

Many patients embrace alternative medicine

PATIENTS TAKE ST. JOHN'S WORT FOR DEPRESSION and chasteberry for PMS. They pop mega doses of vitamins to try to improve their overall health. They seek out chiropractors, acupuncturists, and massage therapists for back pain, and buy homeopathic remedies over the Internet to fight a variety of ailments.

Allopathic physicians may be skeptical of some forms of complementary and alternative medicine, but that doesn't mean their patients are. Studies have shown that about one-third of Americans use some form of complementary and alternative medicine, and most don't discuss their CAM treatment with their physicians. CAM is defined as any practices, therapies, treatments, and interventions that aren't an integral part of the conventional medical system, according to ACOG's *Guidelines for Women's Health Care: A Resource Manual*.

"I think some patients are afraid to discuss their treatment with their regular doctor because they fear ridicule, and other patients may not understand that there's even a connection—they may not see the potential impact on their conventional medical therapy," said Linda R. Chambliss, MD, MPH, ob-gyn professor at St. Louis University School of Medicine. ► PAGE 11



More ACM
courses will
be interactive
this year.



ACM scientific sessions announced

THE PRELIMINARY PROGRAM for the 2008 Annual Clinical Meeting is now available online. Visit www.acog.org/acm to browse through the list of scientific sessions, current issues updates, clinical seminars, postgraduate courses, luncheon conferences, and more. The 2008 ACM will be held May 3–7 in New Orleans.

"Every year the ACM has an increased emphasis on interactive learning, and 2008 is no exception," said Mark D. Pearlman, MD, chair of the ACOG Committee on Scientific

Program. "In fact, the number of hands-on courses will grow by nearly 30% this year, and the audience response system that we use in our popular interactive courses will now also be used in many of our clinical seminars."

Other additions to this year's ACM include the creation of an 030 postgraduate course format, offering three-hour courses on Monday and Tuesday. Also, the ACM basic registration package will now include a clinical seminar of your choice at no extra cost.

For a list of ACM sessions see pages 6–7. ♀



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EXECUTIVE DESK

Help New Orleans recover with ACM volunteer project

AS THE ANNUAL CLINICAL MEETING in New Orleans draws near, ACOG is looking forward to an outstanding meeting. Mark D. Pearlman, MD, chair of the Committee on Scientific Program, has developed an exceptional educational and scientific program.

Attendees will learn about the latest information on all aspects of our specialty, and our exhibitors will highlight the most recent women's health products. For more about the scientific program, see the article on page 1.

At this year's ACM we will have a special opportunity to help New Orleans recover from the damage from Hurricane Katrina. With the help of ACOG President Dr. Kenneth L. Noller's wife, Mary, the nonprofit organization Rebuilding Together is arranging a program that will allow ACOG volunteers to participate in projects that will revitalize local neighborhoods. The program will be held on Friday, May 2.

The Rebuilding Together program is open to you, your spouse, and other family members. Participants must be 18 or older and in good health. No specific skills are needed; all participants will be trained on site. Advance registration is required.

On the ACM website, www.acog.org/acm, you will find more information, a link to the Rebuilding Together website, and a registration form. For those of you who attended the Annual District Meetings, Rebuilding Together presented informational sessions so that you and your spouse could be aware of this opportunity.

This is not an ACOG project, but the College is very happy to assist Rebuilding Together by spreading the word and helping our members learn of this unique opportunity. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

