

Minority ob-gyns encouraged by powerful mentors

GRABBING HIS BLACK LEATHER MEDICAL BAG, Dr. David Reid, an African-American family physician in the 1950s, would make house calls day and night to his patients in Washington, DC. But he brought along more than his stethoscope and thermometer. The doctor had a sidekick, his young nephew Raymond, who became fascinated with medicine at an early age. The boy would usually wait in the car during house calls but often tagged right alongside his uncle during hospital rounds.

That young boy is now ACOG Fellow Raymond L. Cox, Jr, MD, MBA, chair of the ob-gyn department at Saint Agnes Hospital in Baltimore. His uncle, long retired and living in Centreville, VA, just celebrated his 100th birthday.

“My uncle was a family physician in Washington for 50 years. He used to take me on rounds with him, so by the time I was eight years old, I knew I wanted to be a doctor,” Dr. Cox said. “Going with my uncle meant a lot to me. What fascinated me then and what fascinates me still today when I watch him go into ‘doctor mode,’ if you will, is the way he listens to his patients and then asks them very direct questions.”

Dr. Cox is one of several minority ob-gyns who were encouraged and supported in their educational endeavors and ob-gyn careers by strong mentors. While the number of minority physicians today is higher than it was in the 1950s when Dr. Reid was practicing, some racial and ethnic groups continue to be severely underrepresented in medicine when com-

“My uncle was a family physician in Washington for 50 years. He used to take me on rounds with him, so by the time I was eight years old, I knew I wanted to be a doctor.”

—Raymond L. Cox, Jr, MD, MBA

pared with the overall US population. African-Americans and Hispanics make up less than 10% of US physicians, while they account for about 24% of the general population, according to the US Census Bureau.

Studies have shown that minority physicians are more likely to practice in minority neighborhoods and to treat underserved populations. With millions of uninsured Americans and a shortage of primary care doctors, developing a pipeline of minority physicians could increase the number of doctors in poor rural and urban communities.



Dr. Cox moderates an Annual Clinical Meeting session



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EXECUTIVE DESK

2009 FIGO Congress brings focus to women's health care internationally

AS I WRITE THIS EXECUTIVE DESK, I have just returned to the US after attending the 19th FIGO (International Federation of Gynecology and Obstetrics) World Congress of Gynecology & Obstetrics in Cape Town, South Africa. Although exposure to Africa was limited in Cape Town, a modern, westernized city, exposure to the international problems of women's health care was maximized.

The scientific meeting was outstanding thanks to the superb work of the Scientific Program Committee chair, Fellow Thomas F Baskett, MB, professor of ob-gyn at Dalhousie University in Halifax, NS, and chair of the ACOG Committee on International Affairs. The program highlighted the emerging science of genomics that will have an enormous impact on the future of ob-gyn. However, what was most intriguing was hearing about the health care problems women face throughout the world.

Genital cutting, obstetric-caused fistula, and maternal deaths from sepsis and postpartum hemorrhage are still common in many developing areas, as well as

a lack of health care workers and access to care facilities for pregnant women. In the US, we are fortunate to have a wonderful health care system, even if it requires improvement in greater accessibility and coverage. We must remember that much of the rest of the world is still in need of minimum care availability.

The FIGO Congress occurs once every three years and rotates from continent to continent. In 2012, the Congress will meet in Rome, Italy, and Vancouver, BC, was selected for 2015.

ACOG's Committee on International Affairs remains focused on working to improve the health care of women in underdeveloped areas of the world. The needs of these areas are great, and ACOG will continue to work toward FIGO's goals of prevention of death from pregnancy. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

Philip R. Bartholomew, MD
Atlanta • 8/09

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Overland Park, KS

Roy G. Bowen, MD
Danville, IL

Melvin W. Breese, MD
Scottsdale, AZ • 4/09

Gary Micheal Browning, MD
Norfolk, VA • 9/09

David Richard Burrus, MD
Minneapolis • 9/09

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Palm Beach Gardens, FL • 6/09

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Larchmont, NY • 1/09

Billy D. Viele, MD
San Diego, CA • 8/09



Obstetrics & Gynecology
HIGHLIGHTS

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

*Choosing the Route of Hysterectomy
for Benign Disease*

(Gynecologic Committee Opinion, #444, new)
For more information, see page 14.

Antibiotics for Preterm Labor

(Obstetric Committee Opinion #445, new)

*Array Comparative Genomic Hybridization in
Prenatal Diagnosis*

(Genetics Committee Opinion #446, new)

Robot-Assisted Surgery

(Gynecologic Technology Assessment #6, new)
For more information, see page 14.

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.



pause® magazine available online

THE FALL/WINTER 2009 issue of *pause*®, ACOG's online magazine for your perimenopausal and menopausal patients, is available at pause.acog.org. The new issue features an interview with Olympic gold medal figure skater Peggy Fleming and a wealth of information about midlife health. ♀

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→ pause@acog.org



Fellow election voting begins in December

THE 2010 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 III	District VI
Armed Forces District	District XI

Sections

Alberta (VIII)	New York Section 5 (II)
Atlantic Provinces (I)	New York Section 8 (II)
California Section 1 (IX)	New York Section 9 (II)
California Section 7 (IX)	North Carolina (IV)
Central America (VIII)	Ohio (V)
Idaho (VIII)	Pennsylvania (III)
Kansas (VII)	Saskatchewan (VI)
Kentucky (V)	South Dakota (VI)
Maine (I)	Texas Section 3 (XI)
Maryland (IV)	Utah (VIII)
Minnesota (VI)	Vermont (I)
Missouri (VII)	Washington (VIII)
Montana (VIII)	West Indies (IV)
Navy (AFD)	West Virginia (IV)
New York Section 2 (II)	

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

Consider the College in end-of-year giving plans

AS 2009 DRAWS TO A CLOSE, the College 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 the College is prepared and able to meet the challenges it faces in ensuring 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 the College'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. ♀

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- 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 College newsletter, <i>ACM News</i> , <i>Final Program</i> , and <i>Donor Report</i>	✓	✓	✓	✓
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



ACOG updates website on patients with disabilities

ALTHOUGH WOMEN WITH disabilities encounter many of the same health problems as women without disabilities, they consistently report poorer health. How can you ensure the proper treatment of patients with disabilities in your practice? ACOG has a newly updated, interactive website that can help.

