THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

OCTOBER 2008

Weak economy hits ob-gyn practices

AS THE COST OF GOODS, GAS, AND ENERGY REMAIN high across the US, ob-gyns are feeling the pinch. The price tags on supplies—everything from gowns and gauzes to specula and specimen containers—have increased as vendors pass on their costs to medical practices. Ob-gyns also face new costs related to stocking vaccines and purchasing new supplies and equipment to allow for in-office procedures. In some areas, this has combined with a decrease in patient visits as patients postpone their annual exams and forgo elective procedures.

"We're as concerned as any other business person. Inflation impacts our ability to pay our employees, and expenses are rising," said Robert W. Yelverton, MD, chief medical officer of Women's Care Florida in Tampa and chair of ACOG's Committee on Ambulatory Practice Operations.

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2009 FIGO Congress, South Africa

ACOG MEMBERS ARE ENcouraged to make plans now to attend the landmark triennial Congress of FIGO (the International Federation of Gynecology and Obstetrics) next October.

The FIGO World Congress of Gynecology & Obstetrics will be held in Africa for the first time, in Cape Town, South Africa, at the Cape Town International Convention Center, Oct 4–9, 2009.

The Congress is the only event that gathers specialists in ob-gyn from all over the world. FIGO expects to exceed the attendance of the 2006 event, which attracted more than 6,000 delegates from 120+ countries and territories.

"We're one year away from the FIGO Congress, and planning is well under way," said ACOG Executive Vice President Ralph W. Hale, MD, FACOG, who is chairing the FIGO Congress Organizing Committee. "We wanted to give our Fellows this early notice to allow them ample time to plan to attend. FIGO, according to its bylaws, rotates this meeting between the five regions of the world, so FIGO will not be back in Africa for at least 15 years,

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acogTODAY

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EXECUTIVE DESK

Congress fails to fix flawed Medicare fee formula

AS I WRITE THIS AT THE END OF A long, hot summer, it is time to review the primary issue that has occurred since our Annual Clinical Meeting this past May. As we entered June, the major item affecting medicine was the impending reduction in Medicare fees as a result of the flawed Sustainable Growth Rate, a formula derived from factors such as cost of living, medication costs, and health care costs that is used to determine reimbursement.

The Medicare fee cut was projected at 10.6% effective July 1. Fortunately, a coalition of physician groups, the American Medical Association, and others were able to prevail after some US Senate procedural-delaying maneuvers seemed to prevent changes.

The end result was to delay the reduction for 18 months and to allow a small 1.1% increase. During this time, I received a number of emails from our Fellows asking how this affected ob-gyns. It does in two ways: First, the low reimbursement rates affect those who accept Medicare, Medicaid, and TRICARE patients. Second, many private payors use the Medicare reimbursement rates for their plans as well.

Hopefully, this 18-month window will allow the next Congress to address and fix the system and replace the bandage approach that now exists.

Health care and the presidential election

We are now in the home stretch of the presidential and congressional campaign season. Health care—and lack thereof—is a major issue for both parties. ACOG continues to carefully monitor candidates' health care plans and the potential impact such plans would have on women's health care.

This year your Committee on Government Relations and Outreach approved an ACOG "Health Care for Women, Health Care for All" campaign, which outlines the College's national health care reform agenda. ACOG has been successful in getting a congressional resolution supporting this concept. As I write this, we are hoping to get our reform ideas incorporated into the platforms of the Democrats and Republicans. During the past four years, women's health care has not been a high priority in Washington, so we are hoping for a renewed focus on health care, whoever the new president is.

Come November, we will be able to see where and how to respond to the new administration. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

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Columbus, OH

***Obstetrics & Gynecology* HIGHLIGHTS**

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

Ultrasonography in Pregnancy
(Obstetrics Practice Bulletin #98, revised)

Use of Progesterone to Reduce Preterm Birth
(Obstetrics Committee Opinion #419, revised)

Each issue of the Green Journal lists the latest ACOG documents (and their website address) that have been reaffirmed by their respective committees. Documents are reviewed by ACOG on a routine basis and are either revised, withdrawn, or reaffirmed as is.

ACOG *Compendium* slims down for 2009

THE 2009 *ACOG COMPENDIUM of Committee Opinions and Practice Bulletins* will be a more succinct version of ACOG recommendations, including only those documents published in 2007 and 2008. A companion CD-ROM will include all current ACOG documents. Fellows and Junior Fellows in practice will receive the *Compendium* plus the CD-ROM, while Junior Fellows in residency will receive the CD-ROM.

All current Committee Opinions, Practice Bulletins, and other documents are also available on the ACOG website, and the new *Compendium* and the CD-ROM are also available through the ACOG Bookstore.

"As the number of reports from ACOG grows, the size of the *Compendium* grows," Executive Vice President Ralph W. Hale, MD, said. "A few years ago the *Compendium* reached such a large size that we had to divide it into two publications: one for Committee Opinions and one for Practice Bulletins."

A recent survey of Fellows about the *Compendium* identified a number of concerns, Dr. Hale said.

"The major problem is the size and the separation of the two publications. Even though there is an index in each volume that covers both volumes, it has not been effective."

Most members reported rarely using any document that was older than two or three years. All ACOG documents are reviewed 18–24 months after publication and are either revised, reaffirmed, or withdrawn.

"This means that we need to have the most recent documents readily available and the others available by reference," Dr. Hale said. "This change will be a one-year trial, and I hope each member will give us feedback on the new concept." ♀

Finding ACOG documents online

- Visit www.acog.org. Look under the "Publications" tab, and click on the appropriate link
- **Advanced search:** If you're unsure of the type of document, you can use the website's "advanced search" function to search by keyword through all Committee Opinions and Educational/Technical and Practice Bulletins

Fellow voting begins online in December

THE 2009 FELLOW DISTRICT and section officer elections will be held online, with voting beginning December 15.

Fellows will be able to access online ballots by using their last name and their ACOG ID number, which can be found on all ACOG mailings or obtained by contacting the ACOG Membership Department. Paper ballots will be offered only by request.

More information will be in the November/December issue of *ACOG Today*, as well as in monthly resource mailings, on the ACOG website, and by email. ♀

Voting begins December 15:
https://eballot3.votenet.com/acogfellow

info

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

ACOG partners for television cancer event

BE SURE TO WATCH THE landmark television event *Frosted Pink with a Twist* on ABC on Sunday, October 12, from 4 to 6 pm Eastern Time. As a *Frosted Friend* partner, ACOG will join with the nation's leading cancer advocacy groups in this education initiative.

With nearly 261,000 women expected to be diagnosed with a woman's cancer in the US this year, *Frosted Pink with a Twist* aims to provide cancer education, encourage dialogue, celebrate survivorship, and empower women.

The television special will combine sports, entertainment, and health awareness by bringing together the 2008 US men's and women's Olympic gymnasts with today's top music stars and a host of celebrities.