Arthur Adamski, MD
Los Angeles

Millard J. Albers, MD
Saginaw, MI

Clarence L. Anderson, MD
Lakeland, FL

W. Richard Anderson, MD
St. Petersburg, FL

Joseph Antenucci, MD
Port Jeff Station, NY

Robert W. Baker, MD
Colorado Springs, CO

Jennings O. Borgen, MD
Redmond, OR • 9/07

Melvin K. Bottorff, MD
Sam Rayburn, TX • 11/07

Joseph B. Boulos, MD
Halifax, NS • 4/07

Donald H. Bradley Jr, MD
Murfreesboro, TN

Keith R. Brandeberry, MD
Gallipolis, OH

William C. Bryant, MD
Lansing, MI • 11/07

Frank J. Carter, MD
Norwich, CT

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San Antonio • 8/07

O. William Davenport, MD
Miami

Rafael A. Del Valle, MD
Moraga, CA

Marion F. Detrick, MD
Maumee, OH • 12/07

R. Don Gambrell Jr, MD
Augusta, GA • 6/07

Milton H. Goldrath, MD
Franklin, MI

David P. Gorman, MD
Malone, NY • 8/07

Obstetrics & Gynecology
HIGHLIGHTS



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

Surrogate Motherhood
(Ethics Committee Opinion
#397, revised)

*Fatigue and Patient
Safety*

(Patient Safety Committee Opinion #398, new)
For more information, see page 8.

Umbilical Cord Blood Banking
(Obstetrics and Genetics Committee Opinion
#399, revised)

For more information, see page 3.

Asthma in Pregnancy
(Obstetrics Practice Bulletin #90, new)

Submit your nomination for national office

ALL VOTING MEMBERS OF ACOG will receive a letter from the College later this month outlining the process for nominating national officers. Participation in national, district, or section activities is an important prerequisite to serving as a national officer.

April 1 deadline

Individuals may nominate themselves or someone else; ACOG districts and sections may also nominate individuals. Nominations for the offices of president elect, vice president, treasurer (three-year term), assistant secretary, or Fellow-at-Large (restricted to qualified applicants for a two-year term) must be submitted by April 1.

- Nominations must include:
- ▶ A letter stating the office(s) of interest
 - ▶ A one-page CV in a specified format
 - ▶ A complete CV
 - ▶ A signed "Candidate Agreement" (available on the ACOG website)

Candidates must make a presentation about their qualifications at the National Officer Candidates Forum on May 7 during the Annual Clinical Meeting in New Orleans. ♀

info

- For office position descriptions, contact Elsa Brown at 800-673-8444, ext 2517, or ebrown@acog.org, or download the position descriptions from ACOG's website, www.acog.org

Timetable for election of national officers

2008

- February** ACOG sends letter outlining nomination process to Fellows
- March** Candidates are announced on the ACOG national and district websites
- April 1** Nominations deadline
- May 7** Committee on Nominations interviews candidates at the ACM in New Orleans
- July** Personal statements and brief bios of candidates are published in *ACOG Today* and on the ACOG national and district websites
- Fall** Candidates are discussed at Annual District Meetings
- November** Committee on Nominations selects slate of candidates

2009

- February** Executive Board receives and accepts final slate
- March** Slate and proxy ballots are mailed for use by Fellows who do not plan to attend the Annual Business Meeting
- May 4** Slate voted on at Annual Business Meeting in Chicago

ACOG issues opinion on cord blood banking

WHEN DISCUSSING CORD blood banking with patients, physicians should provide balanced information that presents the advantages and disadvantages of public vs. private banking.

Furthermore, physicians who recruit pregnant women for for-profit cord blood banking should disclose their financial interests and other potential conflicts of interest, according to the new Committee Opinion *Umbilical Cord Blood Banking*. The document was published in the February issue of *Obstetrics & Gynecology* by the Committee on Obstetric Practice and the Committee on Genetics.

Cord blood banking has gained attention in recent years, partly from direct-to-consumer marketing campaigns of private cord blood banks, which were developed to store stem cells from cord blood for autologous use.

However, the utility of long-term storage of autologous cord blood has been questioned, according to the Committee Opinion. There is no accurate estimate of the likelihood of using

an autologous unit of cord blood; one estimate is approximately 1 in 2,700, while others argue the rate is even lower.

"Patients need to be aware that the chances are remote that the stem cells from their baby's banked cord blood will be used to treat that particular child—or another member of the family—in the future," said Anthony R. Gregg, MD, chair of the Committee on Genetics. "A child's cord blood cannot currently be used to treat conditions that have an inherited basis, such as inborn errors of metabolism, because the cord blood would have the same genetic mutation."

