

## Emergency contraception approval restricted



**A**COG CONTINUES TO ADVOCATE FOR UNIMPEDED ACCESS to emergency contraception for all women of reproductive age, after the US Food and Drug Administration approved over-the-counter status for Plan B emergency contraception in August—but only for women age 18 and older.

“There is no scientific or medical reason to impose an age restriction and to withhold EC from teenagers. EC is safe for over-the-counter use by women of all ages,” said ACOG President Douglas W. Laube, MD, MEd. “By restricting Plan B’s availability to women 18 and older, the FDA has missed an unparalleled opportunity to prevent teenage pregnancies. Each year there are more than 800,000 teen pregnancies in

the US, with many ending in abortion.”

The FDA has also placed restrictions on how Plan B can be sold to adults. It can be sold only in drugstores that have pharmacies and not through convenience stores or other retail outlets. It must be stocked behind the pharmacy counter and can be sold to women and men 18 and older only with proof of age. Barr Pharmaceuticals, the maker of Plan B, has also agreed to monitor the effectiveness of the age restriction and the distribution to adults.

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## Exploring options for returning to practice

**R**ECENT CLINICAL EXPERIENCE and liability coverage—“cases and coverage”—are big challenges for ob-gyns who want to return to practice after a hiatus. Both hospitals and liability carriers have heightened their scrutiny.

“For ob-gyns, hospitals are increasingly requiring verification of recent clinical experience, including the number of deliveries and gynecological surgery,” said Lindsay Neal, of Medical Doctor Associates, a firm headquartered in Norcross, GA, that recruits physicians for both locum tenens and permanent positions.

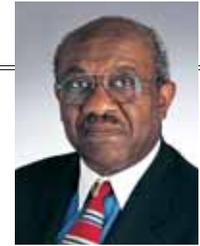
Ob-gyns who have been away from practice sometimes contact ACOG for ideas on how to return, and Immediate Past President Michael T. Mennuti, MD, appointed a task force earlier this year to examine the issue.

### Residency training format used as one approach

Thomas A. Raskauskas, MD, a member of the ACOG Task Force on Reentry, has established a mechanism he hopes can serve as a model to provide the “cases and coverage” for ob-gyns wanting to return to practice after a break.

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EXECUTIVE DESK

# Take a sneak peek at the 2007 ACM

**A**S MANY OF YOU START TO PREPARE for the cold winter months ahead, let's think instead of sunshine and blue skies—early-bird registration is now open for the 2007 Annual Clinical Meeting, to be held in sunny San Diego, which boasts a year-round warm climate and 70 miles of beaches.

The ACM will be held May 5–9 in California's second largest city, and I welcome you to register now. The 2007 scientific program will include several hands-on postgraduate courses, which are in high demand every year. Approximately 20 courses will be designated as "value-added" offerings, a designation we created last year that identifies courses that may contribute to learning in specific areas of clinical competence. Returning to the ACM are the "brown bag seminars," a popular type of session started at the 2006 ACM. These seminars are regular sessions that include boxed lunches for attendees.

A new event at the 2007 ACM will be a "farewell reception" at noon on Wednesday, the final day of the meeting. The reception will be held in the Exhibit Hall, providing ACM attendees quality time with the hundreds of exhibitors.

Another special event will be the annual President's Dinner Dance, which will be held on an aircraft carrier, the USS Midway, which is now the San Diego Aircraft Carrier Museum. The USS Midway is the longest-serving aircraft carrier in US Navy history and is located in downtown San Diego at Navy Pier. Business-casual attire is encouraged, and dinner will be buffet-style. Children are welcome to attend, and adults and kids alike will enjoy the tours and other entertainment, including the use of flight simulators.

This is just a "sneak peek" at a few of the offerings at the 2007 ACM. As we continue to develop a premier scientific program and special events for you, stay tuned to *ACOG Today* and the ACOG website for more information. And don't miss out on the discount offered by early-bird registration,

which is now open. Visit [www.acog.org/acm](http://www.acog.org/acm), and I'll see you in May!™



*The ACM will be held in sunny San Diego, which boasts a year-round warm climate and 70 miles of beaches.*

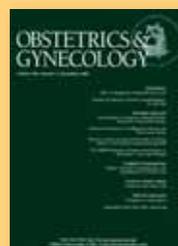
*Sterling B. Williams, MD, MS*

**Sterling B. Williams, MD, MS**  
Vice President, Education Division

IN MEMORIAM

- Albert H. Dudley, MD** • Baltimore
- L. Ange Kozlow, MD** • West Bloomfield, MI
- Arnold Manor, MD** • Carmel, CA • 6/06
- Harold R. Weiss, MD** • Chicago • 2/06
- Horace G. Williams, MD** • Memphis, TN

Obstetrics & Gynecology HIGHLIGHTS



**The October issue of the Green Journal includes the following ACOG documents:**

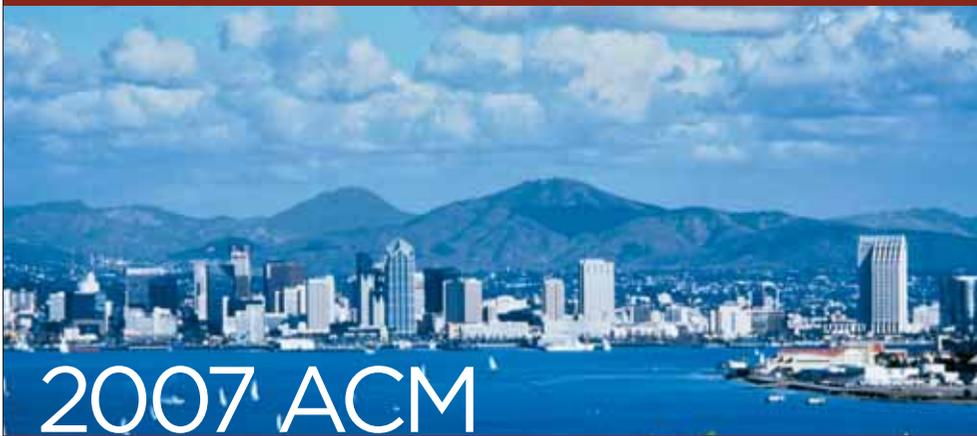
**Vulvodinia**  
(Committee Opinion #345, new)  
For more information, see article on page 13.

