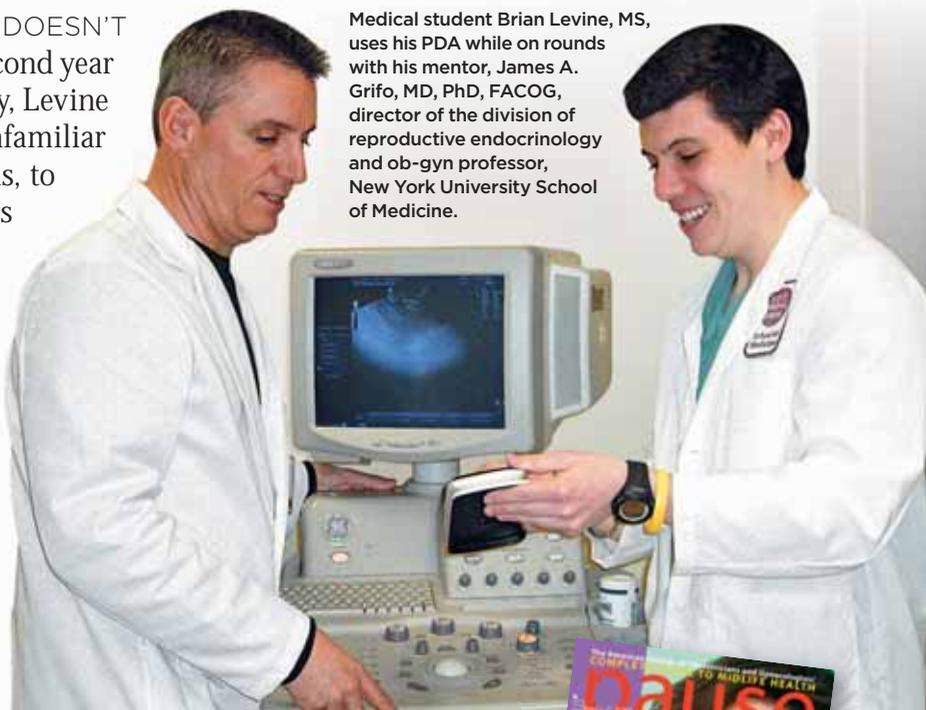


The future of medical school education

MEDICAL STUDENT BRIAN LEVINE, MS, DOESN'T go anywhere without his PDA. In his second year of medical school at New York University, Levine uses his personal digital assistant to look up unfamiliar terms when he accompanies his mentor on rounds, to supplement the lesson during his physical diagnosis class at the hospital, and to test himself on TORCH infections.

Assistant ob-gyn professor Archana Pradhan, MD, MPH, FACOG, uses an audience response system to quiz medical students in her classroom at the University of Medicine & Dentistry of New Jersey-Robert Wood Johnson Medical School. After she asks the students to name some of the most common reasons that women discontinue use of oral contraceptive pills, the students respond with wireless keypads, and the correct answers pop up immediately on the screen ► PAGE 10



Medical student Brian Levine, MS, uses his PDA while on rounds with his mentor, James A. Grifo, MD, PhD, FACOG, director of the division of reproductive endocrinology and ob-gyn professor, New York University School of Medicine.

pause™ celebrates 10 years of informing women

Average reader reads 95.4% of <i>pause</i> ™	
SAVES THE ISSUE FOR FUTURE REFERENCE	65%
DISCUSSES SOMETHING READ WITH A FRIEND/RELATIVE	65%
DISCUSSES SOMETHING READ WITH THEIR DOCTOR	52%
SUGGESTS THAT A FRIEND, RELATIVE, OR COLLEAGUE READ IT	45%
MAKES A DECISION BASED UPON SOMETHING READ	42%



A LOT HAS CHANGED SINCE *Managing Menopause and the Years Beyond*™ debuted in 1997. Now called *pause*™, the magazine celebrates its 10th anniversary with a special edition in May.

The magazine has received multiple national and international awards through the years, and, most recently, was recognized with an Award of Excellence, two Awards of Distinction, and one Honorable Mention in the international Communicator Awards.

Ten years ago, the phrase “hormone replacement therapy” was often used instead of “hormone therapy,” implying that hormones needed to be replaced once women entered this natural phase in their lives.





Volume 50, Issue 5

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EXECUTIVE DESK

ACOG Vice President Dr. Stanley Zinberg retiring

THERE COMES A TIME IN THE LIFE OF every professional organization when key individuals decide to retire. ACOG is no exception and has reached one of those times. Stanley Zinberg, MD, MS, vice president of practice activities, announced at the May 5 Executive Board meeting that he will retire on Dec 31, 2007.

His announcement now gives ACOG adequate time to have an orderly transition for the new vice president



with adequate overlap with Dr. Zinberg. I want to thank Stan for his years of involvement with ACOG and his direction of the Practice Division. He has been outstanding in his work and representation of ACOG to the Fellows and other medical organizations.

On a personal note he has served as the deputy executive vice president and has given me great help in numerous areas. When I am absent on trips or at meetings, it has been reassuring to know Stan was there to handle any situation that arose. Stan will be missed, and we thank him for his devotion to ACOG and to our members.

ACOG will now be recruiting for this position, and all Fellows of the College who are interested should apply. Interested Fellows must be practicing the full range of obstetrics, gynecology, or obstetrics and gynecology to be eligible for the position. If interested, send a letter indicating your interest in the position with

a current curriculum vitae to Office of the Executive Vice President, 409 12th Street SW, Washington, DC, 20024-2188. An electronic submission may be emailed to VPsearch@acog.org.

The letter of interest should include a description of your current practice situation, a short description of why you want to work for ACOG and what you will bring to the position, and two references that know you personally.

All letters of interest must be received (not post-marked) by Aug 19, 2006. ACOG is an equal opportunity employer. Once the candidates have been reviewed, those selected for a personal interview will be notified by Aug 25, 2006. Interviews will take place during September 2006, and the Fellow selected will be presented to the ACOG Executive Board at its October 2006 meeting.

