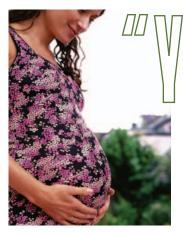


ACOG helps pregnant women say no to smoking



ou don't smoke, do you?"
Let's try that again. Rather than asking a pregnant patient, "You don't smoke, do you?" try asking her a multiple-choice question about her smoking—she's more likely to tell you the truth. How to ask is just one of the "A"s referred to in the 5 "A"s practice, an evidence-based approach to screening

ACOG is promoting the

for and treating tobacco use

and dependence.

5 "A"s—Ask, Advise, Assess, Assist, and Arrange—as part of a national collaborative effort to help pregnant women quit smoking.

The National Partnership to Help Pregnant Smokers Quit was developed two years ago to provide clinicians, policy-makers, professional and patient educators, pregnant smokers, and new parents with the support they need to reduce the prevalence of smoking.

"Smoking cessation is the most important thing a pregnant woman can do to promote a healthy pregnancy," says Janet Chapin, RN, MPH, ACOG director of women's health. "ACOG's goal is to make sure our Fellows know how to implement the 5 'A's in their practice for any pregnant woman who smokes."

Using multiple approaches

Between 12% and 20% of pregnant women in the US smoke—statistics that the partnership is determined to decrease. The partnership's goals are to:

- ▶ Ensure, by 2005, that all pregnant women in the US will be screened for tobacco use and that all pregnant and postpartum smokers will receive best-practice cessation counseling as part of regular care
- ▶ Reduce the prevalence of smoking during pregnancy to 1% or less by 2010, in accordance with the US Department of Health and Human Services' Healthy People 2010 goal

The partnership has addressed the issue from many different angles, offering minigrants, working with the media, collaborating with federal agencies, conducting research, and developing a one-stop shopping website.

Grants were awarded to three states and two American Indian/ Alaska Native organizations to train health care providers on how to incorporate the 5 "A"s into routine prenatal care visits and develop state-specific and culturally sensitive patient information materials.

A toolkit was developed to facilitate reimbursement for patient cessation services through state resources, and the partnership is completing a toolkit for workplaces that support smoking cessation initiatives for pregnant smokers.

"The strength of numerous and diverse organizations joining resources on the issue of smoking cessation is tremendous," Ms. Chapin says.

continued on page 13

besity & Ob-Gyn second in an ongoing series

Can we talk? Speaking about weight with your patients

utting on the pounds is your fault.
You need more willpower. Just stop eating.
This is the message that society often sends to people battling weight problems.

As much as overweight and obesity are being discussed lately, there's still a perception among many Americans that gaining weight is a weakness. In this climate of blame and shame, how do ob-gyns bring up weight issues with their patients?

Discussing a longtime weight problem or a recent weight gain with a patient can be difficult, but it must be done, says ACOG Fellow Sharon T. Phelan, MD, ob-gyn professor at the University of New Mexico.

"The woman who is overweight knows she's overweight," Dr. Phelan says. "You need to communicate with her about it; you need to address it; and you need to let her know you'll help."

Busy summer in Washington, DC



t was an eventful summer for ACOG. The issue of professional liability continued to be on the "front burner" in Congress and in many of the states. We again achieved success in the US House of Representatives when another bill was passed in support of professional liability reform.

On May 12, by a vote of 229–197, the House passed HR 4280, the Health Act of 2004. HR 4280 is identical to HR 5, the Health Act of 2003, which was modeled on California's landmark MICRA law and would place a \$250,000 cap on noneconomic liability awards.

However, in spite of extensive work and effort, the Senate failed on several occasions to allow a companion bill even to be brought to the floor for a vote. Our friends in the Senate tried numerous approaches, including an obstetric provider-only approach, a trauma approach, a neurosurgical approach, and various combinations.

The opposition prevented all of these because of the threat of a filibuster, which requires a vote by 60 senators to overturn.

We honestly believe that if a vote could be taken, we would win, but that is not to be. Our supporters in other affected specialties and the American Medical Association have been helpful and worked hard in these efforts. They are as frustrated as we are by the refusal to even get a vote.

Another issue taking enormous time commitment is the development and initiation of our new competency evaluation program, "Maintaining the Road to Excellence." The approach is currently being tested, and we are developing further evaluation protocols. This is a joint effort between ACOG and ABOG. ABOG will use these programs as an essential component of maintenance of certification. \circ

Ralph W. Hale no

Ralph W. Hale, MD, FACOG Executive Vice President

New logo available for Fellows



COG has developed a special logo that Fellows can use to demonstrate their dedication to women's health care. The logo, which can be used only by active Fellows, Senior Fellows, and Life Fellows, can be displayed on sta-

tionery, brochures, practice forms, business cards, personalized labels, plaques, and office buildings.

The Fellow's name must accompany the logo. The logo cannot be used to represent an entire group practice but is to be used only by individual Fellows.

The logo can be downloaded from the members-access area of ACOG's website. The full guidelines for the use of the logo are also on the website. \mathbb{Q}



www.acog.org/member_access/misc/fellowlogo

OBSTETRICS & Highlights

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

- Management of Postterm Pregnancy (Practice Bulletin #55; revised)
- ► Guidelines for Diagnostic Imaging During Pregnancy (Committee Opinion #299; revised)

Each month, in this new ACOG Today feature, we will list the titles of ACOG documents that were published in the corresponding month's Obstetrics & Gynecology. We hope this will serve as an easy reference point for Fellows and Junior Fellows of the committee opinions, practice bulletins, and technology assessments appearing in the Green Journal each month. $\ensuremath{\mathbb{Q}}$

Dos and nevers when representing ACOG on legislative issues

ecause of its nonprofit status, ACOG is forbidden by law to endorse any political candidate or political party. In all ACOG correspondence or presentations, Fellows and staff must be nonpartisan. However, they may support specific legislation or issues and encourage their senators and representatives to do the same. Please keep the following list in mind when representing ACOG.

- ▶ Do participate in legislative activity
- Do discuss issues, such as the impact of professional liability on the practice of ob-gyn
- Do lobby on a specific legislative proposal or legislation
- ▶ Never participate in political activity
- Never directly or indirectly participate or intervene in any political campaign
- Never endorse or oppose a political candidate or be involved in partisan activity
- ▶ Never write or distribute partisan campaign literature
- Never conduct partisan voter education suggesting a bias for or against a political candidate, such as a forum featuring one candidate
- Never solicit contributions for a Political Action Committee or contribute ACOG money to a PAC
- ▶ Never use ACOG stationery for political activity
- If you are identified as an ACOG representative, keep your remarks related to the ACOG message; do not provide your personal views, even if asked \mathbb{Q}

ACOG disapproves of 'entertainment' ultrasounds

new Committee Opinion from the ACOG Committee on Ethics discourages the use of "entertainment" ultrasounds that are provided to women solely to create keepsake photographs or videos.

Commercial portrait studios have been gaining in popularity throughout the country. The proliferation of the studios led the FDA to reissue its caution earlier this year that using ultrasound equipment for keepsake photos or videos is an unapproved use of a medical device (see cover story, *ACOG Today*, April 2004).

In the Committee Opinion, *Nonmedical Use of Obstetric Ultrasonography*, which was published in the August issue of *Obstetrics & Gynecology*, ACOG endorsed the "prudent use" statement from the American Institute of Ultrasound in Medicine discouraging entertainment ultrasounds. The AIUM statement raises concerns about the unnecessary exposure of the fetus to ultrasound energy.

The AIUM statement says: "The AIUM advocates the responsible use of diagnostic ultrasound. The AIUM strongly discourages the nonmedical use of ultrasound for psychosocial or entertainment purposes. The use of either two-dimensional or three-dimensional ultrasound ... without a medical indication is inappropriate and contrary to responsible medical practice."