The show will reair on cable stations throughout October, and the campaign website will provide resources for women. ♀

info

- communications@acog.org
- www.frostedpink.org

November 5 deadline

Submit abstracts for 2009 ACM Film Festival

YOU STILL HAVE TIME TO SUBMIT abstracts of films for the 2009 Film Festival at the Annual Clinical Meeting, to be held May 2–6 in Chicago. All abstracts must be submitted online.

The films should be on topics of interest to practicing ob-gyns. ♀

info

➜ For submission details and the online application, visit www.acog.org/acm

2009 FIGO Congress, South Africa

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and then most likely not in South Africa."

Details on registration, hotel reservations, and abstract submission will be posted on the Congress website this month (see "info" below).

Thomas F. Baskett, MB, professor of ob-gyn at Dalhousie University in Halifax, NS, is chair of the Scientific Program Committee for the Congress. Dr. Baskett is an ACOG Fellow and chair of the College's Committee on International Affairs.

"The conference offers a comprehensive profile of lectures and international speakers covering the whole spectrum of obstetrics and gynecology," Dr. Baskett said. "Our committee's goal is to ensure the latest information is presented by the best and brightest physicians worldwide."

"The conference offers a comprehensive profile of lectures and international speakers covering the whole spectrum of obstetrics and gynecology."

—Dr. Thomas F. Baskett

One plenary session at the Congress will be the first Howard Taylor Lecture. Howard C. Taylor Jr, MD, was a noted educator and leader at Columbia University.

"Dr. Taylor was a longtime ACOG Fellow, and as an educator he had few equals," Dr. Hale said. "Many of the most prominent researchers and teachers in our specialty were Dr. Howard Taylor trainees."

The current president of FIGO, who will preside over the meeting, is Dorothy Shaw, MBChB, an ACOG Fellow from Vancouver, BC, and the first female president of FIGO.

As the date draws near, more information will be posted on the ACOG website. ♀

info

➜ www.figo2009.org.za

Fellow dedicates career to victims of sexual assault

Dr. Randall L. Brown uses a forensic colposcope to visualize and photograph trace evidence and micro trauma of the vulva and vagina of sexual assault victims.

A GUT-WRENCHING CRY WAS coming from behind the curtain in the emergency department. This wasn't a patient who had been brought in for a dislocated shoulder or a broken bone. This wasn't a patient hysterical after a car accident or a child screaming for her parents. This cry was different.

The devastated, distraught wailing continued, so University of Florida second-year resident Randall L. Brown, MD, went behind the curtain to see what was happening. The patient was a woman, all alone, who had been raped and badly beaten.

"The counselor hadn't arrived yet, so I just held her hands and we talked, and I had an epiphany: If you're going to help someone as an ob-gyn, what better way than to help sexual assault victims?" Dr. Brown said.

Dr. Brown became the residency director of the local rape crisis center, and when he returned home to practice in Baton Rouge, LA, that city's rape crisis center director asked him to serve as the center's medical director. That was 28 years ago.

Dr. Brown practices "regular" ob-gyn by day, but his passion is helping the victims who are brought to the Baton Rouge Rape Crisis Center. Over the years, he has become an expert in conducting a sexual assault exam, but he has taken it several steps further.

Dr. Brown wanted to better understand forensic medicine and offer his patients more by collecting the best evidence he could. He realized that when he was conducting sexual assault exams, if a patient had been bitten in the attack, the exam wouldn't be finalized until Dr. Brown found an odontologist to examine the woman.

"It can be hard to find an odontologist in the middle of the night, and I realized I needed to do this, so I learned how to do bite mark casting and photography, and from there, I joined the American Academy of Forensic Sciences, and I began participating in their trainings and workshops so I could be in the forefront of forensics," he said.

Dr. Brown is the only ob-gyn member of the American Academy of Forensic Sciences and the only ob-gyn known to have received training as a forensic odontologist.

"I think the difference between a generalist doing a rape kit and in what I do is what I've learned by joining the Academy," Dr. Brown said. "I've learned a fair amount about DNA collection and interpretation. I've learned how to search for trace evidence, especially the finest fibers. I am able to look at a wound and postulate what might have caused the injury."

Making the case

Dr. Brown often serves as an expert witness in sexual assault court cases, but he says that the aim is to not go to court.

"We try to spare the victim having to testify and go through the nightmare all over again," he said. "If the evidence is powerful, and your case is strong, the defendant will often accept a plea bargain to avoid trial and a longer sentence."

Throughout Dr. Brown's career, he has seen a lot of changes in science and technology, with the use of DNA drastically changing evidence collection and improving law enforcement's ability to find attackers, especially in cold cases, through the DNA database known as CODIS.

"It's been an interesting evolution. Before DNA, we used a host of markers. We could get some good blood and serum antigenic markers. We could get it down to say that less than 1 in 100,000 people could have committed this crime, but in a city of 1 million that doesn't always impress the jury," Dr. Brown said. "In those days, we relied on eyewitness testimony and fingerprints. Then came DNA, and we had to convince the court, the appeals court, the juries, and the prosecutors about the reliability of DNA."

Then came the murder trial of O.J. Simpson, which brought detailed explanations of DNA into everyone's living room.

"Post O.J., every jury expected to see DNA with the assailant's address in bold letters on the helix, but we have assailants who use condoms; we have assailants who use gloves. It's almost a double-edged sword—juries say 'What do you mean you don't have DNA?'"

Training health professionals

At most of ACOG's Annual Clinical Meetings, Dr. Brown provides training on how to conduct a sexual assault exam, and he developed ACOG's DVD *Forensic Examination of the Adult Female Sexual Assault Victim*. He trains social workers, escort counselors, nurses, residents, other ob-gyns, and ER staff and doctors. Dr. Brown was recognized for his dedication to sexual assault victims by the US Department of Justice in 2007, receiving the Allied Professional Award.

What is Dr. Brown's No. 1 message to those conducting sexual assault exams? "First, compassion, then detail, detail, detail.

"Trace evidence is so important in these crimes," Dr. Brown said. "The serial rapists are smart enough to hide their evidence. They wear condoms. They wear gloves. We even had a guy who wore slippers so there was no shoe imprint at the crime scene.

"I take a lot of time to get [those I'm training] to think outside the box, to think 'where can I find evidence?'

"As a career physician, you find the things you do that are mainstream—delivering babies, doing annual exams—and then there are things that are a calling. My calling was to try to ease the suffering of rape victims, and I've been glad that I've done it."

Doesn't his work ever get to be too much to handle emotionally?

"You've got to hold on to the notion that you're doing some good," Dr. Brown said. "You don't sign up for this kind of work for a week. You sign up for a lifetime. You can see it in a victim's face as you're leaving the room and she holds your hand and thanks you. That's all you need to keep going for a few more days." ♀

Practice management tips to save money

As ob-gyns see prices go up and patient visits drop or stay level, they may have considered postponing new equipment purchases and holding off on filling empty staff positions. Several other practice management solutions can help them reduce expenses or earn more money, according to Mark S. DeFrancesco, MD, MBA, medical director and chief medical officer at Physicians for Women's Health in Connecticut.