Public banks promote related or unrelated cord blood banking, similar to the US system for blood banks. Public banks are usually associated with a local network of obstetric hospitals that send their units to a central processing facility. Federal legislation was passed in 2005 that provides funding for continued growth of



a national cord blood registry in the US.

Some states require physicians to inform patients about cord blood banking options. Physicians should consult their state medical associations for more information.

The Committee Opinion also recommends that cord blood collection not interfere with the appropriate timing of umbilical cord clamping. ♀



ACOG lowers webcast fees

ACOG HAS REDUCED THE cost of its live and archived webcasts, making these valuable online sessions available to more Fellows and their staff.

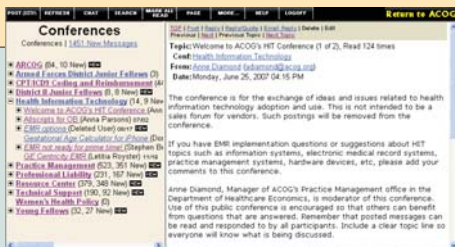
The webcasts now cost \$49 per site, down from \$159. The per-site fee allows multiple viewers to watch the webcasts at each location.

ACOG webcasts are offered on the second Tuesday of each month, helping physicians and their staff stay updated on important issues without leaving the office.

Webcasts are held from 1 to 2:30 pm Eastern Time. Presentations are given in real time over the Internet. Archived webcasts are available approximately two days after the live webcast. ♀

info

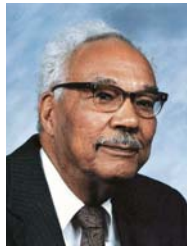
- To register for a webcast or access the webcast archives: On the ACOG website, www.acog.org, under "Meetings," click on "Postgraduate Courses and CPT Coding Workshops"
- Questions? Contact Anne M. Diamond, MS: adiamond@acog.org; 800-673-8444, ext 2444



info

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

Prominent California Fellow dies



LIFE FELLOW LEWIS F. BODDIE, MD, OF LOS ANGELES, died September 11 at the age of 94. Dr. Boddie was believed to be the first black American to be board certified in ob-gyn on the West Coast.

Dr. Boddie earned his medical degree from Meharry Medical College in Nashville, TN, in 1938 and completed his residency at Homer G. Phillips Hospital in St. Louis. In 1949, he moved to Los Angeles to practice ob-gyn, becoming board certified that same year. At that time, most hospitals would not allow black physicians on their staffs. To treat black residents of Los Angeles, who had few facilities where they could receive good health care, Dr. Boddie and colleagues opened up their own medical facility, Vernbro Medical Center, in South Los Angeles. Dr. Boddie was the sole ob-gyn at Vernbro until he retired at age 79.

Soon after Vernbro opened, Dr. Boddie and his colleagues helped to integrate hospital staffs in Los Angeles, starting with Queen of Angels Hospital, where Dr. Boddie later became the ob-gyn department chair. He was also a clinical assistant professor at the University of California, Irvine, and the University of Southern California.

Dr. Boddie was a well-known adoption advocate, believing strongly in finding good homes for minority children. In 1955, he became the first president of the Los Angeles County Bureau of Adoptions Auxiliary Board for Youngsters. ♀

Pioneering Northwestern professor dies



AN AMNIOCENTESIS PIONEER, ALBERT B. GERBIE, MD, of Highland Park, IL, died October 15 at age 80.

Dr. Gerbie conducted early research on the use of amniocentesis for prenatal genetic diagnosis. His groundbreaking article in the *New England Journal of Medicine* in 1970, with colleague Dr. Henry Nadler, established amniocentesis as a legitimate and safe procedure, according to the *Chicago Tribune*.

ACOG presented Dr. Gerbie with a Distinguished Service Award in 1991. He was a former chair, president, and director of ABOG.

Dr. Gerbie received his MD from George Washington University in Washington, DC, and after a rotating internship at Michael Reese Hospital in Chicago, he joined the ob-gyn department at Northwestern University in 1952, where he remained for more than 50 years. An endowed professorship in his name began in 1995, and at Dr. Gerbie's request, the position is focused on medical education. At the time of his death, Dr. Gerbie was a professor emeritus of ob-gyn at Northwestern. ♀

Join ACOG's online discussion forums

ACOG HAS SEVERAL ONLINE DISCUSSION FORUMS, OR "WEB CONFERENCES," that allow members to pose questions to other Fellows across the country.

