

Chair's Message

News from the Chair

by Sherry L. Blumenthal, MD, FACOG



It has been a busy summer. While we expected little legislative activity in PA, several bills have surfaced that impact ob/gyn, including HB 1570, a bill that would modernize the state's hospital licensing process. We have decided to hire a lobbyist, John Milliron, to more effectively fight women's health issues of interest and OB/GYN physician concerns.

I spent several weeks fighting the merger between Abington Health and Holy Redeemer Hospital. While financially efficacious for both hospitals, the restrictions on provision of abortion were unacceptable to both the medical staff and the community. The success of the fight is due in large part to email and social media. Please see my editorial in the newsletter detailing the issues. I wrote a brief statement concerning this type of merger for PA ACOG, however, there were religious issue concerns from National ACOG. There is a committee at the National level working on the issue, and I will join them so that we can craft a position together.

As to HB 1570, we are trying to balance the modernization of hospital privileges as advocated by PAMED, with the activism of nurse midwives and CRNPs. While the bill does not mention them, they are pushing for an amendment to make them independent practitioners. National ACOG is working with their national organizations to increase collaboration and has made a strong policy statement to that effect, but maintains a position against home deliveries and lack of appropriate oversight.

Pennsylvania has a written policy that all CNMs must have a written collaborative agreement with a physician. We, at PA ACOG, have reaffirmed our agreement with this provision. There are many hospitals in PA which have successful collaborations with CNMs, and we believe this model should be maintained. We have reached out to CNMs and CRNPs to try to understand their concerns, but we will maintain our position as the safest for the maternity care of women.

John Milliron has participated in drafting legislation to help protect physicians from liability in emergency situations,

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Note: If you have an important announcement of interest to Pennsylvania ob-gyns, send it to Jan Reisinger at the PA Section of ACOG office.

Legislative Report

by Lynne Coslett-Charlton, MD, Legislative Committee Chair and PA ACOG Treasurer



The past year has proven to be very active legislatively for PA ACOG. As is consistent with other states that have a conservative legislature, multiple bills have been introduced

which have direct impact on women's reproductive rights. As physicians, our task is to fight for the rights of our patients by protecting the sanctity of the doctor-patient relationship. We must continue to convince our legislators that we are the best equipped to make medical decisions and that the practice of medicine should never be legislated. Although we expect a slight pause in activity during this election cycle, it has become apparent that we must become more effective and politically engaged in the process. For that reason, our Section is pleased to announce that we have formed a relationship with the lobbyist group of Milliron and Associates.

Over the past few years, we have relied upon a wonderful relationship with the Pennsylvania Medical Society (PAMED) to track pertinent legislation related to our specialty, and our concerns would then be discussed with members. Our leadership formulates an opinion based on ACOG National Guidelines, and the PAMED lobbyists would speak on our behalf. This year, we have seen a tremendous increase in activity directed at the practice of OBGYN, warranting lobbying directly for our specialty and complementing the efforts of PAMED.

John Milliron of Milliron and Associates has 30 years of experience with his firm in Pennsylvania. He has served a similar role for many medical specialties. He currently represents the societies for Anesthesia, Ophthalmology, Emergency Medicine, Dermatology, and Otolaryngology. His firm is excited to engage in our issues. As we move forward his group will provide a direct voice and presence for PA ACOG in the Capitol. Further information can be found at www.millironassociates.com.

Resident Education: the Next Accreditation System (NAS)

by Mark B. Woodland, MS, MD, Education Committee Chair, Vice Dean for GME, Program Director OB/GYN Drexel University College of Medicine

The Accreditation Council for Graduate Medical Education (ACGME) is a private, non-profit council that evaluates and accredits more than 9,000 residency programs in 135 specialties and subspecialties in the United States, affecting more than 116,000 residents. Its mission is to improve health care in the U.S. by assessing and advancing the quality of graduate medical education for physicians in training through accreditation. Over the past few years it has systematically reviewed and

reconstituted program requirements and our evaluation systems. It has set limits on duty hours and constraints on programs. Notoriously, it does so by conjecture and theory without much if any testing or validation of its methods or procedures. Hopefully at the end of the day, we have more productive programs producing better trained physicians.