"These tips won't work for everybody, but they are things to consider," Dr. DeFrancesco said.

Weak economy hits ob-gyn practices

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"Basic costs of intrauterine devices, disposables for ablation procedures, general office supplies, and hardware have been very expensive this year," Dr. Yelverton continued. "Because gas is up, bringing those disposable drapes to us is more expensive, and we can't pass that cost on to our 'customer' because our reimbursement rates are fixed."

Dr. Yelverton reports that his office has seen a 3.5% to 4% increase in the cost of disposable and nondisposable equipment this year at the same time that patient visits have stabilized or declined.

"New patient growth usually increases every year, but this year there's been no growth, and we think our patients may be trying to delay the expenses of taking care of children, as evidenced by a mild drop in OB rates," Dr. Yelverton said.

ACOG Treasurer James T. Breeden, MD, MSFS, a certified financial planner and president of the Carson Medical Group in Carson City, NV, points out that as people continue to lose their jobs, they also lose their health insurance. Even those who have insurance may have been hit with higher deductibles and copays in the last few years. Furthermore, patients faced with higher gas prices and grocery and energy bills are more likely to cut out doctor visits before other necessities.

"As patients delay payments, our accounts receivable are increasing, and our cash flow is suffering," Dr. Breeden said. "Physicians are holding off on purchasing equipment. Electronic medical records is a good example—they're very expensive to start out with, and there's not an immediate payback."

In Detroit, reproductive endocrinologist Kenneth A. Ginsburg, MD, reports a decline in new patient visits.

"We've definitely felt the crunch," he said. "New patient volume is down somewhat, as patients leave the area for better economic futures, lose their health insurance, or just put off fertility concerns at this time."

Because of this, the large health system Dr. Ginsburg works for has had to downsize staff and not fill some key positions. Other practices haven't had to lay off staff yet, but they are concerned.

"We haven't had to reduce positions, but we are cautious about rehiring when someone leaves," Dr. Yelverton said. "Several divisions of our large consolidated group have decided to delay major purchases of items such as ultrasound equipment until the economy improves."

In Utah, Robert J. Fagnant, MD, a practicing ob-gyn in St. George, has noticed the health effects on the newly uninsured.

"We have noticed that the increasing number of uninsured is bringing patients to the doctor later in their disease process," he said. "I have had a couple of patients who needed to be seen but did not come to the office because they lost their insurance and couldn't pay. They later ended up in the ER. When I talked to the ER doctor, he thought they were seeing quite a bit of this."

Dr. Fagnant sees patients who drive from towns 60 to 100 miles away, and some of his pregnant patients have asked if they can limit the number of their obstetric visits to save on gas. Dr. Fagnant wonders if the economic difficulties will cause the number of home deliveries to increase.

Postponing retirement

Another area the economy is affecting is physicians' retirement opportunities. With low stock prices, ob-gyns may be reluctant to withdraw retirement funds that may not be

tip 1

Schedule annual exams effectively

How do you recall patients? Periodically run a report of your patient list and see who hasn't been in for her annual exam in more than 12 months. Patients tend to average about 16 months before coming in for their annual exams, according to Dr. DeFrancesco. Earlier this year, his practice examined its patient list and found about 250 patients out of several thousand who were beyond due for their annual exam. Reminder letters and phone calls led to about 90 scheduled patient visits.

You can have staff carve out dedicated time to call these patients or instruct staff that whenever there's a break between the day-to-day work, they should call patients on the list.

To make sure patients come in before they ever get overdue for their annual exam, there are several techniques practices can use. Staff can reschedule patients for the next year at the end of their exam. Some of these appointments will have to be rescheduled, but most will not, Dr. DeFrancesco said. Then, staff can give reminder phone calls several days in advance. Because the exams are scheduled so far in advance, it's important to give reminders more than 48 hours before the visit, he said. Practices can also invest in automated telephone reminder systems, and, in the future, practices will probably be using email and text messaging reminders.

tip 2

Create a cross-covering program
Consider how many times physicians from two practices are both waiting in the labor and delivery unit as each of their patients goes through labor. What if the two practices negotiated a call system that meant that only one doctor was on call each night, allowing that ob-gyn to cover both practices' patients? By talking to your "friendly competitors," you may be able to create an effective and unique call-sharing program that could save both groups money.

tip 3

Reevaluate your employees' benefits package
"It might make sense to look at the health savings accounts and large-deductible plans and still make sure you are providing good benefits to your employees," Dr. DeFrancesco said. "Even if you switch to a larger-deductible plan, you can help the employee pay the higher deductible and possibly still save money with your lower premiums."

tip 4

Consider secure email systems
Email can be used to remind patients of visits, schedule new appointments, and notify them when lab results are available. "Think of all the time staff wastes playing phone tag with patients. If a patient gives you approval, you can text message and use email. But you have to be careful what type of information you put in the email."

These technologically savvy programs will improve patient satisfaction as well. "You'll save money and you'll get a practice reputation as being at the forefront of technology," Dr. DeFrancesco said.

worth as much as they were a few years ago.

"In the past, Fellows who no longer found it sustainable to continue to practice were usually of an age and financial means that they could retire," said ACOG Past President Michael T. Mennuti, MD. "Many older Fellows in a good financial situation continue to work, but when their practice starts losing money, retiring may no longer be the best option."

Dr. Yelverton spoke with a few colleagues who fit this bill: "The doctors considering retirement are postponing the decision. They feel this is not a good time to retire—they're waiting for the [stock] market to recover."

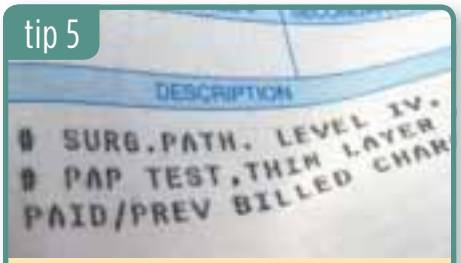
Facing medical school loans

On the other side of the spectrum, young physicians in practice face the additional pressure of paying their medical school loans. A recent practice pattern survey conducted by the Junior Fellow College Advisory Council found that 17% of the Junior Fellows surveyed had more than $200,000 in educational debt, and 23% had $150,000 to $199,999 in debt. In addition, 32% had more than $20,000 in non-educational debt, although 34% had no debt other than their school loans.

"Despite the debt, our survey showed that two-thirds would be a physician again, and, actually, 77% would choose ob-gyn again," said former JFCAC Chair Rajiv B. Gala, MD.

ACOG is currently conducting a socioeconomic survey, and the results should give a more in-depth analysis of how the economy is affecting ACOG members. For more information on the survey, see page 16. ♀

tip 5

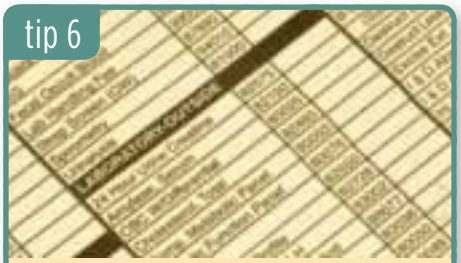


Negotiate with managed care companies
No matter how small your practice, you should try to negotiate better rates with your payors, Dr. DeFrancesco said.