**Amnioinfusion Does Not Prevent Meconium Aspiration Syndrome**  
(Committee Opinion #346, new)

**Postpartum Hemorrhage**  
(Practice Bulletin #76, replaces Committee Opinion #266)

## ACM early-bird registration now open

SAN DIEGO • MAY 5-9



# 2007 ACM

**“Guiding the New Direction of Women’s Health Care”**

- ▶ Register on the ACOG website at [www.acog.org/acm](http://www.acog.org/acm)
- ▶ Register early and save on registration fees and make your hotel reservation

## New committee to focus on practice operations

**A** NEW ACOG COMMITTEE IS evaluating practice management strategies and tools to help members run effective and efficient practices.

The Committee on Ambulatory Practice Operations is a merger of the former Committee on Practice Management and Committee on Electronic Medical Records. The new committee, which held its first meeting at ACOG headquarters in September, is staffed by the ACOG Health Economics Department in the Fellowship Division.

“Merging the committees made perfect sense,” said Mark S. DeFrancesco, MD, chair of the new committee and chair of the former Committee on Practice Management. “It was a natural fit, especially since EMR and other electronic tools, such as e-prescribing and online health records, are expected to play a bigger role in practice operations.”

The committee will continue to look at numerous practice management issues, including pay-for-performance, patient safety, coding, consumer-directed health plans, reimbursement, and negotiating strategies with payors.

### **Practicing in the 21st century**

“We want to examine some of the ways that ob-gyns can redesign their office in the 21st century that will not only increase their practice’s bottom line but will also provide for more patient satisfaction,” Dr. DeFrancesco said.

**“This committee is well qualified to offer ACOG members its expertise on current practice management issues and health information technology.”**

ACOG Vice President of Fellowship Activities Albert L. Strunk, JD, MD, said that the committee answers a need for Fellows.

“Fellows are seeking information about all forms of health information technology, and ACOG is a natural place to turn,” Dr. Strunk said. “This committee is well qualified to offer ACOG members its expertise on current practice management issues and health information technology.”™

## Join Ob-Gyns for Women’s Health



**D**O YOU WANT to shape decisions in Washington, DC, that affect the future of our specialty? Join Ob-Gyns for Women’s Health, ACOG’s advocacy arm on Capitol Hill.

ACOG leads the way in representing ob-gyn and women’s health interests. To enhance the ability of ob-gyns to participate in the political process, ACOG leaders created Ob-Gyns for Women’s Health six years ago. OGWH can, and does, dedicate its entire operations to lobbying and political work, helping elect ob-gyn supporters to the US Congress.

### **Join on your dues statement**

When you receive your ACOG dues renewal mailing in November, join or renew your membership in Ob-Gyns for Women’s Health. OGWH membership is just \$40 a year. Join the thousands of ob-gyns who have already added their names to this powerful organization, and take charge of your future.™

### **info**

→ [www.obgynsforwomenshealth.org](http://www.obgynsforwomenshealth.org)

### **LETTER TO THE EDITOR**

**AS A VOLUNTEER OFFICER** OF the Northeast Florida Health Start Coalition, I wanted to express my appreciation for your article on the importance of psychosocial screening in pregnancy and the tool developed by the Florida Healthy Start Coalition (*ACOG Today*, August 2006).

We are trying very hard to reduce the number of perinatal and infant deaths associated with adverse societal and psychological stressors.

Thank you so much for your enunciation of ACOG’s support.

—James T. Dawsey, MD, FACOG  
Fernandina Beach, FL

### How FIMR works

- FIMR process begins when a fetal or infant death is identified
- FIMR staff collect data, including medical records, about the death and the services the woman received
- A trained professional interviews the woman to record her experience of support services and the care she received
- The case is deidentified, summarized, and presented to a Case Review Team. The team, which can include ACOG Fellows, identifies health system and community factors that may have contributed to the death and makes recommendations for community change
- Findings and recommendations are presented to a Community Action Team, comprised of members who are in a position to direct change at the community level. ACOG Fellows can be members of this team and be influential in implementing FIMR actions.

## Successful FIMR model expanded

**T**HE NATIONAL FETAL AND INFANT Mortality Review program is adapting the FIMR model to examine other maternal and child health sentinel events. The Centers for Disease Control and Prevention has provided grant funding for NFIMR to collaborate with CityMatCH, the national organization of local health departments' maternal and child health programs, to use the successful FIMR model to examine missed perinatal HIV prevention and treatment opportunities. Pilot programs have been set up in Baton Rouge, LA; Jacksonville, FL; and Detroit.

NFIMR is also adapting FIMR to review cases in which women drink alcohol while pregnant and are at risk for having a baby with fetal alcohol spectrum disorders, with pilot projects in Detroit and Baltimore.™

## Fellows strive to reduce infant mortality

**I**N SARASOTA, FL, NUTRITION counseling has been implemented to address poor nutrition and obesity, and child care workers and parents are educated about safe sleeping recommendations to address high rates of infant suffocation due to improper sleeping environments. In Kent County, MI, a written screening tool screens pregnant women for intimate partner violence, mental health issues, and substance abuse.

These public health interventions are outcomes of the Fetal and Infant Mortality Review program, which, in approximately 200 communities across the US, develops interventions to improve perinatal service systems and resources. ACOG's involvement in fetal and infant mortality review began in 1990–91 when Ezra C. Davidson Jr, MD, was ACOG president. Under Dr. Davidson's initiative, ACOG established the National FIMR program resource center in partnership with the federal Maternal and Child Health Bureau—a collaboration that continues today.

### Developing resources and community partnerships

In Sarasota, the case review process showed a need to educate women on the dangers of smoking while pregnant. To reach women effectively, community members suggested that educational advertisements be placed in city buses.

"The best people to tell you how you're going to be successful are people in the community rather than you and I going into the community and telling them 'this is what you need to do,'" said Fellow Washington C. Hill, MD, chair of the ob-gyn department and director of maternal-fetal medicine at Sarasota Memorial Hospital. "FIMR has brought the nurses, physicians, and community together to try to improve pregnancy outcomes. That's what it's all about."

In Kent County, MI, which includes Grand Rapids, the FIMR team found that contributing factors in a fetal or infant death are often interconnected.

"If we looked at mental illness, depression, and multiple stressors, they often related to substance abuse, violence, [lack of] transportation, and 'transition,' which could include a new job or a new living situation," said Fellow Joseph S. Moore, MD, medical director of the Kent County FIMR program.

The program developed a written screening tool for violence, mental health issues, and substance abuse along with a resource guide and a decision tree to assist the practitioner or staff.

"The resource guide has been a useful tool and includes all the various service agencies in areas such as transportation, mental health resources, and substance abuse resources," Dr. Moore said.