In order to allow for orientation before assuming the position, the selected Fellow will begin on Jul 1, 2007, and assume responsibility on Oct 1, 2007. Additional information is available by contacting the Office of the Executive Vice President of ACOG, 202-863-2525; rhale@acog.org.™

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

- James B. Adams, MD • Beulah, MI
- Salim M. Braick, MD • Vernon, NY • 11/05
- William Chester Brannan, MD • Asheville, NC • 10/05
- Martha Buldain, MD • Houston • 12/05
- James H. French, MD • Titus, AL • 7/05
- Robert C. Hays, MD • Syracuse, NY • 1/06
- Joseph E. Maddox, MD • Winchester, VA
- George A. Marples, MD • Pasadena, CA
- Myron K. Nobil, MD • La Jolla, CA
- Sir John Peel • Wiltshire, England
- Wilma B. Schiner, RN • Honolulu • 10/05
- J. Philip Thomson, MD • Austin, TX

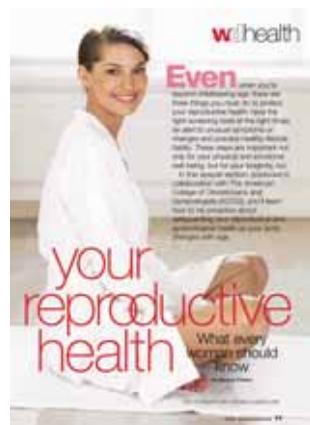


Obstetrics & Gynecology HIGHLIGHTS

The May issue of the Green Journal includes the following ACOG documents:

- Hepatitis B and Hepatitis C Virus Infections in Obstetrician-Gynecologists* (Committee Opinion #332, revised)
- The Apgar Score* (Committee Opinion #333, revised)
- Role of the Obstetrician-Gynecologist in the Screening and Diagnosis of Breast Masses* (Committee Opinion #334, revised)
- The Initial Reproductive Health Visit* (Committee Opinion #335, new)
- See page 13 for more information
- Vaginitis* (Practice Bulletin #72, new)

ACOG partners with *Woman's Day* to reach millions of women



ACOG HAS COLLABORATED with *Woman's Day* magazine for the third consecutive year to present important health information to more than 19 million women in the US. ACOG's Office of Communications partnered with *Woman's Day* on a special section in the May 9 issue.

Your Reproductive Health: What Every Woman Should Know provides critical women's health information based on College guidelines and includes interviews with ACOG Fellows. The supplement includes vital information on four female cancers: ovarian, uterine, breast, and cervical cancer, and information on vaginal infections, STDs, pelvic support problems, pelvic pain, and smoking risks.

The supplement includes a special message on healthy lifestyle choices and preventive care from Douglas W. Laube, MD, MEd, who was inaugurated as ACOG president in May.

"It's up to you to make smart choices, but remember, your ob-gyn is here to help," Dr. Laube writes. "Good health should not only be your priority, but it is our priority as well. We are your partners in helping you stay healthy."™

Dr. Laughead runs for AMA seat

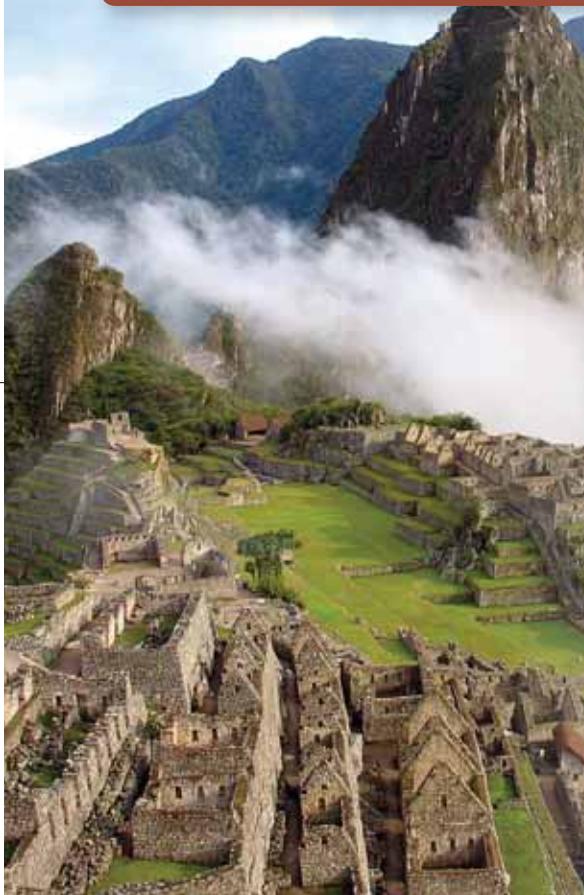
ACOG FELLOW MARILYN K. Laughead, MD, is running for a seat on the American Medical Association



Council on Constitution and Bylaws. ACOG encourages members to support her candidacy.

Dr. Laughead practices ob-gyn in Scottsdale, AZ. She has previously served as the chair of the ACOG delegation to the AMA and chair of the AMA Section Council on Ob-Gyn. She has a special interest in bylaws and is currently involved with major bylaw revisions at Scottsdale Health Care Hospitals and has helped several other organizations with bylaw revisions.™

PRESIDENT MENNUTI MEETS WITH PERUVIAN COLLEAGUES



In February, ACOG President Michael T. Mennuti, MD, accepted honorary membership in the Peruvian Society of Obstetrics and Gynecology from Society President Dr. Miguel Gutiérrez Ramos. Dr. Mennuti met with the president and past presidents of the society. They discussed how the two associations could collaborate, and representatives from the US took part in an educational course and visited local hospitals.



ACOG Fellows speak with Peru Minister of Health Dr. Pilar Mazzetti. From left to right, Thomas C. Randall, MD, FACOG; Katrina Armstrong, MD; Jack Ludmir, MD, FACOG; ACOG President Michael T. Mennuti, MD; Dr. Mazzetti; and Christos Coutifaris, MD, PhD, FACOG.



► PAGE 1
The Women's Health Initiative was just getting under way, and the Internet was a new concept in American culture.

"Ten years ago, most of the 45 million women approaching or just past menopause were faced with an overwhelming array of conflicting studies on how best to manage the symptoms and health risks associated with this biological milestone," said Isaac Schiff, MD, chair of the *pause*TM Medical Advisory Board. "Our mission was to create a comprehensive guide to help make sense of the research and provide objective recommendations for women in midlife."

As *pause*TM celebrates 10 years of educating millions of women, the magazine—which was created and is produced by ACOG's Office of Communications—also celebrates the women who have embraced the magazine since its debut. Over the years, women have read the magazine cover-to-cover, saved copies for future reference, photocopied articles and requested extra issues to share, and asked their ob-gyn about health issues and advice they discovered in the pages of *pause*TM.

Women and their doctors will continue to find the same trusted information they've come to expect from the magazine. Articles cover issues such as how to get a grip on your weight, get started in a fitness program, keep your sex life satisfying and safe, and get a handle on menopausal symptoms. TM

info

→ ACOG Fellows can order free copies of *pause*TM to give to their patients by contacting ACOG's Office of Communications, 800-673-8444, ext 2560; communications@acog.org. Fellows who received the fall/winter 2005 issue will automatically receive the spring/summer 2006 issue.

Expectations of ACOG committee members

WITH THE INAUGURATION of the new ACOG president in May, new members of ACOG committees also begin their terms. Each year, ACOG members can apply to be a member of one of more than 30 committees that address issues of medical practice and women's health. Committee members are appointed by the College president elect for a one-year term, which can be continued for up to three years.

Most committee members are Fellows, but Junior Fellows are also eligible. Also in May, ACOG opens up the application process for the next year's committee membership (see info at right).