Red Alert

Invaluable Red Alert resource updated

COG's Office of Communications has updated *Red Alert—A Resource for Working with the Media*, which helps prepare Fellows for media interviews about the medical liability crisis.

The guide includes:

- ▶ Statistics and background data
- ▶ Basic talking points
- Answers to tough questions a reporter may ask
- ▶ Tips on preparing for interviews and writing letters to the editor
- ▶ Information on how to encourage your patients to support liability reform ♀



▶ Request your free copy: 800-673-8444, ext 2560; communications@acog.org

ACOG adds to AIUM reasons

The Committee on Ethics added two more reasons that entertainment ultrasounds should be discouraged. First, nonmedical ultrasounds may falsely reassure women. Even with disclaimers from the facility, women may incorrectly believe that their entertainment ultrasound is a diagnostic scan and interpret it as evidence of fetal health and appropriate development.

Second, abnormalities may be detected by personnel unprepared to discuss and follow up with the findings. Without prenatal health care professionals, clients obtaining nonmedical ultrasounds may not receive proper support, information, or follow-up care.

"We don't want to give the impression that we think ultrasound is dangerous," says Jeffrey L. Ecker, MD, vice chair of the ACOG Committee on Ethics. "On the other hand, information from an ultrasound can be misused or misinterpreted. Like any medical test, it should be obtained only when there are important questions to answer and when those performing the ultrasound are prepared to interpret results in the appropriate clinical context." \circ

ACOG Today honored with excellence award

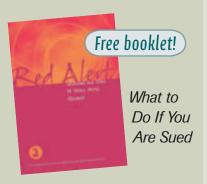


COG Today has been recognized as an exceptional publication with a 2004 APEX Award of Excellence. The publication was saluted for one- to two-person produced newsletters for

issues published in 2003.

Plans are under way at ACOG Today not only to continue its excellence but also to enhance the publication with a new design and other new features. The editorial staff is seeking input from Fellows and Junior Fellows about ACOG Today. Are there issues you want to read about more often? What sections of the newsletter do you like best?

A random sampling of this issue of *ACOG Today* includes a survey about the newsletter. If your copy includes a survey, found at the center of the newsletter, please fill it out and fax it to us at 202-863-5473. You may also email suggestions to Editor Melanie Padgett at mpadgett@acog.org. \$\oint\$



In invaluable Red Alert resource for ob-gyns is the 27-page booklet What to Do If You Are Sued.

What's included in the book?

The booklet has the following sections:

- ▶ Incident Management
- ▶ Settlement
- ▶ Depositions
- ► How to Be an Effective Witness at Trial
- Working with Your Defense Attorney
- ▶ Claims Management
- ▶ Discovery Procedures
- ▶ Trial
- ▶ Post-Verdict

info

Request your free copy: 800-673-8444, ext 2560; communications@acog.org

The information in this article should not be construed as legal advice.
As always, physicians should consult their personal attorney about legal requirements in their jurisdiction and for legal advice on a particular matter.

Facing a lawsuit? What to expect from your attorney



▲ Dr. Fairbrother

on't panic. It may be the first time you've been sued as an ob-gyn, and/or the lawsuit may come as a surprise, but don't panic, says ACOG Fellow Paul F. Fairbrother, MD, a member of the ACOG Committee on Professional Liability.

In his years reviewing ob-gyn claims for the Pennsylvania Medical Society Liability Insurance Company and as a previous chair and member of the society's arbitration panel, Dr. Fairbrother has

seen physicians who have not understood the role of their attorney.

And through it all, he's developed ideas of how ob-gyns should face a lawsuit and what they should expect from their attorneys.

"Have the courage to distance yourself from the lawsuit and look at it dispassionately," he says. "Secure records and never, ever change them in any way, and contact your insurance company."

What your attorney should do for you

After you contact your professional liability insurance company, one of the first things to expect is that a representative from the company and your attorney will want to interview you about the medical case.

Your attorney should go over the case with you, explaining the legal strategy, while, in turn, you explain the medical issues, terms, and procedures to him or her.

You must feel rapport with your attorney and a mutual sense of trust, Dr. Fairbrother says.

"You need to trust the attorney to tell you the truth, and you need to feel you have the attorney's attention," he says.

If you don't feel good rapport nor trust your attorney, you should request a new attorney from the insurance company, Dr. Fairbrother says.

Preparing for a deposition

Depositions are an important part of the discovery process. Attorneys of both parties are present, you are recorded, and you are under oath.

Your attorney should analyze the case and prepare you for deposition just as you would be prepared for trial. You should know the types of questions you'll be asked and how you should respond. This preparation should take place during several meetings with your attorney. You should not meet with your attorney for the first time 30 minutes prior to the deposition, a situation that has occurred in some cases, according to Dr. Fairbrother.

Steps to take before a lawsuit

Before a lawsuit even occurs, ob-gyns should consider the possibility when shopping for professional liability insurance. Study the details of the policy to see what the company will cover if a lawsuit occurs, and ask around to learn which insurance company employs the best attorneys. Call attorneys in the area to find out what an insurance company's reputation among attorneys is.

"You need to know whether your insurance company will fight every case that has merit or if they'll fight for a bottom-line settlement," Dr. Fairbrother says.

If you do face a lawsuit, you're not alone. The number of medical liability claims against physicians has increased steadily in recent years, with ob-gyns facing an average of 2.6 claims in their career. While a lawsuit can be a stressful and unpleasant experience, being prepared and having a strong attorney can help your case immensely. \mathbb{Q}

ACOG promotes women's health at state lawmakers' meeting

COG President Vivian M. Dickerson, MD, called attention to important women's health issues at a gathering of state lawmakers in July. During the National Conference of State

Legislators Annual Meeting in Salt Lake City,

Dr. Dickerson was a featured speaker at the session "Are Women Well? Success Stories for Policy-makers Working to Improve Women's Health."

The session was sponsored by the Women's Legislative Network of NCSL, a bipartsan caucus of women legislators from all 50 states and the District of Columbia.

"We are always seeking opportunities to showcase women's health issues and promote ACOG's legislative priorities with legislators at their annual meeting," said Kathryn Moore, ACOG's director of state legislative and regulatory affairs.

ACOG's ▶ "Stop the Crisis" booth includes information on the medical liability crisis in Utah, the site for the NCSL meeting.



▲ Dr. Dickerson

logic exams, including a pelvic exam, are still crucial for all women 18 and older, she explained.

"There is much work that needs to be done in state legislatures throughout the country to better the life and well-being of women and their babies,"

> Dr. Dickerson said. "ACOG, and our more than 46,000 members, are here to help you."

Sounding the alarm

For the third straight year, ACOG united with other medical organizations to urge state legislators to "stop the crisis," the new theme for the jointly sponsored booth that showcases the devastating effects that skyrocketing medical liability insurance premiums are having on women's health care across the country.

ACOG staff members were able to discuss the need for tort reform with several legislative leaders, including Wyoming Senate Majority Leader Grant Larson (R-District 17), Oklahoma President Pro Tempore Cal Hobson (D-District 16), and Maryland House Speaker Michael Busch (D-District 30).

"The invitation to ACOG's president to speak at an educational forum for leading women legislators helps boost our visibility and credibility with this critical constituency," Ms. Moore said.

Taking care of a woman's health

Dr. Dickerson outlined the findings of the ACOG Gallup survey of female Fellows and Junior Fellows, which was released in December 2003. In the survey, women ob-gyns cited obesity as the leading health problem confronting women today. The respondents were also concerned about menopausal symptoms, stress, depression, smoking, heart disease, and cancer.

