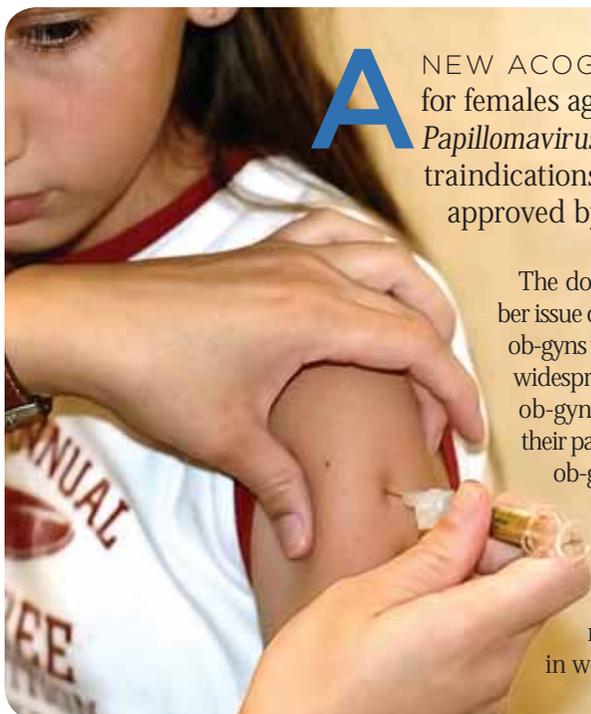


## ACOG releases HPV vaccine recommendations



**A** NEW ACOG COMMITTEE OPINION OUTLINES RECOMMENDATIONS for females ages nine to 26 for the breakthrough HPV vaccine Gardasil. *Human Papillomavirus Vaccination* addresses proper administration, precautions, and contraindications for the vaccine, which is manufactured by Merck and Co. and was approved by the US Food and Drug Administration in June.

The document, published in the September issue of *Obstetrics & Gynecology*, states that ob-gyns will play a critical role in the vaccine's widespread use in girls and women and that ob-gyns should discuss vaccination with their patients younger than 26. Additionally, ob-gyns should stress the importance of continued cervical cytology screening regardless of vaccination status.

"The approval of this vaccine represents a significant development in women's health and the fight against

cancer," said ACOG President Douglas W. Laube, MD, MEd. "Obstetrician-gynecologists should be proactive in educating our patients about the vaccine so that as many women as possible are able to take advantage of this medical milestone. We must be prepared both to administer the vaccine and to answer patient and parent questions that will arise."

### Continued Pap testing important

Given in a series of three shots over six months, Gardasil protects against HPV types 6, 11, 16, and 18, which are responsible for **►PAGE 13**

## After a break from practice, returning not easy

**O**B-GYNS WHO LEAVE CLINICAL practice for a year or more have a mountain to climb to start practicing again.

"There are significant obstacles," said Minnesota Fellow Laura A. Dean, MD, a member of a new ACOG task force examining reentry to practice. "There's no established mechanism—every state, every hospital, has its own rules."

### One ob-gyn's mountain climb

Fellow H. Ascher Sellner, MD, knows about such obstacles firsthand. He closed his solo practice in

Connecticut for health reasons in 2002 and had a liver transplant in 2003.

"By March 2005 I was anxious to get back to work," he said.

Although Dr. Sellner had 30 years of practice experience and was board certified, he faced the twin hurdles of what he calls "cases and coverage": recent experience and being able to obtain liability insurance.

Dr. Sellner decided to work locum tenens, but found only two locum tenens staffing companies (of eight he contacted) that had liability carriers that would cover him. These two companies **►PAGE 10**





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EXECUTIVE DESK

# ACOG loses dedicated advocate for the specialty and for women

IT'S WITH SADNESS THAT I ANNOUNCE that Past ACOG President John M. Gibbons Jr, MD, died on July 22. John was the 54th president of ACOG, serving in 2003–04. It is a great loss when one of our past presidents dies, as they have given much of their life and energy to ACOG. In the obituary on page 3, you will find an extensive list of John's activities and positions, all of which he did exceedingly well. But what I want to emphasize is John as a person.

As the executive vice president of ACOG, I spend a lot of time with the president, first when the Fellow serves as president elect, then president, and, finally, as immediate past president. We travel together, make presentations together, communicate almost daily, and discuss in depth the problems facing our members, our specialty, and medicine in general. I have a unique opportunity to get to know these great men and women and their families. John was truly one of the greatest.

John had many unique characteristics. He was charismatic and could get along well in any situation. He had a great sense of humor that often surfaced when most needed, and he was extremely intelligent and well read. John had the ability to foresee future changes and to understand the direction that ACOG must take—as evident by his push for medical student interest groups and for active recruitment while others

were only lamenting the decrease in students entering ob-gyn training programs.

John could understand sensitive patient care issues and see both sides, replacing contention with consensus. But there was another side that only his closest friends could see: John felt deeply about his patients and the women who needed help. He became interested in vulvodynia because he saw women who felt hopeless and were passed from physician to physician. He felt strongly that the ob-gyn should and must be the advocate for these women or any other woman with problems that were not easy to understand or cure. John cared deeply for all the problems facing women

today and became their advocate internally at ACOG, as well as in public.

John became more than an officer of the College; he became a close friend. He will be missed by all of ACOG

and especially by me. His staunch support and wise counsel were key factors in my activities in ACOG. His early death was unexpected, and my heartfelt wishes of condolence go out to his exceptional wife, Mary, a wonderful supporter of John and his life.™



*John could understand sensitive patient care issues and see both sides, replacing contention with consensus.*

*Ralph W. Hale MD*

**Ralph W. Hale, MD, FACOG**  
Executive Vice President

IN MEMORIAM

**Alfred John Bosche Jr, MD**  
St. Louis, MO • 7/06

**E. Eugene Hunner, MD**  
El Dorado Hills, CA • 5/06

**Sergey G. Krutilin, MD**  
Visalia, CA • 12/05

Obstetrics & Gynecology HIGHLIGHTS



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

*Human Papillomavirus Vaccination*  
(Committee Opinion #344, new)

For more information, see article on page 1.

## Past President Dr. John Gibbons dies

**P**AST ACOG PRESIDENT JOHN M. Gibbons Jr, MD, died on July 22 from cancer at the age of 73. Dr. Gibbons was the 54th president of ACOG, serving in 2003–04. He was a senior attending ob-gyn at the Saint Francis Hospital and Medical Center in Hartford, CT, and an ob-gyn professor at the University of Connecticut School of Medicine. He also maintained a private ob-gyn practice and continued seeing patients up until his death.

Dr. Gibbons was known in the Hartford community as a pioneer in maternal-fetal medicine—becoming the first physician in the area to become board certified in maternal-

fetal medicine—and an innovator in handling high-risk obstetrics. He joined the Saint Francis Hospital and Medical Center staff in 1970 as the first full-time chair of ob-gyn, serving for more than 20 years, and later became the hospital's senior vice president for medical affairs and special assistant to the president. He served on the hospital board for almost 20 years, and his longtime support of the hospital was recognized in 1996 when the new labor and delivery suite was named the John M. Gibbons Pavilion.

Dr. Gibbons served as ACOG's treasurer as well as chair and treasurer of District I, chair of the Council of District Chairs, and chair of the Connecticut Section. He chaired the Committee on Technical Bulletins-Gynecology and served on the committees on Nominations, Finance, Government Relations, Continuing Medical Education, Credentials, and Honors and Recognitions. He also served on the Task Force on Violence, the Task Force on Expert Witness Testimony, and on two different task forces on abortion. He chaired the Finance Subcommittee for Development and the District and Section Financial Services Oversight Committee. He received the Outstanding District Service Award for District I in 1999.

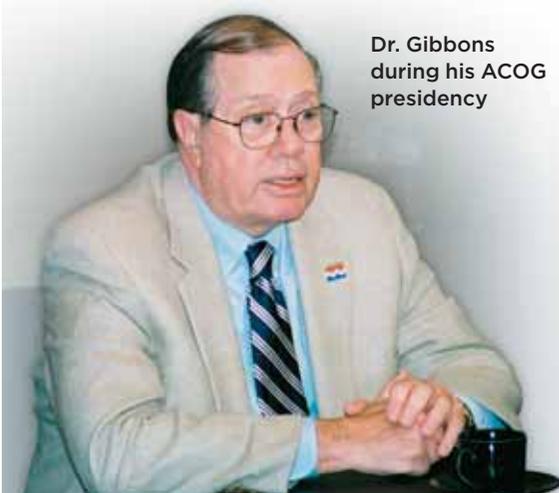
Dr. Gibbons recognized the importance of

medical student recruitment and mentoring of young physicians to ensure the future strength of the specialty, and the College honored his efforts by naming a medical student award after him.

