THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

NOVEMBER/DECEMBER 2008

Nontraditional Junior Fellows embrace ob-gyn as second career

"I felt like I had a once-in-a-lifetime chance to do something more rewarding and more challenging."

—Charles Rittenberg, MD

CHARLES RITTENBERG, MD, COMES FROM A FAMILY of doctors. His father and uncle practiced family medicine together, and his sister trained to become a surgeon. Later, his wife entered medical school, completed her residency, and practiced rehabilitative medicine. So, it was only natural that Dr. Rittenberg became a … computer specialist.

The "MD" after Dr. Rittenberg's name didn't come until he was in his 40s, after a career in computers. Now at age 50 and in his final year of a maternal-fetal-medicine fellowship at the Medical University of South Carolina, he is one of several Junior Fellows who chose medicine—and ob-gyn in particular—later in life. They didn't begin medical school at age 22 or 23; many of them

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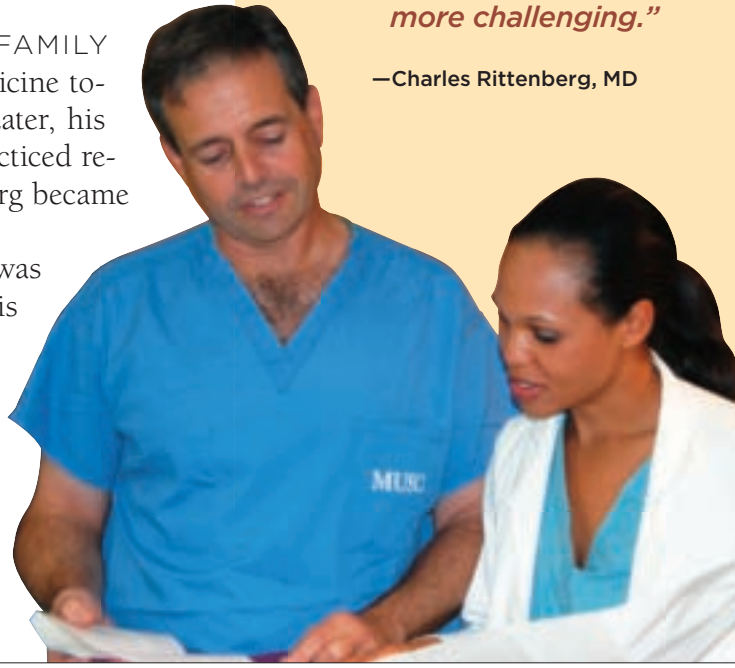
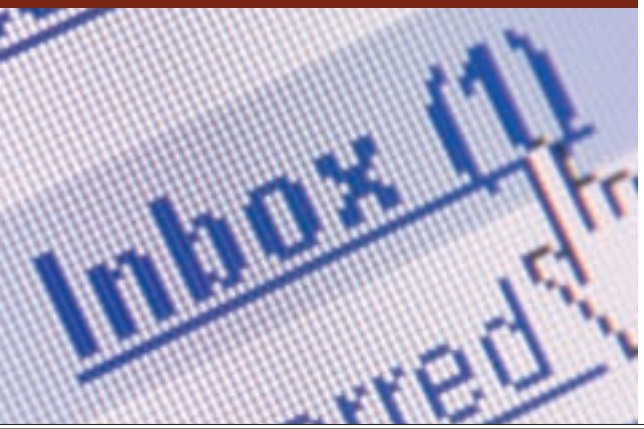


At the Medical University of South Carolina Hospital, Junior Fellow Charles Rittenberg, MD, and fourth-year ob-gyn resident Dené C. Wrenn, MD, at the nurses' station. Dr. Rittenberg didn't attend medical school until he was 38.

WATCH YOUR EMAIL FOR INFO ON

2009 Survey on Professional Liability



Complete liability survey and win

ACOG NEEDS YOUR HELP IN GATHERING CRUCIAL DATA. Page 3 has information on an ongoing practice management survey. And preparations have begun for the 2009 Survey on Professional Liability. All Fellows who complete the liability survey by Mar 6, 2009, will be eligible to win a $100 gift certificate to the ACOG Bookstore. Five winners will be randomly selected.

"All Fellows are encouraged to complete this survey, which is vital in educating lawmakers and the public about the ongoing medical liability crisis and the devastating effects the crisis can have on women's health and access to care," said ACOG President Douglas H. Kirkpatrick, MD.

Look for an email and/or a letter in early January with instructions on how to access and complete the online professional liability survey. ♀

acogTODAY

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EXECUTIVE DESK

Maintenance of Certification: one year later

AS WE APPROACH THE END OF 2008, we have almost completed the first year of the American Board of Obstetrics and Gynecology Maintenance of Certification Program, or MOC. It is still too early to declare the process a success, but all indications are that it is accomplishing the goals set forth by ABOG and its parent, the American Board of Medical Specialties.

ACOG continues to participate in part IV, the self-assessment component of the program. Committees of ACOG Fellows have prepared modules for the generalist and all of the subspecialties. These modules are based on daily practice situations. For the generalist, the modules focus on obstetrics, gynecology, and office-based practice. In addition, there are modules on community, patient safety, ethics, and other areas of the specialty that are important regardless of your major scope of practice.

Failure to maintain certification will result in a process, consistent with our bylaws, that can lead to termination of Fellowship.

The use of the Internet to make the modules easily accessible, as well as less time consuming, is working well. Many of the first takers have already completed their two modules for 2008 and are ready to start on 2009.

Feedback that ACOG has received from its members is showing that these modules are educational and an excellent way to self-evaluate and help keep physicians up-to-date in their practice. However, we still hear complaints about the program, and some who are required to begin the process in 2008 have yet to apply. At ACOG, we are concerned about these nonparticipants, who are in jeopardy of losing their ABOG accreditation. What this will do to hospital privileges, insurance panels, and state licenses varies widely, but it can have an impact. For ACOG membership, board certification is mandatory. Failure to maintain certification will result in a process, consistent with our bylaws, that can lead to termination of Fellowship. For that reason, we strongly urge those who need to recertify in this cycle to begin to do so immediately. Remember, for ACOG Fellows, there is no cost for part IV.