"By serving on an ACOG committee,

Fellows play a vital role in the direction of the College. The decisions and statements developed by ACOG committees have a significant impact on the College and women's health," said ACOG Executive Vice President Ralph W. Hale, MD. "Before applying to serve on a committee, Fellows should be sure that they are able to devote the amount of time required to fulfill this important commitment." TM

info

→ Committee descriptions, member expectations, and an application to apply for a committee seat are available on the ACOG website, www.acog.org. Under "Membership," click on "Committees and Councils"

When members accept a committee appointment, they should become familiar with the following expectations

COMMITTEE MEMBERS...

- ... are expected to consistently attend regularly scheduled meetings for the entire duration of the meeting. Exceptions may occur based on personal emergencies, weather, airline issues, and other extenuating circumstances
- ... should be familiar with the charge and existing work products of the committee
- ... before meetings, are expected to review and be familiar with the agenda and all accompanying materials that will be sent by mail or electronically
- ... are expected to maintain confidentiality of the agenda, agenda materials, discussions, work product, and work plans of the committee
- ... are expected to have expertise or current clinical experience or represent the perspective of a special group (eg, generalist, young Fellow) that will actively contribute to the discussions and work of the committee. Committee members should not be shy
- ... are expected to make relevant and focused comments during discussions that will facilitate the efficiency of the committee. Committee members should avoid repeating themselves or points made by others except to express agreement or refine the argument
- ... are expected to demonstrate flexibility in consensus-building discussions and take into account the viewpoint of different types of providers (eg, generalists vs. subspecialists; academicians vs. private practitioners), regional differences in access (eg, rural vs. urban), scientific evidence, cost-effectiveness, and other relevant factors
- ... are expected to volunteer for their fair share of "homework" assignments between meetings and to meet deadlines
- ... should be able to produce a coherent written draft that may require some reworking, addition of evidence to support a position, and editing. Committee members should be flexible in accepting revision of draft documents that they produce

Western NY Section 10 receives Wyeth Section Award

IN ACOG'S DISTRICT II, SECTION 10 is the recipient of the 2005 Wyeth Pharmaceuticals Section Award for its medical student recruitment program based at the University of Rochester, NY.

The section began by revamping the university's Ob-Gyn Student Interest Group, connecting with students as they begin medical school. As the group's faculty advisor, John T. Queenan Jr, MD, has made it his mission to reach out to first- and second-year medical students.

"It has been very enjoyable for me to get involved with really young and eager minds and allow them to start looking at all aspects of the ob-gyn specialty so they can be prepared for clinical rotations in third and fourth years," said Dr. Queenan, associate professor of ob-gyn at the University of Rochester.



Panel discussions and forums

The Ob-Gyn Student Interest Group holds monthly meetings, panel discussions, and forums that are open to all interested medical students. When the group was initially started six years ago, seminars focused primarily on professional liability and managing lifestyle issues.

Under the advisory of Dr. Queenan, new themes were introduced such as midwifery, alternative medicine, research opportunities, and male physicians in ob-gyn.

"The student leaders come up with the lecture series and topics," Dr. Queenan said. "My job is to get everyone stimulated and provide advice and counseling to the students and the student leaders."

Shadowing program

The group has started a shadowing program for medical students to observe residents.

"I wanted to have medical students learn early what clinical rotations were like without having the pressure of being tested or evalu-

ated," Dr. Queenan said. "Throughout the first two years of medical school, students are immersed in the basic sciences. They can quickly lose sight of their initial reasons for becoming a doctor."

Medical students voluntarily shadow during the week and even on weekends, observing procedures in labor and delivery, outpatient clinics, and the operating room. According to Dr. Queenan, the demand for shadowing opportunities this past fall and winter was so high that all night slots and weekend slots were filled. Students have now signed up for shadowing during school vacations and their summer break.

"First- and second-year medical students told me they were hungry for some exposure to clinical medicine. They wanted this experience to occur in an environment where they would not be graded," Dr. Queenan said.

Workshops and social events

The Ob-Gyn Student Interest Group also holds workshops that highlight career development issues affecting all medical students. Topics include interview skills, applying to residency programs, and the residency Match process.

The group sponsors social events, introducing students to faculty members and private practitioners. As a result, several students are now working with faculty members on research projects, which has been beneficial to both students and faculty, according to Dr. Queenan.

"The faculty in the ob-gyn department showed that we cared; none of the other clinical departments have set up something like this for the students until their third or fourth year in medical school," Dr. Queenan said.™

Four ob-gyn departments receive Pitkin Awards

OBSTETRICS & Gynecology has announced the four winners of the 2005 Roy M. Pitkin Awards, which honor ob-gyn departments that promote and demonstrate excellence in research. The award provides a \$5,000 unrestricted grant to each department whose faculty, fellows, or residents published one of the four most outstanding manuscripts in the Green Journal in the past year. The top papers are selected by an independent panel of experts. This year's winners are:

BAYLOR COLLEGE OF MEDICINE

(Joe Leigh Simpson, MD, chair): Buster JE, Kingsberg SA, Aguirre O, Brown C, Breaux JG, Buch A, et al. *Testosterone Patch for Low Sexual Desire in Surgically Menopausal Women: A Randomized Trial.* *Obstet Gynecol* 2005;105:944-52

UNIVERSITY OF ALABAMA AT BIRMINGHAM

(John C. Hauth, MD, chair): Ramsey PS, White AM, Guinn DA, Lu GC, Ramin SM, Davies JK, et al. *Subcutaneous Tissue Reapproximation, Alone or in Combination with Drain, in Obese Women Undergoing Cesarean Delivery.* *Obstet Gynecol* 2005;105:967-73

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

(Linda Giudice, MD, PhD, chair): Harper CC, Cheong M, Rocca CH, Darney PD, Raine TR. *The Effect of Increased Access to Emergency Contraception Among Young Adolescents.* *Obstet Gynecol* 2005;106:483-91

UNIVERSITY OF UTAH HEALTH SCIENCES CENTER

(Mark Gibson, MD, interim chair): Dizon-Townson D, Miller C, Sibai B, Spong CY, Thom E, Wendel G Jr, et al, for the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. *The Relationship of the Factor V Leiden Mutation and Pregnancy Outcomes for Mother and Fetus.* *Obstet Gynecol* 2005;106:517-24™



District II chair becomes advisor of JFCAC

DISTRICT II FELLOW CHAIR Richard N. Waldman, MD, is the new national advisor to the Junior Fellow College Advisory Council. Dr. Waldman is president of the Associates for Women's Medicine, an ob-gyn group practice based in Syracuse, NY. He succeeds John R. Musich, MD, of District V, as JFCAC advisor.

The JFCAC advisor serves as the voice of experience for the JFCAC and guides the Junior Fellow officers as they deal with issues important to residents, fellows, and young physicians. The advisor also helps communicate Junior Fellow issues and priorities to the ACOG Executive Board and vice-versa.

"This is an extremely exciting opportunity," Dr. Waldman said. "The future of our specialty is vibrant and fresh. The Junior Fellows seem to be tireless in their effort, and their thought processes are provocative and prescient. I am particularly impressed with the book drive fund they created for the residents who were victimized by Hurricane Katrina. These are very impressive individuals who generate new ideas and challenge the status quo."