Dr. Dickerson discussed the importance of mammograms and cervical and colorectal cancer screening and outlined ACOG's revised guidelines that state that a select group of low-risk women over 30 can receive Pap tests every two to three years instead of every year-but stressed that a Pap test and pelvic exam are not the same thing. Annual gyneco-



"There is much

to be done in

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◆ The ACOG booth showcases many ob-gyns' decision to quit OB.

"It's the women legislators who are sponsoring and voting for key health bills like contraceptive equity and ob-gyn direct access," Ms. Moore continued. "But we urge them now more than ever to vote with us for medical liability reform." ♀

Incoming Junior Fellow district chairs were asked:

What would you most like the Junior Fellows in your district to focus on in the next year?



District I Erica E. Marsh, MD Cambridge, MA emarsh@partners.org

The two issues that I would like District I Junior Fellows to focus on the most are medical student recruitment into ob-gyn and medical liability reform. Both issues are central to sustaining a viable specialty and quality health care for women.



District VI Kristine D. Mytopher, MD Saskatoon, Saskatchewan, Canada kristinem@sasktel.net

We must encourage Junior Fellow participation in ACOG. The more involved we are, the stronger we become as an entire specialty and the more attractive it is for potential students. Despite differences facing Canadian and American ob-gyns, there are also many similarities; I'd like to see us working together more to find unique solutions.



District II Nicholas J. Montalto, MD Syracuse, NY njmontalto@hotmail.com

My goal for District II is legislative activism and medical student recruitment. We are faced with discontent regarding the medical liability insurance crisis and issues of declining reimbursement. Policy-makers need to hear from Junior Fellows; we must be more vigorous and intense than ever before.



District VII Patrick S. Ramsey, MD Vestavia Hills, AL pramsey@uab.edu

As a main area of focus, I would like Junior Fellows to become proactive in seeking solutions and providing mentorship for students interested in our specialty. I'd also like to see an impact assessment of the newly implemented duty-hour restrictions on resident training and patient care.



District III Sindhu Srinivas, MD Philadelphia ssrinivas@obgyn.upenn.edu

In the next year, I look forward to organizing educational and advocacy programs in District III that will help improve patients' access to health care, including encouraging medical students to join our specialty and tackling the medical liability issue.



District VIII Stella M. Dantas, MD Portland, OR maddogcoutu@yahoo.com

I would like District VIII Junior Fellows to focus on ways to improve medical student recruitment. If we demonstrate to students how rewarding our specialty is, we will be meeting important goals of fostering professionalism and dedication to our specialty.



District IV
Meredith B. Loveless, MD
Lutherville, MD
meredithloveless@aol.com

I plan to continue our key contact program and expand the use of the ACOG website to communicate with Junior Fellows. I also aim to double the number of medical schools with ob-gyn interest groups. It is critical that we team together to make medical care a top priority.



District IX Sharon E. Moayeri, MD Los Altos, CA smoayeri@yahoo.com

At times, California's large size can lead to a barrier to cohesiveness between sections. I'd like to focus on improving participation of and communication between the sections. Many sections have demonstrated creativity in recruiting medical students to ob-gyn; my goal is to share new ideas and projects between the sections and districts.



District V
Julie-Ann R. Francis, MD
Burlington, Ontario, Canada
dracog@hotmail.com

I would like to see District V focus on the attraction, retention, and development of high-quality ob-gyns. Getting involved in medical student mentorship initiatives and participating in our fall district meeting on "practical medicine" are two ways for our Junior Fellows to help achieve this goal.



Armed Forces Mardi J. Bishop, MD Shalimar, FL bishopmardi@hotmail.com

In addition to medical student recruitment, I want to create a strong communication network within and among the three military services, help Junior Fellows find leadership in ACOG, prepare them for oral boards, help them find new assignments, and provide them with recent information that may affect them as military ob-gyns. $\[\]$

AMA young physicians address a myriad of issues



By Erin E. Tracy, MD, MPH
Junior Fellow representative to the AMA Young Physicians Section

t its annual meeting in June in Chicago, the American Medical Association Young Physicians Section adopted resolutions on several diverse topics. Resolutions included:

- ▶ Initiating a dialogue with major national restaurant chains about the need for healthier children's menu options
- ▶ Using public service announcements that promote the national health agenda
- Working with specialty societies to identify ways to report unethical testimony and develop common standards for responding to reports of unethical testimony

Women's reproductive health issues

During the annual meeting, the AMA considered several issues important to women's health. The AMA agreed to express concern to President Bush and the Department of Justice regarding the DOJ's issuance of subpoenas attempting to disclose the confidential medical records of women who have had second-trimester abortions. The AMA has a longstanding policy supporting women's privacy regarding pregnancy termination.

The AMA is also seeking the Food and Drug Administration's reconsideration regarding the availability of

over-the-counter emergency contraception. In addition, a policy was adopted supporting improved breastfeeding education in medical curricula and nondiscrimination regarding public breastfeeding.

Medical student outreach

The Medical Student Section hosted its first ever Medical Specialty Showcase. ACOG was one of more than 35 specialty societies that participated. The showcase gave ACOG representatives the opportunity to share the rewards of ob-gyn with hundreds of medical students. Endeavors such as this will help medical students realize what wonderful opportunities are available in obstetrics and gynecology.

Ob-gyns' input

As always, if there are any issues of importance to ACOG Fellows or Junior Fellows, please do not hesitate to contact any of us on the AMA delegation to bring them forward at national AMA meetings. \circ



- ▶ eetracy@partners.org
- ► AMA YPS website: www.ama-assn.org/ama/pub/category/16.html



Canadian ob-gyns focus on future of specialty

By Sony S. Singh, MD, past chair, Junior Member Committee Society of Obstetricians and Gynaecologists of Canada

he Society of Obstetricians and Gynaecologists of Canada held its 60th Annual Clinical Meeting

in June in Edmonton, Alberta. The diamond anniversary was an opportunity to host the largest junior member and medical student turnout at one of our ACMs.

Junior members are future leaders

The Junior Member Committee, which represents all residents, fellows, and medical students across Canada as well as members in their first year of practice, hosted a full junior member program at the ACM.

The meeting was host to the first SOGC-Wyeth Canadian Junior Member Leadership Program, with more than 30 residents supported to attend. The program included sessions on medicolegal issues, women's health advocacy, financial planning, physician well-being, and career planning.

A total of 144 junior members attended the meeting, including 56 medical students. Our medical student initiatives included financial support for more than 40

medical students to attend the ACM, a medical student welcome reception, and an opportunity to attend the full ACM program.

ACOG and **SOGC** working together

As per our tradition, the SOGC once again invited several ACOG leaders to participate in our meeting. ACOG's executive vice president, Ralph W. Hale, MD, was the distinguished Cannell Lecturer, and ACOG President Vivian M. Dickerson, MD, was presented with an honorary membership in SOGC. ACOG's Junior Fellow College Advisory Council chair, Leah A. Kaufman, MD, also attended the meeting, which gave us an opportunity to share ideas and initiatives on issues we have in common. The partnership between ACOG and SOGC continues to benefit the junior members and Junior Fellows on both sides of the border. \circ



- ▶ sony605@rogers.com
- www.sogc.org



▲ Dr. Phelan

ACOG President Vivian M. Dickerson, MD, makes it clear to her patients that she is discussing their weight as a health issue.

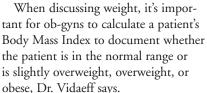
"My comments are not about who they are as a person or what they look like," Dr. Dickerson says. "I also make it clear that our doctor-patient relationship is in no way dependent upon their losing weight."