The newest web conference focuses on health information technology, allowing ACOG members to exchange ideas and discuss issues related to health information technology adoption and use. Postings from vendors are not allowed.

The web conference is moderated by ACOG's Department of Health Economics.

Other web conferences focus on practice management, professional liability, young Fellows, technical support, coding, and more. ♀

2008 ACM scientific sessions

MONDAY, MAY 5

1st Scientific Session | 8:45-10:30 am

PRESIDENT'S PROGRAM

Moderator:

Kenneth L. Noller, MD, MS

▶ **8:45-9:30 am**

Samuel A. Cosgrove Memorial Lecture

The Future of Health Care

*Gail Wilensky, PhD, senior fellow,
Project HOPE*

▶ **9:30-10:30 am**

The Anna Marie D'Amico Lecture

**The Brave New World of Reproductive
Genetics: Biotechnology Again Meets
Bioethics**

*Marcus Hughes, MD, PhD
Another speaker TBA*

2nd Scientific Session | 2:30-4 pm

The Edith Louise Potter Memorial Lecture

▶ **ABCs of Antibiotic Resistance for the
Ob-Gyn: MRSA, CDAD, VRE, and More**
John Bartlett, MD

3rd Scientific Session | 4-5:15 pm

The March of Dimes Lecture

▶ **Birth Defects: Consequences, Causes,
and Cures**
E. Albert Reece, MD, PhD, MBA

TUESDAY, MAY 6

4th Scientific Session | 8-9:15 am

The Irvin M. Cushner Memorial Lecture

▶ **Hooked: the Realities and Ethics of
Medicine's Relationship with Industry**
*Jeffrey L. Ecker, MD
Howard P. Brody, MD, PhD*

5th Scientific Session | 9:30-11 am

The Gerald and Barbara Holzman Stump the Professors session

Fascinating clinical cases submitted
by Junior Fellows of the College are
presented to a panel of professors.

Moderator:

Joseph S. Sanfilippo, MD, MBA

Professors:

Arnold P. Advincula, MD

F. Gary Cunningham, MD

Rebecca G. Rogers, MD

James R. Scott, MD

6th Scientific Session | 2:30-5:15 pm

The Donald F. Richardson International Symposium

▶ **Medical Malpractice Reform:
Beyond Caps**

Richard Boothman, JD

Dr. Robert C. Lyneham

Speaker TBA



WEDNESDAY, MAY 7

7th Scientific Session | 11 am-12 pm

The John I. Brewer Memorial Lecture

▶ **Breast Cancer: Advances in Diagnosis
and Treatment**
Eric P. Winer, MD

8th Scientific Session | 12-1 pm

The John and Marney Mathers Lecture

▶ **Efforts to Improve Quality in
Gynecologic Surgery Through
Outcomes Assessment**
William A. Cliby, MD

9th Scientific Session | 2-3 pm

The Morton and Diane Stenchever Lecture

▶ **Cesarean Delivery on Maternal
Request**
*Mary E. D'Alton, MD
John O.L. DeLancey, MD*

Register now for the ACM

NEW ORLEANS • MAY 3-7

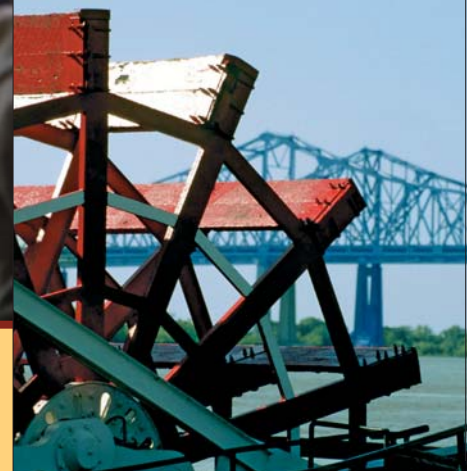


2008 ACM

Register for the ACM and reserve your hotel room through
the ACOG website at www.acog.org/acm