Dr. Waldman has served on multiple ACOG committees, is immediate past president of the Central New York Obstetrics and Gynecology Society, and is medical director of the Performance Improvement Committee at St. Joseph's Hospital Health Center in Syracuse. He is a consultant to the International Childbirth Education Association and a member of the board of directors of the Medical Liability Mutual Insurance Company.™



Mentor has profound impact on national ACOG essay winner

SHORT STARCHED WHITE COAT ... pocket full of "how-to-read-EKGs, chest X-rays, and laboratory values" ... heart pounding ... mouth dry. That was me—a third-year medical student. I had one or two rotations underneath my belt, yet I was a shiny new penny, easily identifiable in all clinical situations. In my youngest, most awkward days as a new clinician, I met my mentor. We were standing at the scrub sink, preparing for a lengthy, difficult gynecologic oncology case. My mind kept chanting, "The ureter exits the renal pelvis, travels along the retroperitoneum ..." when my mentor gave me a few firm claps on the back—right between the shoulder blades—as if to break me from my panic. He stated, "It's my pleasure to be operating with you today, young doctor."

From that first interaction, my mentor and I began to forge a relationship ... I began to learn about the man, and physician, whom I would come to idolize. He spoke to patients as equals. He explored their opinions, thoughts, feelings, and values. He asked them easy questions about their hobbies and families; he asked them tough ones too, about their transition from "healthy" to "sick" and how they wanted to live out their numbered days. He told jokes and had a belly-jiggle laugh. I found myself wanting to model his respect, compassion, and openness with patients.

From the start of her award-winning essay, Junior Fellow Lisa M. Brennaman, MD, paints a clear picture of the influence that a physician can have on a young medical student undecided about her future career path.

Dr. Brennaman's essay was selected the national winner from the 10 district-winning essays in the Junior Fellow essay contest, "How My Ob-Gyn Mentor Influenced Me." District winners received \$500 each, and, as the national winner, Dr. Brennaman received

an extra \$500 and a trip to the ACM in May.

Dr. Brennaman, of District VII, is a second-year ob-gyn resident at the University of Missouri-Columbia. Her essay describes the impact of Herbert "Jack" Schmidt, MD, FACOG, who was division director of gynecologic oncology at the University of Missouri-Columbia when the two met.

Personal interactions

"I had an early interest in ob-gyn due to its unique combination of surgical procedures and continuity of care, but my personal interactions with my mentor helped to cement my decision," Dr. Brennaman told *ACOG Today*. "In particular, he specifically cultivated my interest in gynecologic oncology and highlighted the necessary combination of expertise and compassion required to care for patients with cancer."

During the time that Dr. Brennaman was learning from Dr. Schmidt, he was diagnosed with a terminal illness and died in 2004. Dr. Brennaman remembers her mentor often and tries to follow his words of advice: "Believe in yourself. Keep learning. Teach others."

"I think mentors are the most important, crucial influence on medical students and their future career decisions," Dr. Brennaman told *ACOG Today*. "Mentoring requires great dedication and character, but little time, money, or material resources. I personally think the answer to rejuvenating the specialty of obstetrics and gynecology lies in making personal investments in medical students and residents. Oftentimes one's academic accomplishments cannot be measured in publications or leadership positions, but rather in the lasting impact a teacher may have on his or her student."™

DISTRICT ESSAY WINNERS

The winning essays from each district can be read in their entirety in the May issue of *Obstetrics & Gynecology*.

District I: Lindsay D. De Flesco, MD

District II: Sloane W. Berger-Chen, MD

District III: Erika Johnston-MacAnanny, MD

District IV: Shannon D. MacLaughlan, MD

District V: Heather L. Hilkwitz, MD

District VI: Heather B. Kerrick, MD

District VII: Lisa M. Brennaman, MD

District VIII: Kimberly E. Liu, MD

District IX: Tricia L. Kam, MD

Armed Forces District: Walter J. Yee, MD



JFCAC makes strides in key areas during 2005

By May Hsieh Blanchard, MD, JFCAC chair

ONE YEAR AGO, AS I BEGAN my term as the new chair of the Junior Fellow College Advisory Council, I challenged the JFCAC to focus attention in three primary areas: medical student recruitment, legislative activism and awareness, and postgraduate training and education. An ambitious agenda? Perhaps, but the JFCAC has made strides in these areas during the 2005–06 term, while recognizing that the challenges are ongoing.

Medical student recruitment

Junior Fellows have been actively supporting and establishing several medical student recruitment initiatives, including medical student interest groups at the local level and activities at the 2006 Annual Clinical Meeting.

In the 2006 National Resident Matching Program Residency Match, 98% of all ob-gyn positions were filled, with 72% filled by US medical students (see article on the right). This latter number is significant because just two years ago, the US medical student match rate was at an all-time low, at only 65.1% of positions offered.

While a causal relationship cannot be assumed, ACOG medical student recruitment efforts have been established with the goal of seeing such a turnaround. The challenge, however, is to continue this upward trend and recognize that novel approaches must be implemented to introduce the unaware to the clinical variety and professional rewards of a career in ob-gyn.

Legislative activism and awareness

More than 160 ACOG physicians attended the 2006 Congressional Leadership Conference, including many Junior Fellows.

This year's record attendance demonstrates that ACOG members recognize that maintaining a vocal presence among our legislators plays a vital role in ensuring that our patients have access to excellent ob-gyn care and that ob-gyns are able to provide that care.

There have been many anecdotes about how the liability crisis has negatively affected our patients and colleagues, but a dearth of data on Junior Fellow experiences to support such anecdotes. Thus, the JFCAC conducted a survey of all ob-gyn fourth-year residents to determine how the liability crisis has affected Junior Fellows' decisions on how and where to practice or pursue further training.

Postgraduate training, education

In addition to focusing on acquiring the knowledge and skill expected of them during training, residents and subspecialty fellows face new constraints on time, manner, and breadth of education. Having an impact are new challenges such as the duty-hour restrictions, new ways of learning, and increased education related to billing and coding, the business of medicine, and the core competencies of the Accreditation Council for Graduate Medical Education.

In addition, the issues of patient safety and resident/fellow well-being have begun to be addressed and will surely play a larger role in ongoing discussions about how we train and educate our future ob-gyns.

Ongoing projects

The JFCAC worked to realize the business of medicine course at the 2006 ACM and has a current task force to follow up on preliminary data from residents about the impact of the duty-hour restrictions on residency training. The JFCAC also hopes to conduct a needs assessment to consider how best to implement initiatives identified by the JFCAC evaluation of the ACOG strategic plan.

I'm pleased to report that this is only a sampling of what the JFCAC has been able to accomplish in the past year. It's a pleasure to serve on the council with such dedicated and effective young physicians. I encourage all Junior Fellows to get involved—opportunities abound at the residency/fellowship, section, district, and national level. And, I encourage all Fellows to continue to support and guide the future Fellows of the College.™



OB-GYN MATCH NUMBERS INCREASE

THE PERCENTAGE OF OB-GYN residency positions filled by US medical students continues to increase. In this year's National Resident Matching Program Residency Match, 98% of ob-gyn residency positions were filled, with 72% filled by US medical students, compared with 67.5% last year, 65.1% in 2004, and 68.3% in 2003.