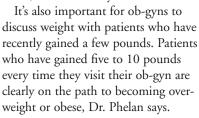


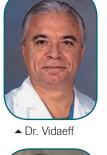
▲ Dr. Dickerson

Screening for overweight and obesity

"Addressing nutrition and overweight issues is part of any individual well-being assessment," says ACOG Fellow Alex C. Vidaeff, MD, associate professor at the University of Texas Houston Medical School. "In ob-gyn, the patient is weighed, just as her temperature and blood pressure are taken. The woman's weight is reported to you at the beginning of the visit. It's an excellent starting point."







▲ Dr. Achong

Discussing overweight and obesity with patients

"I've tried several diets, but they just didn't work," a patient may tell her ob-gyn.

Dieting is seen as a punishment, and it implies deprivation, Dr. Phelan says. Patients need to be encouraged to change their mindset and not think of losing weight as dieting but changing their eating patterns for good.

Instead of dieting, patients should be encouraged to establish realistic goals and timelines and change their eating habits, she says.

Encourage realistic exercise also. If a patient is overweight and never exercises, joining a gym or enrolling in an exercise class can lead to frustration, Dr. Phelan says. Exercise needs to start gradually. Dr. Phelan encourages her patients to begin walking, steadily increasing the distance.

As important as exercise is, exercise alone will not lead to weight loss, says Dr. Vidaeff. Patients should be encouraged to adopt better eating habits and cut back on calories. Ob-gyns can encourage patients to drink skim milk instead of whole milk, choose fresh fruit instead of fruit juices, eat

sliced turkey and baked chicken instead of hot dogs and fried chicken.

Dr. Phelan recommends that her patients have precut carrots or celery ready in the fridge or unbuttered popcorn in the cabinet so they can grab them when they get the munchies.

However simple some of these tips may seem, some patients may never have thought about their food choices.

"A lot of folks just don't know this information unless they were raised in a household that was nutritionally conscious," Dr. Phelan says.

Patients may eat according to the way they were raised: They may have been taught as a child to clean their plates or are accustomed to home cooking with foods rich in butter and oil. Ob-gyns need to be sensitive to a patient's familial, cultural, and ethnic background, Dr. Phelan says.

Referring patients to weight-loss experts

If a patient is interested in starting a weight-loss program, ob-gyns may want to refer her to a weight-loss specialist or nutritionist, Dr. Vidaeff says. Patients may need more counseling or nutrition education than the ob-gyn can provide. However, a patient's ob-gyn is still an important member of the team that is helping her and encouraging her to lose weight, he says.

"Ob-gyns will be part of the support team, but they can't necessarily do it alone," Dr. Vidaeff says.

ACOG Fellow M. Natalie Achong, MD, assistant professor at the University of Connecticut, suggests developing a protocol among your staff on how and whom to refer your patients to when they are seeking weight-loss programs. She recommends adding nutrition counselors, cardiologists, and weight-loss experts to your referral list.

Dr. Dickerson refers her patients to programs such as Weight Watchers but asks them to regularly visit her for "weigh-ins" or pep talks.

"I become a cheerleader in a way and encourage them to set a reasonable weight-loss goal, which we write into their chart," she says. "I answer their questions and screen for underlying problems.

"I am very concerned about the obesity epidemic and know that it is very, very difficult for most patients to lose weight," Dr. Dickerson continues. "I also know that most of them are happy to have a place to discuss the issue dispassionately and in medical terms. They appreciate the support and the encouragement." \circ

Clinical resource for weight issues



The helpful ACOG resource Weight Control: Assessment and Management can assist physicians in addressing overweight and obesity issues with their patients.

Part of the College's quarterly series Clinical Updates in Women's Health Care, the 115-page monograph covers the etiology and pathogenesis of obesity, screening and diagnosis, prevention and counseling, treatment, and follow-up.

info

▶ Order at http://sales.acog.org; 800-762-2264, ext 192

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How new surgery rules affect ob-gyn



▲ Dr. Gluck

ffective July 1, any time ob-gyns conduct a surgical procedure, they must follow new patient safety guidelines.

The new rules are spelled out in the *Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery,* which hospitals and surgical centers must comply with for accreditation by the Joint

Commission on Accreditation of Healthcare Organizations. The guidelines were developed after a summit hosted by

The guidelines were developed after a summit hosted by JCAHO last year that involved leaders from more than 20 medical groups, including ACOG, which has endorsed the universal protocol. (*ACOG Today* will use the term "wrong site" from now on to encompass all three types of errors.)

The protocol allows hospitals to establish how they will enact aspects of the guidelines, and it is incumbent on the ob-gyn to follow the system the hospital has set up, says Paul A. Gluck, MD, chair of the ACOG Committee on Quality Improvement and Patient Safety, a member of the Executive Committee of the National Patient Safety Foundation, and an associate clinical professor of ob-gyn at the University of Miami in Florida.

Preoperative verification process

The protocol outlines three main steps to eliminate wrongsite surgery: conducting a preoperative verification process, marking the operative site, and taking a "timeout" immediately before the procedure.

The preoperative verification process should occur at the time the procedure is scheduled as well as when the patient is admitted, before the patient enters the procedure/surgical room, and any time the care of the patient is transferred to another caregiver. If possible, the patient should be awake, aware, and involved. The protocol suggests that a preoperative verification checklist may be helpful to review relevant documentation, images, and any special equipment.

Marking the operative site

For procedures that involve a distinction between right and left, such as a knee operation, marking the appropriate side is required. This rule does not affect ob-gyns as much as other specialists because many ob-gyn procedures don't have right/left distinction.

Marking is not required by JCAHO—but it's also not prohibited—for procedures without right/left distinction such as a Cesarean delivery, laparotomy, hysteroscopy, or laparoscopy, according to Dr. Gluck.

However, marking would be required for the removal of one ovary—if it is determined with certainty before the operation which ovary is to be removed, Dr. Gluck says.

When marking is required, the mark should be made at or near the incision site with a permanent marker. Nonoperative sites must not be marked. For example, do not write a "no" near the site not to be operated on. The protocol recommends not using adhesive materials, or "sticky notes," and not using an "X" because it's ambiguous.

The protocol recommends that the person who will do the procedure be the one to mark the site. Sites can be marked with a "yes" or the initials of the person doing the procedure. The hospital or clinic should decide on the type of marking to use and use it consistently throughout the facility.

Taking a timeout

Just before starting the procedure, the entire operating team must be present and take a "timeout" to be certain all information is accurate. The timeout may be conducted before or after the patient is anesthetized. The timeout must be documented, such as by a checklist, and must, at least, include:

- ▶ Verification of the patient's identity, correct side and site, and correct patient position
- ▶ Verification of correct implants and any special equipment or requirements
- ▶ Agreement on the procedure to be done

The wrong-site protocol should not be seen as cumbersome regulations, Dr. Gluck says, but a laudable effort to improve patient safety.

"Unfortunately, with all the safeguards that are in hospitals, there are still patients who are exposed to wrong-site, wrong-patient, and wrong-procedure errors," Dr. Gluck says. "It's vitally important that everyone who does invasive procedures do everything they can to ensure this doesn't happen. The JCAHO requirement should be regarded as a constructive change to improve safety—similar to the preflight checklist in an airplane cockpit—and not a burden or a punitive measure." \circ

info

www.jcaho.org/index.htm; click on "Universal Protocol" under the "Top Spots" heading

Gynecologic Cancer Awareness Month in September

eptember marks the fifth annual Gynecologic Cancer Awareness Month, and the Gynecologic Cancer Foundation is once again offering plenty of materials for ob-gyns. Publicity kits, available from GCF at no charge, include answers to commonly asked questions, event planning tips, media outreach ideas, and fact sheets on the types of gynecologic cancers. Also available from GCF are brochures, posters, tent cards, and an ovarian cancer product quide. Q



▶ www.thegcf.org

National Mammography Day: October 15

Month calls attention to mammography screenings

adiologists across the country will again be offering free or discounted mammogram screenings in October in recognition of National Breast Cancer Awareness Month and National Mammography Day on October 15. In 2003, more than 705 facilities accredited by the American College of Radiology took part. ACOG is a cosponsor of National Breast Cancer Awareness Month.