For more information, I encourage you to visit www.abog.org or www.acog.org/from_home/Misc/mocReminder.cfm. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

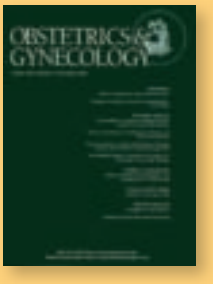
IN MEMORIAM

Laurence Bruggers, MD
Sun City West, AZ • 8/08

John F.J. Clark, MD
Washington, DC

Sam L. Parker, MD
Kinston, NC • 4/08

Donald P. Swartz, MD
Delmar, NY • 9/08



Obstetrics & Gynecology HIGHLIGHTS

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

Hormone Therapy and Heart Disease
(Gynecologic Committee Opinion #420, new)

Antibiotic Prophylaxis for Infective Endocarditis
(Obstetrics Committee Opinion #421, replaces Practice Bulletin #47)

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.

EARLY-BIRD REGISTRATION NOW OPEN

- **Register on the ACOG website at www.acog.org/acm**
- **Register early and save on registration fees and make your hotel reservation**
- **Early-bird registration ends on December 31**

www.acog.org/acm

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

Fellow election voting begins in December

THE 2009 FELLOW DISTRICT and section officer elections will be held online, with voting beginning December 15 at https://eballot3.votenet.com/acogfellow.

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. ♀

Districts and sections with elections this year

Districts

District I District IV District VII

Sections

Connecticut (I)
New Hampshire (I)
New York Section 1 (II)
New York Section 4 (II)
New York Section 7 (II)
New Jersey (III)
Georgia (IV)
Puerto Rico (IV)
Virginia (IV)
Indiana (V)
Ontario (V)
Iowa (VI)
Manitoba (VI)
North Dakota (VI)
Arkansas (VII)
Mississippi (VII)
Tennessee (VII)
British Columbia (VIII)
Colorado (VIII)
Hawaii (VIII)
New Mexico (VIII)
Oregon (VIII)
California Section 2 (IX)
California Section 3 (IX)
California Section 6 (IX)
Army (AFD)

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

Nontraditional Junior Fellows embrace ob-gyn as second career

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didn't even begin at age 32 or 33. They had other careers, started families, and had been out of school for 15 to 20 years before feeling a pull toward a new career in medicine.

When he was in his mid 30s, Dr. Rittenberg was working at the local water company, putting the finishing touches on a computer system he'd created. The company was preparing to spend millions to implement the system when he realized "I didn't want a good computer network for the water company to be my life's work." He had grown up surrounded by doctors and saw the joy his wife got out of practicing medicine.

"I felt like I had a once-in-a-lifetime chance to do something more rewarding and more challenging," he said. "One of the ironies of this is that by the time I finish my MFM fellowship, I'll be eligible for the state retirement fund."

Starting over

Junior Fellow Judith A. Lacy, MD, now in private ob-gyn practice in Bellevue, WA, was also working in a job that was just a job. She went to dental hygiene school after high school, a way to get a good job quickly, but she wasn't passionate about it.

"I was young and just wanted to move out on my own and start my life," she said.

After several years as a dental hygienist, she began to consider medical school, a daunting task considering that she would have to first obtain an undergraduate degree before even applying to medical school. She was in her 30s and faced many years of school and training before she would become a physician, but she marched forward.

"I thought if I contemplated it too long, I wouldn't do it," she said. "I had to take algebra and trig again—I hadn't had math in 16 years—but after I did all right on my first general chemistry test, I thought 'I can do this,' and I didn't look back."

The first year of medical school was difficult, compounded by a lack of financial aid (because monetary need was based on Dr. Lacy's dental hygienist salary) and a 130-mile daily round-trip drive from her home to Oregon Health & Science University School of Medicine. By her second year, she received financial aid but now points out laughingly that her last school loan payment will be made in 2032—when she's in her 70s.