"This year's Match numbers are an improvement and bring us closer to the 2000–02 levels, when 75% of positions were filled by US medical students," said ACOG President Douglas W. Laube, MD, MED. "However, we can still do better, and it's important that we continue to look at innovative ways to introduce and attract medical students to ob-gyn."

The overall number of both ob-gyn applicants and positions also continued to increase. There were 1,154 ob-gyn positions this year, 11 more than last year, and there were 63 more US medical students filling those positions than last year.™

The future of medical school education

► PAGE 1

at the front of the room. Dr. Pradhan can then lead the discussion based on what information the students didn't understand.

Attending physician Todd D. Tillmanns, MD, FACOG, aims to teach the medical students who go through his gynecologic oncology rotation how to effectively and routinely use the Internet in combination with PowerPoint presentations to improve patient care. Dr. Tillmanns is an assistant professor in the division of gynecologic oncology, University of Tennessee and the West Clinic, Memphis.

Medical school education is changing dramatically in the 21st century, particularly with the almost daily advances in technology that affect how medical students learn and how professors teach. But technology is not the only force behind the changes: Medical schools are also responding to advances in diagnosis and treatment, renewed emphasis on professionalism and patient-physician communication, and students' ever-growing interest in the global world. *ACOG Today* asked several ACOG members to prognosticate on the future of medical school education as it relates to ob-gyn: How will medical school education change in the next 10–20 years?

on the faculty at the University of Tennessee–Memphis for 25 years before entering private practice two years ago.

"There's not new information on bedside manner, but the interpersonal model has not carried through the technological age, and that disparity is only going to get greater as the technology increases," Dr. Ling said. "Our perspective has changed. When you look across the country, in some circumstances medical students are now being taught all this technological stuff, but what they're missing out on is how doctors interact with their patients one-on-one."

Medical students learn primarily in university and hospital settings and don't often have the opportunity to observe how physicians in private practice interact with patients in non-emergency visits.

"I recognize that medical schools are underfunded, but they need to look for creative ways to share models of practice with students, whether it's partnering with people who are not full-time faculty, partnering with the community and reducing the 'town-gown' disparity, or developing programs for medical students and residents to do more one-on-one mentoring with physicians in private practice," Dr. Ling said.

QUICK LINK TO ACOG WEB PAGES

Now you can access the **Medical Student** and **Junior Fellow** sections of the ACOG website easier and faster. Visit www.acog.org and click "Medical Students" or "Junior Fellows" in the "Quick Links" box on the left side of the home page.



Some medical schools are evaluating changes in the clinical clerkship to give students more time for elective courses, according to Fellow William N.P. Herbert, MD, chair of the ob-gyn department at the University of Virginia.

"A number of schools are shortening the length of their clerkships from, say, six weeks to four weeks," Dr. Herbert said. "The time that we will have with every medical student is going to be significantly reduced, which is going to be a challenge—everything we want every medical student to know in ob-gyn, we'll have to teach in four weeks."

Technology's impact on education

Levine, an ACOG medical student member, has fully embraced technology, integrating it as much as possible into his everyday life. As a critical care EMT before medical school, he depended heavily on his PDA and was disappointed to learn that it wasn't used much in the preclinical curriculum. So he bought his own, began encouraging NYU to increase the use of PDAs, and negotiated with companies Unbound Medicine and Epocrates to offer discounted PDA software to NYU medical students.

NOW THAT I'VE GRADUATED...

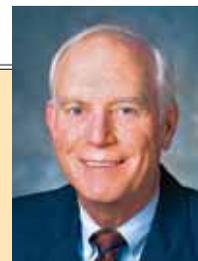
I appreciate how advanced my medical school was in its teaching methods. We had extensive case-based learning, which was invaluable in residency and life after residency. One thing I don't think we learned enough about in medical school and residency was the importance of documentation in all notes and dictations. Everyone discussed it, but no one ever went over this in a didactic format, showing both good and bad examples and what is medically necessary to document. In today's medical-legal climate every little notation in a chart counts.

— Beth W. Rackow, MD, District I Junior Fellow chair

"Recently, ob-gyn medical education has tried desperately to do two things that are very difficult to do at the same time: to teach developing technology, while at the same time continuing to teach the time-honored tradition of maintaining the doctor-patient relationship," said Fellow Frank W. Ling, MD, who was

Restructuring curriculum

Medical school ob-gyn curriculum will continue to evolve as medicine undergoes exciting advances in prevention, diagnosis, and treatment, such as the increase in minimally invasive surgery and the development of an HPV vaccine.



Medical education Q&A with ACOG's president



NOW THAT I'VE GRADUATED...

I think medical schools should provide more guidance on practice issues, such as differences in scheduling, reimbursement, and new practice options, to help med students prepare for their future.

— Stephen A. Contag, MD, District VI Junior Fellow chair

Has his PDA become a crutch? No, Levine says. "It allows me to study anywhere, and I'm using it to solidify what I know. You have to have the knowledge base to access the tool or you're just going to spin your wheels."

Looking ahead, Levine predicts that more medical schools will be recording lectures using MP3 equipment so students can relisten to lectures on headphones using a portable MP3 player, such as Apple's iPod. Levine envisions students reviewing surgical skills by watching a recorded surgery on their PDA, instead of just reading about it, minutes before entering the operating room.

"Medical students today all have cell phones and laptops; they have iPods and PDAs. They're the most technologically savvy generation ever, and they see it as a weakness if professors can't embrace technology," Dr. Tillmanns said.

When students go through the gynecologic oncology rotation, Dr. Tillmanns instructs them to choose a clinical question to research. While in the hospital, he shows them how to use the Internet to take an evidence-based approach and find literature using PubMed, MEDLINE, and UpToDate and tasks them with creating a 5–10-minute PowerPoint presentation on the topic to present to the team.

"It's all-encompassing. I'm teaching them how to use technology to be better physicians, use the resources around them, and give informative and engaging presentations," Dr. Tillmanns said. "I think the key to education is that you set the bar high, and students will achieve."™

ACOG PRESIDENT DOUGLAS W. LAUBE, MD, MEd, SHARES HIS thoughts on the future of medical school education with *ACOG Today*. Dr. Laube is chair of the ob-gyn department at the University of Wisconsin and has a special interest in medical education.

What have been some of the biggest changes in medical school education in the last five years?

More schools are integrating basic science curriculum horizontally, or across the basic sciences—anatomy, biology, pathology—as well as vertical integration from the basic sciences to their clinical applications. Another big change is integration of information systems with electronic technology. A lot of coursework is done online, tests are given online, paper has been replaced by technology. This comes with a generation change; most of these students have been born since 1980 and have grown up with electronic technology.

What changes do you foresee in the next 10–20 years?