The Reproductive Health Care for Women with Disabilities website provides an overview of the health care needs of patients with disabilities and takes ob-gyns through the clinical management of these patients.

The website has information on:

- ▶ Contraception
- ▶ Menses and abnormal uterine bleeding
- ▶ Pregnancy and parenting
- ▶ Diet and exercise
- ▶ Adolescent health
- ▶ Aging and osteoporosis
- ▶ Physical, developmental, and sensory disabilities
- ▶ Office and practice solutions

The website is the culmination of a collaborative project between ACOG and the Centers for Disease Control and Prevention's National Center on Birth Defects and Developmental Disabilities. ♀

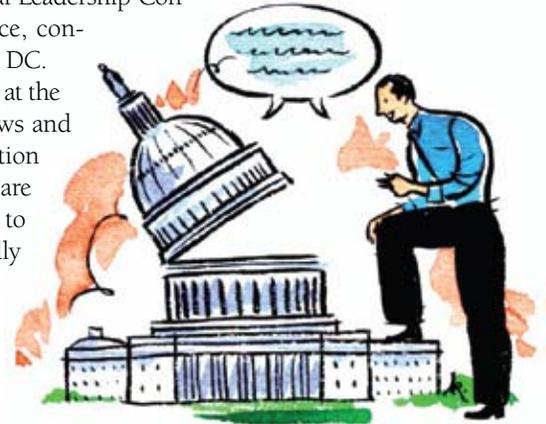
info

- At acog.org, under the "Women's Issues" tab, click on "Women with Disabilities" and then "Interactive site for clinicians serving women with disabilities"

Attend 2010 Congressional Leadership Conference in nation's capital

JOIN MORE THAN 200 ACOG MEMBERS IN LOBBYING CONGRESS WHEN ACOG's 27th Annual Congressional Leadership Conference, The President's Conference, convenes Feb 28–Mar 2, 2010, 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. Fellows and Junior Fellows are sponsored by their district or section chairs to attend the conference. Sponsorship typically covers travel, registration, lodging, and incidental expenses. Participants who self-sponsor can attend by paying a \$300 registration fee, plus travel and lodging expenses. ♀



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- Contact your district or section chair by November 20 if you're interested in attending
- For more information, contact Stacie Miscikowski in ACOG's Government Affairs Department: 800-673-8444, ext 2505; smiscikowski@acog.org

58TH ANNUAL CLINICAL MEETING



May 15–19
2010

- ▶ Mark your calendars
- ▶ Early-bird registration opening soon

acog.org/acm



Dr. Shah

Interest in ethics lands student a spot on ACOG committee

KAVITA R. SHAH, MD, MBE, HAS long been interested in how medicine and ethics intersect. A first-year ob-gyn resident at Thomas Jefferson University in Philadelphia, Dr. Shah studied philosophy in college and received her master's in bioethics while simultaneously earning her medical degree.

Dr. Shah was the sole student representative on the American Medical Association's Council on Ethical and Judicial Affairs in 2007–09 and has been reappointed for 2009–12 as the resident/fellow member. It was at an AMA meeting where she mentioned her interest in ethics to ACOG Executive Vice President Ralph W. Hale, MD. Earlier this year, she was invited to sit in as a medical student observer

on ACOG's Committee on Ethics. While she's not an official member, she is encouraged to take part in the discussions. But mostly, she's been fascinated by watching and listening to the ethical debates.

"It was a great learning experience in that I was with ob-gyns who had practiced for years and with those who published ethical papers that I had read and referenced, people I had looked up to for their ethical insight," Dr. Shah said.

In just her short medical career, Dr. Shah has witnessed the way medical schools relate to industry and the restrictions schools have begun to implement on student interaction with industry.

"While I was a student, Jefferson did go

through a transition with its relationship to industry, and I have loved bringing that firsthand experience to discussions of ACOG's ethics Committee Opinion on industry," Dr. Shah said.

Dr. Shah is also interested in ethical issues relating to reproductive disparity between the developing world and the US, stigma attached to HIV and its impact on women, psychology of infertility, assisted reproductive technology, and genetics.

"I'm interested in pursuing a fellowship in reproductive endocrinology and infertility and staying in academic medicine, where I can continue my clinical and ethical research and involvement with organized medicine," she said. ♀

LAW STUDENT RESEARCHES REPRODUCTIVE HEALTH AND TOXINS

THANKS TO A LAW STUDENT intern, ACOG District IX has a well-researched, 15-page memorandum outlining the legal and political strategies in banning environmental toxins that negatively affect reproductive health. The document will aid District IX as it shapes its legislative agenda.

Law student Victoria Rivapalacio spent the summer researching the effect of environmental toxins on reproductive health for District IX. A native Californian in her third and final year of law school at George Washington University in Washington, DC, Ms. Rivapalacio was paired with ACOG through a summer internship with Law Students for Reproductive Justice. Her ACOG work was recognized in September when she was named the Sheila Kuehl Summer Legal Intern Fellow, an award in California given to a legal intern for work done during a summer internship.

"Her research is well done and comprehensive, and her work has introduced us to experts in the field," said District IX Executive Director Margaret Merritt.



"What struck me most when I was doing my research was how frustratingly slow the response can be to science."