Dr. Gibbons also represented the specialty as a member of the Advisory Council of the National Institute of Child Health and Human Development, and he was a member of several medical organizations, including the American College of Surgeons, Society for Maternal-Fetal Medicine, and Boston Obstetrical Society. He served as president of the Hartford County Medical Association from 1990 to 1991 and chair of the Connecticut State Medical Society's Section of Obstetrics and Gynecology from 1982 to 1985.

Dr. Gibbons received his MD from Georgetown University in Washington, DC, and completed his internship and residency at St. Vincent's Hospital in New York City.

"Dr. Gibbons was a passionate crusader for improving women's health care, spearheading programs to attract young physicians to our field, and serving as a role model for involvement in the legislative and political process to improve conditions for the women we serve," said ACOG Immediate Past President Michael T. Mennuti, MD. "He will be deeply missed."™



Dr. Gibbons during his ACOG presidency

## Executive Board addresses several issues at July meeting

**A**COG'S EXECUTIVE BOARD met July 15–16 at ACOG headquarters in Washington, DC.

The meeting began with an in-depth review of pay-for-performance and how ACOG is adapting its Practice Bulletins to add pay-for-performance measures. The College has completed a workforce study of members older than age 50, and preliminary results were presented. A study of ACOG members younger than 50 will begin early next year, and the combined results will help define the workforce status for the next 10–15 years.

The Committee on Credentials approved the requirements for several non-US ob-gyn

organizations as meeting the requirement for Fellowship in ACOG. This means that those who are working outside the geographic confines of ACOG but are certified by the following organizations are now eligible to become ACOG Fellows rather than Associate Members:

- ▶ Japan Board of Obstetrics and Gynecology
- ▶ Royal Colleges of the United Kingdom, Australia/New Zealand, and Canada
- ▶ Central American Federation of Associations and Societies of Obstetrics and Gynecology Board
- ▶ Mexican Board
- ▶ West Indies, Postgraduate Doctor of Medicine

ACOG does require that eligible Fellows be members in good standing in their country's society recognized by ACOG or the International Federation of Gynecology and Obstetrics (FIGO).

Previously, all of these certification boards met ACOG Fellowship requirements only if the physician was practicing within the geographic confines of ACOG.

The Board added the following statement to ACOG's policy "Access to Women's Health Care": Fellows must not discriminate against patients based on race, color, national origin, religion, sexual orientation, or any other basis that would constitute illegal discrimination.™

## Issue of the Year award winner

**A** GENETICS RESEARCHER at the National Institutes of Health, Melissa A. Merideth, MD, MPH, has been selected to receive the 2006 ACOG Issue of the Year award, which addresses “Ethical Issues Unique to Genetic Testing.”



Dr. Merideth

Dr. Merideth finished her ob-gyn residency in 2001, and after practicing in Arizona for two years, headed to NIH in 2003. She is a fellow in clinical genetics and clinical biochemical genetics at the National Human

Genome Research Institute and an ob-gyn in the Intramural Office of Rare Diseases at NIH.

“Ob-gyns have an increasing opportunity to offer genetic testing to their patients,” Dr. Merideth said. “But as technology leads to increased implementation of genomic information into everyday practice, it is important to address the ethical, legal, and social implications that arise. I would like to bridge the gap between ob-gyn and genetics, facilitating the incorporation of genetics into ob-gyn practice.”

Ethical considerations surface in every aspect of genetic testing. Issues include informed consent, confidentiality, and fear of discrimination from insurance companies and employers, Dr. Merideth said.

### Educating ob-gyns about genetics

As recipient of the Issue of the Year award, Dr. Merideth is required to develop a thoroughly researched and referenced background paper of 50–100 pages. She plans to provide a detailed review of the scope of the issues through research and explore patient and provider perceptions through surveys, focus groups, and information from patient advocacy groups.

Dr. Merideth hopes that her paper will lead to a strategic plan to educate ob-gyns about genetic testing and genomic medicine in general, as well as the complex ethical issues providers need to consider.™

## ACOG partnerships connect patients with tobacco quitlines

**A**COG FELLOWS ARE helping pregnant and postpartum women stop smoking through state-wide partnerships that link patients with tobacco quitlines.

The efforts are part of the Providers Partnership Project, which is administered through ACOG and develops and supports state collaborations among ob-gyns, other health practitioners, community organizations, state government, and/or local government. Many of the partnerships have been formed through a national collaboration between the Association of Maternal and Child Health Programs and Planned Parenthood Federation of America through funding from the Centers for Disease Control and Prevention. Approximately 14 of these partnerships across the US focus on tobacco issues, and some are using quitlines as a key component of their cessation programs.

### Fellow trains clinicians

In Minnesota, ACOG and the state’s Department of Health partnership team conduct training for public health agencies and primary care prenatal clinics. Fellow Douglas M. Soderberg, MD, updates clinicians about the effects of tobacco on maternal-fetal health and teaches prenatal providers how

to use the 5 “A”s, an evidence-based approach to screening for and treating tobacco use.

In addition to counseling patients, the clinicians offer patients ongoing telephone counseling from a tobacco quitline. If a patient consents, instead of simply giving her a phone number, health care workers fax the patient’s contact information to the appropriate quitline. This fax referral system gets the ball rolling quickly, and a quitline counselor can call the patient directly.

After the fax referral feature began last year, 900 smokers were referred to a Minnesota quitline in the first 100 days of operation.

### Indiana quitline launched in March

In Indiana, the statewide coalition Smoke-free Indiana received funding from the state and CDC to develop a quitline to focus on perinatal smoking and Medicaid recipients. Similar to that in Minnesota, the quitline program, launched in March, uses a fax referral system.

Indiana ranks seventh in the US for adult smoking rates, with 24.8% of Hoosiers smoking and 18.5% of pregnant women in the state smoking, according to Smokefree Indiana.

“The single biggest thing you need to do with pregnant women who smoke is educate them,” said Fellow Jeanne E. Ballard, MD, incoming ACOG Indiana Section chair and a member of the state partnership. “The rates are so high in their family, that they don’t see a problem with smoking. Some say ‘my sister and my cousin smoked while they were pregnant and everything turned out fine.’”

The partnership is encouraging clinicians to connect patients to the state quitline, which provides them with a coach who checks in with the patients regularly by phone, helps them set goals to stop smoking, and gives them tools to quit smoking other than just going “cold turkey.”

“It’s something very productive,” Dr. Ballard said. “It’s a very concrete way in which we can actually encourage people to quit.”™

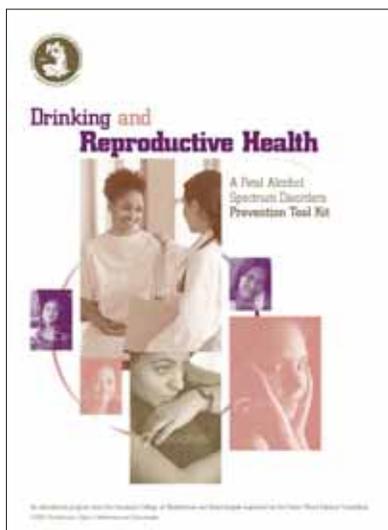


# Free ACOG toolkit battles fetal alcohol disorders

**I**N ITS ONGOING EFFORTS TO combat fetal alcohol spectrum disorders, which includes fetal alcohol syndrome, ACOG has developed a new fetal alcohol spectrum disorders prevention toolkit.

The primary component in the *Drinking and Reproductive Health* toolkit is a CD-ROM that aims to teach women's health care providers how to properly screen and advise their patients about risky drinking and encourage the use of contraception if patients continue to engage in risky drinking. It also addresses drinking during pregnancy.

The toolkit's screening tools and interventions have proven efficacy and can be incorporated into routine care. The toolkit includes downloadable patient and family information handouts and counseling tools.



## Not just pregnant women

The prevention efforts target all women of reproductive age, not only pregnant women. Birth defects associated with prenatal alcohol exposure can occur in the first few weeks of a pregnancy, before a woman knows she is pregnant, according to ACOG's *Special Issues in Women's Health*. The book points out that almost half of pregnancies in the US are unintended—and about half of women of childbearing age in the US drink alcohol. A 2005 US Surgeon General's advisory states that there is not a safe level of alcohol consumption during pregnancy and that no period during pregnancy appears to be safe for alcohol consumption.

The toolkit, which was produced through a cooperative agreement with the Centers for Disease Control and Prevention, is available at no charge to women's health care providers (see info at right).

## FASD awareness day September 9

Prevention of fetal alcohol spectrum disorders will receive national attention on September 9, National Fetal Alcohol Spectrum Disorders Awareness Day.