### Setting community goals

The Kent County FIMR program also created a Prenatal Partnership Council, which developed a list of community recommendations. Goals include:

- ▶ Decreasing the number of women who become pregnant before age 19
- ▶ Having providers screen for STDs routinely, not based on socioeconomic levels or stereotypes
- ▶ Providing nutrition education
- ▶ Decreasing substance use exposure during pregnancy
- ▶ Ensuring appropriate and timely prenatal care services
- ▶ Developing cultural competency programs
- ▶ Addressing the problem of missing data on medical charts

"This is a continuous quality improvement program," Dr. Moore said. "We hope that over time we will be able to see the impact in a particular area based on changes that have been made."™

### info

- [nfmr@acog.org](mailto:nfmr@acog.org)
- On the ACOG website, [www.acog.org](http://www.acog.org), under "Women's Issues," click on "National FIMR Program"

## Fellow election voting begins soon



**T**HE 2007 FELLOW DISTRICT and section officer elections will be held online, with voting beginning Nov 20, 2006, for section elections and Dec 20, 2006, for district elections.

Fellows will be able to access online ballots by using their last name and their ACOG ID number, a seven-digit number that can be found on all ACOG mailings. Paper ballots will be offered only by request. More information will be provided in the November/December issue of *ACOG Today*, as well as in monthly resource mailings, on the ACOG website, and by email.™

### Online Section Elections

Voting begins on November 20 at: <https://eballot3.votenet.com/acogfellow>

### Online District Elections

Voting begins on December 20 at: <https://eballot3.votenet.com/acogfellow>

#### info

- For your ACOG ID, contact the Membership Department: [membership@acog.org](mailto:membership@acog.org); 800-673-8444
- For election updates, on the ACOG website, [www.acog.org](http://www.acog.org), under "Membership," click on "District and Section Activities"
- For questions about elections, contact Megan Willis: 800-673-8444, ext 2531; [mwillis@acog.org](mailto:mwillis@acog.org)

## YOU ASKED, WE ANSWERED

# Settling a claim and your right to fight

**Q** I HAVE BEEN NAMED IN A liability lawsuit which, in my opinion, clearly has no merit. My insurance company wants to settle the case, and I am furious! What are my rights regarding the claims-resolution process?

**A** YOUR ABILITY TO HAVE A SAY in the claims-resolution process is especially important because medical claims payments can have an impact on medical staff privileges, health plan contracts, future medical liability coverage, and sometimes even physician licensure.

Many insurance companies retain the right to settle claims on behalf of their physician clients—whether or not the claim is meritorious and with or without the consent of the insured physician—because the expense or nuisance value of litigating the case is often greater to the insurance company than the settlement demand.

This practice can result in a monetary settlement for a nonmeritorious claim and mandatory reporting to the National Practitioner Data Bank, a cause of great distress to a physician who is not negligent and may even have provided exemplary care.

There are two clauses you should look for in your professional liability insurance policy to determine how much control the insurer has over the decision to settle a claim:

- ▶ "Right to consent to settlement" guarantees that finalizing any agreement to settle the claim must have your consent. Ideally, this is a provision you want to see in your policy; however, increasing num-

bers of policies written today do not provide this right

- ▶ A "hammer clause" requires that if you do not agree to an insurer's recommendation for settlement, you will be responsible for additional costs if a jury trial results in damages that are higher than the settlement the insurer recommended

Either of these clauses might appear in options written into your policy. You probably will not see the words "hammer clause," so look for language stating that if you refuse the insurer's recommendation to settle, you will be responsible for defense costs and any damages that exceed the recommended settlement amount.

If the cost of fielding a defense is subtracted from your indemnity limit, giving you, in effect, less coverage, then you may want to think twice before signing the contract.

Some insurers will allow insured physicians the opportunity to influence which details of the medical liability claim are submitted to the data bank. It is important for physicians to be aware of the details of their liability insurance contract regarding these significant issues. If your policy does not address these important factors, try to negotiate the inclusion of a right-to-consent-to-settlement clause and the exclusion of a hammer clause. The time to do this is before you purchase the policy.™

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

## ACOG WEBCAST → NOVEMBER 14 → 1 - 2:30 PM ET

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

The webcast will provide a comprehensive review of shoulder dystocia, focusing on etiology, incidence, risk factors, and management.

#### info

- Register at [www.acog.org](http://www.acog.org). Under "Meetings," click on "Postgraduate Courses and CPT Coding Workshops"

### How to participate

Participants need a telephone and a computer with Internet access. The cost for each webcast is per site, allowing several people to take part at the same location for one price. Continuing medical education credits are available.™



## Exploring options for returning to practice

► PAGE 1 Dr. Raskauskas is the ob-gyn residency program director at Saginaw's Synergy Medical Education Alliance, which is affiliated with Michigan State University. The program includes an initial evaluation to assess current competence and identify areas in which education and experience will require training. Then the ob-gyn begins practicing under supervision within the residency program.

"Our goal is to give them experience in things they've already been trained in—we don't provide training for procedures they've never done," he said.



*"Our goal is to give them experience in things they've already been trained in—we don't provide training for procedures they've never done."*

Physicians in the program are given a restricted Michigan license (the same type given to residents) if their license has lapsed or they are licensed in another state. Liability insurance is arranged at a discount through the state medical society's wholly-owned carrier.

The \$10,000 a month cost of the program is prohibitive to some. One ob-gyn who has not had any surgery experience for three years told *ACOG Today*, "I thought it would be a great way to get the experience I need to be credentialed, but I would probably need three months. I've been unemployed for a year, and there's no way I could come up with \$30,000."

Regarding the cost, Dr. Raskauskas noted that in some cases a physician could join the hospital as an employee, seeing only ambulatory patients, and the program cost would be applied against his or her salary.

Dr. Raskauskas hopes he can help the ACOG Task Force on Reentry develop some

guidelines for other institutions to create similar programs.

According to Howard A. Blanchette, MD, another task force member and chair of the ob-gyn Residency Review Committee, the reentry task force members believe it is essential that such a program not compromise residency training.

"There would have to be sufficient volume of patients and a supervisory mechanism to accommodate the reentry physician without detracting from the residents' training experience," he said.

### Denver firm offers structured evaluation and reentry plan

Another approach to reentry is offered by the Center for Personalized Education for Physicians, a nonprofit organization launched in 1990 by a coalition of Colorado groups, including the state medical society.

"The initial focus was to offer an evaluation and education strategy for physicians who had come under disciplinary or peer-review scrutiny, but in 2003 we created a program specifically for physicians who had voluntarily left practice," said Executive Director Elizabeth Korinek, MPH. Since then, about 20–30 "elective reentry physicians" have gone through the CPEP program.

For a fee of \$5,000–\$7,000, CPEP evaluates the physician's competence through written tests and interviews and works with the physician to develop a structured plan for reentry, which usually takes place in his or her community.