Students will be assessed in behavioral terms rather than just cognitive terms in light of new competencies, particularly those that have to do with professionalism and communication. And future residency selection may be done by including behavioral assessments, which means assessment of candidates on communication, motivation, and leadership—in other words, attitudinal assessments to add to cognitive assessments to find the students who are most suited to various specialities. In the future, many endoscopic surgical techniques will be learned by simulation the way students learned computer games.

What effect is technology having?

There's been much less use of standard textbooks. Texts are used differently as "depth"

resources rather than an initial contact resource. Students are learning in a way that provides for simulation and interactive exercises. There's interactive problem-solving, done by using case-based informatics.

What do medical schools need to do better?

We need to do better in the teaching of ambulatory care. Some residents are interested only in ambulatory care, and that's increasing. In a CREOG survey of all US residents eight years ago, 7% said they were interested only in ambulatory care; that's probably doubled by now. There needs to be more integration of gender-based biology into the curriculum in the preclinical years, not just in the ob-gyn clerkship. Schools also need to do a better job of directing students in their careers.

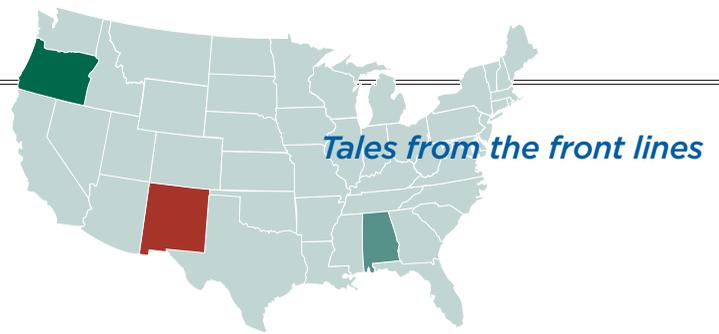
What health issues related to ob-gyn should medical schools be addressing?

I think there needs to be a recognition of gender-based biology and medicine throughout the medical school curriculum, particularly for students who select women's health careers. This is empirically important, and would create, by extension, more awareness of what we do while enabling us to attract students into ob-gyn. Preventive medicine should be a larger part of every clinical course. We should teach more population medicine, and we should look at global medicine. Reproduction and maternal mortality are huge issues in developing countries, and maternal mortality is underappreciated as a significant social issue affecting most of the rest of the world.™

APGO ONLINE RESOURCES

The Association of Professors of Gynecology and Obstetrics' new eLearn website, www.apgo.org/elearn, includes online educational programs and tools for health care providers, students, and educators. For more APGO resources, also visit www.apgo.org/getinfo.

How the uninsured crisis affects your patients



NEARLY 46 MILLION AMERICANS HAVE NO HEALTH insurance. More than half of all uninsured working adults are employed full-time throughout the year. Among female workers ages 30–64, only 20% of those without insurance had a mammography in 2003.

These statistics from the Cover the Uninsured Week campaign illustrate the national crisis. But how do these statistics translate to practice? How are your patients affected?

ACOG *Today* spoke to just a few of the thousands of ACOG Fellows who are on the front lines of this crisis every day, forced to make tough treatment decisions for their patients and who take care of ill patients who didn't have the "luxury" of preventive care or early interventions. Here are a few real-life tales.™

ALAN G. WAXMAN, MD, MPH



Associate Professor of Ob-Gyn
University of New Mexico, Albuquerque

“ I HAD A RECENT PATIENT WITH advanced cervical cancer. She was 24 years old and had had CIN 3 (pre-malignant) on a colposcopic biopsy four years ago. LEEP was recommended, but she couldn't afford it, so she got no treatment.

Now she has cancer and is being treated with the help of the university hospital. ”

SHARON T. PHELAN, MD



Professor of Ob-Gyn
University of New Mexico, Albuquerque

“ WHEN I WORKED IN ALABAMA, I saw a patient in her mid-50s who was too young for Medicare and didn't qualify for Medicaid. She had felt a large lump in her breast and sought care at an urgent care clinic that opened one day a week for indigent patients, but the high demand meant that not all patients would be seen, and she was unable to see a doctor. She finally took a day off work and paid to see a primary care physician, who referred her to a specialist, who told her she needed immediate treatment. Although she found physicians willing to treat her, she couldn't get admitted to a hospital for her surgical care.

She was then referred to the resident continuity clinic at the University of Alabama–Birmingham, a safety net hospital where I worked. But her visit was delayed because she didn't have a car and had trouble finding transportation to the hospital over 100 miles away.

By the time I saw her, she had a very large mass in her right breast; the skin was already ulcerated with much of the areola involved, and she had dense mass under her axilla. At that point, we could only give her palliative therapy.

By the time she tried to access the safety net, she was already in a world of hurt. Without insurance, she didn't have a regular physician and didn't have any preventive screenings—she'd never had a mammogram. And the palliative therapy wasn't free. This was a hard-working US citizen who happened to be poor and had a job without insurance. ”

JOSEPHINE L. VON HERZEN, MD



OB Medical Director, Salem Hospital, Salem, OR

“ ONE PROBLEM FOR WHICH uninsured patients have trouble accessing care is miscarriage. With insured patients, we might schedule a D&C rather than waiting for weeks for someone to miscarry. But here, especially with undocumented patients with this problem, they can continue bleeding for weeks, making repeated trips to the emergency department, and no one will admit them and do the D&C because they are not bleeding significantly enough to consider it an emergency. Having misoprostol available has helped somewhat.

In another case, I had an American Indian patient who had pre-gestational diabetes and was on 40 units NPH prior to her pregnancy. She was a brittle diabetic, having been admitted for diabetic ketoacidosis prior to this pregnancy. On her own she continued the same dose of NPH during the pregnancy. She couldn't find an ob-gyn to care for her so she saw the nurse practitioner at the Indian clinic early on and then again around 32 weeks. She had an ultrasound that demonstrated a very thin lower uterine segment, which was worrisome since she had had three C-sections. She was advised to come directly to the hospital; however, she didn't come in for a few more weeks until her diabetes was out of control and she had an upper respiratory infection and didn't feel very well.

Luckily, we were able to adjust her insulin and get her diabetes under control and schedule a repeat C-section and tubal ligation. We wanted her to come in before delivery for three days to make sure her blood sugar was in control, but she refused due to child care issues. Instead, she did come in every other day for nonstress tests and assessments. Both mom and baby did well. ”



Fellow proactive in battling uninsurance crisis

AS A VOLUNTEER AT THE Union Mission in Savannah, GA, and, later, a member of the mission's health care oversight committee, Iffath A. Hoskins, MD, FACOG, helped establish a health care system for the city's entire homeless population.

"These patients are underserved and have significant health care needs that create a burden on the nation's ERs," Dr. Hoskins said. "By volunteering their time and expertise, ob-gyns can help improve the health of these patients and keep them out of the ERs."

While living in Savannah, Dr. Hoskins was the executive director of the Women's Health Institute at Memorial Health University Medical Center. She recently moved to New York City, where she is the senior vice president and chair and residency director of ob-gyn at Lutheran Medical Center in Brooklyn.