In July, the US Senate unanimously approved a resolution recognizing the day. The measure, sponsored by Sen. Lisa Murkowski (R-AK), contained a number of findings:

- ▶ The incidence rate of fetal alcohol syndrome is estimated at 1 out of 500 live births, and the incidence rate of fetal alcohol spectrum disorders is estimated at 1 out of every 100 live births
- ▶ Fetal alcohol spectrum disorders are the leading nongenetic cause of mental retardation in Western civilization, including the US, and are 100% preventable
- ▶ Fetal alcohol spectrum disorders are a major

cause of numerous social disorders, including learning disabilities, school failure, juvenile delinquency, homelessness, unemployment, mental illness, and crime

Fetal Alcohol Spectrum Disorders Day was first held on 9/9/99 and is an international event with proclamations issued in communities throughout the world. The event occurs on the ninth day of the ninth month to remind women to abstain from alcohol during the nine months of pregnancy, according to the FASD Awareness Day website.™

### info

- For a free copy of the toolkit, email [jmahoney@acog.org](mailto:jmahoney@acog.org)
- FASD Awareness Day: [www.come-over.to/FASDAY](http://www.come-over.to/FASDAY)
- *Special Issues in Women's Health* is available through the ACOG Bookstore: Order at <http://sales.acog.org>; 800-762-2264



**T**HE ACOG COMMITTEE ON Scientific Program is inviting submissions of abstracts of paper or poster presentations on any topic related to ob-gyn for the 2007 Annual Clinical Meeting, to be held May 5–9 in San Diego. All abstracts must be submitted online.

The committee also welcomes online submission of abstracts of films for the 2007 Film Festival on topics of interest to practicing ob-gyns. Submission details and the online application are on the ACOG website, [www.acog.org/acm](http://www.acog.org/acm).

### Deadlines for online submission

- Paper/poster abstracts: September 15
- Film Festival abstracts: November 1

## ACOG TREASURERS CONFERENCE

**C**URRENT AND INCOMING district and section treasurers are invited to ACOG's Ninth Annual Treasurers Conference, to be held Jan 20–21, 2007, in Orlando, FL. Other district and section officers and administrators responsible for the financial management of their district or section are also invited.

The conference is a two-day educational meeting designed to train officers and administrators in the financial management of their district or section and update them on new ACOG policies and changes in tax laws.

Presenters will include ACOG finance staff, district officers, and outside investment managers.™

### info

- Conference registration is free, but participants must register by December 22. Contact Steve Cathcart: 800-281-1551; [scathcart@acog.org](mailto:scathcart@acog.org)

## Prominent Tennessee Fellow dies

**L**IFE FELLOW W. POWELL Hutcherson, MD, of Chattanooga, TN, died May 16, at the age of 87. Dr. Hutcherson was a prominent ob-gyn and gyn oncologist in Chattanooga and was known



for many “firsts” in that city, such as performing the first Pap test and performing the first surgery at Memorial Hospital. He was also one of the first physicians to encourage mammography use to detect early-stage breast cancer and one of the first physicians to regularly send surgical specimens to pathologists for analysis.

Dr. Hutcherson received his MD from the University of Tennessee at Memphis in 1944 and completed his ob-gyn residency at Cook County Hospital in Chicago. He received training in gyn oncology at the Radium Institute, Stockholm, Sweden, and at the M.D. Anderson Cancer Center in Houston. During World War II, he served stateside as a captain in the US Army.

Dr. Hutcherson became an ACOG Fellow in 1953 and was District VII vice chair from 1979 to 1982 and district chair from 1982 to 1985. He was involved in early clinical trials for oral contraceptives in the 1960s and played a key part in establishing the Chattanooga Tumor Clinic at the University of Tennessee College of Medicine/Erlanger Medical Center, a self-supporting clinic for indigent patients from southeastern Tennessee. He was chief of ob-gyn from 1960 to 1967 at Memorial Hospital and chief of ob-gyn at Barones Erlanger Hospital from 1968 to 1972. Although he officially retired from practice in 1999, he remained an active attending physician in the resident clinic at the University of Tennessee, teaching residents until his final hospitalization.

Dr. Hutcherson received numerous awards throughout his career, including the ACOG Outstanding Contributions Award. An award was created in his name at the University of Tennessee that recognizes a senior ob-gyn resident whose clinical behavior and professionalism exemplifies Dr. Hutcherson’s.™

## Former District IV chair dies



**F**ORMER DISTRICT IV CHAIR Lawrence Lamar Hester Jr., MD, died on May 10 at the age of 85. Dr. Hester became professor and chair of the ob-gyn department at the Medical University of South Carolina in Charleston in 1956. At age 36, he was the youngest chair of an ob-gyn department in the country at the time. And when he retired in 1984, he had served longer than any other ob-gyn department chair in the country.

“He built that department. He had vision, and when he became chair, he began to select people as faculty members and send them off to become certified in different areas,” said Dr. H. Oliver Williamson, MUSC retired vice chair and a friend and colleague of Dr. Hester.

All four of the first full-time faculty members that Dr. Hester selected later became chairs of ob-gyn departments.

“That says something about him,” Dr. Williamson said. “This was a man who was a true gentleman, who helped push our ca-

reers and was devoted to his faculty and his patients.”

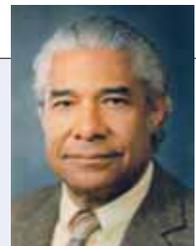
Dr. Hester graduated from The Citadel in Charleston, SC, in 1941, and the Medical College of South Carolina in 1944.

During World War II he served in the US Army, serving as section chief of ob-gyn at Maxwell Field in Alabama from 1946 to 1948.

Dr. Hester was chair of District IV from 1964 to 1967. He was a director and an examiner for the American Board of Obstetrics and Gynecology and a member and/or officer of approximately 25 other medical societies. He authored more than 45 papers and contributed chapters on ob-gyn issues in numerous textbooks.

In 1980, he was awarded an honorary doctor of science degree from The Citadel, and, in 1986, he received the Order of the Palmetto, the highest civilian honor awarded by the governor of South Carolina, for his many years of service to the Florence Crittenton Home.™

## Former DC Section chair dies



**L**IFE FELLOW RICHARD Steele Guy, MD, 80, of St. Croix, Virgin Islands, died on June 24 from a sudden and overwhelming systemic infection. Dr. Guy was chair of the District of Columbia Section in District IV from 1987 to 1990 and served on ACOG’s Committee on Health Care for Underserved Women from 1992 to 1994.

Dr. Guy maintained a private practice in Washington, DC, for 40 years and was among the pioneers in the use of laparoscopy and cryosurgery in gynecology in the DC area.

Dr. Guy received his MD from Meharry Medical College in Nashville, TN, and completed his internship at Forest City Hospital (now Metropolitan General Hospital) in Cleveland and his residency at Freedman’s Hospital (now Howard University Hospital) in Washington, DC. He served as a cap-

tain, ob-gyn officer, in the US Air Force, was a member of the Medical Society of DC, and served on the DC Board of Medicine for many years. He was a founding member of the International Society of Aquatic Medicine.

Dr. Guy chaired or participated in numerous local and national task forces and committees in the areas of underserved women, maternal and infant mortality, the health of women in prison, adolescent health, and “border babies” born to addicted mothers. In 1998 he was honored by the DC Medical Society with the Dr. Charles Epps Community Service Award.

Dr. Guy retired from private practice in 1999 and moved to St. Croix, where he consulted in gynecology for the Virgin Islands Department of Family Planning at the Frederiksted Clinic.™

# ACOG young physicians author AMA resolutions

Erin E. Tracy, MD, MPH  
Representative to the AMA Young Physicians Section



**T**HE AMERICAN MEDICAL Association offers a wonderful forum for physicians to introduce resolutions important to medical providers and/or our patients. ACOG has a very active delegation that has achieved much success in developing AMA policy, and there are a number of young physicians who actively participate in this process.

The policy development process is a democratic one, with any representative allowed to introduce policy for consideration. I encourage you to take advantage of this opportunity and contact any of the AMA ACOG delegation members if there are issues you think should be pursued. As just one member of this delegation, I am delighted to hear from any ACOG members regarding any important items. Feel free to contact me at eetracy@partners.org.

## Cord blood banking

At the AMA's annual meeting in June in Chicago, the AMA House of Delegates adopted two resolutions authored by ACOG young physicians. The first resolution, on cord blood banking, was written to address the ethical issues surrounding the marketing to pregnant women by private cord blood banking companies.

The AMA Young Physicians Section adopted and forwarded a resolution, which was adopted by the AMA HOD, asking that "AMA continue to study cord blood banking in this country and work with appropriate specialty societies and organizations, such as the National Marrow Donor Program, to develop and disseminate materials to educate physicians and the public about the issues of marketing cord blood banking services directly to patients, the informed consent process, and the existence

of federally mandated regulatory oversight of these processes to ensure safety and compliance with specific uniform standards."

## Physician reentry

The second resolution written by the Young Physicians Section and adopted by the AMA HOD involved physician reentry. This issue is of such significance that ACOG Immediate Past President Michael T. Mennuti, MD, appointed an ACOG task force to study the issue. (For more on physician reentry, see page 1.)