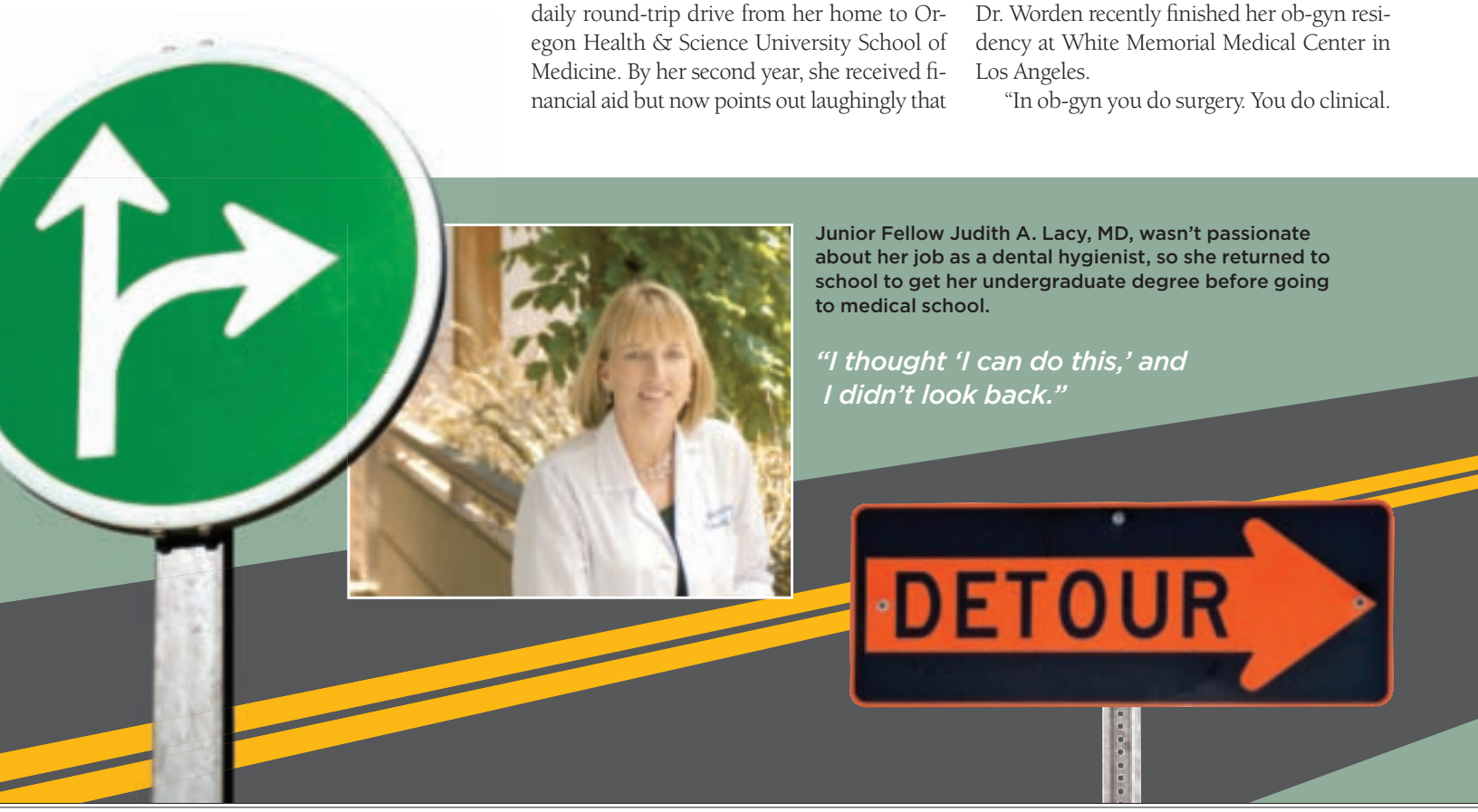
An unusual path

Dr. Catherine Worden's interest in medicine evolved from a career in photography. Dr. Worden, of Riverside, CA, earned a graduate degree in photographic fine arts, with an emphasis in photographic conservation. She worked for museums and eventually opened her own business. She was hired to care for photographic works of art but became more and more interested in medicine after taking a chemistry class and a biochemistry class at a community college.

"I really liked my classes, and I loved interacting with people, and in the back of my mind, I thought 'I'd love to go into medicine and help people.'"

She began to volunteer in the pediatric department at a local hospital and later enrolled in medical school at the University of Southern California. She considered pediatrics but ultimately chose ob-gyn. Now in her mid 40s, Dr. Worden recently finished her ob-gyn residency at White Memorial Medical Center in Los Angeles.

"In ob-gyn you do surgery. You do clinical.



Junior Fellow Judith A. Lacy, MD, wasn't passionate about her job as a dental hygienist, so she returned to school to get her undergraduate degree before going to medical school.

"I thought 'I can do this,' and I didn't look back."

You deliver babies. There are a lot of things that are exciting and diverse. I really love it," she said. "It's wonderful to work with women of all ages, and it's an honor to be able to help them through their pregnancies and deliver their children."

Finally getting there

F. Lee Dutton, MD, PhD, had always wanted to be a doctor, but his plans kept getting derailed by "life"—marriage, kids, military service. Now, a Junior Fellow at age 59, he's been out of residency for only four years and is practicing at the State University of New York Upstate Medical University, where he is the director of the Center for International Medical Activities.

Dr. Dutton received his bachelor's degree in biology in 1971. He and his wife moved to Connecticut, where he planned to go to graduate school and then on to medical school. But after earning a master's in microbiology from the University of Connecticut in 1975, he was commissioned in the Army Reserves and elected to stay at the university. He soon became a single dad, and in 1984 he finished his PhD in genetics and cell biology.

His dream to be a doctor continued to be postponed. He later remarried. With three kids of his own already, he now had three step-kids, and the family instantly became "The Brady Bunch."

"That slows down your plans to go to med school. We chose to wait for all six kids to graduate," Dr. Dutton said.

In 1995, the youngest child graduated high school, and it was time for Dr. Dutton to head to medical school. He thought he might have trouble getting accepted to med school because he was 45 years old—he remembers reading medical college catalogs in 1971 that said medical students couldn't be older than 31.

But times had changed, and medicine was trying to recruit more primary care doctors. He was accepted into George Washington University in Washington, DC. Toward the end of medical school, he was heading toward pediatrics, but his GWU advisor, ACOG Fellow John Henry Grossman III, MD, was an ob-gyn, and his mentorship helped Dr. Dutton figure out his future was in ob-gyn. In 2004, Dr. Dutton finished his ob-gyn residency at Geisinger Medical Center in Danville, PA.

Passionate about ob-gyn

These Junior Fellows weren't 22-year-old college graduates when they started their path toward ob-gyn. They'd had other careers; some had raised families, been married, been divorced, and suffered personal tragedies and economic tough times.

With that life experience and the knowledge of the challenges of the specialty—medical liability lawsuits, low reimbursement, long hours—did they ever step back and reconsider becoming ob-gyns?

The short answer is no. When questioned, all talked briefly about these challenges, but they didn't have much of an effect on their decision-making, let alone dissuade them. In fact, their life experiences seemed to make them more determined and assured of their choice.

"It was a tough thing to go through emotionally," Dr. Lacy said, "but I was resilient. It was a major life decision, and I was very determined and focused."

Dr. Dutton said he really wanted to "do some good," and he enjoys his patients and treats them like family.

"It's been a long road, but it's amazing how happy I am," he said. ♀

"It's been a long road, but it's amazing how happy I am."

Junior Fellow F. Lee Dutton, MD, PhD, on the right, with classmate Alex Boyer, MD, at their medical school graduation at George Washington University in Washington, DC. Dr. Dutton didn't begin medical school until he was 45.

Junior Fellow Dr. Catherine Worden's entry into ob-gyn took a circuitous route, starting with a career in photographic conservation.

ACOG President Douglas H. Kirkpatrick, MD, greets Chile Section Chair Eghon Guzmán, MD, at the 2008 Annual Clinical Meeting in New Orleans.

ACOG creates Chile Section

CHILE HAS BECOME THE FIRST South American country to be represented by an ACOG section. District I leaders invited the new section to join their district, which also includes sections representing Maine, Vermont, New Hampshire, Connecticut, Massachusetts, Rhode Island, Quebec, and the Atlantic Provinces in Canada. Chile has approximately 1,100 ob-gyns.

The Chile Section's chair is Fellow Eghon Guzmán, MD, of Santiago, who is the immediate past president of the Chilean Society of Obstetrics and Gynecology (SOCHOG). The vice chair is Fellow Eugenio Suárez, MD, of Santiago, who is the current president of the society.

The society was created in 1935 and is the oldest national scientific society in Chile and was the fourth ob-gyn society in Latin America. The society has published its own journal of ob-gyn since its foundation, and, in 2003, it hosted the Congress of the International Federation of Gynecology and Obstetrics (FIGO).

"The history that we begin to write now will be very important because we are convinced that we have given a tremendous opportunity to ob-gyns in Chile, as important as the creation of SOCHOG was 72 years ago," Dr. Guzmán said.

Chile's population is estimated to be 16.5 million people. Approximately 38% of the population lives in the capital of Santiago. The current president of Chile, Michelle Bachelet, is a physician. ♀

Consider ACOG in end-of-year giving plans

AS 2008 DRAWS TO A CLOSE, ACOG asks you to give serious consideration to including the College in your year-end giving plans. Annual gifts to the Development Fund allow the College to participate in and initiate new programs and projects that would otherwise be out of reach.