"They're not all going to say 'yes,' but one might, and that will help."

Knowing your market area can give you leverage. "If you're the only doctor in your area, they need you."

tip 6

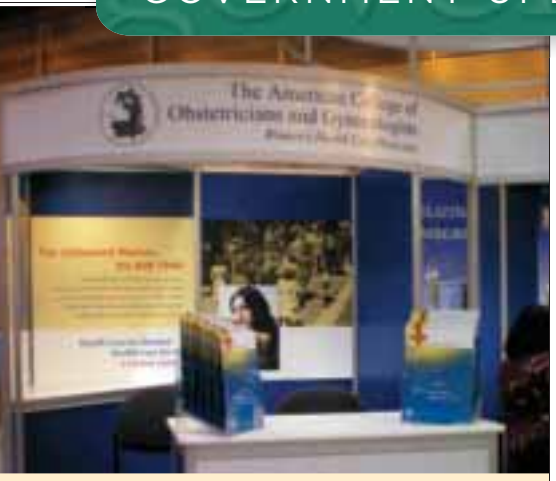


Create an automated lab results system
While there are some upfront costs, automated lab results systems will save time and money. Instead of sending lab results by mail or having staff call patients, patients would be given a phone number and pin number at their visit that they could use to access their results in a couple of days.

tip 7

Consider joining a group purchasing organization
Group purchasing organizations are companies that combine the purchasing power of several businesses to elicit better deals on equipment and supplies.

"You could save 15 to 20% off of supplies. You may already be getting good deals from your vendors, but every so often you should shop it out and at least consider GPOs," Dr. DeFrancesco said.



ACOG advocates at state legislator conference

ACOG TOOK ITS "HEALTH CARE for Women, Health Care for All" message direct to state lawmakers in July, advocating for health care reform during the National Conference of State Legislatures Annual Legislative Summit in New Orleans.

For the seventh straight year, the College united with other medical organizations, including the American Medical Association and the Louisiana State Medical Society, to sponsor a booth at the conference. The booth proclaimed "For uninsured women, it's still 1940," while highlighting the devastating health consequences that women with inadequate or no insurance must face.

The conference allowed ACOG staff to familiarize state legislators with important women's health issues and disseminate "Health Care for Women, Health Care for All" campaign packets. This new campaign outlines ACOG's national health care reform agenda, calling for universal access to maternity care and reform of the US health care system.

Health care issues were prominent on the conference agenda this year. Sessions included "Can We Afford Our Health Care?" and "Health Care Reform, An Economic Imperative?" ♀

info

➜ To access the campaign online, go to www.acog.org/goto/healthcarereform

➜ For more information or to order campaign kits: govtrel@acog.org

Help shape the future of the specialty

Join Ob-Gyns for Women's Health

ACOG LEADS THE WAY IN representing ob-gyn and women's health interests on Capitol Hill, addressing the issues that affect our specialty as no other national organization can.

Because ACOG is limited by law in how much it can spend in lobbying on your behalf, ACOG leaders created Ob-Gyns for Women's Health. OGWH dedicates its entire operations to lobbying and political work, helping elect ob-gyn supporters to the US Congress and augmenting ACOG's lobbying efforts on Capitol Hill.

Since OGWH was formed eight years ago, thousands of ob-gyns have joined and are helping make great strides in how Congress thinks about, and votes on, ob-gyn issues.

"I'm making sure that as many Fellows and Junior Fellows as possible join this important organization," said OGWH President Kenneth L. Noller, MD, MS. "Under my leadership, Ob-Gyns for Women's Health is focused on fighting for health care reform in Congress through effective lobbying and political action."

Join or renew today for just $40. You may join online (see "info" below) or join in November when you receive your ACOG dues renewal. ♀

info

➜ www.obgynsforwomenshealth.org

EARN CME CREDITS

Mar 1–3, 2009 • Washington, DC

Attend ACOG's 2009 Congressional Leadership Conference

JOIN MORE THAN 200 ACOG members in lobbying Congress when ACOG's 27th Annual Congressional Leadership Conference, The President's Conference, convenes Mar 1–3, 2009, in Washington, DC.

Following two days of advocacy training at the CME-accredited conference, ACOG Fellows and Junior Fellows will urge congressional action on key issues. Participants will learn to communicate with legislators at federal and state levels, gain valuable knowledge from Washington insiders about legislation that affects the specialty and patients, and lobby members of Congress.

Fellows and Junior Fellows are sponsored by their district or section chairs to attend the conference. Sponsorship covers travel, registration, lodging, and incidental expenses. Participants who self-sponsor can attend by paying a $300 registration fee, plus travel and lodging expenses. ♀

At ACOG's 2008 Congressional Leadership Conference, US Sen. Susan Collins (R-ME), left, and a staff member discuss women's health issues with Maine Junior Fellow Nell V. Suby, MD, center.

info

➜ Contact your district or section chair if you're interested in attending. For more information, contact ACOG's Government Affairs staff at 800-673-8444, ext 2509

YOU ASKED, WE ANSWERED

Resident feels unqualified to perform certain procedures

Q I'M IN MY FIRST YEAR OF residency at an institution where I'm feeling pressured by my supervisor to perform procedures I don't feel qualified to carry out. What is the best way to handle this without jeopardizing my reputation?

A THE BEST TIME TO FIND out the procedures you should follow and resources available to you to resolve dilemmas like this is before the situation arises. The following actions will help you handle these situations:

- Learn about your residency program's protocols for services that you find objectionable
- Find out whether the hospital or residency program has specific procedures or resources to help you address dilemmas
- Obtain and review copies of the department policies and hospital procedures
- Know the chain of command for reporting problems
- Talk with more senior residents and attending physicians about possible informal ways for addressing dilemmas

Care you are not trained to provide

Always be aware of the limitations of your own skills, knowledge, and expertise. Remember, too, that not every supervising physician will be familiar with the details and extent of your training and abilities. If asked to perform a duty beyond your training, follow these guidelines:

- When you work without direct supervision, perform only procedures for which you have been fully trained
- Do not provide a service you are not qualified to perform. Ask for assistance
- Follow your program's procedures for requesting help or refusing to provide a service
- If there is no specific protocol, make your request through the hospital's chain of command

If no one is available to substitute for you or assist you, you will have to weigh the risks: Is the risk of harm greater if you provide the service or will the patient suffer more harm if you do not provide care? Be sure to document your efforts to find someone more qualified to take over or assist you. ♀

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.

Safe Count program reduces cases of retained sponges

HOSPITALS IN MINNESOTA are using a new protocol to reduce the number of foreign objects left in patients. However, the focus is not on instruments left inside patients undergoing surgery. Instead, the hospitals are reducing the number of sponges left inside women giving birth vaginally.