—Ms. Rivapalacio

According to Ms. Rivapalacio's research, a vast majority of the 53,500 chemicals humans are regularly exposed to are untested for their toxicity to humans. Advocates in California are fighting for restrictions on chemicals such as lead, flame retardants, and Bisphenol A,

which is used in plastics and, in animal studies, has been shown to cause harm.

In an effort known as Proposition 65, advocates in the state tried but failed to add Bisphenol A, also known as BPA, to the list of chemicals that would require labeling that notifies consumers of the chemical's presence in a product. Ms. Rivapalacio attended an all-day meeting this summer held by the panel that ultimately decided not to add BPA to the list.

Advocates plan to introduce legislation in the California Legislature that would ban BPA, and Ms. Rivapalacio's research will help District IX determine whether to support such legislation.

"What struck me most when I was doing my research was how frustratingly slow the response can be to science," Ms. Rivapalacio said. "And although the legislative process is intentionally slow, in certain circumstances time needs to be of the essence." ♀

Dr. Aeby uses a computer analogy to explain how to inform and engage your audience:



Boot up: Use something dramatic like a provocative quote or a case report to get the learners' attention and to make them recognize that the information will be useful.



Spin up the hard drive: A powerful way to help adults learn is to get them thinking about what they already know on the subject. To stimulate prior recall, use a case report or ask some questions that will challenge them to start thinking.



Program for multiple platforms: Respect and teach to the many different learning styles.



Make your desktop interesting: Add different types of audio, visual, and tactile stimulation to your learning environment. If you use a PowerPoint presentation, add images, use bullet points often, and limit each slide to 20 words or less.



Save often: Always integrate new information with the old. "You should always go back and forth between the new material you just covered and the information they've already learned, continuing to stimulate their prior recall," Dr. Aeby said.



Think in folders and documents: Recognize that some of your audience will be analytical learners (they build the big picture after learning the details), while the rest will be global learners (they start with the big picture and drill down to the details). Frequently moving from concepts to details will keep both of these types of thinkers engaged.



Use spellcheck: Check on your learners constantly to see how they are doing. Give positive and negative feedback as they learn, pointing out the things they are doing right and the things they are doing wrong.



Maintain a user-friendly network: Encourage an open environment that allows for interaction and collaboration. Create comfortable opportunities to speak up and ask questions. Adults do best in small groups (5-7 is ideal), and they get bored learning strictly in a lecture format.

How to engage your physician audience

ONE OF DR. TOD C. AEBY'S BIGGEST PET PEEVES IS WHEN a lecturer "doesn't give the audience credit for what they already know." Dr. Aeby recalls presentations in which the physician audience was restless and tuned out for the first 30-45 minutes because the presenter was going over information the doctors already knew. The physicians only perked up when the question-and-answer session began and they heard discussion of cutting-edge issues that related to patients they were currently caring for.

Unlike children and teenagers, adult learners don't like to sit through a lecture. They arrive at a session with ideas of what they want to learn and varying amounts of background knowledge of the subject. They want to interact with the lecturer and collaborate with fellow audience members. They like feedback, and if they become overwhelmed with information, they tune out. Dr. Aeby, the generalist division director at the University of Hawaii John A. Burns School of Medicine, department of obstetrics, gynecology, and women's health, and course director for the ACOG postgraduate course "Reawakening the Excitement of Obstetrics and Gynecology," is passionate about perfecting the art of giving a presentation, whether it's at the Annual Clinical Meeting or to a group of medical students informally at the hospital or in a lecture hall.

"Presenters can determine what the audience already knows by asking questions at the beginning of the session. Audience response systems are an excellent way to tally answers and gauge knowledge," said Dr. Aeby, who uses a coral reef image to adjust his lecture to what the audience knows. Answers to questions are "hidden" behind various fish in the coral reef. Depending on how the audience answers, he clicks on the appropriate fish. The lecture may veer off in different directions for different audiences, and he won't always click on all the fish, meaning he can adjust his script to fit his listeners.

"You don't have to use a coral reef. You can use any interesting picture that has a lot of objects in it and place answers behind each of the objects," he said. "A lot of people already have lectures they give and they just need to break them down into five to seven major concepts and divide their slides into five to seven mini-lectures addressing those main points." ♀



Online help available to prepare for your oral boards

IF YOU'VE VISITED THE ACOG Junior Fellow website recently, you may have noticed some changes. The website has been redesigned to be more aesthetically pleasing and user-friendly. Much of the content has remained the same, but one new item is a link to the Pearls of Excellence Program from the Foundation for Excellence in Women's Health Care, the nonprofit foundation of the American Board of Obstetrics and Gynecology.

Each year, the foundation reviews data from ABOG's three oral certification exams and compiles a list of the 10–12 most challenging topics. Reviews of and related references to each topic are then posted throughout the year for ob-gyns to read free of charge. Some of the topics from 2009 are:

- ▶ Complications of gynecologic laparoscopic surgery
- ▶ Contraceptive choices for women with common medical problems
- ▶ Pregnant women with an adnexal mass
- ▶ Postmenopausal vulvar lesions
- ▶ Nonimmune hydrops fetalis

The Foundation for Excellence in Women's Health Care is committed to reinforcing the education and excellence of the nation-

al ob-gyn community by providing ob-gyns with information and resources they can use to improve care for women.

More resources

Other programs the foundation offers that Junior Fellows can take advantage of are:

- ▶ Excellence in Mentoring: Ob-gyn experts update medical students, residents, and fellows on the latest research and treatment techniques
- ▶ Excellence in Life Long Learning: Keeps ob-gyn residents and physicians up-to-date on new technologies, best practices, and medical findings with a series of current articles throughout the academic year
- ▶ Excellence in Clinical Research (formerly Excellence in Faculty Development): Offers a course in epidemiology and research methods that, with the approval of ABOG, fulfills the fellowship requirements for a university graduate-level course in quantitative techniques ♀

info

- ➔ Visit acog.org and click on "Junior Fellows" under "Quick Links" on the left side of the page. Then, click on "ABOG"



Submit 'Projects in a Box' entries by November 30

SUBMIT SUMMARIES OF your successful projects for ACOG's new "Project in a Box" contest. The contest, created by the Junior Fellow College Advisory Council, will highlight notable projects, posting project descriptions on the JFCAC website so that others can duplicate the projects in their own communities.