Whether you are contributing for the first time or renewing your membership in one of the giving societies, your charitable donation ensures that ACOG is prepared and able to meet the challenges we face in providing the best possible health care for women.

Each of the four giving societies offers outstanding recognition of your generosity and unique benefits (see below).

Your contribution to the Development Fund reaffirms your commitment to ACOG's ongoing mission and future.

With your help, the College will continue to advocate quality health care, maintain the highest clinical and educational standards, promote patient education, and increase awareness of issues affecting women's health care. ♀

info

- Mail your end-of-year charitable donations to ACOG Development Department, 409 12th Street SW, Washington, DC 20024
- For more information or assistance: 800-673-8444, ext 2546; development@acog.org

	President's Society $2,500+	Beacham Society $1,000 to $2,499	Reis Society $500 to $999	Schmitz Society $100 to $499
Distinctive ACM Badge	✔	✔	✔	✔
Recognition in *ACOG Today*, *ACM News*, *Final Program*, and *Donor Report*	✔	✔	✔	✔
VIP Lounge Access at ACM	✔	✔	✔	
Free ACM Registration†	✔	✔		
ACM President's Dinner Dance ticket	✔ (2)*	✔		
ACM Free Spouse/Guest Registration**	✔			

†nontransferable *second ticket is non-tax-deductible **non-tax-deductible

COGNATE PROGRAM DEADLINE APPROACHING

THE ACOG AWARD FOR CONtinuing Professional Development for the three-year cycle 2006–08 will be issued in January.

Be sure to submit all data for this cycle by December 31 to be included in the initial processing of this cycle's award. Late submissions can be added, but your award certificate will be delayed.

You can view your continuing medical education credits and print a transcript on the ACOG website at www.acog.org/myacog/. After logging in, your personal page will pop up, and you can access your transcripts and the brochure about the ACOG Program for Continuing Professional Development, or Cognate Program.

This is the last year to submit data for the 2004–06 cycle. After Dec 31, 2008, ACOG can no longer accept any submissions for that cycle. ♀

info

- Fax submissions to 202-484-1586 or mail to ACOG Cognate Department, PO Box 96920, Washington, DC 20090-6920
- Questions? Contact 800-673-8444, ext 2543; cognates@acog.org

Legislative leaders share strategies at annual ACOG State Lobbyist Roundtable

APPROXIMATELY 40 SECTION leaders and lobbyists shared their legislative challenges and successes during ACOG's State Lobbyist Roundtable in October. Participants representing 22 states shared winning strategies and discussed a wide range of issues, including medical liability reform, lay midwife licensure, STD partner therapy, and universal health care for women.

Louisiana Maternal and Child Health Coalition Executive Director Sandra Adams speaks with District XI Legislative Chair Ralph J. Anderson, MD.

"The roundtable provided an excellent opportunity to learn from other similarly involved people," said first-time attendee Jacques S. Abramowicz, MD, Illinois Section legislative chair. "It's reassuring to see that problems are similar everywhere and to see that ACOG is involved as a central organization with the issues at the state level."

College develops new toolkit

ACOG's State Legislative Subcommittee provided tips on how to increase legislative activity in sections and distributed a new toolkit. *ACOG State Legislative Chair: Recruiting, Role, and Responsibilities* offers information on how to use a section legislative committee to achieve section goals, how to work with the state medical society, and how to hire and work with a lobbyist.

"The State Lobbyist Roundtable provides a forum for an invaluable exchange of ideas, strategy, and information about changes occurring at the state level," said State Legislative Subcommittee member Clayton H. "Tersh" McCracken III, MD. "It truly represents ACOG's early warning system for trends and developments as they emerge across the country."

Keith R. Brill, MD, Nevada Section legislative chair, was impressed with the states that have legislative offices and lobbyists. He hopes to expand legislative efforts in Nevada, where the Legislature only meets biannually.

"When they do meet, the pace is very quick, and only a lobbyist with a presence in our state's capital will be able to represent us effectively," Dr. Brill said.

An emerging issue in Nevada is a move by lay midwives to expand their scope of practice. In addition, the state's tort reform measures will be up for possible reversal in the upcoming legislative session, according to Dr. Brill.

At the State Lobbyist Roundtable are District III and Delaware Section Legislative Chair Gregory W. DeMeo, DO; Florida Section Secretary-Treasurer Robert W. Yelverton, MD; Florida Obstetric and Gynecologic Society lobbyist Amy Young; and Illinois Section Legislative Chair Jacques S. Abramowicz, MD.

"After the reform measures were passed, many new liability insurance carriers came to Nevada, and our professional liability insurance premiums have stabilized or gone down," Dr. Brill said. "However, the current climate in our state is a demand for accountability and better regulation of physicians. Our goal will be to once again unite the physician and patient community to show that together we can help keep doctors in Nevada by keeping our tort environment stable." ♀

JOIN 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.

Selected 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. ♀

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

Seek help for you and your colleagues

JUST AS OB-GYNS SHOULD screen their patients for depression, they should be aware of their own signs of depression. But physicians should not try to treat themselves.

"We have a tendency to keep everything inside," said ACOG President Elect Gerald F. Joseph Jr, MD. "But if someone feels they might be clinically depressed, I strongly urge them to seek advice from someone they trust and respect."

Psychiatrist Peter Mansky, MD, director of the Nevada Health Professionals Assistance Foundation, urges physicians to get a primary care doctor, obtain a referral to a psychiatric provider, and get help confidentially.

Physicians should also be aware of signs of depression in their colleagues. A change in behavior or appearance is an important warning sign. If a physician you know becomes hard to reach, cancels office hours, withdraws, or shows less interest in practice, friends, or family, express your concern and encourage that person to seek help.

As a physician, you have a responsibility to patients and to your colleagues to help another physician who seems to be troubled. Most important, you may save a life. ♀

Preventing physician suicide by 'coming out' about depression

PHYSICIANS ARE AT A HIGHER risk of suicide than almost any other profession. Every year, about 300–400 physicians kill themselves. Among women physicians, the suicide rate is particularly high—four times that of women in the general population.

These unsettling facts exist in a culture of medicine that perpetuates attitudes and institutional policies that create barriers for vulnerable doctors to get the treatment they need, according to experts.

What's behind the high rate? "Depression, depression, depression," said Paula Clayton, MD, medical director of the American Foundation for Suicide Prevention.

Although physicians have about the same rate of depression as do people in the general population—about one in 10 males and two in 10 females—Dr. Clayton says that physicians do not seek the help they need.

"Study after study shows that the high suicide rate mostly comes because they have untreated depression or substance abuse."

In fact, 35% of physicians do not even have a regular source of health care.