CPEP has approximately 150 physician consultants in the Denver area who provide specialty-specific evaluation. The resulting plan specifies skills and education needed and lays out how the education and experience will be attained. The plan usually calls for a transition from practicing with a specified degree of supervision to independent practice.

"The physician is often able to begin clinical practice and earn an income during the course of the plan," Ms. Korinek said. "It helps tremendously to have a document that says 'here are my strengths, these are the areas to work on, and here is the plan for how it is to be done safely.' Everyone understands what is expected, and the written document gives partners and the hospital something to respond to."

### Other options

Ms. Neal, of Medical Doctor Associates, offers this advice to individuals who want to return to practice: "First, they should update their CME hours. Then, find an ob-gyn colleague willing to allow them to shadow."

She suggests going to facilities close to home—"the local doctors are often willing to help because they know the ob-gyn."

Commenting about a case in which an ob-gyn has decided to stop practicing to be with her family, Ms. Neal said, "If she knows she's coming back in five years, the smartest thing she could do is work locum tenens—even short weekend stints would help her keep her skills level up. There's a huge need for ob-gyns right now. It's not just the need for vacation and emergency coverage—it's also the quality of life issue. Practitioners don't want to be on call 24-7; they want more balance, more time off to spend with family. You end up with a huge gap between the available workforce and the rising demand for ob-gyns."™

### info

- ACOG Task Force: Albert L. Strunk, JD, MD, ACOG vice president of fellowship activities, astrunk@acog.org; 800-673-8444, ext 2468
- Dr. Thomas A. Raskauskas: traskauskas@synergymedical.org; 989-583-6934
- CPEP: www.cpepdoc.org; Elizabeth Korinek: 303-577-3232



▲ 2006 Stump the Professors participant Jamie N. Bakkum, MD

Submission deadline: December 1

## Wanted: intriguing cases for Stump the Professors

**H**AVE YOU EVER COME ACROSS a case that stumped you and your colleagues? Have you managed a case that was unique, challenging, and exciting? The quest is on for cases relating to women's health that are intriguing, mind-boggling, and difficult for the Stump the Professors program at the 2007 Annual Clinical Meeting, which will be held May 5–9 in San Diego.

You must be a Junior Fellow to submit a case. Cases should require thought and attention to potential change in practice and represent the depth and breadth of ob-gyn.

Several cases will be presented for discussion at the ACM. The event will be held from 9:30 to 11 am on Tuesday, May 8.

Each presenter will receive free Junior Fellow ACM registration, coach airfare, and three days per diem for room and board. Cases must be submitted online. Submissions should consist of a one-page summary of 700 words or less, including final diagnosis. Deadline for submissions is December 1.™

### 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
- Chris Himes: 800-673-8444, ext 2561; [chimes@acog.org](mailto:chimes@acog.org)



### 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)

## ACOG's Career Connection offers new features

**C**AREER CONNECTION, ACOG'S OFFICIAL ONLINE job bank, has launched several new features to make your career search or career advancement easier than ever. All features are free to job seekers.

A new, easy-to-use resume builder allows you to create a resume online or upload your existing resume. You can store multiple resumes, post your resume online (confidentially, if desired), and create and send a cover letter along with your resume.

A new "My Site" section allows you to easily create and maintain your own password-protected career website, where you can:

- ▶ Create a home page
- ▶ Upload a photo
- ▶ Post your resume
- ▶ List references
- ▶ Upload or link to articles you've written or published
- ▶ Provide your unique website address to anyone you wish, including potential employers
- ▶ Brand your site as a member of ACOG™

## CREOG UPDATE

By Tamera J. Hatfield, MD, PhD, and Whitney B. You, MD, resident representatives to CREOG

### SURGICAL SIMULATION CENTERS

Many of the new surgical simulation centers are currently being evaluated and may soon be fully functional. Sterling B. Williams, MD, MS, ACOG vice president of educational activities, told attendees at the CREOG Council meeting in July. The idea is that residents will travel to a center to participate in a structured curriculum. With the decline in gynecologic surgery volume, the goal is that these centers will enhance surgical training for junior residents and others in need of further experience and skill development.

### RESIDENT WORKSHOPS

There will be three resident workshops in 2007. CREOG's *Workshop for Ob-Gyn Residents: Preparing to be Teachers & Leaders* provides great tips about teaching and adult learning that residents can incorporate into their individual training program. The workshops continue to be very successful, with increases in attendance every year. Look for upcoming announcements on the 2007 workshops.

### GENOMICS EDUCATIONAL OBJECTIVES

A hot topic at the July CREOG meeting was the new genomics educational objectives, a supplement to the CREOG *Educational Objectives: Core Curriculum in Obstetrics and Gynecology*. The genomics objectives, as well as all the educational objectives, can be downloaded from the CREOG website (see info below). Look for genomics questions on your next CREOG exam.

### CREOG EXAM

The 2006 CREOG exam was changed to a Thursday-Saturday format and had 5,272 examinees, with results returned within three weeks. Next year, the CREOG exam will have three different versions to enhance exam security.™

### info

- For more information on CREOG, on the ACOG website, [www.acog.org](http://www.acog.org), under "Education," click on "CREOG"

# ACOG conference cultivates future leaders

**S**ITTING UP STRAIGHT AND poised, yet relaxed and approachable. Presenting yourself as authoritative and knowledgeable, yet conversational and caring. Remembering to reiterate the important points and deliver good sound bites but explaining the facts effectively and in detail.

Rene B. Allen, MD, District IX Junior Fellow chair, met these challenges head-on as he took part in a mock television interview during a media training session, conducted by Penny Murphy, MS, ACOG director of communications, at the ACOG Future Leaders of Obstetrics and Gynecology Conference in August.



District IX Junior Fellow Chair Rene B. Allen, MD, practices his communication skills during a mock television interview.

"Participating in the mock interview was a great opportunity," Dr. Allen said. "It was much harder than I thought it was going to be. You really have to stay calm and quickly compose your answers while trying to deliver the right message, and it's also difficult to remember to stay smiling, maintain eye contact, and communicate clearly and efficiently, all while a bright spotlight is shining in your face. I will be much better prepared for the next time, or a real interview, because of this experience."

## Becoming involved in ACOG

The Future Leaders of Obstetrics and Gynecology Conference is held every two years to provide an opportunity for Junior Fellows in

practice and Fellows who have been in practice less than five years to hone their leadership skills and learn how to become more active in ACOG.

ACOG Executive Vice President Ralph W. Hale, MD, initiated the Future Leaders conference 10 years ago at the request of the Council of District Chairs. Each ACOG district is invited to send up to three participants.