All Junior Fellows are eligible to submit descriptions of successful educational or community service projects. Entries must be submitted online (see "info" below) and are due by November 30.

The winner will receive a \$2,500 prize for travel and meeting expenses to present his or her project at the 2010 Annual Clinical Meeting in San Francisco, May 15–19. ♀

info

- ➔ For more information or to submit a project, go to acog.org and click on "Junior Fellows" in the "Quick Links" box on the left

Submit your intriguing cases for 2010 Stump the Professors

SUBMIT YOUR UNIQUE, CHALLENGING, AND UNFORGETTABLE ob-gyn cases by the November 30 deadline for The Gerald and Barbara Holzman Stump the Professors program at the 2010 Annual Clinical Meeting, May 15–19, in San Francisco.

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 18. Each presenter will receive free Junior Fellow ACM registration, coach airfare, and travel and hotel expenses for three days. ♀

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- ➔ At acog.org, click on "Junior Fellows" in the "Quick Links" box on the left side
- ➔ Erica Bukevicz: 800-673-8444, ext 2428; ebukevicz@acog.org



SUBMITTING CASES

- ▶ You must be a Junior Fellow in Training to submit a case
- ▶ Cases should require deliberation and consider potential change in practice
- ▶ 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

EYES ON THE PRIZE

Four poster presentations were honored at the Annual Clinical Meeting in May as blue ribbon poster winners. ACOG Today interviewed the winners about their research.



1st

MONDAY POSTER SESSION

Hospital finds EHRs decrease rate of GBS screening uncertainty

In 2005, when the Oregon Health and Science University Hospital considered implementing an electronic health record system, physicians saw an opportunity to measure the effectiveness of using EHRs as compared to paper-based records.

They knew that group B streptococcus screening wasn't being done for all pregnant women as ACOG and the Centers for Disease Control and Prevention recommend and that it was often because clinicians were uncertain whether a woman had been previously screened. GBS is a leading infectious cause of neonatal death in the US, yet the transmission of it from mother to infant can be prevented if the mother is treated with antibiotics during labor.

"GBS screening needs to happen as close as possible to when you think the mother will deliver," said lead author Jeanne-Marie Guise, MD, MPH, director of quality and safety for OHSU Hospital women's

services.

The research team reviewed charts for all OHSU patients who delivered vaginally at 36 weeks or greater between June 2005 and March 2008, recording the rate of GBS screening uncertainty. In that same time period, the hospital incrementally implemented an EHR system.



Dr. Guise

The study's results showed that from the first phase of implementation to the last phase, the hospital's rate of uncertainty decreased from 10.2% to 5.6%. Today, the hospital's rate of uncertainty is down to 2% to 3%, which most likely is accounted for by patients who have had no prenatal care, Dr. Guise said.

"The value we got wasn't just switching the hospital from paper to computer," Dr. Guise said. "The more we integrated our systems and built a way that information could be shared, the better our care became." ♀



2nd

MONDAY POSTER SESSION

Fellow discovers past in ob-gyn specialty's present

For most ob-gyns, reading about the first ovariectomy performed may seem dull in comparison to learning about new advancements in surgical technology. Ob-gyn historian Ronald M. Cyr, MD, would disagree. For Dr. Cyr, reading about ob-gyn history is stimulating and can be an indicator of where the field is headed.

Dr. Cyr, associate professor of ob-gyn and reproductive medicine at Michigan State University in East Lansing, has presented three times at ACOG meetings on his historical research of ob-gyn. The most recent research project he presented focuses on the most influential individuals and institutions in American ob-gyn from 1850 to 1930.

The period Dr. Cyr studied began with the rise of surgical gynecology, following the discovery of anesthesia during the 1840s, and ended with the formal organization of the American Board of Obstetrics and Gynecology in 1930. The years in between are full of accomplishments

by ob-gyns who still influence the field today.

"Notwithstanding the tribute paid to evidence-based medicine within academic circles, most ob-gyns practice what they were taught during residency," Dr. Cyr said. "So, it's interesting to see where we've come from as ob-gyns and who our professional ancestors were.



Dr. Cyr

"If you read enough about the history of ob-gyn, you realize that physicians before us were doing a lot of what we're doing now; we just have better technology. The 'dust bins of history' are replete with discoveries that were either ignored or discredited in their time. While they may have deserved their fate, such judgment needs periodic reassessment and may suggest paths for future research to physicians today."

Dr. Cyr is working on a number of historical projects and is eager to collaborate with anyone interested in medical history. If you are interested in collaborating or have questions, contact him at ronald.cyr@hc.msu.edu. ♀

HONORABLE MENTIONS

Eric Siegel, MD
"Smoking in Pregnancy: Analysis of a Smoking Cessation Project in West Virginia"

Timothy W. Victor, PhD
"Sex-Related Differences in the Relative Risk of Migraine over the Life Span"



Dr. Siegel



Dr. Victor



1st

TUESDAY POSTER SESSION

Study shows IUDs attractive to older women

Identifying why women choose specific contraception methods can help physicians better anticipate patient needs. This is especially true when the reasons identified break previously held assumptions.

In 2008, while investigating the characteristics of women choosing intrauterine device insertion over tubal sterilization as a form of contraception, researchers at the University of Iowa Carver College of Medicine in Iowa City made an important, surprising discovery.