After an adverse event reporting law in Minnesota took effect in 2003, hospital personnel were surprised to learn that sponges in vaginal delivery were the retained objects reported most often, according to Julie Apold, director of patient safety for the Minnesota Hospital Association.

Individual hospitals began instituting count systems, but the hospital association decided to develop a program that would standardize the count system statewide. The Safe Count program is based on a best-practice protocol developed by the Institute for Clinical Systems Improvement in Minnesota. The program requires two people—one must be a registered nurse—to do the count. They must count together, out loud, while both look at the sponges. Counting may seem like a simple task, but by not focusing on counting, and by continuing to open new packets of sponges during delivery, it can be easy to lose track.

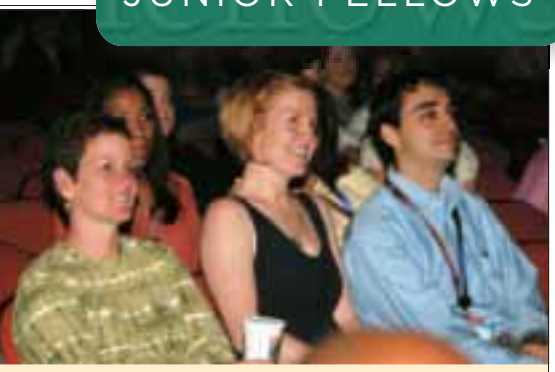
The Joint Commission's list of reportable sentinel events includes retained foreign objects in vaginal deliveries. A retained sponge can cause patient discomfort and anxiety, and there's potential for infection.

Fellow Kathryn G. Flory, MD, chief of obgyn at North Memorial Health Center in Robbinsdale, MN, was on the planning committee for the statewide initiative. Her hospital had begun its own sharp and sponge count program in 2004 in response to Minnesota's adverse event reporting law.

"We had had four cases of retained sponges, so we changed our delivery tray setups and trained nursing staff on how to do sponge counts," Dr. Flory explained. "A big change is that we took our uncounted sponges off the tray and now only put counted sponges on the table once the physician asks for them. At this point, we've not had another retained sponge since the program began." ♀

info

➜ Safe Count Toolkit: www.mnhospitals.org/index/tools-app/tool.385



2008 Stump the Professors audience

November 30 deadline

WANTED:

Challenging, intriguing cases for 2009 Stump the Professors

HAVE YOU EVER COME across a case that stumped you and your colleagues? Have you managed a case that was extremely unique, challenging, and unforgettable?

The quest is on for ob-gyn cases that are intriguing and mind-boggling for The Gerald and Barbara Holzman Stump the Professors program at the 2009 Annual Clinical Meeting, May 2–6 in Chicago.

Submitting cases

You must be a Junior Fellow In-Training to submit a case. Cases should require deliberation and be considerate of potential change in practice.

Four Junior Fellows will be selected to present their cases at the ACM. The event will be held from 9:30 to 11 am on Tuesday, May 5. Each presenter will receive free Junior Fellow ACM registration, coach airfare, and travel and hotel expenses for three days.

Cases must be submitted online. Submissions should include a one-page summary of 700 words or less, including a final diagnosis. The deadline for submissions is November 30. ♀

info

- On the ACOG website, www.acog.org, click on "Junior Fellows" in the "Quick Links" box on the left side of the home page
- Erica Bukevicz: 800-673-8444, ext 2428; ebukevicz@acog.org

Junior Fellows' top concerns

RESULTS OF A JUNIOR FELLOW needs assessment show that the Junior Fellow College Advisory Council is on track in the services and opportunities it provides Junior Fellows.

Junior Fellows listed the top ACOG issues that the JFCAC should focus on as:

- Addressing the medical liability crisis
- Teaching business and practice management skills
- Developing curricula for education simulators and models
- Protecting women's reproductive rights
- Recruiting medical students

"We conducted this needs assessment to take the pulse of the Junior Fellows in practice and training," said JFCAC Chair Eric J. Hodgson, MD. "The JFCAC projects should be focused on the issues that matter most to Junior Fellows, and it's gratifying to know that Junior Fellow officers have been effectively bringing forth ideas and concerns from the Junior Fellows in their districts."

ACOG has long advocated the protection of women's reproductive rights and the need to address the medical liability crisis. The College advocates these issues at state legislatures, on Capitol Hill, and through media outreach.

In the area of the business of medicine, ACOG offers a successful business of medicine course for Junior Fellows at the Annual Clinical Meeting every year and publishes *The Business of Medicine: An Essential Guide for Obstetrician-Gynecologists*. In addition, the College offered a free webcast earlier this year on the topic.

The JFCAC has led the way in ACOG's medical student recruitment efforts, creating mentorship programs, supporting ob-gyn student interest groups, and greatly expanding ACM offerings with the creation of a medical student course, an ob-gyn residency fair, and hands-on workshops created specifically for medical students.

To address the need for more educational opportunities, with a primary focus on patient safety, ACOG has created a Simulations Consortium, a group of existing simulation centers that will allow residency programs to have access, on a strictly voluntary basis, to established centers. The current consortium consists of nine simulation centers, but plans are to more than double that number in the next two years. ♀

info

- eric.hodgson@yale.edu

'THE DAY I MADE A DIFFERENCE' ESSAYS DUE NOVEMBER 30

JUNIOR FELLOWS ARE ENCOURAGED to share their thoughts on "Ob-Gyn … The Day I Made a Difference" for this year's Junior Fellow essay contest. Essays are due November 30.

Submissions should provide reflection on a day that you felt you made a difference, whether it was a clinical, political, social, public, or international event. You must be a Junior Fellow, and essays should be between 500 and 750 words. ♀

info

- On the ACOG website, www.acog.org, click on "Junior Fellows" in the "Quick Links" box on the left side of the home page

JFCAC projects move forward during summer meeting

Executive Board approves creation of leadership program for section officers

By Eric J. Hodgson, MD, JFCAC chair

THE JUNIOR FELLOW COLLEGE Advisory Council met in August in Washington, DC, for our summer working meeting. This was the first time that both district chairs and vice chairs were able to attend together, which allows our rising chairs to hit the ground running on initiatives important to Junior Fellows. Synergistically, we continue to build on the work of last year and move forward on key initiatives for the coming year.

Some of the newest areas of activity are directly related to physician leadership development, my major initiative as JFCAC chair.

Training program for Junior Fellow section officers

Being a Junior Fellow leader is beset with many rewards and many challenges, particularly on the section level. Our newest ACOG leaders—most often resident physicians—usually have not been exposed to ACOG's many programs, benefits, and resources before becoming an ACOG representative. They have no formalized training about ACOG and often have a difficult time reaching their goals during this two-year position.

In light of this, a major initiative of the JFCAC will be to create a formal national training program for Junior Fellow section vice chairs held immediately prior to the Congressional Leadership Conference, The President's Conference, a three-day event about ACOG's legislative initiatives that culminates in lobby visits on Capitol Hill.

The ACOG Executive Board approved the section vice chair leadership program in July, and planning is in full swing. In addition to this program, we are working to incorporate Junior Fellow-specific training sessions during the Congressional Leadership Conference.