In this year's promotion guide for National Breast Cancer Awareness Month, physicians can learn about ways to promote breast cancer awareness and mammography screening. The guide lists "bright ideas" used by health care facilities such as speaking to the media about breast cancer detection and discussing the importance of mammography screening on a prerecorded telephone message that patients listen to while on hold.

Visit the National Breast Cancer Awareness Month website for the promotion guide (under "Promote NBCAM" heading), patient resources, and information on how to find a facility in your area that is offering free or discounted screenings. \circ



www.nbcam.org/about_mammography.cfm

Flu shots OKd for all pregnant women

Reminder: The CDC updated its flu shot recommendations earlier this year to include all pregnant women. Previously, the CDC recommended that pregnant women be immunized against influenza only if they would be in their second or third trimester during the flu season. A flu vaccine given to a pregnant woman not only protects her but also protects her baby from birth to three to six months, according to Stanley A. Gall, MD, ACOG's representative to CDC's Advisory Committee on Immunization Practices.



▶ www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430a1.htm

More health care workers need flu vaccines

eveloping an influenza vaccine program for your health care staff can protect your patients, reduce staff absenteeism, and save money, according to a new report.

Although the CDC recommends all health care workers—including physicians, nurses, and support staff—receive flu vaccination, data from the National Health Interview Survey show that only 36% of health care workers receive flu shots each year.

The National Foundation for Infectious Diseases convened a panel of experts to address how to increase this rate and recently released a call to action and a report titled *Improving Influenza Vaccination Rates in Health Care Workers: Strategies to Increase Protection for Workers and Patients*.

The report recognizes that many health care organizations conduct flu vaccination programs but says such programs have not increased vaccination rates enough. A comprehensive, concerted effort is needed, and administrators need to make vaccination convenient and affordable for their staff, according to the report.

"It's really important for all health care workers—whether they work in the front office or back office—and all hospital employees to get the influenza vaccine every year," says Stanley A. Gall, MD, ACOG's representative to CDC's Advisory Committee on Immunization Practices.

A flu vaccine will not only protect the individual, it will also limit flu exposure to patients, which is especially important for pregnant women.

"Pregnant women are more susceptible to the serious aspects of influenza," Dr. Gall says. "Whereas a normal person may feel horrible for seven days, a pregnant woman with the flu may have to be hospitalized."

Unvaccinated health care workers can be a key cause of outbreaks in private practices, hospitals, and long-term care facilities, the report says.

Developing an effective vaccination program

Making vaccination convenient—by offering vaccine clinics at different times or taking the vaccine to the employees—appears to be the most effective strategy, the report says. However, multiple interventions are needed to build a successful vaccination program.

"It's important that an office has somebody who's going to be leading this," Dr. Gall says. "Everybody has to buy into the program."

The report lists several strategies, such as:

- Selecting a leader to administer the flu immunization program
- ▶ Receiving commitment from top management
- Using numerous, diverse avenues to get the message across
- ▶ Providing education and reeducation to personnel on the importance of vaccination for staff and the patients they'll be interacting with
- ▶ Removing cost barriers
- ▶ Auditing programs and providing feedback to key personnel ♀

info

- ▶ Report and call to action: www.nfid.org
- CDC recommendations: Click on "vaccination" at www.cdc.gov/flu
- Vaccination programs and materials: www.cdc.gov/nip

Incorporating teen health care into your practice

ave you considered specializing in adolescent ob-gyn care or tailoring part of your practice specifically to teens? The ACOG Committee on Adolescent Health Care is encouraging Fellows to consider adding more adolescent health care to their practice.

"We need more Fellows to start seeing adolescent patients," says S. Paige Hertweck, MD, the committee's immediate past chair. "There are not enough pediatric and adolescent gynecologists to go around, so it's very likely that adolescents in a Fellow's community are not getting care."



▲ Dr. Hertweck

Teenage girls are often anxious about their first gynecologic visit and apprehensive about their first pelvic exam. They may only be visiting your office because their mother brought them in or they're concerned about a specific health issue. By adopting an adolescent-friendly atmosphere, you can put teens at ease quicker and encourage them to schedule regular gynecologic visits.

Introducing reproductive health care early

ACOG recommends that a teen's first visit to the gynecologist occur between ages 13 and 15 to allow for health guidance, screening, and provision of preventive services. The first visit does not need to include a pelvic exam. However, if an adolescent is sexually active, screening for STDs is appropriate, and the patient should have her first Pap test approximately three years after first intercourse but no later than age 21.

Dr. Hertweck, who sees exclusively pediatric and adolescent patients in her university-based practice in Louisville, KY, says taking care of teens' gynecologic health care is not just about sexuality. According to Dr. Hertweck, gynecologists should be educating girls on issues such as what to expect from their menstrual cycle and how to handle menstrual pain and should be screening patients for depression, eating disorders, and STDs.

It may take more time to educate teen patients than it takes for adults.

"So many women are really uneducated about their bodies," Dr. Hertweck says. "I think it's important to take the time to teach teens about their bodies, instruct them about their anatomy, and inform them about normal gynecologic function in order to empower them to better care for their reproductive health."

Creating a teen-friendly atmosphere

To attract adolescent patients to your practice, Fellows should create an atmosphere that will be comforting and friendly to teens.

You may need to schedule frequent visits initially so the teen patient becomes familiar and comfortable with you.

Keep in mind that an adult-friendly atmosphere may not be a teen-friendly atmosphere. For example, nonpregnant teens may be uncomfortable sitting in a reception area full of pregnant women. You may want to consider dedicating special time slots only to teen patients.



▲ Dr. Laufer

Display adolescent-specific patient education materials, such as posters and brochures. Have appropriate equipment on hand, such as a narrow-blade speculum, and teaching models, such as a three-dimensional pelvic model, contraceptive use model, or breast examination model.

"I think it's very important for gynecologists to provide care to teens where they can feel secure," says Marc R. Laufer,

MD, chair of the ACOG Committee on Adolescent Health Care and chief of gynecology at Children's Hospital Boston.

"There are many problems that affect an adult woman's life that start during the teen years," Dr. Laufer continues. "If we can diagnose and treat these problems as a teen we can help her to lead a healthy life." φ



- ▶ On the ACOG members-access website, www.acog.org, click on "Adolescent Health Care" on the right side of the page
- ▶ www.naspag.org
- ▶ www.youngwomenshealth.org
- ▶ Confidentiality laws: The Alan Guttmacher Institute updates state laws on sexual and reproductive health and rights each month at www.agi-usa.org/statecenter/spib.html

ACOG tool kit: everything you need to treat adolescent patients

o help ob-gyns best serve adolescent patients, ACOG has produced the *Tool Kit for Teen Care*, which includes information on communicating with, assessing, and treating adolescent patients.

The tool kit includes:

- ▶ Tools for making the office adolescentfriendly
- ▶ Adolescent assessment tools, such as laminated sheets detailing the stages of pubertal development, a blood pressure chart, and a BMI chart
- ► Forms such as a visit record and a questionnaire
 - CPT coding information, including a laminated billing sheet for staff and a

monograph providing scenarios of adolescent patient visits and the appropriate way to code for reimbursement

- ▶ Facts sheets on topics pertinent to teens
- ► ACOG Patient Education Pamphlets from the *Especially for Teens* series
- "Primary and Preventive Health Care for Female Adolescents" and "Confidentiality in Adolescent Health Care," two chapters in ACOG's Health Care for Adolescents



▶ Order at http://sales.acog.org; 800-762-2264, ext 192

Revised diagnostic codes take effect in October

new abridged coding book will be available in a few months from ACOG that includes the new and revised ICD-9-CM codes published every October.