The AMA HOD adopted the following resolution: "That our AMA study the issue of physician reentry into practice after a leave of absence from practice, or a limitation of certain aspects of practice, including a consideration of issues related to retraining, certification, and credentialing."™

## ACOG RESEARCH PROVIDES PORTRAIT OF PRACTICE PATTERNS

to indicate your agreement or disagreement).

Strongly Agree      Neither Agree Nor Disagree      Strongly Disagree

**A**COG'S RESEARCH initiative has led to increased awareness of ob-gyn practice patterns and knowledge of issues on topics such as obesity, breastfeeding, mental health, preeclampsia, diabetes, cystic fibrosis screening, and VBAC.

The ACOG Department of Research conducts several surveys each year to learn "what our Fellows are doing, what their needs are, and where we can ameliorate their knowledge," explained Jay Schulkin, PhD, ACOG director of research.

Most of the surveys are mailed to Fellows who are members of the Collaborative Ambulatory Research Network, or CARN, a core group of approximately 1,800 Fellows who have agreed to respond to several ACOG surveys a year. CARN was established in 1990 to assess ob-gyns' knowledge and practice patterns to understand how they are meeting patients' needs and how to enhance education in

unfamiliar areas. Most of the studies survey a random sampling of Fellows in addition to the CARN Fellows.

"Results from surveys conducted through CARN provide information about the impact of evidence-based guidelines over time, such as those related to cystic fibrosis and neonatal encephalopathy, and aid in the development of educational materials," Dr. Schulkin said. "These surveys have also documented the extent to which ACOG Fellows are following existing clinical practice guidelines. For example, recent surveys have shown that most Fellows are in concordance with ACOG guidelines for management of thyroid disease in pregnancy but less so for management and screening of hepatitis C and group B streptococcal disease."

ACOG findings have been published in *Obstetrics & Gynecology*, *Academic Medicine*, *The Journal of Maternal-Fetal and Neonatal Medicine*, *The American Journal of Obstetrics and Gynecology*, *The Journal of Reproductive*

*Medicine*, *Menopause*, *Depression and Anxiety*, *Genetics in Medicine*, *Journal of Medical Ethics*, and *American Journal of Perinatology*.

The ideas for survey topics come from individual members, ACOG committees and staff, and requests from federal agencies. Many surveys are supported with grants from the federal Maternal and Child Health Bureau, the National Heart, Lung, and Blood Institute, and the Centers for Disease Control and Prevention.

The survey response rate depends on the topic: "In the cesarean section upon maternal request study we just did, we received the highest response rate we've ever had, at almost 70%," Dr. Schulkin said. "The surveys provide important feedback to the College, and, ultimately, to the Fellows themselves via the published results. For every survey, our goal is to achieve as accurate a representation as possible of the opinions, knowledge, and practice patterns of our Fellows. We understand that Fellows are very busy, but every response is important."™

## Special health courts offer alternative to current liability system

**S**PECIAL HEALTH COURTS, IN which medical claims are evaluated by trained adjudicators and court-appointed experts, might be able to correct many of the flaws in the current tort system.

Ob-gyns are well aware of the flaws and injustices created by the current system of medical “justice”—inconsistent awards, a lengthy litigation process, frivolous claims, costly defensive medicine practices, high liability insurance premiums, and barriers to effective patient-physician communication.

“Health courts are one of numerous approaches being talked about as alternatives to our current tort system,” said Stewart J. Wetchler, MD, JD, vice chair of ACOG’s Committee on Professional Liability. “The specifics of health courts could take shape in many different ways, but the most developed ideas have been proposed by Common Good.” (Common Good is a nonprofit bipartisan organization whose mission is to “restore reliability to law.”)

### How health courts might function

The following are the elements of health courts as proposed by Common Good, in conjunction with the Harvard School of Public Health:

- ▶ Trained judges with expertise in adjudicating medical malpractice disputes would consult with neutral experts to determine the standard of care; these judges would issue rulings to provide guidance for future cases
- ▶ Noneconomic damages (in addition to medical costs and lost wages) would be paid to claimants according to a schedule of compensation for specific types of injuries
- ▶ Injuries would be compensated if they could have been avoided had care been provided according to best practice; this “avoidability” standard differs from the negligence standard, which focuses on whether care fell below customary practice
- ▶ Evidence-based scientific evidence would be used to decide the extent to which adverse events are preventable and to develop compensation recommendations; early offers of compensation would be encouraged

- ▶ Parties would be able to appeal decisions to appellate courts
- ▶ Systems would be established to contribute to patient safety through processes such as root cause analyses and standard event reporting to facilitate the development of preventive practices

“To me, the key principles of health courts are to make the compensation system more consistent, to establish precedents for standard of care and for awards, and to have more of the awards go to the victims,” Dr. Wetchler said. “I think we need to support a system that fairly compensates patients who are injured and that contributes to enhancing patient safety.”

### Demonstration projects needed

Common Good emphasizes that specialized courts already exist in several other areas, such as family law, probate, workers’ compensation, and tax disputes. But experience with health courts is needed to find out how well they work, how patients respond to them, and how much they cost.

Such experience is proposed in a pending Senate bill that calls for establishing up to 10 state demonstration projects. ACOG supported this bipartisan bill—the Fair and Reliable Medical Justice Act (S.1133)—in a June Senate hearing on new ideas for making the medical liability system work better for patients.

States interested in piloting a health court project would have to make a number of choices about its design, such as:

- ▶ Whether it would be voluntary or mandatory
- ▶ Qualifications for judges and how they would be appointed
- ▶ The appeals process
- ▶ The structures for determining economic and noneconomic damages
- ▶ How the system would be financed

Common Good recommends a voluntary system and notes that claims involving obstetrics and anesthesia may be “particularly appropriate starting points for demonstration projects.”

*“I think we need to support a system that fairly compensates patients who are injured and that contributes to enhancing patient safety.”*



An administrative system using a compensation schedule and avoiding standard litigation expenses would likely cost about the same as the current system, according to Common Good. In the current system, “if someone has a \$20,000 injury, most lawyers won’t take the case because their share of the damages would not cover their costs,” Dr. Wetchler said. “The battle of two lawyers trying to convince the jury of the standard of care gets expensive. But in the health court model, a patient with such an injury would receive most of that amount.”

Will health courts become a reality? Will a pilot even be tried? “I used to think it would never happen,” Dr. Wetchler said. “But to actually see a bill introduced and to have congressional hearings—it’s moving, but at an incremental pace.”™

### info

- ACOG testimony: On the ACOG website, [www.acog.org](http://www.acog.org), under “Advocacy,” click on “Government Relations and Outreach.” Then, click on “ACOG Testimony” and “Testimony on Medical Liability”
- Common Good’s “Frequently Asked Questions about Health Courts: <http://cgood.org/f-healthcourtsfaq.html>

## ACOG president defends ob-gyn in-office imaging to Congress

**A**COG PRESIDENT DOUGLAS W. Laube, MD, MEd, testified at a US House of Representatives committee hearing in July about the importance of in-office ultrasound to ob-gyn patients.

In testimony before the House Committee on Energy and Commerce's Health Subcommittee, Dr. Laube testified that ultrasound is a safe and important tool in women's prenatal and gynecologic care and urged Congress not to pass legislation that could delay women's access to diagnosis and treatment for basic health care needs.



ACOG President Douglas W. Laube, MD, MEd, on the right, testifies before the US House Committee on Energy and Commerce's Health Subcommittee, urging Congress not to pass legislation that would place restrictions on ultrasound use by ob-gyns.

### Congress should exempt ultrasounds from regulations

The House committee is reviewing the growth and costs of imaging services in Medicare and whether there should be new restrictions on their use. ACOG believes the safety, necessity, and cost-saving value of ultrasounds in the ob-gyn office should exempt ultrasounds from new restrictions. This includes any requirements that women must visit other physicians to get the services they can quickly and safely get from their ob-gyn.

*"Many ultrasound exams need to be performed urgently, such as when a woman experiences unexplained bleeding, pelvic pain, or discovery of a mass."*

Restricting in-office imaging would result in substantial inconvenience and costs for patients, who would have to schedule a new appointment, with a different facility and a different physician, when the necessary testing could be performed on the spot by the patient's own physician. Continuity of care would be interrupted, and the treating physician would lose valuable time in detecting and treating a condition, Dr. Laube told the committee.

Dr. Laube stressed the importance of quick access to ultrasound: "Many ultrasound exams need to be performed urgently, such as when a woman experiences unexplained bleeding, pelvic pain, or discovery of a mass," Dr. Laube said. "Some emergencies, like ectopic pregnancies and complications during active labor, can be life-threatening and require immediate ultrasonography."