Expanding medical student recruitment efforts

Attracting the best and brightest into ob-gyn continues to be a major effort of the College. The primary focus this year will be the creation of a new medical student recruitment video. Filming is under way, and we hope to have a finished project by the end of the year.

Upcoming JFCAC projects

The results of our recent Junior Fellow needs assessment reveal that our membership wants more resources focused on three main areas: addressing the liability crisis, business of medicine/practice management skills, and development of programs for educational simulators and models (see article on page 10).

Many Junior Fellows are also interested in women's health advocacy and want to see improvements in the medical liability crisis. We are working to create an easier way for Junior Fellows to get involved at the state and national level. If you are interested in getting more involved in women's health advocacy, please email me at eric.hodgson@yale.edu, and we will find a way to get you involved.

Continuing projects of the JFCAC

Of course, there are many exciting initiatives that the JFCAC will continue to advance. We are finalizing a survey of residency programs to gather information about existing maternity/paternity leave policies so we can determine the most productive next steps to ensure an equitable and fair maternity/paternity leave policy.

It is an honor and a privilege serving as a national JFCAC officer. I look forward to an exciting and productive year. If you have any questions or would like more information on how to get involved, please email me at eric.hodgson@yale.edu. ♀

Advance your career with ACOG's online job bank

CAREER CONNECTION, ACOG'S OFFICIAL online job bank, has several features to make your career search or career advancement easier than ever. All features are free to job seekers.

An easy-to-use resume builder allows you to create a resume online or upload your existing resume. You can also store multiple resumes and create and send a cover letter along with your resume.

A "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 ♀

info

→ Click on the ACOG Career Connection logo on the ACOG home page, www.acog.org

→ 888-884-8242; info@healthecareers.com

An occasional series in which *ACOG Today* looks at emerging trends for a specific women's health issue

What's new in urinary incontinence

As the US population continues to age, the number of women who will suffer from stress incontinence and pelvic organ prolapse is likely to increase.

To evaluate a patient for incontinence, a history and physical examination are necessary first steps. After proper evaluation, management options to consider include behavior and lifestyle modifications, such as pelvic muscle exercises and scheduled voiding. Some prescription drugs can be effective for frequency, urgency, and urge incontinence, but they don't work for everyone, and side effects are common, according to ACOG Practice Bulletin *Urinary Incontinence in Women* (#63, June 2005).

For pelvic organ prolapse, pessaries are the only specific nonsurgical treatment and are often considered as first-line treatment.

When nonsurgical options aren't effective for stress incontinence, it may be time to consider surgery. Several new surgical techniques and products have been developed in recent years, but there are few randomized controlled trials comparing them. Because data are insufficient, ACOG makes no recommendations about many of the following products.

"Some of these products and new techniques are being rapidly incorporated into clinical practice, but ACOG cautions clinicians to follow the emerging data as they become available," said Hal C. Lawrence III, MD, ACOG vice president for practice activities.

There have been two pivotal trials comparing the open Burch procedure to slings.

Michael E. Albo, MD, et al, conducted a multicenter, randomized clinical trial aimed at reducing stress incontinence that compared the Burch colposuspension with the pubovaginal sling using autologous rectus fascia. The study, which was published in the May 24, 2007, issue of the *New England Journal of Medicine*, showed that, at 24 months, the sling procedure had a higher success rate, at 47%, compared with the Burch procedure, at 38%. Even though there were more complications of urinary tract infections, urge incontinence, and voiding dysfunction with fascial slings, subjective treatment satisfaction rates at 24 months were greater for the sling group, at 86%, compared with the Burch group, at 78%.

In contrast, a randomized trial published in 2002 by Karen Ward and Paul Hilton, MD, showed similar success rates for the Burch procedure and the tension-free vaginal tape (TVT) sling.

Which slings to use?

As more surgeons use sling procedures for incontinence, the question becomes which slings are the best? Again, few data exist.

When using mesh slings, the configuration of the mesh is very important, as not all polypropylene mesh is the same, according to Cheryl B. Iglesia, MD, director of the section of female pelvic medicine and reconstructive surgery at Washington Hospital Center and associate professor in the ob-gyn and urology departments at Georgetown University in Washington, DC.

"People will pick something up because it's newer and they think it's better, but that's not necessarily the case," Dr. Iglesia said.

Concern for vascular and visceral injury, as well as voiding dysfunction, led to the development of transobturator (TOT) slings, which completely avoid the retropubic space.

There have been a few studies comparing retropubic slings to TOT slings. One recent multicenter trial by Matthew D. Barber, MD, MHS, et al, reported in the March 2008 issue of *Obstetrics & Gynecology*, showed that the TOT sling was not inferior to the retropubic midurethral sling and was associated with fewer cystotomies.

At a mean follow-up of 18 months, abnormal bladder function, a composite outcome including subjective and objective criteria, was seen in 47% of TVT patients and 43% of TOT patients.

Assessment of less common complications from both slings, such as nerve and vascular injury and muscle and thigh pain or abscess, will require larger studies with longer follow-up, Dr. Iglesia said.

Because of the potential for major vascular, bowel, and bladder injury with traditional slings, newer, shorter "mini slings" are now on the market.

These slings have been designed using a smaller piece of polypropylene mesh that goes through the vaginal area to the retropubic or transobturator space with no exit wounds through the skin. The slings stick behind the pubic bone or insert via pledgets into the transobturator muscle.

However, because there are few data on the use of mini slings and the outcomes, ACOG makes no recommendations on their use. ♀

FDA DEVICE APPROVAL

Ob-gyns should be aware that the US Food and Drug Administration device approval process is less stringent than the drug approval process. The FDA's Center for Devices and Radiological Health does not require device manufacturers to conduct clinical trials to show safety and efficacy; they must only prove that their device is "substantially equivalent" to a medical device already on the market. To report adverse events or to check the MAUDE database for existing adverse event reports, visit www.fda.gov/medwatch/how.htm.

info

- Practice Bulletin *Urinary Incontinence in Women* (#63, June 2005): www.acog.org/publications/educational_bulletins/pb063.cfm
- Practice Bulletin *Pelvic Organ Prolapse* (#85, September 2007): www.acog.org/publications/educational_bulletins/pb085.cfm

OTHER OPTIONS FOR URINARY INCONTINENCE

PATIENTS WITH STRESS INcontinence who aren't good candidates for surgery might benefit from injectable bulking agents. However, the problem has been that an injectable such as cross-linked bovine collagen isn't long lasting and has to be repeated periodically due to break-down.

New injectables include Coaptite, particles of calcium hydroxylapatite in a water-based carrier gel, and DurasphereEXP, pyrolytic carbon-coated beads in a water-based carrier gel. These new products do not break down as quickly, but because they're new, there are minimal long-term data on efficacy and particle migration, said Cheryl B. Iglesia, MD, director of the section of female pelvic medicine and reconstructive surgery at Washington Hospital Center and associate professor in the obgyn and urology departments at Georgetown University in Washington, DC.