Conference participants were given an overview of ACOG lobbying efforts and learned how they could educate the public about legislative and medical issues through the media. They learned about ACOG's internal and external structure, legal obligations and restrictions as a 501(c)(3) nonprofit organization, and parliamentary procedure. In addition, they took part in sessions on interpersonal skills development, decision-making, and meeting effectiveness, led by Dr. Hale.

"The team-building activities were wonderful," said Cynthia Gyamfi, MD, District II Junior Fellow chair. "I really enjoyed the media portion as well, and I developed much more of an understanding about the tax

category that ACOG falls under." Another benefit of the conference was the opportunity for the young ob-gyns to interact with their peers.

"I wanted to meet other young, goal-oriented physicians who will be the future leaders of our specialty," said John J. Thoppil, MD, Air Force Section Junior Fellow chair. "Junior Fellows and young Fellows have a different perspective on certain elements of the specialty, especially relating to graduate medical education. Younger physicians may also have a better grasp of what our generation wants from their physicians. Many issues that face the specialty, such as the liability crisis, impact us more than anyone else since we have our whole careers ahead of us."™



ACOG Executive Vice President Ralph W. Hale, MD, listens to Nicole E. Williams, MD, Illinois Section Junior Fellow chair. Dr. Hale created the Future Leaders conference 10 years ago.

## Why did you want to participate in the ACOG Future Leaders of Obstetrics and Gynecology Conference?

*"Through my practice and committed service to ACOG, I hope to create sound public policy that could move the profession forward as efficiently as possible. Only through collaboration with ACOG can sweeping progressive change take place. I am excited about my potential as a leader in this change."*

**Deborah A. Bartz, MD**  
Junior Fellow in Boston

*"As the future chair of District VII, I am extremely motivated to learn the working details of ACOG. I also want to develop my personal skills so that I can provide effective leadership to the Junior Fellows with whom I'll serve."*

**Neil Hamill, MD**  
District VII Junior Fellow vice chair

*"I have wanted to stay involved in ACOG because I really want to think about women's issues in a broader sense than I do every day in my office."*

**Eliza Buyers, MD**  
Young Fellow in Denver



## Breast cancer: what's new and promising

**R**ESearchers continue to look for more effective preventive, screening, and treatment options for breast cancer, whether it's evaluating film vs. digital mammography or studying the risks and benefits of raloxifene vs. tamoxifen.

During National Breast Cancer Awareness Month in October, *ACOG Today* is reviewing some of the most promising news in breast cancer prevention and treatment.

### MRI

"Breast MRI is an important ancillary tool to evaluate certain women," said ACOG Past President Vicki L. Seltzer, MD, vice president for women's health services at North Shore-Long Island Jewish Health System and chair of ob-gyn at North Shore University Hospital and Long Island Jewish Medical Center, New Hyde Park, NY.

While MRI should not be used for routine screening for average-risk women because of a high risk of false positives, "it may be helpful as an adjunct in high-risk women and may be helpful to define something further when other radiographic images are inconclusive," Dr. Seltzer said. The American College of Radiology has a list of indications for when breast MRI is appropriate ([www.acr.org](http://www.acr.org)).

### Film vs. digital mammography

The DMIST trial showed that film and digital mammography were equally efficacious, but in subset analyses, digital mammography missed fewer cancers in premenopausal women and in women with dense breasts.

"The take-home message, in my opinion, is that women need to know what kind of mammography they are having and what it shows; for example, fatty breasts or dense breasts," said Fellow Carolyn D. Runowicz, MD. "For women with dense breasts, I am recommending digital mammograms when available—most centers are getting digital machines or already have them."

Dr. Runowicz is director of the Carole and Ray Neag Comprehensive Cancer Center at the University of Connecticut Health Center and the current president of the American Cancer Society.

### Tamoxifen vs. raloxifene

The STAR Trial results earlier this year indicated that the osteoporosis drug raloxifene was as effective as tamoxifen in reducing the risk of invasive breast cancer in postmenopausal women who were at increased risk for breast cancer, but that raloxifene had a lower risk of uterine cancers and blood clots than tamoxifen did. Women taking either drug had an equal number of strokes, heart attacks, and bone fractures.

"Only postmenopausal higher-risk women were included in the STAR Trial. Prophylaxis is not recommended for women at average risk of developing breast cancer," Dr. Seltzer said. "A conclusion of the STAR Trial for prevention of breast cancer in high-risk, postmenopausal women was that raloxifene had a better risk profile. However, since tamoxifen was associated with a lower incidence of preinvasive breast cancers, there has been continued discussion regarding the clinical implications for women."

A study in the Jul 13, 2006, issue of the *New England Journal of Medicine* on raloxifene's effect on heart disease and breast cancer found that raloxifene was associated with an increased risk of fatal stroke and venous thromboembolism when compared with placebo. In an accompanying editorial, Marcia L. Stefanick, PhD, wrote, "An important question raised by [this] trial is how to balance the substantial relative reductions in the risks of invasive breast cancer and clinical vertebral fractures with the increases in the risks of venous thromboembolism and fatal stroke."

"The logical question is, what level of breast cancer risk would justify the use of raloxifene for the prevention of breast cancer for a given person, if one takes into account the competing risks and patient preferences? Complicating the answer is our inability to predict these risks with high accuracy on an individual basis," she continued.

### BRCA1 and BRCA2

Bilateral prophylactic mastectomy is an option chosen by some women with BRCA1 and BRCA2 gene mutations. Because women with BRCA1 and BRCA2 mutations are also at

increased risk for ovarian and fallopian tube cancers, some have chosen to have a prophylactic bilateral salpingo-oophorectomy to reduce this risk. There are data to suggest that bilateral salpingo-oophorectomy also reduces a woman's risk of breast cancer in women with BRCA1 and BRCA2 mutations, according to Dr. Seltzer.

### Partial breast radiation vs. whole breast radiation

An ongoing national trial is comparing the effectiveness of partial breast radiation vs. whole breast radiation for women with early breast cancer who have had a lumpectomy with negative margins. Although it is very important to have much more definitive data on comparative efficacy, benefits, and risks, some patients are already choosing partial breast radiation rather than whole breast radiation because the treatment is given over a much shorter interval (10 treatments over five days rather than the traditional daily treatments for approximately six weeks), Dr. Seltzer said.