The ACM Preliminary
Program is now available
online

www.acog.org/acm



2008 ACM current issues updates

MONDAY, MAY 5

1st Current Issues Update 2-3 pm

- ▶ The 2006 ASCCP Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Test and CIN: A Case-Based Presentation
Richard S. Guido, MD

TUESDAY, MAY 6

2nd Current Issues Update 11:15 am-12:30 pm

- ▶ Screening and Early Detection of Ovarian Cancer
Barbara A. Goff, MD
Karen H. Lu, MD
Ed E. Partridge, MD

3rd Current Issues Update 2-3 pm

- ▶ New Uses for IUDs: Contraception and Beyond
David A. Grimes, MD

WEDNESDAY, MAY 7

4th Current Issues Update 7:30-8:30 am

- ▶ Exploring Illness Through the Patient: A Sensory Journey in Ethics, Humanism, and Professionalism
Hope K. Haefner, MD

ACM hands-on courses expanded

ACOG HAS EXPANDED THE line-up of hands-on courses at the 2008 Annual Clinical Meeting, including the introduction of two brand-new courses.

Pelvic floor disorders

The returning course “Hands-On Anatomy Related to Gynecologic Surgery and Pelvic Floor Disorders” will be held off site this year. Participants will travel to the Louisiana State University campus for cadaver dissection and didactic lectures on important aspects of surgical anatomy. The course will cover anatomical aspects of surgery for pelvic floor dysfunction, how to avoid ureteral injury, and the prevention and management of hemorrhage.

Laparoscopic techniques

The course “Hands-On Laparoscopic Techniques in Advanced Gynecologic Surgery” will be enhanced with a new wet-lab experience that incorporates live porcine stations.

New courses available

New this year is a course on office-based procedures, which will review several outpatient gynecologic procedures and anesthesia techniques. Procedures include uterine evacuation with a manual vacuum aspirator, IUD insertion and removal, Implanon contraceptive im-



plant placement and removal, and saline infusion sonography.

Another new course will focus on obstetric emergencies simulation, offering participants the opportunity to practice for emergencies such as shoulder dystocia, breech vaginal delivery, operative vaginal delivery, postpartum hemorrhage, and eclampsia.

Three hands-on courses at this year's ACM have been developed just for medical students, helping students get excited about ob-gyn and preparing for residency. ♀

ACM RECEPTIONS

Welcome Reception

Join colleagues at the 2008 ACM Welcome Reception for fun, food, and dancing for all ages. Complimentary to registrants.

When: Sunday, May 4
7 to 10 pm

Where: Hilton New Orleans
Riverside Hotel

Ice Cream Social for All Spouses

Mary Noller, wife of ACOG President Kenneth L. Noller, MD, MS, invites spouses of ACOG members to a special ice cream social. Join Mrs. Noller and other spouses for this fun afternoon. Complimentary to registrants. Early registration is strongly encouraged.

When: Monday, May 5
2 to 4 pm

Where: Hilton New Orleans
Riverside Hotel

President's Reception and Dinner Dance

This year's President's Reception and Dinner Dance will be casual dress, with the entire family invited to a fun and educational evening at the Audubon Aquarium of the Americas, located along the New Orleans riverfront. Advance registration is required.

When: Tuesday, May 6
6:30 to 11 pm

Farewell Reception

Attendees are invited to the Farewell Reception in the Exhibit Hall on the final day of the meeting. The reception will offer ACM attendees the opportunity to spend quality time with hundreds of exhibitors. A light lunch will be available.

When: Wednesday, May 7
12 to 2 pm

Physician fatigue may affect patient safety

ALTHOUGH TRUCK DRIVERS and airline pilots have restrictions on their work hours to avoid accidents resulting from fatigue, no such restrictions exist for practicing physicians.

Fatigue and Patient Safety, a new Committee Opinion from the Committee on Patient Safety and Quality Improvement, urges ob-gyns to consider restricting themselves when they are significantly fatigued. The document was published in the February issue of *Obstetrics & Gynecology*.