"Maybe it's feeling invincible or maybe it's because we're not our own highest priority, but we don't get help for any illness, and depression and psychological illness are way down on the list," said psychiatrist Peter Mansky, MD, director of the Nevada Health Professionals Assistance Foundation and coauthor of the 2003 consensus statement published in the *Journal of the American Medical Association,* "Confronting Depression and Suicide in Physicians."

It's not just stress

Although medical practice has significant stressors—being sued and the fear of being sued, reimbursement hassles, and long working hours—the evidence doesn't support the notion that the stresses are correlated with physician suicide or that physicians are subject to more stress than professionals in other occupations.

If you are in crisis, call 800-273-TALK (8255).

Instead, research indicates that stressful events that may precipitate suicide are themselves brought on by the behavior of individuals with substance use or affective disorders. In addition, individuals with preexisting depression often experience stressful events more intensely than others do.

While stress alone doesn't necessarily cause depression, it may kindle depression in someone susceptible to it, and the use of drugs or alcohol, often a mechanism for coping with stress, adds to the risk of suicide. Depression and alcohol abuse are the two major risk factors for suicide—more than 90% of individuals who kill themselves have one or both of these disorders.

Unfortunately, physicians face a number of barriers in seeking and receiving treatment for depression. Dr. Clayton cites several impediments physicians face: "They are afraid of restrictions from the state licensing board, afraid of peers who might not refer patients to them, and they worry about their privileges at hospitals."

One avenue for change is within medical institutions themselves. Advocates for suicide prevention recommend a shift in policies and attitudes so that such institutions are nondiscriminatory and support physicians seeking mental health treatment.

Another barrier to care is the stigma still attached to mental health disorders. And, when physicians do seek help, their treatment may be less aggressive than it should be because they are given "special treatment." Their professional reputation or simply the fact that they are a physician may lead their provider to underestimate their vulnerability. ♀

info

➜www.doctorswithdepression.org
➜www.suicidepreventioninternational.org

New CPT codes set for 2009

THE CURRENT PROCEDURAL TERMINOLOGY code set for 2009 includes several changes of interest to obgyns, including new and revised CPT codes. The changes take effect January 1. Because of HIPAA requirements, insurers must accept new codes beginning January 1. ACOG's Committee on Coding and Nomenclature proposed the CPT code changes to the American Medical Association CPT Editorial Panel, which approved them for 2009. ♀

info

- On the ACOG website, www.acog.org, click on "Coding" in the "Quick Links" box on the left side of the home page
- Questions and comments: coding@acog.org or fax to 202-484-7480
- For the latest ACOG publications on coding: www.acog.org/bookstore/Coding_Resources_C56.cfm

Insertion of mesh with paravaginal defect repair

Code 57267 is an add-on code that describes the insertion of mesh or other prosthesis through a vaginal approach and is always performed in conjunction with certain primary procedures. The parenthetical note following code 57267 will be revised with the addition of code 57285 [paravaginal defect repair (including repair of cystocele, if performed); vaginal approach]. This will allow for the reporting of code 57267 in addition to 57285 under CPT coding rules. The code will read:

- 57267: Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (list separately in addition to code for primary procedure). (Use 57267 in conjunction with 45560, 57240–57265, 57285.)

Anesthesia services references

Codes 57400, 57410, and 57415 will be revised to add "other than local." The revision will clarify the intent of the references to anesthesia services and the circumstances under which these services would be reported. The new codes will read:

- 57400: Dilation of vagina under anesthesia (other than local)
- 57410: Pelvic examination under anesthesia (other than local)
- 57415: Removal of impacted vaginal foreign body (separate procedure) under anesthesia (other than local)

Insertion of Heyman capsules for clinical brachytherapy

Codes 77781–77784 (remote afterloading high-intensity brachytherapy) will be deleted and replaced by codes 77785–77787. As such, the parenthetical note following 58346 (insertion of Heyman capsules for clinical brachytherapy) has been revised to state: For insertion of radioelement sources or ribbons, see 77761–77763, 77785–77787.

HPV vaccine

CPT code 90650 will be established to report a human papillomavirus vaccine. This new vaccine contains an adjuvant formulation and is intended to protect against infection of oncogenic types of cervical cancer (types 16 and 18). The existing HPV vaccine, 90649, targets both oncogenic (types 16 and 18) and non-oncogenic (types 6 and 11) but does not contain the adjuvant. The vaccine adjuvant system is intended to provide a more sustained immune response and may contribute to the cross-protective benefit of the vaccine against other oncogenic HPV types.

The dosing schedules for these HPV vaccines also differ. The administration schedule for the product reported with code 90649 is 0, 2, 6 months for the current product, while the product reported with code 90650 is administered at 0, 1, 6 months for the new vaccine. Code 90650 will appear in the CPT code set with the US Food and Drug Administration approval-pending symbol (↗). Updates on the FDA status of this code will be provided on the AMA CPT website under Category I Vaccine Codes at www.ama-assn.org/ama/pub/category/10902.html. The new code will be:

- ↗90650: Human papillomavirus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use

Preventive medicine services

The last paragraph of the introductory language for the "Preventive Medicine Services" section has been revised to indicate that the two groups of codes required to report immunizations (ie, vaccine/toxoid product 90476–90749 and immunization administrations 90465–90474) are separately reportable when performed in conjunction with a preventive medicine service. Examples of the types of screening tests that may be separately reported in addition to preventive medicine service will be added to include vision, hearing, and developmental tests.

Prolonged E/M services

The guidelines for the face-to-face outpatient and inpatient prolonged evaluation and management services, reported with codes 99354–99357, will be revised. The revisions will clarify that the prolonged services are intended to be reported with E/M services in addition to any other physician service that occurs at the same session. The guidelines for the outpatient services will be revised to indicate that only the outpatient services are intended to report the total duration of face-to-face time with the patient, while the inpatient codes are intended to report the total duration of the time spent (continuous or noncontinuous) by the physician on the unit.

Directions will also be added to clarify that time-based add-on codes can be used only with E/M services codes that have a typical or specified time included in their descriptor. Additionally, the referenced codes in the parenthetical instructions following codes 99354 and 99356 will be revised to reflect which services (psychotherapy with medical evaluation and management) and sites of services (inpatient nursing facility services) can be reported in addition to these categories. CPT will also clarify that these services should not be reported in addition to the team conference services (99366–99368), telephone (99441–99443), or other non-face-to-face services.