On October 1, several new and expanded diagnostic codes will take effect. ACOG's Committee on Coding and Nomenclature requested the codes outlined below to better serve ACOG Fellows.

For each of the last 10 years the committee has published *ICD-9-CM Diagnostic Coding in Ob/Gyn*. However, to better assist Fellows with appropriate diagnostic reporting, the College has developed a new publication, *ICD-9-CM Abridged*, which will take the place of *ICD-9-CM Diagnostic Coding in Ob/Gyn*.

The format of *ICD-9-CM Abridged* better resembles that of the complete ICD-9-CM book and includes more codes than the previous version. It will serve as a pocket-sized listing of the most common

diagnostic codes used by ob-gyns. *ACOG Today* will keep you posted on the publication of this new book, due out at the end of the year.

Check with payers for effective dates

Although Medicare recognizes the new and expanded ICD-9-CM codes on October 1, other third-party payers may decide not to use the codes until January 2005. Physicians should check with their third-party payers to see when they will begin accepting the new codes.



- ▶ Savonne Alford: salford@acog.org; 800-673-8444, ext 1459
- Click on Coding and Nomenclature on the right side of the ACOG members-access website

Cervical dysplasia and gynecologic examinations

Two sets of codes are of particular interest to Fellows: cervical dysplasia and gynecologic examinations.

The code for cervical dysplasia (622.1) will be expanded to enable coding for:

- ▶ Unspecified dysplasia (622.10) → Moderate dysplasia (CIN II) (622.12)
- ▶ Mild dysplasia (CIN I) (622.11)

Severe dysplasia (CIN III) will still be coded as 233.1. These codes should be used only when there is histologic confirmation (i.e., from biopsy tissue) and should not be used for abnormal findings from a Pap smear only.

The code for gynecologic exams (V72.3) will be expanded to enable coding for:

- ▶ Routine gynecological examination with or without Pap cervical smear (pelvic examination, annual or periodic) (V72.31)
- ▶ Encounters for Pap cervical smear to confirm findings of recent normal smear following initial abnormal smear (V72.32)

A note following code V72.31 instructs coders to use code V76.47 in addition to identify a routine vaginal Pap smear.

Pap smears

The code for nonspecific abnormal Pap smear of cervix (795.0) will be expanded to more accurately reflect the terminology used in the revised Bethesda system, including low- and high-grade squamous intraepithelial lesions (LGSIL and HGSIL) and a positive HPV test.

New codes will specify:

- ▶ LGSIL (795.03)
- ▶ HGSIL (795.04)
- ▶ Cervical high-risk HPV DNA test positive (795.05)
- ▶ Unsatisfactory smear (795.08)
- Cervical low-risk HPV DNA test positive (795.09)
 When CIN or dysplasia is diagnosed from a Pap smear test only (without histologic confirmation), use codes from the 795.0 series.

Prolapse of vaginal walls

The code for prolapse of vaginal walls without mention of uterine prolapse (618.0) will be expanded into subcategories to enable coding for:

- ▶ Unspecified prolapse of vaginal walls (618.00)
- ▶ Cystocele, midline (618.01)
- ▶ Cystocele, lateral (paravaginal) (618.02)
- ▶ Urethrocele (618.03)
- ▶ Rectocele (protocele) (618.04)
- ▶ Perineocele (618.05)
- ▶ Other prolapse of vaginal walls without mention of uterine prolapse (cystourethrocele) (618.09)

Other specified genital prolapse

The code for other specified genital prolapse (618.8) will be expanded to include:

- ▶ Incompetence or weakening of pubocervical tissue (618.81)
- ▶ Incompetence or weakening of rectovaginal tissue (618.82)
- ▶ Pelvic muscle wasting (disuse atrophy of pelvic muscles and anal sphincter) (618.83)
- ▶ Other specified genital prolapse (618.89)

Endometrial hyperplasia

The code for endometrial hyperplasia (621.3) will be expanded to enable coding for:

- ▶ Unspecified endometrial hyperplasia (621.30)
- ▶ Simple endometrial hyperplasia without atypia (621.31)
- ▶ Complex endometrial hyperplasia without atypia (621.32)
- ▶ Endometrial hyperplasia with atypia (621.33)

Female genital mutilation

A new subcategory code for female genital mutilation status (629.2) will be created to allow coding for:

- ▶ Unspecified female genital mutilation status (629.20)
- ▶ Female genital mutilation type I status (clitorectomy) (629.21)
- ▶ Female genital mutilation type II status (clitorectomy with excision of labia minora) (629.22)
- ▶ Female genital mutilation type III status (infibulation) (629.23)

Pregnancy examination

The code for a pregnancy examination or test (V72.4) will expand to differentiate among:

- ▶ Pregnancy examination or test in a pregnancy not yet confirmed (V72.40)
- ▶ Pregnancy examination or test with negative results (V72.41)

Genetic diagnoses

To capture genetic diagnoses, a new category for genetic susceptibility to disease (V84) will be created. This category will include a subcategory to allow coding for genetic susceptibility to malignant neoplasms (V84.0).

New codes are:

- ▶ Genetic susceptibility to malignant neoplasm of breast (V84.01)
- ▶ Genetic susceptibility to malignant neoplasm of ovary (V84.02)
- ► Genetic susceptibility to malignant neoplasm of endometrium (V84.04)
- ▶ Genetic susceptibility to other malignant neoplasm (V84.09)
- ▶ Genetic susceptibility to other disease (V84.8) ♀

Smoking Partnership continued from page 1

"ACOG Fellows can become involved at the local level by leading or participating in smoking cessation training—using free ACOG slide lectures and handouts—and by encouraging tobacco- and smoke-free legislation."

State partnerships expand

In other collaborative efforts to further clinician involvement in smoking cessation, state teams developed by ACOG continue to train health care providers, educate legislators, and coordinate services for women. Recently, in partnership with the Association of Maternal and Child Health Programs and the Planned Parenthood Federation of America, five additional state-level women's tobacco cessation partnerships were formed. The latest partnerships were funded through the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation. \circ



www.helppregnantsmokersquit.org

Smoking Cessation Resources

ACOG has two self-study educational programs for Fellows to learn how to streamline office systems and patient visits to include tobacco screening and treatment.

- ▶ The College developed a training manual on how to implement the 5 "A"s method. The manual, Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking, includes photocopy-ready office tools, a quick reference card on how to ask about smoking status, case studies, and a patient education workbook.
 - Order free copies at smoking@acog.org. To complement the manual, a slide lecture is available at www.acog.org/goto/smoking
- ▶ The virtual practicum and interactive CD-ROM, *Smoking Cessation for Pregnancy and Beyond, Learn Proven Strategies to Help Your Patients Quit,* combines visual, audio, text, experiential, and documentary elements on how to promote smoking cessation in your clinic setting. The program, hosted by ACOG Fellow Sharon T. Phelan, MD, and developed by Dartmouth Interactive Media Laboratory, offers up to five CME credits.

Download a free copy at www.helppregnantsmokersquit.org/care/learn.asp or purchase a CD-ROM version at http://sales.acog.org; 800-762-2264, ext 192

More resources

- ▶ Patient cessation workbook: Need Help Putting out the Cigarette? Order at http://sales.acog.org; 800-762-2264, ext 192
- ▶ ACOG Patient Education Pamphlet: *It's Time to Quit Smoking* (AP065) Order at http://sales.acog.org; 800-762-2264, ext 192
- ▶ ACOG Educational Bulletin: Smoking Cessation During Pregnancy, September 2000 (#260) Published in ACOG's 2004 Compendium or find by doing an "advanced search" on the members-access section of the ACOG website: www.acog.org

Board emphasizes teens in revised tobacco statement

obacco companies must stop aiming their advertisements at adolescent girls, the ACOG Executive Board asserted at its July meeting.