"Our assumption was that women opting for tubal sterilizations over IUD insertion would be more certain of their decision to cease childbearing and uninterested in the reversible IUD," said Leticia Cox, a third-year medical student and lead author of the study. "Therefore, it was predicted that patients choosing sterilization would be older with higher gravidity and parity. However,

what we found was that though women opting for IUDs did have lower gravidity and parity, on average they were actually older than those choosing tubal sterilizations."

A retrospective chart review of women at 10 different teaching hospitals across the US showed that the number of tubal sterilizations performed had remained relatively stable in the past 10 years, while IUD placements had increased.

Though Ms. Cox found that patients choosing tubal sterilization are younger than those choosing IUD insertion, they have a higher parity and are more likely to want its permanence.

"Our research results provide insight into the current trends of long-term contraception and highlight the importance of noncontraceptive benefits in attracting older women to IUDs," Ms. Cox said. "The identification of patient characteristics will help physicians better serve their patient population." ♀



Ms. Cox



2nd

TUESDAY POSTER SESSION

New questionnaire for women with heavy menstrual bleeding

Heavy menstrual bleeding can significantly diminish a woman's quality of life. She must often choose her work hours, physical and social activities, and even clothing based on the level of bleeding she is experiencing.

Holly E. Richter, MD, PhD, director of the division of women's pelvic medicine and reconstructive surgery at the University of Alabama at Birmingham, has studied treatment approaches for abnormal menstrual bleeding for several years. She sees how her patients suffer embarrassment, stress, and isolation, and she recognizes that effective communication is an important part of managing their problems.

Dr. Richter recently aided in the assessment of a new questionnaire designed to better characterize the effect heavy menstrual bleeding has on women and to test the value of a heavy menstrual bleeding medication. The Menorrhagia Impact Questionnaire was developed for clinical

trials evaluating a new proprietary oral formulation of tranexamic acid for menorrhagia. The items in the MIQ were designed to individually capture:

- ▶ A patient's perception of blood loss
- ▶ How bleeding limited a patient's day-to-day activities and what those activities were
- ▶ The degree and meaningfulness of change in bleeding from the patient's previous menstrual period

"It's exciting that the questionnaire reflects all of the important issues characterizing women with heavy menstrual bleeding," Dr. Richter said. "The questions are specific to the condition, and the questionnaire is short enough to not seem like a burden to patients participating in these studies."

A team of researchers conducted a validation study that found the questionnaire to be a reliable instrument for measuring improvements in the quality of life of women with menorrhagia who were being treated for the condition. ♀



Dr. Richter

BEATING THE ODDS

As a child in South Central Los Angeles, Fellow Diana E. Ramos, MD, MPH, and her family received health care at the community health clinic. Dr. Ramos never saw a physician of color, and she often translated her aunt and grandmother's Spanish to English for health care providers.

"I was from a single parent household; I was a latchkey kid. By all statistics and all means, I should have never graduated high school. I might have ended up pregnant," said Dr. Ramos, director for reproductive health for the Los Angeles County Department of Public Health. "I credit my accomplishments to my mom. She never graduated from high school, but she understood the importance of education. She worked two to three jobs to send me to private school."

That said, there was not a focus on minority education at her school, and none of the counselors ever mentioned that scholarships existed for minority students. If she hadn't earned a full academic scholarship to the University of Southern California, college would have been more difficult to reach. In college, her assigned adviser told her during her freshman year that with her GPA she should just face the fact that she wasn't going to be a doctor.

"Thankfully, I didn't listen to him," she said. Instead, she sought out a Hispanic adviser she felt she could better relate to and count on for support.



Minority ob-gyns encouraged by powerful mentors

► PAGE 1



"It's important to expose these kids to medicine. I want them to see that I didn't start out with a lineage of doctors in my family. I set my mind on [becoming a doctor], and that was my goal, and I went after it. But, I didn't do it by myself. I had great mentors."

—Deneishia S. Fisher, MD

"Diversity in ob-gyn is important because there are certain patients who can identify with physicians of the same race, and it's also good for the specialty to reflect what the rest of the country looks like," said Fellow Deneishia S. Fisher, MD, an African-American generalist ob-gyn in a private group practice in East Brunswick, NJ. "On some levels culturally, there's a commonality; at times, I may be able to relate better to the concerns of an African-American patient simply due to the cultural familiarity."

Some black patients are sometimes surprised to see a young black female ob-gyn walk into the room and will comment that it's good to see an African-American doctor, Dr. Fisher said. Some of her patients have even brought in their daughters "to see me as an inspiration, to show that you can achieve whatever you want to do, especially if [the daughters] don't have professionals in their life they can look up to."

As a Native American, Junior Fellow Jeanine L. Valdez, MD, a fourth-year ob-gyn resident at the University of New Mexico, automatically understands certain cultural aspects of pregnancy and birth among her Native American patients. After a baby is born, she knows to ask the mother, "Who gets to name the baby?" or "What goes into the naming ceremony?" instead of "What's the baby's name," which assumes a name has already been given. A lot of thought and tradition usually goes into the naming of a Native American baby, who may not have a name before leaving the hospital. Physicians unaware of this often pressure the mother for the baby's name and the mother may make up a name because she's embarrassed or worried what the physician may think, Dr. Valdez said. Because tribal customs and traditions are often not easily

shared outside the reservation communities, physicians can mistake reticence as lack of cooperation.

Fellow Diana E. Ramos, MD, MPH, who is Hispanic, said she understands how to use her Hispanic patients' common fatalistic view of life to encourage healthy behaviors. When a patient tells Dr. Ramos, "What's meant to be is meant to be. I don't need to have a mammogram," Dr. Ramos reframes the conversation, telling the patient that she understands her view but that perhaps what's meant to be is for the patient to see Dr. Ramos so she could encourage her to get a mammogram.

"I understand the cultural nuances," said Dr. Ramos, director for reproductive health for the Los Angeles County Department of Public Health. "When I see a red ribbon around a baby to protect it or a safety pin on a patient's underwear during pregnancy to protect the baby, I understand why she has it there. It's an opportunity to educate her on other ways to protect the baby."