Modifier 21

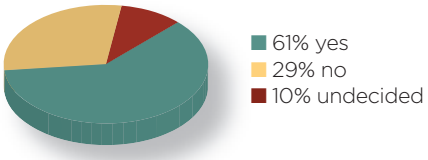
Modifier 21 (prolonged evaluation and management service) will be deleted because it provided a duplicate mechanism for the same concept that is reported by using prolonged evaluation and management services codes 99354–99357. The CPT manual will state:

- Modifier 21 has been deleted. To report prolonged physician services, see 99354–99357

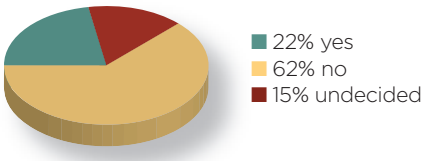
Lifestyle issues rank high among Junior Fellows

THE FUTURE OF RESIDENCY

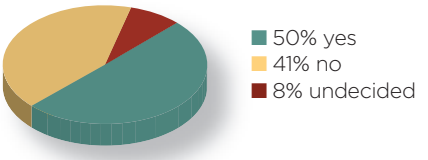
Would you be interested in a residency program that had general ob-gyn for the first two years and then offered specialized tracks for the last two years?



Do you believe that ob-gyn should be a five-year residency to increase the amount of surgical experience and exposure?



Do you think there should be a research requirement in residency?



FINDINGS FROM THE JFCAC PRACTICE PATTERN SURVEY

JUNIOR FELLOWS ARE LOOKing for personal fulfillment, flexible hours, and surgical experiences in their ob-gyn careers, according to a new ACOG survey.

When asked about the most important aspects of their future career, 77% of respondents chose personal fulfillment, 44% chose flexible hours, and 32% chose surgical experiences. (Participants could choose more than one category.)

Among women, the top three choices were personal fulfillment, with 60% selecting it; flexible hours, with 38%; and surgical experiences, with 22%. Among men, personal fulfillment was cited by 71%, surgical experiences by 43%, and compensation by 42%.

Sixty-seven percent of respondents said they would become a physician again, and 77% would choose ob-gyn again.

The findings are part of a practice pattern survey conducted online by the Junior Fellow College Advisory Council. The survey was sent to all active Junior Fellows; of the 7,748 surveyed, 994 responded, for a 13% response rate.

In a self-assessment portion of the survey, the majority "agreed" or "strongly agreed" that they were equipped to competently perform outpatient surgical procedures, major vaginal and abdominal procedures, operative laparoscopy, obstetric ultrasound, and vacuum delivery. However, more respondents said they disagreed or strongly disagreed that they were equipped to competently perform outlet forceps delivery. Results were split for gynecologic ultrasound, with 25% disagreeing they were equipped, 25% neutral, and 31% agreeing.

"As the clinical practice of ob-gyn continues to evolve, the JFCAC designed this survey to see if Junior Fellows are taught what they end up practicing," said Immediate Past JFCAC Chair Rajiv B. Gala, MD. "These data will help the JFCAC continue to advocate for changes in resident education to ensure that we are promoting workforce competence."

The types of practice desired

The survey showed that many Junior Fellows hope to focus their careers in academic settings or group practice. Very few want to work in administrative or hospitalist positions, solo practice, or obstetrics-only or office-practice-only settings.

Junior Fellows were split on whether they want to serve as primary care physicians. Forty-nine percent said they would not consider managing patients' primary care, such as hypertension, diabetes, arthritis, and osteoporosis, while 38% said they would and 12% were undecided. Forty-six percent said they would consider cosmetic procedures in their scope of practice, while 34% said they would not and 20% were undecided. ♀

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

ESSAYS FOR THIS YEAR'S JUNIOR Fellow essay contest are due November 30. Junior Fellows are encouraged to share their thoughts on "Ob-Gyn … The Day I Made a Difference."

Submissions should provide reflection on a day that you felt you made a difference. The experience could have been a clinical, political, social, public, or international event that affected your outlook on medicine and ob-gyn as a career.

Essay participants must be Junior Fellows. Essays should be between 500 and 750 words. No specific names of patients should be mentioned.

A national winner will be selected from the winning district essays. ♀

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

Online modules help residents educate medical students

RESIDENTS IN DISTRICT I AND District VIII are using new online tools to educate medical students on specific ob-gyn topics during down time in labor and delivery, while honing their own teaching skills.

Junior Fellows in the two districts created short PowerPoint presentations, available on their ACOG district websites, giving residents easy access to ready-to-use teaching modules for medical students.

"Obstetric residents are often so busy that it is difficult to prepare or do teaching sessions with medical students on service," said Kimberly L. Trites, MD, District I immediate past Junior Fellow chair. "We've provided a variety of brief, basic, easy-to-access teaching modules, and because they are templates, they can be adapted to the level of the trainee. This can facilitate mini teaching sessions between ORs, deliveries, or when there are a few minutes that would have previously been a missed teaching opportunity."

District I topics include abnormal uterine bleeding, breast cancer, cervical cancer screening, hypertension in pregnancy, labor, menstrual cycle, and shoulder dystocia. In District VIII, the modules cover ectopic pregnancy, endometriosis, ovarian torsion, postpartum hemorrhage, prenatal care, premature rupture of membranes, shoulder dystocia, and the triage microscope slide.

"With the advent of the 80-hour work week, many residency programs moved to a night-float rotation with a night shift," said Shauna M. Hicks MD, District VIII immediate past Junior Fellow chair. "Many programs try to use the occasional night down time on L and D for teaching. Often, this type of teaching is done ad hoc, and we thought a set of pre-made teaching topics would help develop our teaching skills with a ready set of topics consisting of slideshows lasting less than 20 minutes."

Besides directly educating medical students, the teaching sessions can energize the students and enhance their experience, which benefits the specialty.

"Medical students often choose a specialty based on their experience during their rotations," Dr. Trites said. "Recruitment has been an ongoing issue for ob-gyn, so anything we can do to improve medical student rotation experience will hopefully help improve recruitment." ♀

info

➜ Any ACOG member can access the modules. Visit www.acog.org/acog_districts and click on "District I Junior Fellows" or "District VIII Junior Fellows"

COMMITTEE LABOR

Junior Fellows and young physicians are active members of many of ACOG's committees.

Junior Fellow Joelene J. Shelton Werden, DO, a member of the ACOG Committee on Ethics, listens to a discussion at the committee's meeting in September. Next to her is Douglas Diekema, MD, a liaison member representing the American Academy of Pediatrics.

Junior Fellow Caroline L. Stella, MD, reviews documents during the September meeting of the ACOG Committee on Genetics.