"It's intuitively obvious that a fatigued physician may not practice as effectively as a well-rested physician, but there are no good data that evaluate practicing ob-gyns," said committee chair John S. Wachtel, MD.

The Committee Opinion cites a number of studies that have examined the effect of sleep restriction on cognitive function. For example, surgeons operated more slowly in simulated procedures when sleep deprived, and emergency physicians took longer to intubate a mannequin. In addition, a wealth of published data from other industries, such as aviation, might be applicable to medical practice.

No 'fatigue-o-meter'

Dr. Wachtel said that some of the challenges the committee faced in providing guidance is that there's no useful metric to measure fatigue and that the variables are numerous.

"Many causes of fatigue have nothing to do with practicing medicine, and these variables should be considered. For example, you can have one doctor who was on call the night before surgery but is well rested, while another doctor was not on call but was up all night at home with a newborn."

The Committee Opinion calls on each physician to recognize his or her limitations due to fatigue and to self-impose limits, stating that "even though there may be some economic impact of changing schedules to accommodate avoidance of fatigue, patient care and safety must take priority."

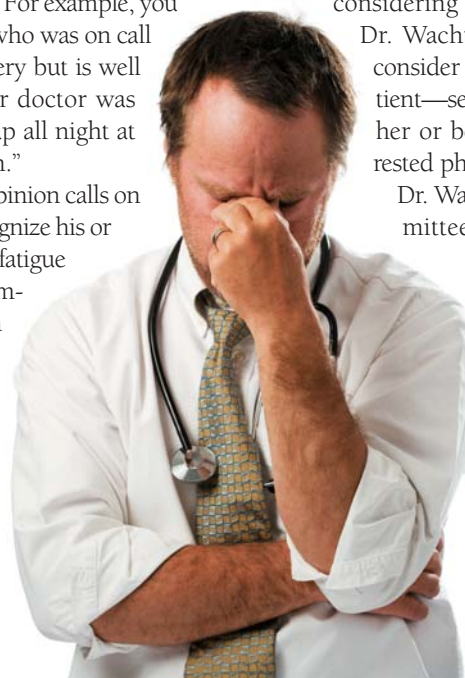
The document offers questions that physicians should ask themselves about their ability to provide safe care, and it calls for physician groups and hospital departments to work together to develop a system of backup care for physicians affected by fatigue.

"Continuity of care is a trade-off when considering the problem of fatigue,"

Dr. Wachtel said. "But we should consider which is better for the patient—seeing a doctor who knows her or being cared for by a well-rested physician."

Dr. Wachtel noted that the Committee Opinion was carefully written not to be prescriptive and tell people what to do but "to ask questions and try to get people to think about the issue."

"If you recognize that you're tired, you should do something about it," Dr. Wachtel said. ♀



Learn practical tools at interactive patient safety course

LEARN KEY PATIENT SAFETY and quality improvement principles and techniques at ACOG's annual patient safety postgraduate course. This highly interactive, educational, and popular offering, "Quality and Safety for Leaders in Women's Health Care," is ideal for incoming and current department chairs, other hospital and private practice leaders, and medical staff involved in quality improvement efforts, such as chairing a patient safety committee.

This year, the College is issuing a special invitation to Junior Fellows and young Fellows and encouraging ob-gyn academic de-

partments to fund their chief resident to attend the course on June 5–7 in Chicago.

"Traditionally, the course was attended mostly by chiefs-elect of ob-gyn departments and others in leadership positions," said course director John P. Keats, MD. "This year, we're trying to expand the audience to include chief residents and other Junior Fellows to try to make physicians more aware of patient safety much earlier in their career."

The course will teach core patient safety and quality improvement principles, while focusing on techniques that enhance patient safety through prevention, interception, and

mitigation of medical errors.

New for the 2008 course, participants are encouraged to bring real-world patient safety issues from home to discuss with faculty and attendees. Two faculty members have been added to this year's course and will address simulation and ethics.