"It's important that women enroll in clinical trials comparing partial breast radiation to standard radiation treatment so that we can determine the efficacy of partial breast radiation," Dr. Runowicz said. "Ob-gyns can play an important role in informing patients about these and other trials that help further our clinical knowledge."™

### info

- STAR Trial: [www.mdanderson.org/star](http://www.mdanderson.org/star)
- DMIST: [www.cancer.gov/dmist](http://www.cancer.gov/dmist)



Vicki L. Seltzer, MD, at the 2006 ACM

# Immunize pregnant patients against flu

**W**ITH THE ARRIVAL OF FLU season, ACOG reminds ob-gyns that an intramuscular, inactivated flu vaccine should be given to pregnant women in any trimester.

The ideal time to vaccinate pregnant women is October and November, but any time throughout the influenza season is appropriate—the flu season runs from October 1 through mid-May, usually peaking in February.

“Flu shots should be a part of routine prenatal care,” said Stanley Zinberg, MD, MS, ACOG’s vice president of practice activities. “Immunizing the mother offers some immunity to her infant also, which is important to protect infants because there is not a flu vaccine approved for infants younger than six months.”

## Vaccinating health care workers

It’s also important for all health care workers—physicians and their staffs—to be vaccinated so they don’t infect patients. The Cen-

ters for Disease Control and Prevention has been placing special emphasis on the vaccine recommendation for health care workers because of the number of patients who become infected by health care workers each year.

The federal Advisory Committee on Immunization Practices released updated recommendations for the prevention and control of influenza in July. Updated recommendations include:

- ▶ Vaccinate healthy children ages 24 months to 59 months and their household contacts and out-of-home caregivers
- ▶ Health care providers and agencies should develop plans for expanding outreach and infrastructure to vaccinate more people than the previous year and develop contingency plans for vaccine delays
- ▶ Continue to offer flu vaccines throughout flu season even after influenza activity has been documented in a community

## Inactivated vs. live vaccine

The inactivated influenza vaccine is safe for



people six months and older, including those with high-risk conditions. The live, attenuated influenza vaccine, marketed as FluMist, is approved for use among healthy people ages 5 to 49, but is not recommended for pregnant women.™

## info

- Committee Opinion *Influenza Vaccination and Treatment During Pregnancy* (#305, November 2004)
- ACOG Patient Education Pamphlet *Immunizations for Women*: available through the ACOG Bookstore, <http://sales.acog.org>; 800-762-2264
- [www.cdc.gov/flu/professionals/vaccination](http://www.cdc.gov/flu/professionals/vaccination)
- Patient education materials: [www.cdc.gov/flu/professionals/patiented.htm](http://www.cdc.gov/flu/professionals/patiented.htm)

# Emergency contraception approval restricted

▶ PAGE 1



## ACOG continues EC education efforts

Through its **Ask Me.** campaign launched earlier this year, ACOG will continue to educate women about EC and how they can get it. ACOG reaffirms its priority of preventing unintended pregnancy and reducing the number of abortions in the US.

The theme of the **Ask Me.** campaign is “Ac-

cidents happen. Morning afters can be tough.” Campaign materials include posters for physicians’ examination and waiting rooms and the **Ask Me.** button—a key element designed to promote dialogue between the patient and her ob-gyn about emergency contraception (see info below).

## EC access still hindered

While the FDA’s approval of over-the-counter EC for adults may be perceived as a substantial victory for women across the country, that is not necessarily the case. Women will still have difficulty obtaining EC in some areas where individual pharmacists refuse to fill prescrip-

tions or may not stock EC. In addition, the FDA requirements that Plan B be stocked behind the pharmacy counter and sold only in stores with pharmacies will hinder access.

“A common goal is for every pregnancy to be planned for the optimal health of the woman and her baby. However, contraceptive failures occur, accidents happen, and teenage women in particular may not always have control over their own sexuality,” Dr. Laube said. “Pregnancy should not be viewed punitively, as a ‘price’ that they have to pay. Emergency contraception offers a safe and effective alternative that should be readily available.”™

## info

- For **Ask Me.** campaign buttons and posters, email [communications@acog.org](mailto:communications@acog.org)
- [www.fda.gov/cder/drug/infopage/planB/default.htm](http://www.fda.gov/cder/drug/infopage/planB/default.htm)

## Screening patients for depression during pregnancy and postpartum

**A**BOUT 10% OF WOMEN SUFFER from depression during pregnancy, and 10% suffer from postpartum depression, but experts believe that depression during and after pregnancy is greatly underdiagnosed and undertreated.

“Screening for depression is part of good health care for anyone, particularly women,” said Fellow Linda R. Chambliss, MD, MPH, ob-gyn professor at St. Louis University School of Medicine. “Depression is a common problem. If you think you can predict someone who is depressed by some sort of outward characteristic, you’re going to miss an awful lot of patients. Screening for depression takes just a few minutes, and you can make a huge difference in patients’ lives.”

*“Depression is a common problem. If you think you can predict someone who is depressed by some sort of outward characteristic, you’re going to miss an awful lot of patients.”*

Fellow Paul A. Gluck, MD, immediate past chair of the Florida Section, saw how prevalent depression was when he took part in a Florida Section screening project. “In a two-week period, I screened all 250 patients seen in my office, and about 20% screened positive for depression and some of them, previously undiagnosed, had severe symptoms,” he said.

That screening project asked two questions, which can be asked on the patient intake form and/or by the nurse or physician:

- ▶ Do you feel down or sad?
- ▶ Do you no longer enjoy the same activities that you used to?

“The physical symptoms of depression can be similar to the physical symptoms of pregnancy and postpartum—such as not sleeping well, having a backache, changes in appetite—which can make depression difficult to diagnose,” Dr. Gluck said. “Be aware that not one symptom will make the diagnosis. The two-question screening tool needs to be validated by other tools and further discussion.”

### Management of depression

Although ob-gyns are able to prescribe antidepressants to patients, some may feel they don’t have the expertise to treat a patient for her depression. But that shouldn’t stop ob-gyns from screening their patients, according to Dr. Chambliss.

“As ob-gyns we screen patients for conditions and diseases all the time that we might not treat ourselves. Just because you’re not fluent with the latest management of cardiac diseases, doesn’t mean you don’t screen for heart disease,” she said. “When you screen for something it doesn’t mean that you have to treat it yourself; you just need to be aware of where to refer your patient for management.”

Practices that screen for depression should have systems in place to ensure that positive screening results are followed by accurate diagnosis, implementation of treatment, and follow-up either within the practice or through referral, according to ACOG Committee Opinion *Psychosocial Risk Factors: Perinatal Screening and Intervention* (#343, August 2006).

When Dr. Chambliss suggests counseling, sometimes patients are initially taken aback, so she continues to educate and encourage them.