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Screening for Genetic Disease in the Jewish Population

by Adele Schneider, MD, FACMG, Genetics Division, Albert Einstein Medical Center, Philadelphia, PA. and Stephen Smith, MD, PA ACOG Secretary

In my patient care and teaching duties, the question “Who should be screened and for what?” often arises. I recently discussed this subject with Adele Schneider, who is an accomplished medical geneticist at Albert Einstein Medical Center in Philadelphia. I posed several questions to Adele that I thought were relevant to our specialty.

Who should be offered carrier screening and why?

Any individual of Ashkenazi (Eastern/Central European) descent should be offered preconception and prenatal carrier screening. The American College of Medical Genetics (ACMG) recommends you offer carrier testing if your patient or her partner have one grandparent of Ashkenazi Jewish descent. If the individual is unsure of his/her exact heritage, the ACMG recommends that testing be offered. Why? One in four Ashkenazi Jews is a carrier of one of 19 genetic diseases that occur with a high frequency in this population. In a 2010 study by Scott, a carrier rate of 1 in 3.3 was found among Ashkenazi Jews in New York City when tested for 16 recessive disorders.¹

The diseases being tested for on these panels are autosomal recessive. When both parents are carriers of a mutation in the same disease-causing gene there is a 25% risk, with each pregnancy, of having a child with that disease. Carriers do not display any outward signs of carrier status and being a carrier does not affect one's health.

When should screening take place and which partner should be screened?

Ideally, screening should be offered before conception, when the full range of reproductive options are available. In vitro fertilization with pre-implantation genetic testing is sanctioned by all religious groups within Judaism.

Preconception testing can be offered to either partner of an Ashkenazi Jewish couple. If the woman is already pregnant, you may choose to screen both partners simultaneously to allow adequate time for counseling and prenatal diagnosis in case both screen positive for a particular disorder.

If only one partner is of Ashkenazi descent, that individual should be tested first. Initial testing of the non-Jewish partner is discouraged because the carrier frequencies and detection rates for many of these disorders are not well established in non-Ashkenazi ethnicities. If testing is positive, carrier testing should be offered to the non-Jewish partner. Genetic counseling should also be offered if the service is available. Remember that a negative screening test for the partner reduces but does not eliminate the risk of an affected infant because the sensitivity of carrier testing is not 100%. This is called the residual risk.

For what conditions should individuals be offered carrier screening?

I recommend testing for the following 19 diseases in Ashkenazi Jews:

Bloom syndrome, Canavan Disease, Cystic Fibrosis, Dihyrolipoamide Dehydrogenase Deficiency (DLD Deficiency), Familial Dysautonomia, Familial Hyperinsulinism, Fanconi Anemia Type C, Gaucher Disease, Glycogen Storage Disease, Type 1a, Joubert Syndrome, Maple Syrup Urine Disease, Mucopolysaccharidosis IV (ML4), Nemaline Myopathy, Niemann-Pick Disease Type A, Spinal Muscular Atrophy, Tay-Sachs Disease, Usher Syndrome Type 1F, Usher Syndrome Type III, and Walker-Warburg syndrome. These 19 disorders fulfill the ACMG criteria for selection of diseases for testing: that the disease is serious and presents a significant burden, the carrier rate is 1 in 100 or greater and/or the detection rate is >90%.