Exposure and mentoring can recruit minority students

Colleges, medical schools, and residency programs can strive to increase the number of minority physicians through various programs. Dr. Cox and Dr. Ramos are both involved with Doctors Back to School, a program through the American Medical Association's Commission to End Health Care Disparities, with the National Medical Association and the National Hispanic Medical Association, that encourages minority students—starting at the middle school level—to consider careers in medicine.

High schools can educate minority students about careers in medicine through health fairs and career days and by pairing

'GIVING BACK' TO THE NEIGHBORHOOD



Dr. Lewis

Minority physicians who grew up in poor neighborhoods may feel pressured to “give back” to their communities, but ACOG Fellow Kerry M. Lewis, MD, has no problem accepting the challenge.

“Black physicians face a set of expectations that I’m willing to fulfill,” said Dr. Lewis, director of maternal-fetal medicine and interim chair of ob-gyn at Howard University in Washington, DC. “Most black physicians have this feeling that we always have to strive for excellence, to strive to be

the best, and what’s important to us is that our community recognizes that. It’s important that we maintain access to our community and that our commitment is to the highest quality of care.”

Dr. Lewis grew up with his two brothers in a poor neighborhood in Oakland, CA, raised by a single mom who determined when Dr. Lewis was just a boy that he would become a doctor.

“My mother was very focused and very encouraging for me to become a physician even though we lived in the projects and were on welfare,” Dr. Lewis said. He began to embrace his mom’s dream when he was about 12 years old after an elderly woman living next door to the Lewis family suffered a heart attack and died. Dr. Lewis remembers that it took a long time for the ambulance to arrive.

“My impression at that age was had there been someone there to help her, she might have survived.”

Dr. Lewis graduated from the University of California at Berkeley and entered medical school at the University of Wisconsin-Madison. Going from Oakland, CA, to Madison, WI, was a culture shock, but Dr. Lewis said the school was keenly aware of this and was very supportive of his transition to a different cultural environment, even providing therapists for students adjusting to a different atmosphere.

Dr. Lewis earned a maternal-fetal medicine fellowship at Georgetown University, located in a posh DC neighborhood not close to public transit, making it rare for DC residents from the poorer parts of town to step inside Georgetown’s doors.

“I learned good quality care at Georgetown. It probably had the strongest MFM division in DC at that time, and I wanted to be able to apply all this high-risk obstetrical care to the inner city,” Dr. Lewis said.

Georgetown supported his desire to work at DC General Hospital, the city’s safety net hospital until it closed in 2001. His work there solidified his devotion to caring for patients in the inner city, and he later joined the ob-gyn team at Howard University.

“Howard has provided me the opportunity to take my high-quality training that I received in Madison [at the University of Wisconsin] and at Georgetown and apply it to Howard’s primary mission to be responsible to the needs of the inner city,” Dr. Lewis said.

up students with minority physician mentors in their communities. Colleges and medical schools can offer minority scholarships and loan repayment programs and actively recruit minority students and faculty members.

When only 2% of medical faculty is black, compared with 13% in the overall US population, it “creates a problem with developing mentors who would attract people into academic medicine,” Dr. Cox said.

The University of New Mexico has placed an emphasis on improving diversity through recruitment of underrepresented minorities, according to Fellow Tony Ogburn, MD, UNM associate professor of ob-gyn and residency program director. This year, the number of Native Americans in the incoming medical school class doubled to nine students, and two of the 24 ob-gyn residents are Native Americans, including Dr. Valdez.

“The mentorship I can provide is different from what someone like Dr. Valdez can provide,” said Dr. Ogburn, who is Caucasian. “I couldn’t provide the same type of relationship that she could to a 14-year-old female on a reservation who is good in science. Those students aren’t going to bond with me as they might with her. . . . It needs to start before they apply to med school. We have to establish a pipeline.”

“I think the biggest thing is exposure,” Dr.

Fisher said. “There were no doctors in my family. I’m the first. It’s important to expose these kids to medicine. I want them to see that I didn’t start out with a lineage of doctors in my family. I set my mind on [becoming a doctor], and that was my goal, and I went after it. But, I didn’t do it by myself. I had great mentors.”

One of Dr. Ramos’s proudest experiences was mentoring a young Mexican-American female college student who went on to become an ob-gyn. Mayra Contreras, MD, met Dr. Ramos at a question-and-answer session for pre-med students who wanted to learn about different specialties. Dr. Ramos was on the panel.

“She seemed very approachable, and I introduced myself to her during the break,” said Dr. Contreras, an ob-gyn at AltaMed in Orange County, CA. “She willingly gave me her contact information and also invited me to participate in a research study she was planning to initiate. Before I knew it, I was helping her collect data at the hospital and also got to shadow her on multiple occasions.

“She made me realize becoming a doctor was an attainable goal,” Dr. Contreras said. “We had many similarities in our backgrounds and culture, and here she was living her dream. She gave me the self-confidence to realize I could do the same.” ♀

LIKE PARENTS, LIKE DAUGHTERS

Junior Fellow Jeanine L. Valdez, MD, was influenced by her family’s commitment to their community. Dr. Valdez is a member of the Isleta Pueblo tribal community and a fourth-year ob-gyn resident at the University of New Mexico. Growing up on the Isleta Pueblo Indian Reservation in New Mexico, Dr. Valdez saw the way her father, a physician’s assistant, and her mother, a nurse, cared for patients. Although medical facilities in Albuquerque were only a 20-



Dr. Valdez

minute drive away, access to urgent care was often limited because people didn’t own their own cars and because of the lack of ambulance service.

“Some people in our community would seek medical care and guidance at our house because that was the closest after-hours care they could get,” Dr. Valdez said.