In Savannah, Union Mission opened the



J.C. Lewis Health Center, a federally qualified health center that offers 32 primary care beds for respite care and is the main site for general outpatient care. The center reduces the number of people who receive their health care only through hospital emergency departments and provides a facility for homeless people to recuperate after they're discharged from the hospital. For the center, Dr. Hoskins organized specialty physicians to volunteer their time to treat specific patient needs.

In 2005, the center's outpatient services saw 1,653 patients and had 10,505 medical patient encounters and 221 emergency room diversions.

The center offers health promotion activi-

ties, including special cancer screening events in which women are provided a meal along with an educational presentation, followed by mammograms and Pap tests.

"These are people who had no regular care before—whatever care they got was from ERs and was superficial at best," said the Rev. Micheal Elliott, president and CEO of Union Mission.

Now, the mission serves as a "gatekeeper" for the hospitals, managing the health care and referring patients to the hospital for specific treatment.™

info

- Committee Opinion *Health Care for Homeless Women* (#312, August 2005)
- Committee Opinion *The Uninsured* (#308, December 2004)
- Committee Opinion *Racial and Ethnic Disparities in Women's Health* (#317, October 2005)

Initial ob-gyn visit should occur between ages 13 and 15

ACOG RECOMMENDS THAT teenage girls go to an ob-gyn for the first time when they're between the ages of 13 and 15. A new Committee Opinion, *The Initial Reproductive Health Visit*, clarifies the services that should be provided during the first visit and provides information on coding and confidentiality. The document was published in the May issue of *Obstetrics & Gynecology*.

"The initial visit provides an excellent venue for the obstetrician-gynecologist to start a physician-patient relationship, build trust, and counsel patients and parents/guardians regarding healthy behaviors while dispelling myths and fears," the document states. "It also will assist young women in establishing a 'health home' and negotiating entry into the health care system when she has a specific health care need."

The focus during the initial visit should be on health guidance, screening, and the provision of preventive health care services. The visit is usually not the appropriate time for the first pelvic exam, unless indicated. In fact, because

ACOG guidelines call for females to have their first Pap test approximately three years after vaginal intercourse but no later than age 21, some teenagers may visit the ob-gyn several times before a speculum or manual pelvic exam is indicated.

The physician should greet the adolescent and parent/guardian together while the patient is still dressed and take the time to give a thorough explanation of the visit and explain confidentiality issues. Conversations about normal pubertal development and menstruation can be reassuring to both patients and parents.™

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- More detail on the first visit is provided in the chapter "Primary and Preventive Health Care for Female Adolescents" in ACOG's *Health Care for Adolescents*, available online at www.acog.org/publications/adolescents/ado102.cfm or through the ACOG Bookstore: <http://sales.acog.org>; 800-762-2264
- ACOG's Tool Kit for Teen Care: Order at <http://sales.acog.org>; 800-762-2264

ACOG
documents
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Journal

OBSTETRICS &
GYNECOLOGY



Genetic advances, new legal theories raise liability risks

ADVANCES IN MEDICAL SCIENCE and recent changes in legal doctrine make it more important than ever for a physician to elicit a patient's personal and family history and take appropriate action.

Fellow John C. Elkas, MD, JD, a gynecologic oncologist, cautions ob-gyns to take a thorough family history and refer patients for screening or genetic counseling as appropriate.

"An ob-gyn's failure to elicit a family history or to recognize the importance of that history for the patient's health puts the physician at risk for a liability lawsuit," Dr. Elkas said. "It's important to stay abreast of familial patterns and genetic mutations that are reported in the literature. Most doctors are well aware of the importance of family history of breast and ovarian cancer, but as new genetic or familial links are found they need to take them into account in caring for the patient."

As an example, Dr. Elkas pointed out that a family history that would raise suspicion of

HNPCC (hereditary nonpolyposis colorectal cancer) syndrome may not be readily recognized. Clues to HNPCC syndrome include multiple relatives with colon cancer or colon and endometrial cancer, and clusters of cancers of the gastrointestinal, urinary, or female reproductive system.

"Patients with hereditary cancer syndromes account for up to 10% of all breast, ovarian, and colon cancers," Dr. Elkas said.

An example involving personal history is the link between a history of gestational diabetes and increased risk of developing type 2 diabetes.

"A patient who had gestational diabetes should be counseled about this risk and advised to take steps to limit her risk for diabetes."

Emerging legal theories

Changes in the interpretation of legal liability increase ob-gyns' risk of lawsuits regarding delayed diagnosis. Beginning in the 1990s, courts have increasingly allowed plaintiffs to

recover damages on the basis of "loss of chance."

The loss of chance theory allows a plaintiff to argue that a physician's negligence lessened or eliminated the patient's chance of survival or recovery. This differs from traditional tort law, which requires a plaintiff to prove that there was a greater than 50% chance that the physician caused the alleged injury.

"In a state that recognizes the theory of lost chance, a patient whose cancer diagnosis was delayed, regardless of presenting stage, could be entitled to damages because of the loss of chance of survival," Dr. Elkas said. "Tying the patient's personal and family history to the patient's treatment plan is becoming more and more important. The growing use by litigators of the loss of chance doctrine opens the door to liability even further."™

YOU ASKED, WE ANSWERED

Physician-owned insurance companies a stabilizing force

Q WHAT EFFECT HAVE PHYSICIAN-OWNED insurers had on the professional liability market?

A SKYROCKETING CLAIMS AND legal costs are putting the squeeze on professional liability insurers across the country. Although commercial, multiline carriers have left the market, physician-owned-and-operated medical liability insurance companies have helped fill the gap.

Through prudent underwriting and effective risk management, doctor-owned insurance companies have been a stabilizing force in the medical professional liability market for almost 30 years. During the 1970s, doctors who felt commercial carriers were charging unjustifiably high insurance premiums joined together

with their medical societies to form the first physician-owned professional liability insurance companies.

Now, roughly 30 years later, the provider-directed companies have realized that medical liability insurance is one of the most volatile and unprofitable lines of insurance. Companies have had to raise premiums for many doctors in the US because of increasing claims and legal costs.

Few specialties have felt the impact as severely as ob-gyn. Ob-gyns now face some of the highest premiums in the nation—up to \$300,000 in some areas. However, it is important to note that at least there is liability insurance available for most physicians—something that was not a sure bet a few years ago.