Please note that ACOG and ACMG offer recommendations for screening which differ from each other and from my recommendation. ACOG recommends that all Ashkenazi Jews be offered screening for cystic fibrosis, Tay-Sachs disease, Canavan Disease and familial dysautonomia.² The ACMG recommends screening for Bloom Syndrome, Fanconi anemia Type C, Gaucher Disease, mucopolysaccharidosis IV and Niemann Pick Disease along with the four disorders recommended by ACOG.³

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PA ACOG Addresses Members' IUD Concerns

by John Gallagher, MD, Division V Representative

Fellows across the state have contacted PA ACOG with concerns regarding third party coverage of Mirena for their patients. Several described rejections of medically indicated procedures upon submission of claims. PA ACOG, working with PAMED, investigated the problem to allow all providers the ability to offer patients every available approved therapeutic option. Discussions were held with insurers statewide, including Highmark, Aetna, & UPMC, among others. Our findings include:

For non-contraceptive reasons, all plans cover Mirena for treatment of menorrhagia and dysmenorrhea as approved by the FDA. This can be considered one of many options available for management of these conditions consistent with ACOG guidelines. If any member experiences difficulty with reimbursement for these indications, please notify PA ACOG immediately so we can address the issue on a larger scale.

Contraceptive coverage, however, is a more complex issue. This is an additional rider that not all employers will purchase for their employees. At this time, insurers are also not required to cover all approved methods of contraception even if the rider is purchased. As a result,

third party payers may select options based on cost or other issues of their choice. Preapproval of long acting reproductive options including IUD's and Nexplanon are critical to adequate reimbursement. Several states have passed legislation mandating contraceptive coverage in all insurance plans and including all FDA approved methods. Pennsylvania has no such law. A PA ACOG sponsored resolution was approved at the 2011 PAMED House of Delegates making passage of such legislation in Pennsylvania policy of the Society. To date, no progress has yet been achieved due to the current political composition of the legislature. Upon full implementation of the Affordable Care Act, contraception will be a basic component of all plans offered through the health insurance exchanges. Grandfathered health plans outside the exchanges will not have this mandate, making passage of state laws a priority.

PA ACOG will continue to pursue this issue actively and lobby aggressively for full access to all contraceptive options for our patients. We need your help! It is essential to our success to speak with your elected representatives and provide financial support to PAMPAC and our own national Ob-GynPAC.

Editorial: Merger Defeated by Medical Staff and Social Network

by Sherry L. Blumenthal, MD

At the end of June 2012, Abington Memorial Hospital announced its plan to merge with Holy Redeemer Hospital. The announcement was in the newspaper on the same day the medical staff at Abington was informed. The intent was to shore up the financial future of Abington Health in the coming years, position Abington to survive as the Affordable Care Act became effective, and unite with a hospital in the same geographic area which has some complementary services such as Home Health care.

The merger came with the caveat that Abington would no longer perform abortions, however, no other point of Catholic doctrine would be imposed. The decision was made without consulting the department of OB/GYN,

although the Chair, Dr. Joel Polin, was informed months earlier and opposed the conditions of the merger. He was not invited to the Board meeting when the final decision to go ahead with the merger was voted upon.

The announcement was met with anger and disbelief. Apparently, since Abington only performs about 65 abortions a year, the administration felt that no one would care about the provision to stop providing this service. They grossly miscalculated the response!

There have been 90 proposed mergers between secular and Catholic hospitals in the US, 45 of which were stopped. The secular hospitals made differing

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such as in the emergency room and the DR. We support this position and hope that we can help shepherd this bill through the state legislature. We are collaborating with the Pennsylvania Chapter, American College of Emergency Physicians and PAMED is also supporting the bill.

The Obesity Project has been presented three times so far, and is continuously undergoing revision and improvement. The National ACOG Obesity taskforce has met twice, with our next meeting in September. Dr. Ann Honebrink has joined the task force. An online compilation of resources is being produced so that our colleagues have the tools to successfully educate and implement strategies to fight the obesity epidemic. The Obesity Project slides are included as a resource.

Several of us attended a meeting about the Victor Center, which has a robust program to screen for the 19 “Jewish Genetic diseases.” Of interest was that there are many couples who are not of Jewish heritage who carry these mutations, due to historical intermarriage.