Being surrounded by medicine and watching their parents care for their community inspired Dr. Valdez and her twin sister to go into medicine. Her sister is a physical therapist and athletic trainer.

Vaginal hysterectomy often better option than abdominal

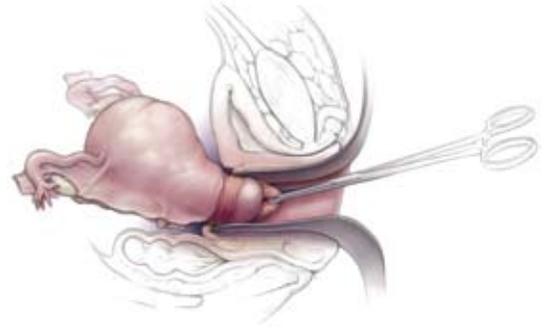
EVIDENCE HAS SHOWN THAT vaginal hysterectomy is the safest and most cost-effective way to remove the uterus. However, US surgical data show that abdominal hysterectomy is performed in 66% of cases, while vaginal hysterectomy is performed in 22% of cases and laparoscopic in 12%, according to the new ACOG Committee Opinion *Choosing the Route of Hysterectomy for Benign Disease*, published in the November issue of *Obstetrics & Gynecology*.

When compared with abdominal hysterectomy, vaginal hysterectomy had shorter duration of hospital stay, faster return to normal activity, and fewer febrile episodes or unspecified infections, according to the Committee Opinion.

“Some physicians choose not to perform a vaginal hysterectomy because they believe

such things as a narrow pubic arch or vagina, poor uterine descent, mild uterine enlargement, nulliparity, or prior cesarean delivery are contraindications,” said Cheryl B. Iglesia, MD, chair of the ACOG Committee on Gynecologic Practice. “However, many women who have not given birth have vaginal caliber that will allow the surgeon to successfully perform a vaginal hysterectomy.”

Some have proposed guidelines that would determine who could undergo a vaginal hysterectomy. Selection criteria might incorporate uterine size, mobility, accessibility, and pathology confined to the uterus. In a randomized trial, when residents followed specific selection guidelines, vaginal hysterectomy was selected in more than 90% of the cases, according to the Committee Opinion. The document states that the decision to electively perform a



salpingoophorectomy should not be influenced by the route of hysterectomy and is not a contraindication for vaginal hysterectomy.

A Cochrane review of 34 randomized trials of abdominal, laparoscopic, and vaginal hysterectomies concluded that vaginal hysterectomy has the best outcomes and that when vaginal hysterectomy is not possible, laparoscopic hysterectomy has advantages over abdominal hysterectomy. ♀

Potential advantages of robotic surgery:

- ▶ Three-dimensional visualization with improved depth perception
- ▶ Improved dexterity and instrument articulation secondary to increased freedom of movement and elimination of tremor and counterintuitive motions
- ▶ Use in telesurgery
- ▶ Shorter hospital stays and decreased blood loss

Disadvantages of robotic surgery:

- ▶ The high costs—more than \$1 million for the initial system, with additional yearly service contracts and disposable instrumentation
- ▶ The increased operating time associated with setting up the equipment
- ▶ The lack of tactile feedback and sensation
- ▶ The inability to reposition the patient once the robotic arms have been attached
- ▶ The bulkiness of the current system, making it difficult for assistants to maneuver around, for example, when applying uterine manipulation

ACOG examines the role of robotic surgery

ROBOT-ASSISTED SURGERY needs randomized trials to evaluate the long-term clinical outcomes and cost effectiveness of this new technology, according to the new ACOG Technology Assessment *Robot-Assisted Surgery*, published in the November issue of *Obstetrics & Gynecology*.

The document describes the da Vinci Surgical System, the only commercially available robotic system approved by the US Food and Drug Administration for gynecologic surgery, and discusses the potential advantages and disadvantages, gynecologic applications, and the current state of the evidence.

Robotic surgery allows a surgeon to sit at a console away from the patient, viewing a three-dimensional image of the pelvic area.

Three or four robotic arms hold instruments through trocars attached to the patient and move according to the commands of the surgeon at the console. Assistant surgical team members switch out the instruments and provide suction, irrigation, and countertraction.

To date, the data have mostly been from heterogeneous, small, retrospective case series and a few small nonrandomized, mostly retrospective comparative studies, according to the Technology Assessment.

Few data exist on how surgeon experience relates to overall complication rates, operative time, and costs, and data are insufficient to show which patients or indications might benefit from robotic surgery rather than conventional surgery. ♀

2009-10 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

NOVEMBER

5-8
Academy of Breastfeeding Medicine 14th Annual International Meeting
 Williamsburg, VA
 bfmed.org

6
Society of Gynecologic Oncologists Annual State of the Art Conference
"Personalized Gynecologic Cancer Care: Moving from the Disease to the Patient"
 Washington, DC
 sgo.org

6-11
American Association of Medical Colleges Annual Meeting
 Boston
 aamc.org

7-10
American Medical Association Interim Meeting
 Houston
 ama-assn.org

10
ACOG WEBCAST Team Training and Simulation in Ob-Gyn Risk Management
 1-2:30 pm ET
 800-673-8444, ext 2498

11
New England Obstetrical and Gynecological Society 81st Annual Fall Meeting
 Sturbridge, MA
 neogs.org

12-14
Society for Gynecologic Investigation 3rd International Summit—"Preeclampsia"
 Sendai, Japan
 sgionline.org

15-18
ACOG Armed Forces District Annual Meeting
 Honolulu
 202-863-2571

15-19
American Association of Gynecologic Laparoscopists 38th Global Congress of Minimally Invasive Gynecology
 Orlando, FL
 aagl.org/annual-meeting