The board revised its
Statement of Policy on tobacco
advertising to oppose the targeting of women of all ages, not
just adults. The original statement was approved in 1990
and reaffirmed in 2000. The
revised statement follows.

Tobacco Advertising Aimed at Women and Adolescents

The American College of Obstetricians and Gynecologists opposes the unconscionable targeting of women of all ages by the tobacco industry.

The health risks of tobacco use to women are well documented. It also is well known that smoking by a pregnant woman may be harmful to her fetus. It is unnecessary to catalogue all of these risks here. Because of these well-known dangers, it is irresponsible for tobacco companies to single out women, especially those who are young, educationally or otherwise disadvantaged women, and encourage them to smoke.

Specifically, tobacco companies must stop targeting their advertising to encourage adolescent women to smoke cigarettes. The health of all women and future generations demands that consideration. Q

Surgeon general report focuses on health consequences of smoking

"We've known for decades that smoking is bad for your health, but this report shows that it's even worse than we knew."

> -Richard H. Carmona, MD, MPH, US Surgeon General

he list of diseases linked to smoking has been expanded in a report from US Surgeon General Richard H. Carmona, MD, MPH.

Forty years after the surgeon general's first report on smoking, Dr. Carmona released *The Health Consequences of Smoking: A Report of the Surgeon General,* which adds cervical cancer to the list of diseases linked to smoking. Also added were acute myeloid leukemia, cataracts, abdominal aortic aneurysm, periodontitis, pneumonia, and cancers of the kidney, pancreas, and stomach. The report was released in May, days before World No Tobacco Day on May 31.

The 960-page report is available on the surgeon general's website, along with a patient booklet, What the Surgeon General's Report Means to You; a searchable database of more than 1,600 articles cited in the report; and 11 fact sheets, including those on the effects of smoking on fetuses and on reproductive health. Q



Letters to the editor

would like to make a few comments about your article titled "Prenatal ultrasound portrait studios find market niche" [ACOG Today, April 2004]. I think it is fair to say that the main opinion expressed in the article was that these commercial ultrasound studios were bad and that we should be discouraged from referring our patients to them. May I express a different point of view?

Contrary to what critics are saying of these studios, they do offer very professional scans by well-trained technicians. A limited report is generated for the referring health care provider, and no scan is done unless it is confirmed that there is a health care provider who could be contacted if any problem were to be found. The patient pays for this 3-D/4-D experience, not the health care system.

In 1994, I founded Fetal Fotos in Salt Lake City, later selling the business, but I continue to serve as the studio's medical director while practicing ob-gyn full time.

In over 10 years and 50,000 scans done at Fetal Fotos locations, fetuses' lives have been saved and information was given to the health care provider that improved the outcome of the pregnancy. There is no evidence of harm done to a pregnancy in over 50,000 experiences at Fetal Fotos locations. I'm afraid I can't say the same for every referral I have made to a perinatologist, yet they are still invaluable to my practice.

May I submit that well-supervised commercial ultrasound studios do fill a very important role and their use should not be discouraged but encouraged if a patient feels she could benefit from that experience. These scans never have, nor ever will, replace the medically indicated scans we perform daily in our offices. They can, however, serve to augment a pregnancy experience without increasing national health care dollars and with no proven harmful effects.

Leon W. Hansen, MD, FACOG, Sandy, UT

any of us have been personally affected by the skyrocketing costs of medical liability insurance. We can all tell personal stories of the impact this crisis is having on our practice. Please allow me to share one tragedy with you and to tell you what's happened to women in Athens, GA.

It is with great sadness that I announce that my good friend and colleague, Dr. Cynthia A. Mercer, is abandoning the practice of obstetrics. Dr. Mercer and her group of board-certified ob-gyns, Drs. Margaret K. Cramer, J. Leon Smith, Robert E. Kelley Jr, Cary C. Perry, Gregory D. Perry, and Melissa M. Halbach, were unable to obtain satisfactory levels of medical liability insurance coverage for OB at a reasonable cost.

This is an outstanding group of physicians who have an important practice in Athens, GA. Dr. Mercer is past Georgia Section chair, and Dr. Halbach is immediate past District IV Junior Fellow chair. Both of them served as chief residents at Emory University.

This issue arose because one physician in the group settled an obstetric case, and, as a consequence, this physician became uninsurable. The case in question was the physician's first and only medical liability case in 12 years of practice.

The members of the group had to make a painful decision. They could continue OB, paying a very high premium for inadequate coverage, or they could quit OB altogether. They decided to quit OB, and the women in the Athens area lost one-fourth of their OB providers.

This unfortunate example reminds us again why we must increase our efforts to change the status quo as far as medical liability insurance is concerned. The survival of our specialty hangs in the balance. Our ability to care for our patients is at risk. I urge you to become involved in your state's efforts to achieve tort reform. Share your concerns with your patients. Athens, GA, could happen to any of us.

Ramon A. Suarez, MD, District IV chair 9

in memoriam

- ▶ Walter S. Bousa, MD Fairfield. CT
- ▶ Bernard R. Hall, MD Logansport, IN
- ► Sherman A. **Karpen,** MD Las Vegas 1/04
- ▶ Richard I. C. Muckerman, MD St Louis
- ➤ Tommy Lee **Neel**, MD Carrollton, TX 5/04
- ► Edward C. Rainey II, MD Hopewell Jct, NY
- ▶ Laurence M. Scheininger, MD Venice. FL • 5/04
- ➤ Zachary **Wohl,** MD New Orleans • 3/04

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Early developer of birth control pill dies



elso-Ramon Garcia, MD, 82, of Merion Station, PA, died February 1. He was Emeritus William Shippen Jr. Professor of Human Reproduction at the University of Pennsylvania.

Dr. Garcia had an enormous social impact as one of the developers of the oral contraceptive pill. His seminal work on the development of the oral contraceptive was published in multiple journals and most notably in three *Science* manuscripts, which formed the foundation of the applied field of hormonal contraception.

Dr. Garcia came to the University of Pennsylvania in 1965 to head the program in human reproduction. He helped build the foundations of the Human Reproduction

Program at the university, pioneering innovative surgical, microsurgical, and endoscopic techniques for the treatment of female infertility.

Dr. Garcia established one of the first training programs in human reproduction in the world, and he instilled in his trainees and colleagues the philosophy that good clinical practice should always be based on sound scientific principles and basic or clinical experimental evidence.