Dr. Laube distinguished ultrasound from other, more complicated imaging services—such as CT, MRI, or PET scans—in which further regulation is being examined. He also pointed out that ob-gyns are well-trained in ultrasound—diagnostic ultrasonography is part of ob-gyn residency training and part of board certification—and that use of ob-gyn ultrasound in clinical care increases quality and saves costs.

The hearing focused on imaging in Medicare only, but decisions about Medicare policy are often adopted widely by private payors and TRICARE, the health care system for 9 million military families.™

## Contraceptive implant approved by FDA

**W**OMEN IN THE US WILL SOON have another contraceptive method available to them. The Food and Drug Administration has approved Implanon, a contraceptive implant.

Its manufacturer, Organon International, announced in July that it will begin training health care workers this year on how and where to insert and remove the implant. Only providers trained through Organon-sponsored programs will be allowed to order Implanon.

"We haven't had a contraceptive implant in the US since the marketing of Norplant was stopped in 2000," said Fellow Herbert B. Peterson, MD, professor of ob-gyn and maternal and child health at the University of North Carolina at Chapel Hill. "This implant's main mechanism of action is the prevention of ovulation, and it's highly effective."

Implanted into the inner side of the upper arm, Implanon contains etonogestrel, a different progestogen than Norplant used, and is expected to be easier to insert and remove. Unlike the six-capsule Norplant, Implanon is a single-rod implant and has a special insertion applicator. The matchstick-size rod provides contraception for up to three years; it must be removed after three years, but a new implant can be inserted at that time.

According to the physician insert, the nonbiodegradable rod consists of an ethylene vinylacetate (EVA) copolymer core, containing 68 mg of etonogestrel, surrounded by an EVA copolymer skin. The release rate is 60 to 70 µg per day in week five to six and decreases to approximately 35–45 µg per day at the end of the first year. It then decreases to approximately 30–40 µg per day at the end of the second year and to approximately 25–30 µg per day at the end of the third year.™

## After a break from practice, returning not easy

► PAGE 1

had numerous clients that needed an ob-gyn, but hospital credentialing requirements presented roadblocks.

"The employer would be perfectly happy to take me, but the hospital wouldn't credential me," Dr. Sellner said. "First this happened in Wisconsin, then Delaware—same thing; Virginia—same thing."

The first opportunity he had to work was in a small town in Maine. "They were desperate. I worked there four days, and they were so happy that they asked me to apply for privileges in case they needed me again."

Dr. Sellner had a five-month assignment at the Alaska Native Medical Center in Anchorage, an ob-gyn referral center for the entire state. With eight ob-gyns on staff, the hospital had the capacity to proctor him through several initial cases. His stint in Alaska gave him the cases he needed to be credentialed elsewhere, and after several other assignments he's now working as a hospital employee in that little town in Maine, where the only other ob-gyn in town is "thrilled" to have a colleague to share the load of about 15 deliveries a month.

### Changes in medicine coupled with increased scrutiny

"There has been a sea change in the assessment of physician competency," said James Thompson, MD, CEO of the Federation of State Med-

ical Boards. "Twenty years ago, if somebody stayed out of practice for a year or two, there weren't the changes in technology and science that there are today. The rapid changes have placed a greater burden on regulatory agencies that are charged to protect the public. We are here to protect the public, not the profession. That ethic has guided the great interest now in ensuring competency."

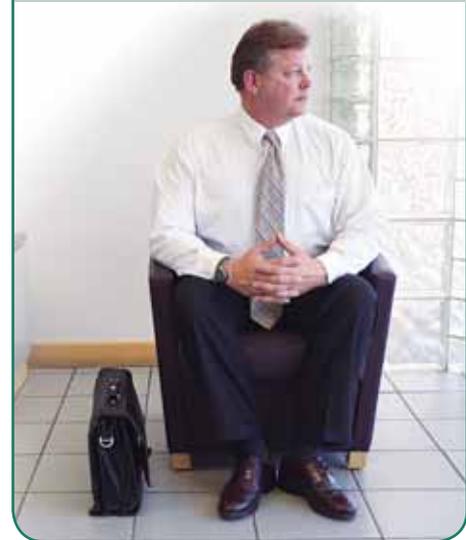
The increased scrutiny by hospitals and licensing boards has evolved at the same time that changes in the physician workforce have altered the traditional model of starting practice and not stopping until retirement. Illness or disability, premature retirement, dual-career marriages, administrative careers, military deployment, and family needs are among the numerous reasons ob-gyns may have a hiatus from clinical practice.

The liability insurance crisis has added to the number of ob-gyns who retired early or limited their practice to ambulatory care and want to return to obstetric and surgical practice. Said Dr. Sellner, "If I could buy an affordable malpractice policy, I would open my practice again."

The ACOG task force is gathering information about the problem of reentry and potential mechanisms for assessment of competency and programs for development of skills needed for reentry to practice.

NEXT MONTH...

ACOG Today will examine programs that help physicians with reentry



Dr. Dean spoke of the personal and professional loss when a physician is unable to return to practice: "I know someone who retired after 13 years in practice. She is the best doctor I know—so good with her patients, so skilled. She didn't have good options to cut back, and she felt her kids needed her more. If she never practices medicine again, it's a loss to our specialty and to her patients."™



info

→ Visit [www.acog.org](http://www.acog.org). Under "Practice Management," click on "Practice Management and Managed Care"

### Learn more about practice management on the ACOG website

Find information on:

- ▶ Electronic health systems
- ▶ Ob-gyn financial and income trends
- ▶ Responding to inappropriate payor denials
- ▶ Protecting assets
- ▶ Starting a practice
- ▶ Assisting hearing-impaired and non-English-speaking patients

### Do you have a coding question?

Facing a coding conundrum? Help is available. Fellows or their staff can submit specific questions to ACOG's coding staff.

Submit questions by email to [coding@acog.org](mailto:coding@acog.org) or by fax to 202-484-7480.

### Coding online

On the ACOG website, [www.acog.org](http://www.acog.org), click on "CPT Coding" in the "Quick Links" box on the left side of the home page.

# New codes must be used beginning October 1

**E**VERY OCTOBER 1, THE NEW, EXPANDED, AND revised ICD-9-CM codes take effect. Under HIPAA rules, these codes must be used beginning October 1. There is no longer any grace period to use discontinued codes for services provided after the effective date of the new codes.

Order new code books, *ICD-9-CM Abridged, Diagnostic Coding in Obstetrics and Gynecology, 2007*, or *ICD-9-CM Professional Edition for Physicians, Volumes 1 and 2, 2007 edition*, through the ACOG Bookstore: <http://sales.acog.org>; 800-762-2264.™

## Pain, not elsewhere classified

Previously, the index listed pain by site and in many cases referred coders to an “other specified symptom” code. To differentiate between acute and chronic pain, a new category titled “pain, not elsewhere classified” (338) will be created.

- Ⓢ Acute pain due to trauma (338.11)
- Ⓢ Acute post-thoracotomy pain (338.12)
- Ⓢ Other acute postoperative pain (338.18)
- Ⓢ Other acute pain (338.19)
- Ⓢ Chronic pain due to trauma (338.21)
- Ⓢ Other chronic pain (338.29)
- Ⓢ Neoplasm related pain (acute) (chronic) (338.3)
- Ⓢ Chronic pain syndrome (338.4)

## Inflammatory diseases of cervix, vagina, and vulva

Two new codes will be added within the other specified inflammatory diseases of cervix, vagina, and vulva subcategory (616.8):

- Ⓢ Mucositis (ulcerative) of cervix, vagina, and vulva (616.81)
- Ⓢ Other inflammatory disease of cervix, vagina, and vulva (616.89)

## Genital prolapse

To describe cervical stump prolapse, a new code will be added to the list of genital prolapse codes (618.8):

- Ⓢ Cervical stump prolapse (618.84)

## Other disorders of female genital organs

The word “cutting” will be added to the female genital mutilation status subcategory (629.2): Female genital cutting

- Ⓢ Female genital mutilation status, unspecified (629.20)
  - Female genital cutting status, unspecified
- Ⓢ Female genital mutilation Type I status (629.21)
  - Female genital cutting Type I status
- Ⓢ Female genital mutilation Type II status (629.22)
  - Female genital cutting Type II status
- Ⓢ Female genital mutilation Type III status (629.23)
  - Female genital cutting Type III status
- Ⓢ Other female genital mutilation status (629.29)
  - Female genital cutting Type IV status
  - Female genital mutilation Type IV status
  - Other female genital cutting status

The 629.8 subcategory will be expanded to enable reporting for a habitual aborter who is not currently pregnant and to capture other specified disorders of female genital organs.

- Ⓢ Habitual aborter without current pregnancy (629.81)
- Ⓢ Other specified disorders of female genital organs (629.89)

## Current conditions complicating pregnancy

A new category, 649, will be added to include current conditions complicating pregnancy. All of these codes can be reported during the antepartum, delivery, or postpartum periods. The code for uterine size-date discrepancy was changed from 646.8 (other specified complications of pregnancy) to a new code in this category.