“I explain it like this: ‘I’m primarily an ob-gyn and although I have some training in this area, I would prefer to send you to an expert. It’s just like if you had a bad heart. While I can begin to do some of the work, your condition would be best managed by a cardiologist, someone with expertise in that particular area. It’s the same for depression—it would be best managed by an expert.’”

### Not just the “baby blues”

Dr. Chambliss educates both her patients and their partners and other family members about the signs of depression and the difference between the “baby blues” and postpartum depression.



#### DEPRESSION RESOURCES

- ▶ [www.4woman.gov/faq/postpartum.htm](http://www.4woman.gov/faq/postpartum.htm)
- ▶ [www.nimh.nih.gov](http://www.nimh.nih.gov)

#### ACOG RESOURCES

- ▶ Committee Opinion *Psychosocial Risk Factors: Perinatal Screening and Intervention* (#343, August 2006)

The following are available through the ACOG Bookstore:  
<http://sales.acog.org>; 800-762-2264

- ▶ ACOG Patient Education Pamphlet *Postpartum Depression*
- ▶ ACOG Patient Education Pamphlet *Depression*
- ▶ *Clinical Updates in Women’s Health Care* monograph *Depression in Women*

“The baby blues happens very soon after the delivery, and patients usually feel better after a week or two, while postpartum depression lasts longer and has more severe symptoms. It may occur any time after delivery, even a few months later.”

She encourages patients and their families to contact her immediately if symptoms begin to appear—not to wait for the patient’s scheduled follow-up appointment.™

# Too few Americans receiving effective preventive health services

**C**HLAMYDIA SCREENING, colorectal cancer screening, and smoking interventions are among the top preventive health services that are being underutilized, according to a study sponsored by the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality.



*Priorities for America's Health: Capitalizing on Life-Saving, Cost-Effective Preventive Services* identifies the most beneficial and cost-effective preventive health services and highlights that, for many of these valuable preventive services, more than 50% of Americans go without them.

The study evaluated all the preventive services currently offered by physicians and developed a ranking of 25 recommended services on the basis of those that provide the greatest health benefits, both in terms of saving lives and improving quality of life, while offering the most value for health care dollars.™

## info

- *Priorities for America's Health* report: [www.prevent.org/hcpp](http://www.prevent.org/hcpp)
- Smoking cessation: On the ACOG website, [www.acog.org](http://www.acog.org), under "Women's Issues," click on "Smoking Cessation"
- Colorectal cancer screening and chlamydia screening: Committee Opinion *Primary and Preventive Care: Periodic Assessments* (#292, November 2003)

## Diagnosing, treating vulvodynia

**A**NEW ACOG COMMITTEE Opinion provides an introduction to the diagnosis and treatment of vulvodynia, a complex disorder that can be difficult to treat.

Vulvodynia is a diagnosis given when no other cause can be found for a patient's vulvar pain and discomfort, which can include burning, stinging, irritation, and rawness. The document, *Vulvodynia*, was published jointly by ACOG and the American Society for Colposcopy and Cervical Pathology, in the October issue of *Obstetrics & Gynecology*.

To diagnose and evaluate patients, cotton swab testing should be used to localize painful areas and classify the pain.

Most treatment information is based on clinical experience, descriptive studies, or reports of expert committees; there are very few randomized trials of vulvodynia treatments. Treatments that have been used by clinicians include medication, biofeedback training, physical therapy, dietary modifications, cognitive behavioral therapy, sex counseling, and surgery.

"No single treatment is successful in all women," the Committee Opinion concludes. "Expectations for improvement need to be realistically addressed with the patient. Emotional and psychological support are important for many patients, and sex therapy and counseling may be beneficial."™

## Some of the top effective but underutilized preventive services

### Chlamydia screening

Chlamydia is the most common bacterial STD in the US, with an estimated 3 million new cases each year, but 60% of sexually active women younger than age 25 have not been screened for chlamydia, according to the report. ACOG recommends routine screening for chlamydia for sexually active women 25 and younger and any woman with risk factors.

### Colorectal cancer screening

Colorectal cancer is 90% preventable and, if caught early, 90% treatable, but the report showed that 65% of the target population is not up-to-date on screening. As outlined in ACOG's Committee Opinion *Primary and Preventive Care: Periodic Assessments* (#292, November 2003), ACOG recommends that women age 50 and older be screened for colorectal cancer by one of the following:

- ▶ Fecal occult blood testing every year or
- ▶ Flexible sigmoidoscopy every five years or
- ▶ FOBT every year plus a flexible sigmoidoscopy every five years or
- ▶ Double-contrast barium enema every five years or
- ▶ Colonoscopy every 10 years

Some women in high-risk groups should be screened before age 50 (see Committee Opinion #292 for more information).

### Tobacco intervention

Effective but underutilized tobacco intervention includes screening patients to determine if they smoke or use other tobacco products, providing brief smoking cessation counseling, and offering patients therapies and referrals to help them quit. Although it's one of the three most important and cost-effective preventive services, 65% of adults have not received this service as it is recommended, the report stated. ACOG promotes the 5 "A"s—Ask, Advise, Assess, Assist, and Arrange—an evidence-based approach to screening for and treating tobacco use.

## South Dakota Fellows alert public to abortion ban's effect on ob-gyn care



**ACOG FELLOWS IN** South Dakota are educating citizens about the detrimental effects an abortion ban would have on ob-gyn patient care.

In preparation for a November 7 vote on the ban, the ACOG South Dakota Section has been speaking out against the ban, and some individual Fellows are involved in the South Dakota Campaign for Healthy Families, a coalition created to oppose the ban.

In March, the South Dakota Legislature passed HB 1215, the harshest abortion bill passed in the US in the last 33 years. HB 1215 criminalizes almost all abortions, forbidding a woman from having an abortion except when her life is in danger. In response, the South Dakota Campaign for Healthy Families was created and waged a successful petition drive to suspend implementation of the ban and place it on the November ballot. It's now up to South Dakota citizens to decide whether to reject or approve the ban.

"There was a backlash that was unexpected by the ban's supporters. South Dakota is a conservative state, but this bill was considered too extreme—it doesn't have any exceptions for rape or incest or for the health of the mother," said ACOG Fellow Marvin E. Buehner, MD, a cochair of the coalition. "The intent

of the ban all along was to challenge Roe vs. Wade at the Supreme Court level, all at the expense of the South Dakota taxpayers."

### Criminalizing ob-gyn care

Ob-gyns are speaking out in the media and to state legislators, explaining how ob-gyns care for and counsel patients and outlining the negative impact the ban would have on ob-gyn practice.