Physician-owned companies insure more

than 60% of practicing physicians and are leading the charge to a more viable market. According to analysts at Milliman Inc, these insurers' average combined ratio has outperformed the industry-wide combined ratio for the past five years. While commercial, multiline companies sought lower premium increases during the heart of the crisis, provider-directed companies adjusted premiums in a manner dictated by the actuarial realities of the time. Now, as commercial carriers are abandoning the market, physicians insured by provider-directed companies are experiencing smaller or no increases in their liability insurance rates.™

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→ liability@acog.org

2006 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

MAY

6-10

ACOG 54th Annual Clinical Meeting

Washington, DC
800-673-8444, ext 2442
www.acog.org/acm

18-20

North American Society for Pediatric and Adolescent Gynecology 20th Annual Clinical Meeting

Orlando, FL
www.naspag.org

31-June 3

The Western Association of Gynecologic Oncologists

Olympic Valley, CA
800-673-8444, ext 1648

JUNE

10-14

American Medical Association Annual Meeting

Chicago
www.ama-assn.org
800-673-8444, ext 2515

13

ACOG WEBCAST: Coding for Female Reproductive Services

1-2:30 pm ET
800-673-8444, ext 2498

22-27

The Society of Obstetricians and Gynaecologists of Canada 62nd Annual Clinical Meeting

Vancouver, BC
www.sogc.org/acm2006/index_e.shtml
613-730-4192

JULY

11

ACOG WEBCAST: Pay-for-Performance

1-2:30 pm ET
800-673-8444, ext 2498

23-29

Second Annual Summer Institute in Maternal-Fetal Pharmacology

Sponsored by the National Institute of Child Health and Human Development and the Office of Research on Women's Health at NIH and the Canadian Institutes of Health Research
Denver
www.circlesolutions.com/summerinstitute

24-26

34th Physicians Seminar on Breastfeeding

San Diego
www.lalecheleague.org/ed/PhysSem06.html

AUGUST

3-5

Infectious Diseases Society for Obstetrics and Gynecology 33rd Annual Scientific Meeting and Symposium

Monterey, CA
www.idsog.org
800-673-8444, ext 2570

8

ACOG WEBCAST: Changing Physician Behavior: Issues and Approaches

1-2:30 pm ET
800-673-8444, ext 2498

SEPTEMBER

6-9

Society of Laparoendoscopic Surgeons Annual Meeting

Boston
www.sls.org

12

ACOG WEBCAST: Physician Employment Contracts

1-2:30 pm ET
800-673-8444, ext 2498

13-16

The American Gynecological and Obstetrical Society and the American Association of Obstetricians and Gynecologists Foundation

Williamsburg, VA
800-673-8444, ext 1648

OCTOBER

5-7

ACOG District V Annual Meeting

Louisville, KY
800-673-8444, ext 2574

10

ACOG WEBCAST: Neonatal Encephalopathy and Cerebral Palsy

1-2:30 pm ET
800-673-8444, ext 2498

11-14

North American Menopause Society 17th Annual Meeting

Nashville, TN
www.menopause.org

18-21

Central Association of Obstetricians and Gynecologists Annual Meeting

Las Vegas
www.caog.org
701-838-8323

19-21

American Urogynecologic Society 27th Annual Scientific Meeting

Palm Springs, CA
www.augs.org
202-367-1167

21-25

American Society for Reproductive Medicine 62nd Annual Meeting

New Orleans
www.asrm.org
205-978-5000

27-29

ACOG District II Annual Meeting

New York City
518-436-3461

ACOG COURSES

- For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
- For Coding Workshops, visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Telephone registration is not accepted for Coding Workshops.

Registration must be received one week before the course. On-site registration subject to availability.

MAY

11-13

CPT and ICD-9-CM Coding Workshop

Washington, DC

JUNE

2-4

CPT and ICD-9-CM Coding Workshop

Portland, OR

22-24

The Art of Clinical Obstetrics

Kohala Coast, HI

AUGUST

4-6

CPT and ICD-9-CM Coding Workshop

Secaucus, NJ

10-12

Screening in Obstetrics and Gynecology

Vancouver, BC

25-27

CPT and ICD-9-CM Coding Workshop

Kansas City, MO

SEPTEMBER

8-10

CPT and ICD-9-CM Coding Workshop

San Diego

14-16

Quality Improvement and Management Skills for Leaders in Women's Health Care

San Francisco

OCTOBER

13-15

CPT and ICD-9-CM Coding Workshop

Chicago

NOVEMBER

8-11

Obstetrical and Gynecological Pearls

Kohala Coast, HI

16-18

Fetal Assessment: Ultrasound, Doppler, Heart Rate Monitoring

Coronado, CA

17-19

CPT and ICD-9-CM Coding Workshop

New Orleans

30-Dec 2

Office Procedures for the Clinician

New York City

DECEMBER

7-9

New Surgical Approaches to Incontinence and Prolapse

Chicago

8-10

CPT and ICD-9-CM Coding Workshop

Atlanta

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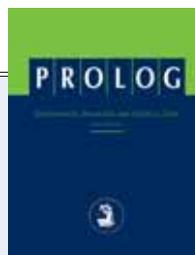
Each PROLOG is designated for a maximum of 25 category 1 credits toward the AMA Physician's Recognition Award or up to a maximum of 25 category 1 ACOG cognate credits. Fellows who submit their answer sheets will automatically have their online transcript credited with the hours claimed. All participants will receive a letter stating hours of CME earned.

In January, the fifth edition of *Gynecologic*

Oncology and Critical Care (formerly titled *Gynecologic Oncology and Surgery*) was published. Each unit of PROLOG covers a different major aspect of the specialty, presenting clinical evidence in case scenarios, and features a multiple-choice test plus a critique book that thoroughly discusses each answer. ACOG awards CME credit for each unit of PROLOG for its initial three years, including the year of publication. At the end of the three years, the College's content experts reevaluate the unit and, if appropriate, extend credit for an additional three years. An individual can request credit only once for each unit.™

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→ PROLOG registrar: 800-673-8444, ext 2569



Guidelines released to prevent recurrent stroke in patients

THE AMERICAN STROKE Association has released guidelines for the prevention of recurrent stroke among survivors of an ischemic stroke or a “mini stroke” known as transient ischemic attack. Ischemic strokes are caused by a blood clot that blocks blood flow to the brain. TIA occurs when an artery is temporarily blocked.

The evidence-based guidelines include recommendations for preventing stroke among women, with emphasis on pregnancy and on the use of hormone therapy. Hormone therapy for postmenopausal women is not recommended for women with stroke or TIA.

Strokes are the third leading cause of death in the US. About 700,000 Americans suffer a new or recurrent stroke each year, and in 2003, an estimated 157,000 people died from stroke. Because women live longer than men, more women than men die of a stroke each year.

May is Stroke Awareness Month

May is Stroke Awareness Month, and the American Stroke Association, a division of the American Heart Association, will be releasing new guidelines on preventing a first stroke. The organization's website includes resources for health care professionals, patient education materials, statistics, and research updates.™

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→ Guidelines for prevention of recurrent stroke:
<http://stroke.ahajournals.org/cgi/content/full/37/2/577>
→ www.strokeassociation.org

NOW AVAILABLE

Newly revised Patient Education Pamphlets

- ▶ *Emergency Contraception* (AP114)
- ▶ *Birth Control Pills* (AP021)
- ▶ *Hysterectomy* (AP008)
- ▶ *Staying Healthy at All Ages* (AB006)

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→ Order at <http://sales.acog.org>;
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