Entries for Stump the Professors due November 30

SUBMISSIONS ARE DUE November 30 for The Gerald and Barbara Holzman Stump the Professors program at the 2009 Annual Clinical Meeting, May 2–6 in Chicago.

You must be a Junior Fellow in Training to submit a case. Each presenter will receive free Junior Fellow ACM registration, coach airfare, and travel and hotel expenses for three days.

Cases must be submitted online and should include a one-page summary of 700 words or less, including a final diagnosis. ♀

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

DIABETES

In January, ACOG Today *will address diabetes in pregnant patients*

Screening your nonpregnant patients

ALTHOUGH OB-GYNS ROUTINELY SCREEN FOR DIABETES during pregnancy, they need to be more vigilant about detecting the disease in their nonpregnant patients, according to Fellow Nanette F. Santoro, MD, a reproductive endocrinologist at Albert Einstein College of Medicine in New York City.

The good news, according to Dr. Santoro, is that testing for diabetes is a much less onerous procedure than in the past. ACOG recommends a fasting glucose test for screening.

Develop a team management plan

Once diabetes has been diagnosed, a physician-directed team should coordinate a management plan that incorporates nutrition, exercise, and medical therapy. The patient's active role in managing the disease is critical. Dr. Santoro noted that increasing exercise will improve glucose tolerance whether or not the patient loses weight. She added that for preconception patients, the better the glycemic control, the lower the risk of birth defects. Moreover, some evidence indicates that fertility may decrease for women whose diabetes is not well controlled. ♀

info

- ➜ *Clinical Updates in Women's Health Care* monograph *Diabetes Mellitus: Early Detection, Prevention, and Management*: www.clinicalupdates.org. Click on "Select Issue" and look under "2007"
- ➜ *Guidelines for Women's Health Care*: www.acog.org/publications/guidelinesforwomenshealth

DIABETES SYMPTOMS

- Extreme thirst or hunger
- Weight loss or weight gain
- Fatigue or weakness
- Frequent urination
- Nausea
- Blurred vision
- Sores that are slow to heal
- Dry, itchy skin or skin changes
- Numbness or tingling in feet
- Recurrent infections
- Irregular menstruation

WHO SHOULD BE SCREENED

Patients 45 and older: Ob-gyns need to start "thinking like a geriatrician" in terms of long-term care of patients, according to Dr. Santoro. "When patients hit 45, put them on a long-term program for periodic, systematic screening for diabetes." For your patients in this age group, if the test results are normal, testing should be repeated every three years, according to ACOG's *Guidelines for Women's Health Care.*

Patients of all ages with risk factors: The increased prevalence of overweight and obese individuals is adding to the burden of needed diabetes screening. It's critical to be alert to the risk factors for diabetes because patients may have only mild or no symptoms during the initial stages of the disease. This absence of symptoms is likely why approximately one-third of all individuals with diabetes have not been diagnosed.

Symptomatic patients: If you suspect that someone has signs and symptoms of diabetes, conduct a fasting glucose test. Be alert to the fact that the symptoms of diabetes overlap those of many other conditions. For example, "Waking up at night to urinate is a common gynecologic complaint that many gynecologists would process as a urinary incontinence issue, but it's also a sign of diabetes," Dr. Santoro said.

New monograph on depression, anxiety disorders

YOUR PATIENT MAY FEEL SHE'S in a "funk." Another may feel she has a case of the "baby blues," while another may think her irritability is a normal part of menopause. However, these patients could all be experiencing mood and anxiety disorders and be unaware that management and treatment options are available.

According to the National Institute of Mental Health, as many as 20% of women will have at least one episode of treatable depression at some point during their lives. Nearly twice as many women as men in the US are affected by a depressive disorder each year.

Mood and Anxiety Disorders, the latest monograph in the *Clinical Updates in Women's Health Care* series, provides ob-gyns helpful information on the screening, diagnosis, and treatment of depression, bipolar disorder, and anxiety disorders.

Depression and other mood and anxiety disorders can have a tremendous impact on the quality of life of Fellows' patients.

"These are very common disorders and may cloud so many gynecologic problems, especially when there is pain involved," said ACOG President Elect Gerald F. Joseph Jr, MD. "It's important for Fellows to ask patients how they're feeling and be able to recognize the symptoms and have referral plans in place." ♀

info

- ➜ www.clinicalupdates.org

ACOG opposes shackling of pregnant women

SHAWANNA NELSON WAS going into labor. An inmate at the Arkansas Department of Correction, Ms. Nelson was placed in handcuffs and leg restraints as she was driven to the hospital. Upon arrival, she was admitted into labor and delivery, and the officer accompanying her shackled her to the bed's handrail. When medical staff needed to draw blood, the officer removed the handcuffs, but the shackles remained. When the physician arrived to deliver the baby and asked that the shackles be removed, the officer complied, but immediately put the shackles back on after Ms. Nelson gave birth.

After her experience in 2003, Ms. Nelson sued the Arkansas prison system, arguing that her Eighth Amendment rights against cruel and unusual punishment were violated. A panel for the Eighth Circuit Court of Appeals ruled against Ms. Nelson this past July, but, in a rare move, the full court agreed to rehear the case. The full court heard oral arguments on September 24.

ACOG opposes the shackling of incarcerated women during labor and has encouraged state and federal lawmakers and federal agencies to prohibit physical restraints on pregnant women. However, the practice is currently outlawed in only three states: California, Illinois, and Vermont. Elsewhere, it's often left up to medical staff and physicians to request that handcuffs and shackles be removed, but the correctional officers might refuse. Or, they might remove the restraints only during delivery—but not labor—and might replace them immediately after the baby is born.

ACOG's *Guidelines for Perinatal Care* states "Applying physical restraints to pregnant women should be needed only very rarely, in extreme situations, for short periods. If restraint is needed after the first trimester, it should be performed with the individual on her side, not flat on her back or stomach. If she needs to be restrained for more than several minutes, she should be allowed to lie on her side, preferably on her left side. Pressure should not be applied either directly or indirectly to the abdomen while restraining the patient."

The Federal Bureau of Prisons has placed some restrictions on shackling, and prisons are now required to document any instances of shackling during labor and delivery, but shackling is still common in local jails and state prisons.