"The legislative criminalization of an accepted medical procedure places an undue burden on women and their health care providers," said Keith A. Hansen, chair of the South Dakota Section. "It places the health care provider in an untenable position in which he or she must decide whether to deviate from medical ethics or the law. An example is the first-trimester patient with cervical cancer who desires the most effective therapy for the cancer. This law does not allow one to treat, or refer for treatment, someone with a clearly health-altering medical condition, which may become life-threatening in the future if not aggressively and immediately treated."

It's this type of example ob-gyns want citizens to understand.

"When people are truly educated about the bill and its ramifications, they're against the ban," Dr. Buehner said.™

### ACOG weighs in on Supreme Court cases

**A**COG IS FILING A "FRIEND-OF-THE-COURT" brief in the US Supreme Court in two cases challenging the federal Partial Birth Abortion Ban Act of 2003. President Bush signed the act into law in November 2003, but it has never taken effect because of legal challenges.

Physicians and medical groups filed three separate lawsuits challenging the act in federal courts in New York, Nebraska, and California. In each case, the trial court ruled the act unconstitutional and the decision was upheld on appeal. The government then sought review of the Nebraska and California cases by the US Supreme Court.

ACOG's amicus brief will support the parties challenging the law, pointing out that the ban does not include an exception to protect a pregnant woman's health and that its terms are vague and overly broad. The cases are expected to be argued back-to-back in November.

These cases are very similar to a case regarding a law passed by Nebraska to prohibit so called "partial-birth" abortions. In 2000, the Supreme Court ruled that the Nebraska law was unconstitutional because it did not include an exception for the health of the woman. In striking down the Nebraska law, the Court relied heavily on ACOG's Abortion Policy and the amicus brief that the College filed in that case. The Court's opinion cited ACOG's policy several times and took the unusual step of quoting a portion of ACOG's amicus brief.™



### ACOG meets with state legislators

**A**COG ADVOCATED medical liability reform and women's health issues at the National Conference of State Legislators Annual Meeting in August in Nashville, TN.

This marked the fifth straight year that the College united with other medical organizations to sponsor a booth. The message at the ACOG booth was "Dear state legislator, it's time to deliver!" with information about the devastating effects that increasing medical liability premiums are having on women's health care. ACOG also distributed materials for the College's **Ask Me.** emergency contraception campaign and provided the College's statement on the new HPV vaccine.™

# 2006-07 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

## 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

28-30

### Summit on Environmental Challenges to Reproductive Health and Fertility

(University of California, San  
Francisco School of Medicine  
and the Collaborative on Health  
and the Environment)  
San Francisco  
www.ucsf.edu/coe/prhesummit.  
html

## FEBRUARY

7-10

### International Symposium on Radical Hysterectomy: 16th Annual Review Course on Gynecologic Oncology and Pathology

Kyoto, Japan  
info@macc.jp

9-10

### North American Society for Psychosocial Obstet- rics and Gynecology Annual Meeting

Portland, OR  
www.naspog.org  
800-673-8444, ext 2570

## MARCH

3-7

### Society of Gynecologic Oncologists Annual Meeting on Women's Cancer

San Diego  
www.sgo.org  
312-235-4060

7-10

### CREOG and APGO Annual Meeting

Salt Lake City  
CREOG: 800-673-8444,  
ext 2558  
APGO: 410-451-9560

## 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.

## 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

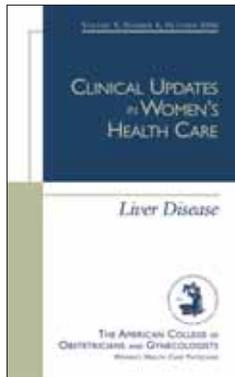
Chicago

8-10

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

Atlanta

## Newest *Clinical Updates* on liver disease



**T**HE LATEST MONOGRAPH IN THE *CLINICAL UPDATES* in *Women's Health Care* series is *Liver Disease*.

The publication points out that many liver conditions are more common in women than men and that the liver may be damaged by alcohol, drugs (prescribed, over-the-counter, illicit, and herbal substances), infection, toxins (in the environment, the home, or the workplace), and complications of pregnancy. In addition, liver disease is more common in obese women, and the current obesity epidemic will place many more patients at risk, according to the publication.

The monograph, written by two hepatologists, should help ob-gyns identify patients with liver disease and those at risk of developing it, diagnose specific conditions, offer preventive counseling or therapy, refer patients to hepatologists when indicated, and improve the quality of health care for patients. <sup>TM</sup>

### info

→ [www.clinicalupdates.org](http://www.clinicalupdates.org); 800-762-2264

## ACOG PATIENT EDUCATION

### Information you and your patients can trust

These titles are 20% off for a limited time. Order at <http://sales.acog.org>; 800-762-2264.

#### *Problems of the Digestive System (AP120)*

- ▶ How does the digestive system work?
- ▶ What are some common digestive problems?
- ▶ How will I be screened for colorectal cancer?

#### *Weight Control: Eating Right and Keeping Fit (AP064)*

- ▶ What is a healthy weight for me?
- ▶ What are some of the risks of being overweight?
- ▶ What are some tips to help me control my weight?

#### *Healthy Eating (AP130)*

- ▶ What is a well-balanced diet?
- ▶ How can I make nutritious food choices?
- ▶ What nutrients do I need to stay healthy?



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Permit No. 6418



## National Infertility Awareness Week

**T**HE 2006 NATIONAL INFERTILITY Awareness Week will be held October 29 to November 4. The week is sponsored by Resolve: The National Infertility Association and is supported by ACOG.

National Infertility Awareness Week is a nationwide effort to raise awareness of infertility through educational events and media coverage. Resolve will also offer educational events for women and men suffering from infertility. <sup>TM</sup>

### info

→ [www.resolve.org](http://www.resolve.org)

## Ob-gyns needed for BRCA study

**H**EALTH CARE PROFESSIONALS who provide care to young women at risk for hereditary breast and ovarian cancer are invited to participate in the study *Health Care Provider Interactions with and Recommendations for Young Women at Risk for Hereditary Breast and Ovarian Cancer*.

The study aims to describe how health care providers perceive their interactions with young women who have received a positive or uninformative BRCA mutation test and describe the recommendations for follow-up treatments or plans given by the health care providers.

Participants will be interviewed by phone or email, whichever is more convenient for them. Phone interviews will take approximately 30–60 minutes and will be audiotaped. Email interviews will include exchanging approximately 4–5 emails with 3–4 questions each. <sup>TM</sup>

### info

→ For questions, contact researcher Rebekah Hamilton, PhD, RN, at 412-648-9259 or [hamilr@pitt.edu](mailto:hamilr@pitt.edu)