"The course will give people a basic foundation and a vocabulary of quality improvement and patient safety issues," Dr. Keats said. "I want participants to take an interest in patient safety and, after attending the course, seek out other resources, to continue to study patient safety on their own and make it a priority." ♀

Nominations due June 1

Nominations sought for Junior Fellow district officers

BECOME AN ACTIVE LEADER and an energetic voice for Junior Fellows in your district. Every year, each district elects a Junior Fellow district vice chair and district secretary/treasurer.

Junior Fellow vice chairs progress to chair after one year; after a year as chair they continue to serve as immediate past chair (for a total commitment of three years).

Qualifications for Junior Fellow district officers

Vice chair

- ▶ Junior Fellow member of the district (but may become a Fellow during term of office)
- ▶ History of service to ACOG at section, district, or national level as an officer or committee/task force member
- ▶ Able to attend required national and district meetings (about four per year)

Secretary/treasurer

- ▶ Junior Fellow member of the district

info

- If you are interested in an office or in nominating someone, contact Chris Himes: 800-673-8444, ext 2561; chimes@acog.org
- On the ACOG website, www.acog.org, click on "Junior Fellows" in the "Quick Links" box on the left side of the home page

Process for submitting nominations

Submit a letter stating the office that you are seeking and a one-page summary of your CV to chimes@acog.org. ♀

ELECTION SCHEDULE

June 1

Nominations due

June

District Nominating Committee develops slate of up to three candidates for each office

July

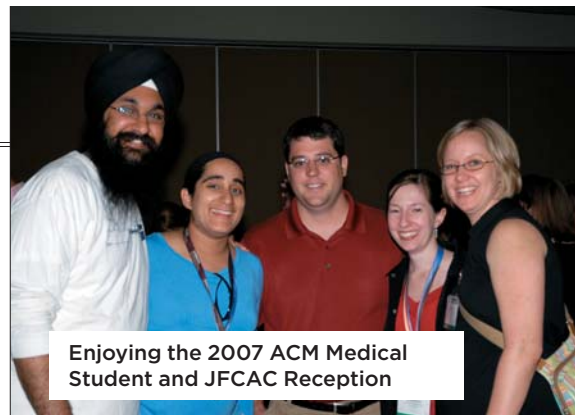
Slate of candidates posted on Junior Fellow website

August 1-31

Online polls open

Annual District Meetings

Elected officers will begin their terms after their ADM



Enjoying the 2007 ACM Medical Student and JFCAC Reception

Junior Fellow ACM events

JUNIOR FELLOWS ATTENDING the Annual Clinical Meeting have a number of educational and fun events specifically geared toward them. Be sure to take advantage of these activities at the ACM, May 3-7 in New Orleans.

A new luncheon seminar for Junior Fellows will focus on subspecialty training as a career option. The seminar will cover the general requirements and rules for getting into a subspecialty training program, as well as fast-track options and unaccredited subspecialty fellowships, and offer advice on the interview and application process. The "ABCs of Applying for Subspecialty Training: Perspectives from Subspecialty Fellows and Program Directors" will be held from 11:30 am to 1 pm on Monday, May 5. Advance registration is required, and space is limited. ♀

info

- www.acog.org/acm

MONDAY, MAY 5

"ABCs of Applying for Subspecialty Training: Perspectives from Subspecialty Fellows and Program Directors"
11:30 am to 1 pm

The Business of Medicine Symposium for Junior Fellows
12:15 to 2:30 pm

Medical Students and JFCAC Reception
5 to 7 pm

TUESDAY, MAY 6

Junior Fellow Breakfast and Business Meeting
7 to 8:30 am

Stump the Professors
9:30 to 11 am

Ob-Gyn Residency Fair
11 am to 3 pm

The Business of Medicine Symposium for Junior Fellows
11:30 am to 2 pm

Free business of medicine webcast

JUNIOR FELLOWS ARE INVITED to register for a free webcast based on the ACOG publication *The Business of Medicine: An Essential Guide for Obstetrician-Gynecologists*.

The webcast, which will be held from 1 to 2 pm ET on February 19, will help participants understand both the personal and business side of practice.