- Ⓢ Other conditions or status of the mother complicating pregnancy, childbirth, or the puerperium (649)
  - Tobacco use disorder complicating pregnancy, childbirth, or the puerperium (649.0)
  - Obesity complicating pregnancy, childbirth, or the puerperium (649.1)
  - Bariatric surgery status complicating pregnancy, childbirth, or the puerperium (649.2)
  - Coagulation defects complicating pregnancy, childbirth, or the puerperium (649.3)
  - Epilepsy complicating pregnancy, childbirth, or the puerperium (649.4)
  - Spotting complicating pregnancy, childbirth, or the puerperium (649.5)
  - Uterine size-date discrepancy (649.6)

## Symptoms, signs, and ill-defined conditions

New codes will be added to the category for symptoms involving the urinary system, abnormal findings of breast tests and Pap smears, and for tumor markers.

- Ⓢ Other abnormality of urination (788.6)
  - Urinary hesitancy (788.64)
  - Straining on urination (788.65)
- Ⓢ Nonspecific abnormal findings on radiological and other examination of body structure (793)
  - Ⓢ Breast (793.8)
    - Mammographic microcalcification (793.81)
      - Excludes: mammographic calcification (793.89) and mammographic calculus (793.89)
    - Other abnormal findings on radiological examination of breast (793.89):
      - mammographic calcification and mammographic calculus
  - Ⓢ Other (793.9)
    - Image test inconclusive due to excess body fat (793.91)
    - Other nonspecific abnormal findings on radiological and other examinations of body structure (793.99)
- Ⓢ Abnormal Papanicolaou smear of cervix and cervical HPV (795.0)
  - Papanicolaou smear of cervix with cytologic evidence of malignancy (795.06)
- Ⓢ Abnormal tumor markers (795.8)
  - Elevated carcinoembryonic antigen (795.81)
  - Elevated cancer antigen 126 (795.82)
  - Other abnormal tumor markers (795.89)

## Factors influencing health status and contact with health services

Changes will be made to the categories for family history of conditions, genetic counseling and testing, postprocedural status, and genetic screening. A new category will be created to enable reporting of estrogen receptor status.

- Ⓢ Family history of certain other specific conditions (V18)
- Ⓢ Digestive disorders (V18.5)
  - Family history, colonic polyps (V18.51)
  - Family history, other digestive disorders (V18.59)
- Ⓢ Procreative management (V26)
  - Genetic counseling and testing (V26.3)
    - Testing of female for genetic disease carrier status (V26.31)
    - Other genetic testing of female (V26.32)
      - Genetic counseling (V26.33)
        - Testing of male for genetic diseases carrier status (V26.34)
      - Encounter for testing of male partner of habitual aborter (V26.35)
        - Other genetic testing of male (V26.39)
- Ⓢ Other postprocedural status (V45)
  - Other postprocedural status (V45.8)
    - Bariatric surgery status (V45.86)
- Ⓢ Special screening for other conditions (V82)
  - Genetic screening (V82.7)
    - Screening for genetic disease status (V82.71)
      - Other genetic screening (V82.79)
- Ⓢ Estrogen receptor status (V86)
  - Estrogen receptor positive status (ER+) (V86.0)
  - Estrogen receptor negative status (ER-) (V86.1)

In addition, the index will change the reference for vaginal intraepithelial neoplasia (VIN I and VIN II) from code 624.8 (other specified noninflammatory disorders of vulva and perineum) to 624.0 (dystrophy of vulva).



## Free mental health screening kit

**O**B-GYNS ARE encouraged to screen patients for mental health disorders next month as part of the National Depression Screening Day Mental Health Screening program. National Depression Screening Day is October 5, but ob-gyns are asked to select any one day in October to conduct mental health screening as part of their office-based appointments. ACOG is a cosponsor of the day.

The first 500 ACOG members who register for National Depression Screening Day online will receive a free hard-copy screening kit, or members can download kits online at no cost (see info below). Both the hard-copy and online kits include screening tools on four common and treatable mental health disorders: depression, bipolar disorder, generalized anxiety disorder, and posttraumatic stress disorder.

The kits include scoring and referral guidelines and patient education brochures, including ACOG's *Postpartum Depression Patient Education Pamphlet*. A clinician guide and pocket cards are included to provide guidance on how best to initiate a conversation with patients about mental health issues. The materials also explain how and when to refer a patient to a mental health specialist.™

### info

- To register and be eligible to receive a free hard-copy screening kit, click on the link on ACOG's home page, [www.acog.org](http://www.acog.org), under "Announcements"
- To download free kits, visit [www.mentalhealthscreening.org/events/ndsd/index.aspx](http://www.mentalhealthscreening.org/events/ndsd/index.aspx)
- ACOG Patient Education Pamphlets *Depression* and *Postpartum Depression* are available through the ACOG Bookstore: Order at <http://sales.acog.org>; 800-762-2264

## New report outlines advances in gynecologic cancer

**O**NE OF THE GREATEST strides in the fight against gynecologic cancer was made this year with the approval of an HPV vaccine, aimed at eliminating cervical cancer, according to the Gynecologic Cancer Foundation's *2006 State of the State of Gynecologic Cancers: Fourth Annual Report to the Women of America*.

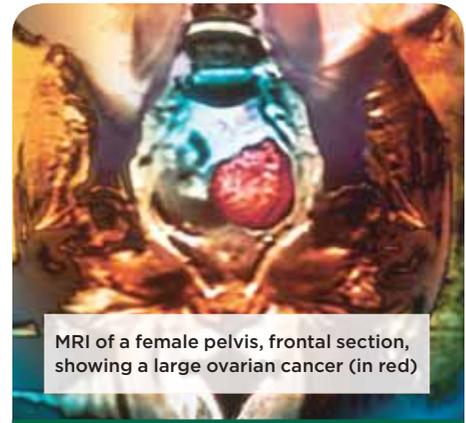
"With widespread use of this vaccine, it is expected that patient suffering and the economic burden from cervical cancer will decrease by up to 70%," the report states. "The vaccine will also decrease the costs related to the treatment of abnormal Pap tests as well as the costs of managing genital warts." (See page 1 for more on the HPV vaccine.)

The report outlines the latest advances and provides descriptions, incidence rates, symptoms, screening and prevention information, and risk factors for the deadliest gynecologic cancers: ovarian, cervical, uterine, vaginal, and vulvar cancer. This year's report includes a special section on the importance and role of clinical trials.

The report will be released in September, which is Gynecologic Cancer Awareness Month. Throughout September, GCF aims to educate women about familial breast-ovarian cancer syndrome, caused by BRCA1 and BRCA2 gene mutations.

In the US, approximately 10% of women will develop breast cancer, and 1.8% of women will develop ovarian cancer sometime in their lifetime. However, women with familial breast-ovarian cancer syndrome have up to a 90% lifetime risk of developing breast or ovarian cancer, according to GCF.

GCF will educate women about how they can manage this increased risk and about the importance of knowing their family history of these cancers and discussing various risk-reducing options with their health care provider. According to GCF, women with BRCA1 or BRCA2 mutations should consider more intense clinical monitoring, including mammograms, pelvic ultrasounds, and CA 125 testing, and be informed about protective measures, including medication, lifestyle changes, and preventive surgery.™



MRI of a female pelvis, frontal section, showing a large ovarian cancer (in red)

### REPORT HIGHLIGHTS

#### ▶ Efforts to find a reliable screening test for ovarian cancer

In one cancer screening trial, surgery was done on women who had abnormalities detected through ultrasound or a CA 125 blood test. Of 570 surgical procedures, 26 cases of ovarian cancer were diagnosed. Initially, the study also used pelvic exams to screen women but dropped this component after early data found no ovarian cancers through pelvic exams alone.

#### ▶ Advances in endometrial cancer

Patients with a genetic predisposition to cancer known as Lynch syndrome (hereditary nonpolyposis colorectal cancer) have a 40% to 60% lifetime risk of developing endometrial cancer as well as other cancers, according to the report. One study showed that women with Lynch syndrome who had a hysterectomy with removal of both fallopian tubes and ovaries developed no endometrial, ovarian, or peritoneal cancers.

Another study was designed to determine the risk of cancer in women with precancer changes on an endometrial biopsy, used to evaluate abnormal bleeding. Among women who had a biopsy that showed atypical cells and then had a hysterectomy to decrease the chances of developing uterine cancer, 40% showed endometrial cancer at the time of hysterectomy.

### info

- [www.thegcf.org](http://www.thegcf.org)

## ACOG releases HPV vaccine recommendations

► PAGE 1

70% of cervical cancers and 90% of genital warts cases. A second HPV vaccine, Cervarix, manufactured by GlaxoSmithKline, is in development and would offer protection against HPV types 16 and 18.