The Victor Center provides affordable screening for couples, however, the word needs to “get out” to physicians and patients. Highmark BC/BS does not cover this screening. We will work with the Center to educate the public and insurance companies about the value of this screening.

Now that the Affordable Care Act has been upheld by the Supreme Court, we are waiting to see what private insurance companies will do about contraceptive coverage. All newly established insurance plans have to cover contraception. Pennsylvania has neglected to set up a framework for the Health Insurance Exchanges, therefore the federal government will have that responsibility. States were allowed, under the Supreme Court Ruling, to opt-out of Medicaid expansion. Even though the federal government will subsidize over 90% of the cost, many states have elected to opt out. Pennsylvania has not yet stated whether the Commonwealth will opt-out, though we suspect it will.

The District III Road Show task force hopes to have the program “up and running” by 2013. There will still be an Annual District Meeting, but these road shows will be in collaboration with other Districts and will be more “cost-effective.” The ADM this year will be in Philadelphia and is sponsored by Districts I and III.

In June Dr. John Gallagher and I participated in a session at the state capitol sponsored by a national non-profit on Expedited Partner Therapy. While permissible under state law (i.e. there are no restrictions that prohibit this), many physicians are afraid to prescribe treatment for sexual



Dr. John Gallagher



Dr. Sherry Blumenthal

partners of women infected with Chlamydia or gonorrhea due to liability concerns. We will begin to draft legislation to indemnify doctors who provide this service for the benefit of the patient. There is legislation in effect in Illinois that addresses this issue which we will use as a model. ACOG supports the provision of EPT.

Our Legislative Day in Harrisburg is October 2, 2012. We encourage all members of PA ACOG to attend and become more comfortable with talking to their legislators and staffs about our issues.

Respectfully submitted,

Sherry L. Blumenthal, MD, FACOG
Chair, Pennsylvania Section ACOG

Resident Education: the Next Accreditation System (NAS)

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To further explore our success or outcome in providing a better education and educational experience for our physicians and to better gauge our program success and resident achievement, the ACGME has proposed a new accreditation system. The ACGME's **next accreditation system (NAS)** is an outcomes-based accreditation process through which the doctors of tomorrow will be measured for their competency in performing the essential tasks necessary for clinical practice. The aims are threefold: to enhance the ability of peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes and to reduce the burden associated with the current structure and process-based approach.

The NAS as listed will require **clinical learning environment review (CLER)** as a foundation,

continuous RRC Oversight and Accreditation Sponsorship oversight, limited site visits, continuous institutional review, and inherent ongoing site self-study. To do this, programs will not only assess the resident's **competency achievement**, but align this with established **milestones** for each resident to achievement through residency and eventually tie this to the achievement of **Entrustable Professional Activities (EPA)**.

What does this mean for all of us providing graduate medical education (GME)? There is a hope that there will be less work on an already jammed plate of the programs and the program directors. There is the hope for improved validation of our teaching methods. There is anticipation that our programs will produce an improved level of functioning physicians ready to enter the healthcare work force. We will certainly wait and see. The proof will be in the pudding and to be quite honest; our GME pudding is a bit runny right now.

For more information please refer to <http://www.acgme-nas.org/>.

Screening for Genetic Disease in the Jewish Population

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How is testing performed?

DNA-based mutation testing is the primary means of testing. For Tay-Sachs Disease, testing should include both the Hex A enzyme assay and mutation analysis. To accomplish this, testing must be performed on a blood sample. When Hex A enzyme is not included in the testing, 11.4% of carriers of Tay-Sachs will be missed.⁴ This is attributable to the changing demographic of young Jewish adults, in which the gene pool is being modified by intermarriage and adoption. Tay-Sachs also occurs in the Irish, Cajun and French Canadian populations and for these patients enzyme testing is the only accurate test. When ordering Tay-Sachs testing, make sure to check off the Hex A enzyme as a separate test because the "Jewish panel" usually includes only mutation testing.