20-21
Council of Medical Specialty Societies
 Rosemont, IL
 cmss.org

DECEMBER

8
ACOG WEBCAST Preview of New Codes for 2010
 1-2:30 pm ET
 800-673-8444, ext 2498

2010 JANUARY

16-17
12th Annual ACOG Treasurers Conference
 Phoenix
 scathcart@acog.org
 800-281-1551

22-24
Maine Section Winter Meeting
 Sugarloaf, ME
 crotec@mmc.org
 jnaliboff@fchn.org

28-30
Montana Section Annual Meeting
 Big Sky, MT
 406-752-5260

29-31
Gynecologic Oncology Group Semiannual Meeting
 San Diego
 gog.org

FEBRUARY

1-6
Society for Maternal Fetal Medicine 30th Annual Meeting—The Pregnancy Meeting
 Chicago
 smfm.org

10-13
36th Annual Meeting of the North American Society for Psychosocial Obstetrics and Gynecology
 Richmond, VA
 naspog.org
 202-863-2570

18-21
International Society for the Study of Women's Sexual Health
 St. Petersburg, FL
 isswsh.org

28-Mar 2
ACOG Congressional Leadership Conference, The President's Conference
 Washington, DC
 smiscikowski@acog.org
 800-673-8444, ext 2505

MARCH

3-6
Council on Resident Education in Obstetrics and Gynecology and Association of Professors of Gynecology and Obstetrics Annual Meeting
 Orlando, FL
 appgo.org
 202-863-2558

10-13
International Society for Clinical Densitometry Annual Meeting
 San Antonio
 iscd.org
 860-586-7563

14-17
Society of Gynecologic Oncologists Annual Meeting on Women's Cancer
 San Diego
 sgo.org
 312-235-4060

17-20
American College of Osteopathic Obstetricians and Gynecologists 77th Annual Conference
 New Orleans
 acoog.org
 817-377-0421

24-27
Society for Gynecologic Investigation 57th Annual Scientific Meeting
 Orlando, FL
 sgionline.org
 202-863-2544

24-27
American Society for Colposcopy and Cervical Pathology Biennial Meeting
 Las Vegas
 asccp.org
 301-733-3640

APRIL

12-14
Society of Gynecologic Surgeons 36th Annual Meeting
 Tucson, AZ
 sgsionline.org
 314-251-6881

15-17
District XI Section Meeting and the 81st Annual Meeting of the Texas Association of Obstetricians and Gynecologists
 acog.org/acog_districts
 325-235-1959

22-24
American College of Physicians Internal Medicine 2010
 Toronto, ON
 acponline.org
 215-351-2546

MAY

15-19
ACOG 58th Annual Clinical Meeting
 San Francisco
 acog.org/acm

ACOG COURSES

- 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."
 - 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

12-14
Practical Obstetrics and Gynecology
 Las Vegas

13-15
Coding Workshop
 Atlanta

DECEMBER

3-5
Update on Cervical Diseases
 New York City

4-6
Coding Workshop
 Tampa, FL

10-12
Incorporating Gynecologic Ultrasound Into Your Office Practice
 Chicago

2010 FEBRUARY

11-13
Quality and Safety for Leaders in Women's Health Care
 San Diego

11-13
Incorporating Gynecologic Ultrasonography into Your Office Practice
 St. Thomas, Virgin Islands

26-28
Coding Workshop
 Naples, FL



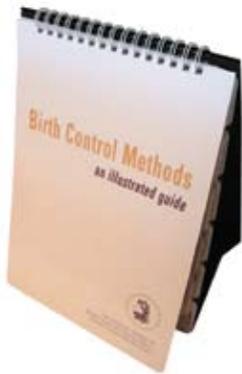
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RESOURCES

Use flip chart to discuss birth control options with your patients



HELP YOUR PATIENTS LEARN ABOUT THEIR BIRTH control options with ACOG's unique new flip chart. Designed for use in patient counseling, each flip chart card explains one of the available birth control options. The front of the card displays a picture of the method, and the back discusses its effectiveness, how it's used, advantages, disadvantages, and side effects. Tear sheets (25 sheets per pad) for each method are also available in packs of five per method. ♀

info

→ *Birth Control Methods: An Illustrated Guide*: sales.acog.org; 800-762-2264



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ACOG treasurers invited to conference

DON'T FORGET TO REGISTER for ACOG's 12th Annual Treasurers Conference if you are a current or incoming district treasurer or new section treasurer. The conference will be held in Phoenix, Jan 16–17, 2010. The deadline to register is December 20.

Other officers and administrators responsible for the financial management of their district or section are also invited. There is no registration fee to attend the conference, a two-day educational meeting designed to train officers and administrators in the financial management of their district or section and update them on new ACOG policies and changes in tax laws. There will also be a discussion about the financial implications of the startup of the 501(c)(6) Congress in 2010. Presenters will include ACOG finance staff, national and district officers, and outside investment managers. ♀

info

→ For info or to register, contact Steve Cathcart, CPA, at 800-281-1551; scathcart@acog.org

ACOG PATIENT EDUCATION

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Information you and your patients can trust



NEW

Early Preterm Birth (AP172)

- ▶ Explains survival rates for early preterm babies by gestational age and weight and the health problems that affect babies who do survive
- ▶ Describes interventions for preterm labor
- ▶ Discusses treatments for early preterm infants, including resuscitation and surfactant therapy
- ▶ Offers advice about how parents can make treatment decisions
- ▶ Gives information about the how-to care for an early preterm infant and additional resources
- ▶ Explains the need for support if the baby does not survive

OTHER POPULAR TITLES



- ▶ *Preterm Labor (AP087)*
- ▶ *How to Tell When Labor Begins (APO04)*
- ▶ *Special Tests for Monitoring Fetal Health (APO98)*

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- To preview these pamphlets: acog.org/goto/patients
- To order pamphlets: sales.acog.org; 800-762-2264 (use source code DM68 1006)
- To request a free sample: resources@acog.org