Patients with urge incontinence who have had limited success with behavioral or anticholinergic therapy may be candidates for neuromodulation. This procedure

involves permanently implanting a device under the skin to stimulate sacral nerves to calm an overactive bladder. A less-invasive, nonsurgical treatment is new to the market that uses acupuncture techniques to stimulate the tibial nerve in 30-minute sessions. While neuromodulation systems may not cure incontinence, they may provide relief to women who've been unsuccessful with other treatments, Dr. Iglesia said. ♀

WOMEN DON'T DISCUSS INCONTINENCE

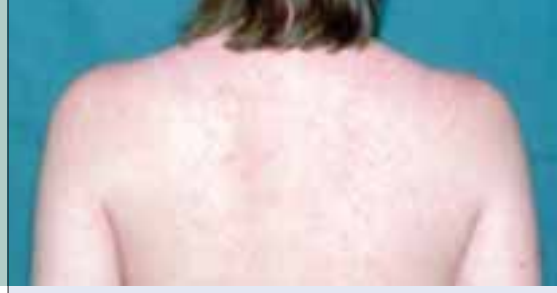
"INCONTINENCE IS STILL A fairly hidden issue. The average time patients wait to tell their providers is 5 to 7 years," said Jill Maura Rabin, MD, head of urogynecology and chief of the division of ambulatory care at the Long Island Jewish Medical Center-Northshore LIJ Health System.

Patients may be embarrassed and may think frequent bathroom breaks and leakage are normal as they age. Dr. Rabin suggests asking questions such as:

- How often does the urge to urinate wake you up in the middle of the night?
- Do you leak when you laugh, cough, sneeze, lift, or hear running water?
- Do you run to the bathroom several times an hour?
- Do you have sudden, uncontrollable urges to use the bathroom?

A history and physical exam are the first, most important steps in evaluation.

"Before you give them a pill to treat what may or not be an unstable or overactive bladder, it's important to rule out a bladder infection, for example," Dr. Rabin said. "Maybe it's not idiopathic, and perhaps there is an explanation, a physiologic reason. A careful and thorough diagnostic workup may be just the thing to delineate your options and maximize treatment outcomes." ♀



Measles erupts in pockets of US

IN JUST THE FIRST SEVEN months of this year, more people in the US were infected with measles than in any other entire year since 1996.

From January to July 2008, 131 cases of measles were reported, compared with an average of 63 cases a year from 2000 to 2007, according to the Centers for Disease Control and Prevention. The cases, which were reported in 15 states and the District of Columbia, occurred primarily among school-age children whose parents chose not to have them vaccinated.

ACOG recommends that adults born in 1957 or later should be offered vaccination with one dose of the measles-mumps-rubella vaccine if there is no proof of immunity or documentation of a dose given after their first birthday. Individuals vaccinated between 1963 and 1967 should be offered revaccination (two doses), and a second dose should be offered to health care workers, students entering college, international travelers, and rubella-negative postpartum patients.

If unvaccinated, women should receive an MMR vaccine at least one month before they get pregnant. Vaccination is safe during breastfeeding.

Before measles vaccination became available in the 1960s, measles caused 450 deaths and 4,000 cases of encephalitis in the US each year, according to the CDC. By 2000, the disease was declared eliminated in the US, although sporadic importations are reported.

Measles can lead to pneumonia and encephalitis. Additional risks during pregnancy include miscarriage and low birth weight. ♀

info

→ www.cdc.gov/mmwr/preview/mmwrhtml/mm5733a1.htm

ACOG prepares for flu pandemic

THE CENTERS FOR DISEASE Control and Prevention and state and local public health departments are preparing for a future flu pandemic, and ACOG is at the forefront to ensure that the special concerns of pregnant women are taken into account. Pregnant women have higher rates of morbidity and mortality from the flu.

The CDC is expected to release recommendations in 2009 from a group of experts that met earlier this year to address the unique considerations of pregnant women during an influenza pandemic. ACOG Vice President Iffath Abbasi Hoskins, MD, represented ACOG at the meeting. Several other Fellows also took part, including Denise J. Jamieson, MD, MPH, a medical officer at CDC.

"Most influenza experts now agree there will be a large pandemic. We're due for one," Dr. Jamieson said.

To qualify as a pandemic, three criteria must be met: It must be a new influenza subtype, it must infect humans and cause illness, and it must spread easily and be sustained in humans. Avian flu met the first two criteria.

"Ob-gyns are frontline clinicians, so they can really serve a critical control point," Dr. Jamieson said.

Ob-gyns are encouraged to develop flu pandemic plans for their practices. "Tell your staff that you may get an onslaught of phone calls and teach them what things to ask the pregnant patient to see if they're developing problems," Dr. Hoskins said. "Look at it as disaster planning. It's coming. You're better off preparing yourself, your practice, and your patients." ♀

info

➜ www.pandemicflu.gov

Immunize patients and your staff against flu

WITH THE ARRIVAL OF flu season, ACOG reminds ob-gyns that an intramuscular, inactivated flu vaccine should be given in any trimester to women who will be pregnant during the flu season. 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. Immunizing the mother offers some immunity to her infant also. ACOG also recommends flu vaccines for the following groups:

- Anyone age 50 and older
- Anyone who wishes to reduce the chance of getting the flu
- Health care workers
- Residents and employees of nursing homes or other long-term care facilities
- Individuals likely to transmit influenza to high-risk individuals, such as caregivers of the elderly, or of newborns and children up to age 59 months, or of adults with high-risk conditions
- Those with chronic cardiovascular or pulmonary disorders, including asthma
- Those with chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, and immunosuppression
- Those with conditions that compromise respiratory function or the handling of respiratory secretions or that increase the risk of aspiration

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 two to 49 but is not recommended for pregnant women. Breastfeeding mothers can choose either vaccine.

Thimerosal-free vaccines

Pregnant patients may be concerned about the safety of flu vaccines because some flu vaccines contain thimerosal, a mercury-containing antibacterial compound. ACOG supports the recommendations and findings of the federal Advisory Committee on Immunization Practices, which has determined there is no evidence showing that thimerosal is a danger to the health of the mother or her fetus. Thimerosal-free flu vaccines are available, but ob-gyns and patients should be aware that they tend to be more expensive. ♀

flu resources

- Committee Opinion *Influenza Vaccination and Treatment During Pregnancy* (#305, November 2004): www.acog.org/publications/committee_opinions/co305.cfm
- Committee Opinion *Primary and Preventive Care: Periodic Assessments* (#357, December 2006): www.acog.org/publications/committee_opinions/co357.cfm
- ACOG Patient Education Pamphlet *Immunizations for Women*: http://sales.acog.org; 800-762-2264
- ACOG Immunizations Wheel: http://sales.acog.org; 800-762-2264
- www.cdc.gov/flu/professionals/vaccination

2008–09 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

OCTOBER

11–14
American Academy of Pediatrics National Conference & Exhibition
Boston
www.aap.org
847-434-4000