Despite the protection Gardasil offers, ACOG emphasizes that the recommendations for cervical cytology screening remain unchanged. While the vaccine protects against four types of HPV, there are additional HPV strains that can cause cervical cancer. Pap testing can detect abnormal cervical cells caused by other HPV strains not covered by the vaccine. Pap screening should begin within three years of sexual intercourse (or by age 21) and then annually until age 30. After age 30, most women can continue annual testing or can choose to be tested every two to three years after three consecutive negative Pap tests.

### Who should be vaccinated

The HPV vaccine is most effective when administered to girls and women before the onset of sexual activity. While the FDA has approved the vaccine for girls and women ages nine to 26, the federal Advisory Committee on Immunization Practices recommends that girls routinely receive the vaccine between the ages of 11 and 12. Although most ob-gyns may not see many girls ages 11 to 12, ACOG recommends that teens first visit an ob-gyn between the ages of 13 and 15. This initial reproductive health visit is an ideal time to discuss the benefits of the vaccine and to offer it to teens.

Vaccination is also recommended for women up to age 26, regardless of sexual activity. Ob-gyns are encouraged to talk about the vaccine any time they see a patient within the target population and offer it to those who have not yet received it. However, women who are already sexually active should be counseled that the vaccine may be less effective if there has been prior HPV exposure.

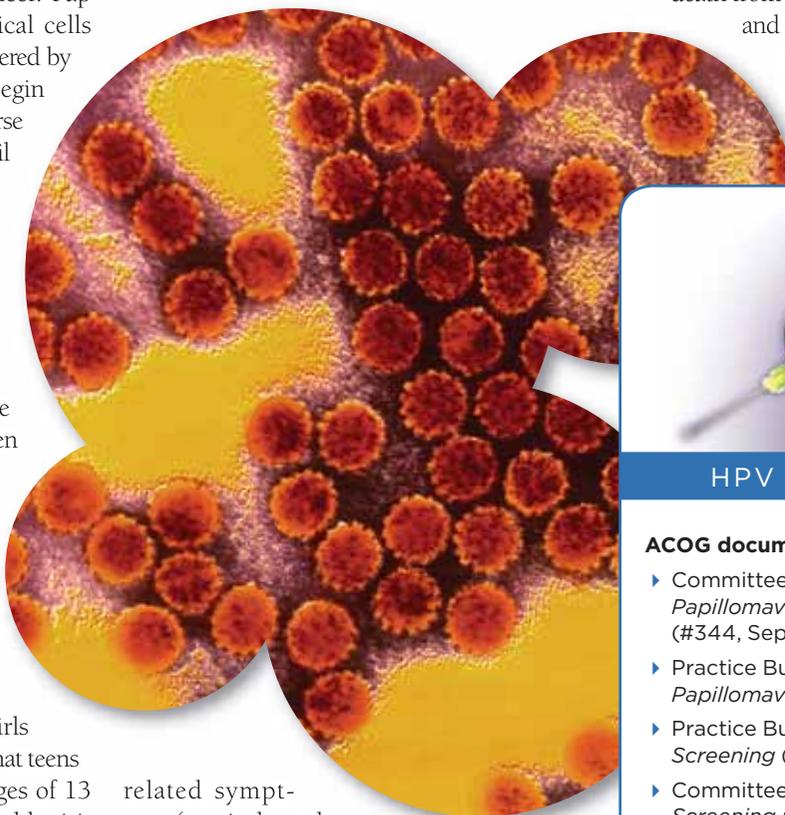
Women who previously have had abnormal cervical cytology, genital warts, or precancerous lesions can be vaccinated, but the effects on this population are unknown. Those with suppressed immune systems also can be vaccinated, although the protection may be less than that for patients with normal immune function. The HPV vaccine is not a treatment for current HPV infection or genital warts. Patients undergoing treatment for HPV-

related symptoms (cervical cytology abnormalities, genital warts) should continue with their prescribed medication and therapy.

Although the vaccine has not been shown to have a harmful effect on pregnancy, it is not recommended that pregnant women be vaccinated. If a woman discovers she is pregnant during the vaccine schedule, she should delay finishing the series until after she gives birth. Women who are breastfeeding can receive the vaccine.

### A breakthrough in cancer prevention

With widespread use, HPV vaccination has the potential to lower the occurrence of cervical cancer in future generations. Worldwide, cervical cancer is the second leading cause of cancer death in women, with nearly half a million new cases and 275,000 deaths annually. An increase in routine Pap testing has led to a decrease in new cervical cancer cases and death from the disease in the US (9,710 and 3,700 respectively), but there is still a significant population of women who are not regularly screened.™



### HPV RESOURCES

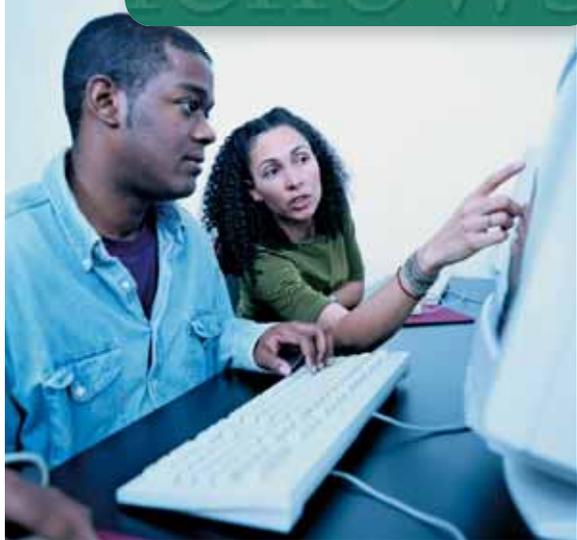
#### ACOG documents

- ▶ Committee Opinion *Human Papillomavirus Vaccination* (#344, September 2006)
- ▶ Practice Bulletin *Human Papillomavirus* (#61, April 2005)
- ▶ Practice Bulletin *Cervical Cytology Screening* (#45, August 2003)
- ▶ Committee Opinion *Cervical Cancer Screening in Adolescents* (#300, October 2004)
- ▶ Committee Opinion *Sexually Transmitted Diseases in Adolescents* (#301, October 2004)

#### Patient Education Pamphlets

- ▶ *How to Prevent Sexually Transmitted Diseases* (English and Spanish)
- ▶ *Human Papillomavirus Infection*

Order through the ACOG Bookstore:  
<http://sales.acog.org>; 800-762-2264



### Online resource can prepare Junior Fellows for boards

A VALUABLE RESOURCE THAT can help Junior Fellows prepare for their American Board of Obstetrics and Gynecology examinations is available on the ACOG website. "Preparing for the Boards" is a PowerPoint presentation developed by members of the Junior Fellow College Advisory Council.

"There is a need to enhance the education of Junior Fellows about the ob-gyn board certification process," said JFCAC Chair Patrick S. Ramsey, MD, MSPH. "These materials will help better inform the membership about the timeline, process, and logistical issues related to board certification and should help to address many questions that arise."

The presentation gives examples of traditional and accelerated timelines to follow to apply and prepare for the oral and written exams. The guide also provides information on how to collect case lists and what they should include and stresses to Junior Fellows not to procrastinate and to allow ample time for required sign-off on medical records.™

#### info

→ On the ACOG website, [www.acog.org](http://www.acog.org), click on "Junior Fellows" in the "Quick Links" box on the left side of the home page. Then, click on "Preparing for the Boards"

## District III Junior Fellows get connected

TRADITIONALLY, JUNIOR Fellows have experienced difficulty maintaining communication with each other throughout their district because of the large number of Junior Fellows and the high turnover. As young physicians in residencies and fellowships and at the beginning of their careers, Junior Fellows may be more likely to relocate to different cities and states, and therefore switch districts and sections, than they would as Fellows.

But Junior Fellow officers in District III have come up with a solution to the communication challenges, developing a Junior Fellow online discussion group and online newsletter to keep the young doctors connected.

Section and district members have worked together to compile an online group list of more than 500 Junior Fellow members and have begun distribution of their online newsletter, which is intended to keep Junior Fellows updated on important issues throughout the year such as the district and section elections as well as the district's highly touted Second Annual Town Hall Meeting in September.

"By using the web as a means to reach out to our constituents, we hope to overcome some of the hurdles that have traditionally hindered efforts at the Junior Fellow level," said Armando E. Hernandez-Rey, MD, former District III Junior Fellow chair.

The Junior Fellow leaders plan to update the online discussion group list each year with

the help of the district secretary/treasurer and program directors and residency coordinators throughout the three sections that make up the district: Pennsylvania, New Jersey, and Delaware.

*"By using the web as a means to reach out to our constituents, we hope to overcome some of the hurdles that have traditionally hindered efforts at the Junior Fellow level."*

"By reaching out to the incoming class of residents at the beginning of July each year, we hope to demonstrate to them early on the incredible benefits and opportunities afforded to them by joining ACOG," Dr. Hernandez-Rey said. "We will also share these benefits and opportunities with upperclassmen as they consider their career paths and try to navigate the road ahead."