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accommodations to the ban on abortion, in many cases establishing a “hospital within a hospital,” or an outpatient facility. Abington proposed the latter. Unfortunately, the abortions done at Abington often involve medical complications of pregnancy, fetuses with genetic or lethal structural defects, or procedures which are life-saving for the gravid woman. These would be unsafe in a free-standing facility. The security of the physicians and patients at an outpatient facility is also a concern. Statements that there are many other places for women to have an abortion ignore the reality that this is not the case in Abington. In addition, Pennsylvania legislature is doing everything possible to close the existing clinics which do abortion, including Planned Parenthood. If the Abington administration and Board had just asked us...

Banning abortion raises other major questions, such as invitro fertilization, selective reduction, disposal of frozen embryos, ectopic pregnancy of a fetus with a heartbeat in the tube, incomplete abortion with a fetal heartbeat and maternal hemorrhage, etc, etc.

Subsequent to the announcement, letters poured into the offices of the CEO, Laurence Merlis, and the chair of the Board, Robert Infarinato. The media started a welcome frenzy, interviewing many of us. There were emergency meetings of the medical staff and the department of OB/GYN. There was unanimous opinion to block the merger. The OB residents became active in opposition due to the effect the merger would have on ACGME requirements and their personal objections. Mergerwatch.org, a non-profit based in Washington, DC, worked with some of us to strategize. Included in the conference calls were Catholics for Choice, the ACLU, the National Women's Fund, the Women's Law Project, and the National Jewish Women's fund.

The community rose against the merger, and started a Facebook site “Stop the Abington Merger.” An online petition was circulated on change.org. Clergy in the area responded with letters and pressure on the administration. Community residents picketed on Old York road.

Three weeks after the initial announcement, the Board voted to cancel the merger. There was a huge sigh of relief from the community and medical staff. The victory showed how physicians and community can unite to fight decisions which violate their beliefs and values. Mergerwatch.org claimed that we held the record for the least time required to defeat a merger in their 15 years of existence.

This is a time when we are continually fighting for women's reproductive rights. Abortion is the hot-button issue, but women's entire reproductive freedom rests on our continued vigilance and action. ACOG has stated that we support “equal access to all reproductive health care for women, including abortion.” The Supreme Court had upheld the constitutionality of Roe vs. Wade twice, affirming that states cannot pass laws to prohibit abortion before the age of viability. So opponents of abortion are pursuing laws to establish “personhood” starting with a fertilized egg, ban abortion after 18 weeks on the grounds that a fetus feels pain at 20 weeks (unproven), force physicians to counsel women that abortion increases the risk of suicide (untrue), close free-standing clinics which provide many reproductive services such as contraception, cancer and STI screening, require ultrasound and force the woman to view or hear the heartbeat, and pass numerous other laws at the state level to make it impossible for a woman to have a safe, legal abortion in that state.

As a woman and a physician who takes care of women, I am outraged. I hope everyone in our specialty will fight with me to preserve our patient's right to comprehensive reproductive health care. This is a fight we cannot afford to lose.

2012 PA ACOG Legislative Day is Almost Here!

PA ACOG Legislative Day is open to physicians who want to get involved and speak with their elected representatives about the serious issues facing ob/gyns today. The meeting is scheduled for **Tuesday, October 2**, and will include an informational briefing session, meals, and transportation to the Capitol to meet with your elected official.

Please plan to attend and to bring your colleagues, residents and students. We need to have a strong and united effort to effectively reach the decision-makers! **A registration form is available in this newsletter**, please return today. Please call the PA ACOG office at (888) 726-2496 for more information.

PA ACOG Legislative Day

Tuesday, October 2, 2012

Registration

Home address must be included to make legislative appointments within your district

Name: _____

_____ MD DO

Home Address: _____

Home City: _____

State: _____ Zip: _____

Email: _____

- PA ACOG Member Non-PA ACOG Member Resident
 Yes, I plan to have lunch
 No, I will not be attending lunch

Practice Information

Practice Name: _____

Practice Address: _____

City: _____

State: _____ Zip: _____

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