"Most incarcerated women are nonviolent offenders and pose no physical harm to prison guards or medical staff, particularly when the women are pregnant or in active labor," said Luella Klein, MD, ACOG vice president of women's health issues. "Physical restraints are demeaning and uncomfortable to laboring women and can prevent ob-gyns from being able to properly assess and evaluate the patient's physical condition." ♀

COURTESY OF REBECCA PROJECT FOR HUMAN RIGHTS

An inmate feeds her newborn in a hospital while remaining cuffed to the bed rail.

info

➜ See the "Health and Health Care of Incarcerated Adult and Adolescent Females" section in the "Special Populations" chapter of ACOG's *Special Issues in Women's Health*: www.acog.org/publications/specialissuesinwomenshealth

Stress folic acid importance in prevention of birth defects

ACOG ENCOURAGES OB-GYNS to remind their patients about the importance of folic acid supplementation during National Folic Acid Awareness Week, January 5–11. Neural tube defects affect an estimated 4,000 pregnancies each year.

National Folic Acid Awareness Week is sponsored by the National Council on Folic Acid, of which ACOG is a founding member. The theme this year is "New Year–New You." Resources are on the event website.

ACOG recommends that all women who may become pregnant take 0.4 milligrams of folic acid daily. Women who have previously had a child with a spine or skull defect should take 4 milligrams daily. ♀

info

➜ www.folicacidinfo.org

➜ *Neural Tube Defects* Practice Bulletin (#44, July 2003): www.acog.org/publications/educational_bulletins/pb044.cfm

Register now

Pregnancy and diabetes webcast November 18

LEARN HOW TO DEVELOP AN EFFECTIVE management system for your diabetic pregnant patients during ACOG's webcast on November 18, "Evaluation & Management of Diabetes in Pregnancy." The webcast will be held online from 1 to 2:30 pm Eastern time. You must register by 12 pm Eastern time on November 17.

The challenges of caring for the diabetic patient during pregnancy can be significant. The management of preexisting diabetes differs greatly from that of the patient who develops "mild" gestational diabetes in the third trimester. The optimal level of glycemic control remains a subject of controversy, and achieving such glycemic control may require a team approach.

The webcast will help you:

- Improve preconceptional glycemic control in the patient with preexisting diabetes
- Establish glycemic control standards
- Become more effective in preventing complications
- Manage patients who have had gastric bypass, use oral agents, or employ an insulin pump
- Improve glycemic control during labor
- Counsel the postpartum patient to decrease her risk of developing Type II diabetes

The webcast program director is Kathleen M. Berkowitz, MD, regional director of the Sweet Success Program Region 6.1, a diabetes and pregnancy program at Long Beach Memorial Medical Center, Long Beach, CA.

New webcast every month

ACOG webcasts are $49 per site, allowing multiple viewers to watch the online webcast at each location for one price. ACOG webcasts are usually offered on the second Tuesday of each month, helping physicians and their staff stay updated on important issues without leaving the office.

Archived webcasts are available approximately two days after the live webcast. ♀

info

➜ www.acog.org/postgrad/pgpage.cfm?recno=464

Professional liability, risk management guide

THE NEWEST EDITION OF ACOG's popular guide *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists* can be a helpful tool for Fellows and Junior Fellows.

The updated edition covers a wide array of professional liability and risk management issues, concepts, and strategies in an easily accessible format. Chapters are devoted to such topics as emerging legal theories, the role of the expert witness, consent issues, risk management, liability insurance, high-risk areas for obgyns, special liability issues for residents, and litigation stress. ♀

info

➜ http://sales.acog.org; 800-762-2264

Liability quizzes online for residents

RESIDENCY PROGRAM INSTRUCTORS CAN gauge residents' comprehension of professional liability concepts with ACOG's online quizzes. The quizzes supplement the ACOG publication *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists*.

There are five quizzes, each with 10 to 20 multiple-choice questions. Residents may print their scores immediately after taking a quiz and submit them to program directors. ♀

info

➜ To access the quizzes, go to the ACOG website, www.acog.org. Under "Practice Management," click on "Professional Liability" and then "Resources" on the menu bar on the left side

➜ Program directors may request a copy of the answer key by submitting a request with their ACOG ID number to jklagholz@acog.org

2008–09 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

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

14
ACOG WEBCAST:
Intrapartum Fetal Heart Rate Monitoring—The Evolution of Consensus
1–2:30 pm ET
800-673-8444, ext 2498

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

21–27
American College of Nurse-Midwives 54th Annual Meeting & Exposition
Seattle
www.midwife.org/am
240-485-1800

JUNE

13–17
American Medical Association Annual Meeting
Chicago
www.ama-assn.org

17–21
Society of Obstetricians and Gynaecologists of Canada Annual Clinical Meeting
Halifax, NS
www.sogc.org
800-561-2416

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 W[illegible]op SOLD OUT
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

2009

FEBRUARY

12–14
Emerging Issues in Office Practice: Sexuality, Body Image, and Psychological Well-Being
St. Thomas, US Virgin Islands

27–Mar 1
Coding Workshop
Chandler, AZ

MARCH

6–8
Coding Workshop
Atlanta

26–28
Quality and Safety for Leaders in Women's Health Care
Washington, DC

27–29
Coding Workshop
Houston

MAY

7–9
Coding Workshop
Chicago

JUNE

26–28
Coding Workshop
Minneapolis

JULY

10–12
Coding Workshop
Baltimore

AUGUST

7–9
Coding Workshop
Kansas City, MO

27–29
Reawakening the Excitement of Obstetrics and Gynecology
La Jolla, CA

28–30
Coding Workshop
Seattle

OCTOBER

30–Nov 1
Coding Workshop
Coronado, CA

Interstitial cystitis resources available online

THE ASSOCIATION OF REPRODUCTIVE Health Professionals and the Interstitial Cystitis Association have teamed up to raise awareness about interstitial cystitis/painful bladder syndrome, creating several free online resources for physicians.

As part of the Screening, Treatment, and Management of Interstitial Cystitis/Painful Bladder Syndrome program, the following materials are available on the ARHP website:

- A *Clinical Proceedings* monograph
- A quick reference guide for health care providers
- A fact sheet highlighting key data
- A patient education fact sheet
- Three archived webinar sessions ♀

info

→ www.arhp.org/Professional-Education/Programs/ICPBS

Episiotomy monograph now online

THE ACOG MONOGRAPH *EPISIOTOMY: PROCEDURE and Repair Techniques* is now available on the ACOG members-only website in both English and Spanish. Hard copies in English are mailed each year to first-year residents. The Spanish version is not available in hard copy.

Episiotomy is likely the most common surgical procedure that obstetricians will perform. Because teaching of episiotomy is usually left to junior residents, the Residency Review Committee for Obstetrics and Gynecology asked ACOG to prepare a teaching aid for all residents. The monograph was produced in 2007 through a grant from the ACOG Development Fund. ♀

info

→ www.acog.org/publications/episiotomy

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