12–15
ACOG Armed Forces District Annual Meeting
Norfolk, VA
202-863-2571

12–16
American College of Surgeons 94th Annual Clinical Congress
San Francisco
www.facs.org/clincon2008
312-202-5000

14
ACOG WEBCAST:
Physician Employment Contracts
1–2:30 pm ET
800-673-8444, ext 2498

15–19
Pacific Coast Obstetrical and Gynecological Society
Victoria, BC
www.pcogs.org
650-723-8156

17–19
ACOG District V Annual Meeting
Cincinnati
202-863-2574

22–25
Central Association of Obstetricians and Gynecologists
New Orleans
www.caog.org
701-838-8323

23–26
Academy of Breastfeeding Medicine 13th Annual International Meeting
Dearborn, MI
www.bfmed.org

24–26
ACOG District II Annual Meeting
New York City
518-436-3461

28–Nov 1
The 37th Global Congress of Minimally Invasive Gynecology—American Association of Gynecologic Laparoscopists Annual Meeting
Las Vegas
www.aagl.org
714-503-6200

31–Nov 5
Association of American Medical Colleges Annual Meeting
San Antonio
www.aamc.org
202-828-0553

NOVEMBER

8–11
American Medical Association Interim Meeting
Orlando, FL
www.ama-assn.org

8–12
American Society for Reproductive Medicine 64th Annual Meeting
San Francisco
www.asrm.org
205-978-5000, ext 114

13–15
ACOG Junior Fellow District VI Annual Meeting
Las Vegas
800-673-8444, ext 2588

13–15
Council of Medical Specialty Societies Annual Meeting
Chicago
www.cmss.org
847-295-3456

18
ACOG WEBCAST:
Evaluation and Management of Diabetes in Pregnancy
1–2:30 pm ET
800-673-8444, ext 2498

DECEMBER

9
ACOG WEBCAST:
Preview of New Codes for 2009
1–2:30 pm ET
800-673-8444, ext 2498

2009

JANUARY

17–18
ACOG's 11th Annual Treasurers Conference
Orlando, FL
scathcart@acog.org
800-281-1551

23–25
Gynecologic Oncology Group Semi-Annual Meeting
Garden Grove, CA
www.gog.org
215-854-0770

26–31
Society for Maternal-Fetal Medicine 29th Annual Meeting—The Pregnancy Meeting
San Diego
www.smfm.org
800-673-8444, ext 2476

FEBRUARY

5–8
Society of Gynecologic Oncologists 40th Annual Meeting on Women's Cancer
San Antonio
www.sgo.org

MARCH

1–3
ACOG 27th Annual Congressional Leadership Conference, The President's Conference
Washington, DC
800-673-8444, ext 2509

11–14
CREOG and APGO Annual Meeting
San Diego
www.apgo.org

16–19
American College of Osteopathic Obstetricians and Gynecologists 76th Annual Conference
Tucson, AZ
www.acoog.org
817-377-0421

18–21
Society for Gynecologic Investigation Annual Meeting
Glasgow, Scotland
www.sgionline.org

30–Apr 1
Society of Gynecologic Surgeons 35th Annual Scientific Meeting
New Orleans
www.sgsonline.org

APRIL

23–25
American College of Physicians Internal Medicine 2009
Philadelphia
www.acponline.org

MAY

2–6
ACOG 57th Annual Clinical Meeting
Chicago
www.acog.org/acm

8–9
Council of Medical Specialty Societies Spring Meeting
Chicago
www.cmss.org

ACOG COURSES

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

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

NOVEMBER

6–8
Practical Obstetric and Gynecologic Ultrasonography: Spotlight on Chronic Pelvic Pain
Naples, FL

14–16
Coding Workshop
Atlanta

20–22
New Surgical Approaches to Incontinence and Prolapse
Chicago

DECEMBER

4–6
The Art of Clinical Obstetrics
New York City

5–7
Coding W[illegible]op
SOLD OUT
Las Vegas

Keep updated on latest ACOG news

BE AMONG THE FIRST TO KNOW when a new Committee Opinion or Practice Bulletin is published or when College news is posted on the ACOG website, www.acog.org.

By subscribing to an RSS feed, you can keep track of the latest announcements and new documents soon after they are posted.

RSS, which stands for "Really Simple Syndication," allows your computer to automatically download the newest information from a website without having to browse through multiple web pages looking for the information.

You can sign up for notification in these categories: ACOG announcements, department notices, district and section notices, new and updated publications, and news releases. The way you view the latest content online is determined by your browser. If you use Internet Explorer, you will need version 7 to properly see the content. Both Firefox and Safari for Macs allow you to view RSS links.

Even if you don't subscribe to an RSS feed, each time you visit the ACOG website, you can click on the orange RSS image at the top of the home page to view headlines of the most recently posted documents and links. ♀

info

➜ To subscribe to RSS links or to read the latest headlines, visit www.acog.org/rss/acogrss.cfm

Take ACOG practice management survey

ALL PRACTICING OB-GYNS OF ACOG are urged to complete the 2008 Socioeconomic Survey, which will assess the impact of the economic environment on ob-gyn practice and track important trends in practice structure, workload, and finances.

ACOG will use the findings to provide reports to the membership about the economics of ob-gyn practice, as well as to guide advocacy and educational efforts. Documenting the impact of rising practice costs and declining reimbursement will help immeasurably with the College's efforts to effect positive change for ACOG Fellows and their patients.

This year's survey includes new questions about electronic medical records and health information technology. Reports will be made available to all ACOG members on topics such as ob-gyn practice arrangements, workload, and productivity. ♀

info

➜ Access the survey on the ACOG website, www.acog.org. Under "Practice Management," click on "Practice Management and Managed Care" and then click on "Members Encouraged to Participate in 2008 ACOG Socioeconomic Survey"

➜ Questions: James Scroggs, 800-673-8444, ext 2447

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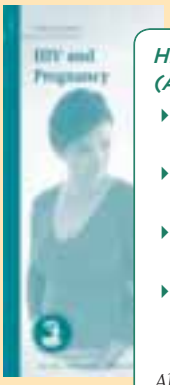
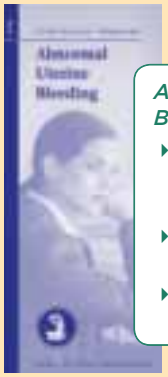


HIV and Pregnancy (AP113)

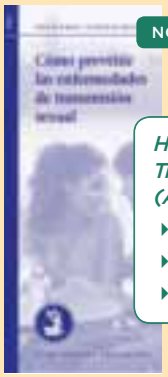
- How HIV can affect pregnancy
- Criteria for third-trimester testing
- Ways to reduce the risk of vertical transmission
- Why mothers need to continue treatment after their babies are born

Also available in Spanish



Abnormal Uterine Bleeding (AP095)

- Signs, symptoms, and causes of abnormal bleeding
- Tests that are used in diagnosis
- Treatments for various causes



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How to Prevent Sexually Transmitted Diseases (AP009)

- Types and symptoms of STDs
- Risks of getting an STD
- How to prevent STDs

info

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