In 1995, the University of Pennsylvania School of Medicine established the Celso-Ramon Garcia Endowed Professorship, and in 2000, the United Nations honored Dr. Garcia with the Scientific Leadership Award in recognition of his efforts in the development of the first oral contraceptive in the 1950s and '60s and of his innovative holistic programs and surgical interventions in women's health. \circ

2004 calendar

Please contact individual organizations for additional information.

september

ACOG Webcast: Internal Financial Controls to Protect Your Practice

7 1–2:30 pm ET 202-863-2498

AGOS: Amer Gyn-Ob Soc 9-11

Bolton Landing, NY 202-863-1647

ACOG District VI Fellows

17-19

Salt Lake City 202-863-2540

ACOG District VIII

17-19

Salt Lake City 202-863-2540

ACOG District IX

17-19

Salt Lake City 202-863-2540

ACOG District V Junior Fellows

17-19

Columbus, OH 216-778-7731

Soc of Laparoendoscopic Surgeons

29-0ct 2

New York City 800-446-2659 www.sls.org

ACOG District III

29-Oct 1

Atlantic City, NJ 202-863-2540

ACOG District I

30-Oct 3

Kennebunkport, ME 207-622-3374

(october)

ACOG Webcast: Financial Statement Analysis for a Medical Practice

5 1–2:30 pm ET 202-863-2498

NAMS: N Amer Menopause Soc

6-9

Washington, DC 440-442-7550 www.menopause.org

ACOG District VII

9-11

Washington, DC 202-863-2540

CAOG: Central Assn of Ob-Gyns

13-16

Washington, DC 202-863-1648 www.caog.org

ASRM: Amer Soc for Reproductive Medicine

. 16–20

Philadelphia 205-978-5000 www.asrm.org

ACOG Armed Forces District

17-20

San Diego 202-863-2540

ACOG District IV

22-24

Savannah, GA 202-863-2540

ACOG District II

29-31

New York City 518-786-1529

october)

ACOG District V Fellows

31-Nov 4

Kohala Coast, HI 202-863-2540

november

ACOG Webcast: Breast Management and Medical Liability Risk Reduction

2 1–2:30 pm, ET 202-863-2498

FIGO-IFFS Joint Conference on Recent Progress in Reproductive Medicine

5-6

Barcelona, Spain www.pacifico-meetings.com/ figo-iffs2004

Global Congress of Gynecologic Endoscopy

10-13

San Francisco Sponsored by American Association of Gynecologic Laparoscopists www.aagl.com

American Society of Cytopathology's 52nd Annual Scientific Meeting

13–17

Chicago www.cytopathology.org

december

ACOG Webcast: Physician-Patient Communications: Reducing Medical Liability Risks

7 1–2:30 pm, ET 202–863–2498

ACOG Postgraduate Courses

Two ways to register:

- 1 Call 800-673-8444, ext 2540/2541, or 202-863-2540/2541, weekdays 9 am-4:45 pm ET
- **2** Go to www.acog.org and click on "Postgraduate Courses" under "Meetings and Events"

Registration must be received one week before the course. Onsite registration subject to availability.

September

Controversies in Obstetrics

9-11 • Tucson, AZ

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

9-11 • Chicago

Medical Liability Litigation: Gaining Perspective and Control

10-12 • Washington, DC

CPT and ICD-9-CM C 501D OURShop 10-12 • New Orleans

October

CPT and ICD-9-CM C SOLD orkshop

1-3 • Atlanta

November

Practice Management Update for the Ob-Gyn

5-7 • Washington, DC

The Mature Woman: From Perimenopause to the Elderly Years

11-13 • Boca Raton, FL

Obstetrics Update: Emergencies

18-20 • Las Vegas

CPT and **ICD-9-CM** Coding Workshop

19-21 • San Francisco

"No Frills" Urogynecology

20-21 Chicago

December

Gynecology Update

1-4 • New York City

connect to ACOG

Address changes:

800-673-8444, ext 2427, or 202-863-2427 fax 202-479-0054

email membership@acog.org **Website:** www.acog.org

Main phone line: 800-673-8444 or 202-638-5577

Resource Center: 202-863-2518

toll-free for members only: 800-410-ACOG (2264)

Order publications: online at sales.acog.org or call 800-762-ACOG (2264), ext 192, or 304-725-8410, ext 339

ACOG Today

Executive Vice President

Ralph W. Hale, MD, FACOG

Director, CommunicationsPenelope Murphy, MS

Editor

Melanie Padgett

Contributors

Savonne Alford Amanda Hall Susan Klein, MBA

Design and Production

Marcotte Wagner Communications

Send letters to:

Melanie Padgett, editor *ACOG Today* PO Box 96920 Washington, DC 20090-6920

fax 202-863-5473 email mpadgett@acog.org Letters may be edited for length.

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ACOG award nominations sought

Outstanding District Service Award

It's time to honor Fellows for their unwavering service to their districts. ACOG is seeking nominations from each district for the Outstanding District Service Award.

Forward your nomination to one of your section or district officers before your Annual District Meeting this fall. Individual district advisory councils will discuss nominations at the fall district meetings and submit nominations to ACOG.

Nominees must:

- ▶ Be a Fellow who has made a significant contribution within the district, in government, research, teaching, or patient care
- ► Have provided service to the district sufficient to receive national ACOG recognition

Wyeth Pharmaceuticals Section Award

Section chairs are asked to consider exceptional section projects for nomination for the 2004 Wyeth Pharmaceuticals Section Award. Section chairs can select one outstanding activity conducted within the section during 2004 and submit a report of that activity to their district chair. All reports are due to the district chair before the district's fall Advisory Council Meeting. The Advisory Council, in turn, submits its nomination to ACOG.



District and Wyeth awards:

▶ Click on the Districts and Sections link on the right side of the members-access section of the ACOG website, www.acog.org, or contact Marlena Wyandt: 800-673-8444, ext 2332; mwyandt@acog.org

Distinguished Service Award and Honorary Fellowship:

► Terrie Gibson: 800-673-8444, ext 2515; tgibson@acog.org

Distinguished Service Award and Honorary Fellowship

ACOG is seeking nominations for the College's Distinguished Service Awards and Honorary Fellowships to be presented in 2006.

Send a recommendation letter and the nominee's CV to Terrie Gibson in ACOG's Office of the Executive Vice President by Feb 1, 2005. Nominations will be considered by the ACOG Committee on Honors and Recognitions at its May 2005 meeting.

Criteria for the Distinguished Service Award

- ▶ Must be an outstanding individual in ob-gyn who has made important contributions within the College or in government, research, training, or direct patient care
- May include individuals in maternal and child health
- ▶ Should be an individual living within the geographic confines of the College
- May be any person who has made an outstanding contribution to the College and/or the discipline of ob-gyn

Criteria for Honorary Fellowship

- ▶ Must have made an outstanding achievement in ob-gyn or an allied discipline in any country
- Must have obtained national and international recognition (achieved distinction and recognized for a leadership position by being elected president or a senior officer of a national or international ob-gyn society or organization)
- ▶ May be an editor of a major international ob-gyn journal
- ▶ May be involved in international public service (may have achieved major leadership in international organizations that relate to ob-gyn)
- ▶ May be a non-ob-gyn who has distinguished himself or herself internationally in an area that affects women's health and the specialty
- ▶ Should have a relationship with US activities involving women's health care ♀



The American College of Obstetricians and Gynecologists

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ACOG research grant applications

Due October 1

pplications for ACOG research fellowships and awards are due October 1.

Awards are available in many women's health areas, including:

- ▶ Menopause
- ▶ Ultrasound
- ▶ Contraception
- ▶ Cervical cancer prevention
- ▶ Gynecologic infections
- ▶ Health policy

Applicants must be ACOG Fellows or Junior Fellows. 9

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- ▶ ACOG members-access website, www.acog.org; under "Educational Services" on the right side, click on "Research Fellowships and Awards"
- ► Lee Cummings: 800-673-8444, ext 2577; lcummings@acog.org

Call for abstracts for heart disease conference

he Second International Conference on Women, Heart Disease, and Stroke is seeking abstracts for the meeting, which will be held Feb 16–19, 2005, in Orlando, FL.

The submission deadline is October 1. Clinical, public policy, and public health/advocacy abstracts may be submitted under several categories. The meeting is jointly sponsored by the American Heart Association, Centers for Disease Control and Prevention, American College of Cardiology Foundation, World Heart Federation, Heart and Stroke Foundation of Canada, and National Heart, Lung, and Blood Institute. Q

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► For a list of all categories and submission requirements, visit www.americanheart.org/presenter. jhtml?identifier=3022283