by any data. More than 98% of all deliveries are done by regular obstetricians. To state that 1–2% of sub specialist have more expertise than 98% of regular obstetricians constitutes an unsubstantiated conceit and insult.

Finally, the authors suggest multiple publications constitute "superior expertise." Many regular obstetricians feel the opposite: "the number of publications is inversely related to clinical expertise." First, the great majority of publications have nothing to do with cerebral palsy and would convey little expertise. Second, the heavy publishers are usually academics who spend much time in research, administration, and lecturing at great vacation spots. The daily work on their patients is done by interns, residents, and fellows. These academics lack the hands-on expertise of thousands of personal deliveries. One must wonder that they could qualify at all, because most obstetricians don’t practice where house staffs do the great majority of the work.

Richard L. Stokes III, MD
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REFERENCE

In Reply:
Limitations of space do not permit a comprehensive response to Dr. Stokes, but we would like to clarify two points. First, regarding his statement that "no data are presented to indicate that 732 of 770 million deliveries is an inappropriate number of cases to litigate," we want to emphasize that the subject of our analysis was the characteristics of experts who testify frequently in neurologic birth injury litigation, not the frequency of cerebral palsy claims.1 The data set we used is unsuited to estimates of the latter for several reasons: it is focused on verdicts, and most malpractice claims never reach trial or verdict; the cases were drawn from a subset of states; and only 57% of the cases involved cerebral palsy. The more relevant question is whether it is reasonable to generalize our findings regarding the characteristics of frequent experts to the substantial body of birth injury litigation we did not observe. For the reasons set forth in the paper’s Discussion section, we believe that it is.

Second, Dr. Stokes objects to our use of the subspecialty certification and publication record of witnesses as markers of their expertise. These markers may not be strong indicators of clinical proficiency, but in the type of litigation we studied, physician experts’ opinions of the skillfulness of the care the defendant rendered are generally only one aspect their testimony. Physi-

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REFERENCES

Performance of Contraceptive Patch Compared With Oral Contraceptive Pill in a High-Risk Population

To the Editor:
We are writing in response to the article by Drs. Bakhru and Stanwood, published in the August issue.1 We acknowledge the importance of understanding “real-world” use of contraception, particularly in high-risk groups, but note some potential limitations in design and analysis. In randomized trials, the contraceptive patch Ortho Evra [ethinyl estradiol and norelgestromin; Ortho-McNeil Pharmaceutical, Inc, Raritan, NJ] was as efficacious as oral contraception (overall Pearl Index, 0.88), with superior compliance (number of cycles with perfect use). Hence, it is surprising that this study shows poor continuation and effectiveness in the patch group.

Although the authors discuss some study limitations (eg, selection bias), other limitations are not well elucidated. The demographic disparities between subjects who chose the oral contraceptive pill and patch are striking: the patch group contained more minorities, was less educated, and had more abortions than the pill group. One wonders what led to these disparities. As the authors acknowledge, there seems to be a preference toward offering the patch to a perceived higher-risk group. If the perception of a “compliance advantage” exists for the patch, then appropriate counseling and follow-up are necessary to ensure successful pregnancy prevention. The higher discontinuation rate with the patch suggests its novelty may warrant greater follow-up in young new starters of hormonal contraception.

We question the authors’ use of the Pearl Index in this study, which is intended to measure efficacy in an ideal setting, (eg, randomized clinical trial) and is not applicable here. Although this does not necessarily invalidate the Pearl Index comparison be-

Financial Disclosure: Dr. LaGuardia is an employee of Ortho Women’s Health and Urology of Johnson & Johnson.
IVF success rates for Womack Army Medical Center Fertility Clinic of Fort Bragg, NC. View complete fertility success rates for all fertility clinics in the United States. 2817 Reilly Rd Fort Bragg, NC 28310 - map it Phone: (910) 907-9270. Medical Director: Jason Parker, DO. Total Cycles: 127. Success rates may be misleading if they are based on a small number. We omit graphed data if there are less than 20 transfers in a segment. You can find these outcomes expressed as a fraction in the table following the graphed data. The bottom of the fraction indicates the number of transfers and the top shows the number of live births. View more IVF Clinics in North Carolina. Home. Reports. Find and research local Obstetrics & Gynecology Specialists in Fort Bragg, NC. Read reviews and make an appointment on Healthgrades. Experience Matters Filter to show doctors with experience in these practicing areas. Clear filter. Learn more about Obstetrics & Gynecology Specialists and how to choose the right one for you. Learn more about Obstetrics & Gynecology Specialists and how to choose the right one for you. An obstetrician-gynecologist (Ob/Gyn) specializes in the health needs of adolescent and adult women. Ob/Gyn doctors specialize in the medical and surgical care of the female reproductive system. Ob/Gyn doctors often serve as a woman’s primary care doctor and they care for pregnant women and their unborn children. Obstetrics & Gynecology, Reproductive Endocrinology & Infertility. See Profile. Hospital Location. Womack Army Medical Center. 2817 Reilly Road, Fort Bragg, NC, 28310-7302. Map Key. US News has published patient experience ratings at Womack Army Medical Center in up to 10 key categories. See ratings. How many doctors practice at Womack Army Medical Center? 159 providers practice at Womack Army Medical Center. See a list of providers at US News. 1 Department of Obstetrics and Gynecology and Division of Maternal Fetal Medicine, Department of Obstetrics and Gynecology, Womack Army Medical Center, Fort Bragg, North Carolina. Case: A 24-year-old primigravid woman with Cogan syndrome diagnosed 3 years before her pregnancy presented to our clinic for prenatal care. During pregnancy she experienced no worsening of symptoms of her disease but reported subjective improvement in vision and hearing. Cesarean delivery was performed at term because of nonreassuring fetal status. There were no obstetric or postpartum complications. Conclusion: Cogan syndrome requires close monitoring.