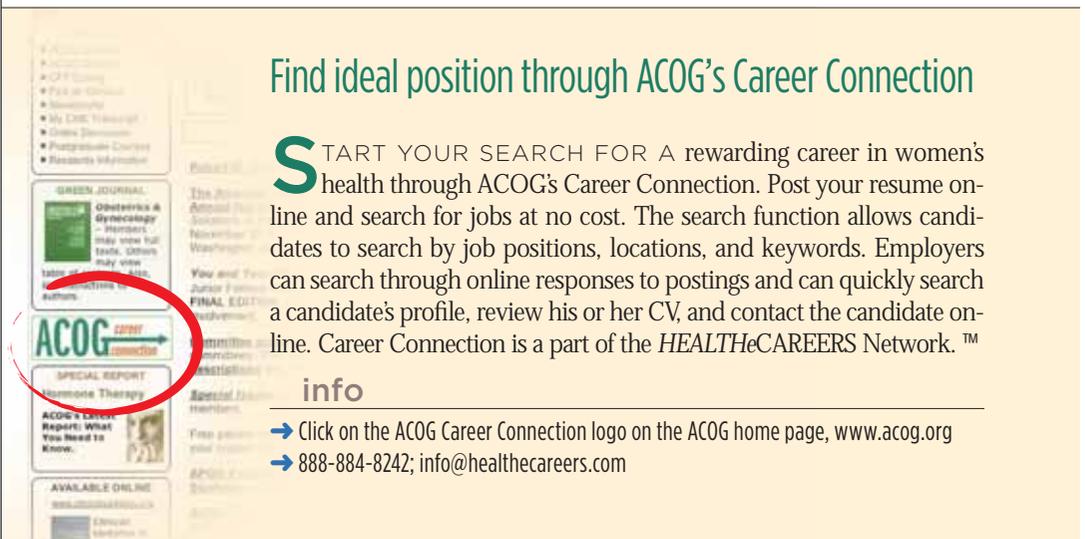
The online discussion group and newsletter were put to good use this past spring to get the word out about a roundtable discussion on the do's and don'ts of applying for a subspecialty fellowship. The event was coordinated by District III Chair Irina Burd, MD, a third-year resident at Thomas Jefferson University in Philadelphia.™

### Find ideal position through ACOG's Career Connection

START YOUR SEARCH FOR A rewarding career in women's health through ACOG's Career Connection. Post your resume online and search for jobs at no cost. The search function allows candidates to search by job positions, locations, and keywords. Employers can search through online responses to postings and can quickly search a candidate's profile, review his or her CV, and contact the candidate online. Career Connection is a part of the *HEALTHeCAREERS* Network.™

#### info

→ Click on the ACOG Career Connection logo on the ACOG home page, [www.acog.org](http://www.acog.org)  
 → 888-884-8242; [info@healthcareers.com](mailto:info@healthcareers.com)



# 2006-07 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

## 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

19-22

### The Academy of Breastfeeding Medicine 11th Annual International Meeting

Niagara Falls, NY  
www.bfmed.org  
914-740-2115

## 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

27-29

### ACOG District IV Annual Meeting

Palm Beach, FL  
800-673-8444, ext 2488

27-29

### ACOG District VII Annual Meeting

White Sulphur Springs, WV  
800-673-8444, 2542

28-31

### Armed Forces District Annual Meeting

Sonthofen, Germany  
800-673-8444, ext 2571

29-Nov 4

### ACOG District I Annual Meeting

St. Johns, Virgin Islands  
800-673-8444, ext 2531

## NOVEMBER

5-10

### International Federation of Gynecology and Obstetrics (FIGO) World Congress

Kuala Lumpur, Malaysia  
www.figo2006KL.com  
+60-3-4252-9100

6-9

### American Association of Gynecologic Laparoscopists

Las Vegas  
www.aagl.org  
800-554-2245

8-11

### ACOG District III Annual Meeting

Kohala Coast, HI  
800-673-8444, ext 2574 or 2556

8-11

### ACOG District VI Annual Meeting

Kohala Coast, HI  
800-673-8444, ext 2574 or 2556

8-11

### ACOG District VIII Annual Meeting

Kohala Coast, HI  
800-673-8444, ext 2574 or 2556

8-11

### ACOG District IX Annual Meeting

Kohala Coast, HI  
800-673-8444, ext 2574 or 2556

11-14

### American Medical Association Interim Meeting

Las Vegas  
www.ama-assn.org  
800-673-8444, ext 2516

14

### ACOG WEBCAST: Shoulder Dystocia and Brachial Plexus Injury: Can They Be Predicted and Prevented?

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

17-18

### Council of Medical Specialty Societies Annual Meeting

Chicago  
www.cmss.org  
847-295-3456

## DECEMBER

12

### ACOG WEBCAST: Preview of New Codes for 2007

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

## 2007

## JANUARY

12-14

### Gynecologic Oncology Group

San Diego  
www.gog.org  
215-854-0770

15-20

### Society for Maternal-Fetal Medicine 27th Annual Meeting

San Francisco  
www.smfm.org  
800-673-8444, ext 2476

20-21

### ACOG's Ninth Annual Treasurers Conference

Orlando, FL  
scathcart@acog.org  
800-281-1551

27-30

### South Atlantic Association of Obstetricians and Gynecologists

Hot Springs, VA  
www.saaobgyn.org  
904-384-8230

## ACOG COURSES

- For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit [www.acog.org](http://www.acog.org) and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
- For Coding Workshops, visit [www.acog.org](http://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.

## 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

## Campaign mobilizes patients in medical liability reform fight



**F**ELLOWS CAN HELP THEIR OB PATIENTS join the fight for medical liability reform through ACOG's free Birth Announcement Campaign. Physicians give their patients preaddressed, postage-paid birth announcements to send to their US senators with a simple message: "Please pass medical liability reform so my ob-gyn can keep delivering beautiful babies like ours."

Fellows and Junior Fellows across the country are participating in the campaign, and ACOG birth announcement cards have been arriving at the US Senate from 19 states and Washington, DC. In particular, New York, Nevada, and Delaware have generated a high volume of cards.

The cards, which come with an attractive set-up display ideal for physician reception areas, are free and come in sets of 250. <sup>TM</sup>

### info

→ Email [govtrel@acog.org](mailto:govtrel@acog.org) your name, phone number, delivery address, and quantity of cards wanted



## Promoting early detection

**I**NFORMATION IS AVAILABLE online on how to promote National Breast Cancer Awareness Month next month. Throughout October many mammography facilities will be offering special programs and extended hours.

Resources available from the National Breast Cancer Awareness Month campaign include tips on how to get the word out about the importance of mammograms and early detection through physician offices and workplaces and throughout the community. Some of the successful ideas include:

- ▶ Running a prerecorded telephone message about the importance of mammograms for patients to listen to while on hold
- ▶ Scheduling a physician from your practice to speak to local media about breast cancer detection
- ▶ Combining local flu shot clinics with enrollment for mammography and clinical breast exams

Resources also include a sample proclamation, a press release, and public service announcement scripts. <sup>TM</sup>

### info

- [www.nbcam.org](http://www.nbcam.org)
- To find a local mammography facility accredited by the Food and Drug Administration: 800-4-CANCER and select option for "information specialist"
- The National Breast and Cervical Cancer Early Detection Program of the Centers for Disease Control and Prevention provides screening for medically underserved women: [www.cdc.gov/cancer/nbccedp/index.htm](http://www.cdc.gov/cancer/nbccedp/index.htm)

## Advocacy fellowship accepting applications

**A**PPLICATIONS ARE BEING accepted for the Physician Advocacy Fellowship, which supports doctors to develop or enhance their advocacy skills by implementing a project in partnership with an advocacy organization. The deadline for short proposals is October 6.

The program is sponsored by the Center on Medicine as a Profession at Columbia University's College of Physicians and Surgeons.

The fellowship seeks to make advocacy a core professional value for physicians by developing a cadre of advocates with expertise in achieving system or policy-level social change at the local, state, and national level.

The fellowship supports 50% of a fellow's time for 12 to 24 months, is open to physicians nationwide, and does not require relocation. <sup>TM</sup>

### info

→ [www.imapny.org/advocacy](http://www.imapny.org/advocacy)



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## NASPAG calls for abstracts

**T**HE NORTH AMERICAN SOCIETY for Pediatric and Adolescent Gynecology is now accepting abstracts for its 2007 Annual Clinical Meeting, to be held April 19–21 in Atlanta. Abstracts must be submitted electronically and be received by November 15. <sup>TM</sup>

### info

→ [www.naspag.org/ACM/abstracts.html](http://www.naspag.org/ACM/abstracts.html)