The speaker will be L. Michael Fleischman, of Gates, Moore and Company in Atlanta. An experienced consultant for ob-gyn practices, Mr. Fleischman will cover topics such as practice options, insurance, practice finances, em-

ployment contract terms, and selecting professional advisers.

Although there is no charge for the webcast, participants will need to register at least 24 hours in advance to receive log-in instructions. An archived presentation will be available approximately one week after the live event. ♀

info

- For registration and other information, click on "Junior Fellows" in the "Quick Links" box on the left side of the home page, www.acog.org

More is not necessarily better in CF screening

ACOG AND THE AMERICAN College of Medical Genetics recommend offering cystic fibrosis carrier screening to couples in whom one or both partners are Caucasian and are planning a pregnancy or seeking prenatal care, individuals with a family history of CF, and reproductive partners of individuals who have CF. They also recommend making the screening available to couples in other racial and ethnic groups who are at lower risk. A standard laboratory panel that tests for 23 CF mutations is recommended.

Since the CF guidelines were published in 2001, some laboratories have been marketing expanded panels that test for many more CF mutations. However, experts urge physicians to stick with the recommended panel of 23 mutations.

“Testing for 100 instead of 23 mutations sounds four times better, but it’s not,” said ACOG Past President Michael T. Mennuti, MD, co-chair of the joint steering committee that oversaw the development of the screening guidelines along with the American College of Medical Genetics and the National Institutes of Health’s Human Genome Project. “More is not necessarily better, and in fact, in this situation, more information may cause uncertainty and confusion and can lead to bad decision making.”

Echoing this perspective, Fellow Deborah A. Driscoll, MD, former chair of ACOG’s Task Force on Genetic Screening and former chair of ACOG’s Committee on Genetics, said, “In our culture, we seem to think that more is better. Most ob-gyns do not have the expertise in genetics to be able to understand the subtle differences between panels or when an expanded panel may be indicated based on a patient’s family history, so when laboratories offer different panels, ob-gyns may be led to believe that offering their patients more testing is in their patients’ best interests.”

The physicians point out that in some clinical circumstances—such as with a positive family history—a geneticist may determine that it would be useful to test for more mutations or even to fully sequence the patient’s CF genes.

Why screening for 23 is recommended

In 2001 when ACOG and ACMG first issued the guidelines for CF carrier screening, 25 mutations were selected that were present in at least 0.1% of patients with cystic fibrosis.

“With more than 1,400 CF mutations known at that time, the most common mutations that cause the severe form of cystic fibrosis were included in the panel,” Dr. Mennuti said.



Several years after the initial guidelines were published, two mutations were removed from the panel of 25. One mutation was leading to confusing information, and the other was causing false positives. Hence, the current recommended panel comprises 23 mutations.

The known CF mutations now number more than 1,500, and new mutations and variants continue to be identified.

Expanded panel can lead to anxiety or false sense of security

Dr. Mennuti notes that CF is a highly variable disease and that the genetic or environmental modifiers that affect the clinical manifestation of CF mutations are not well studied. The ability to predict clinical severity is limited, especially for rare mutations.

“An important goal of testing is really to give reassurance to most couples that they do not carry common serious mutations,” Dr. Mennuti said. “The other goal is to detect

the small number of couples who have a high risk—25%—for having a child with a serious form of the disease.

“When you start to test for more mutations, the marginal gain you get in lowering the risk for couples who have negative screening can be offset by introducing anxiety and uncertainties for couples who carry rarer mutations,” Dr. Mennuti continued.

The federal recommendations for CF screening set off an “arms race” for lab tests, according to geneticist Wayne W. Grody, MD, PhD, who coauthored an editorial on the subject in the November 2007 issue of *Genetics in Medicine*. Dr. Grody cochaired the American College of Medical Genetics’ joint working group that developed the laboratory testing standards for the CF screening guidelines.

“Right after our recommendations came out in 2001, we began to see a kind of competition among the reference labs as well as the manufacturers of testing platforms—essentially for bragging rights—with claims that adding more [mutations] would greatly enhance the pick-up rate for identifying carriers,” Dr. Grody told

ACOG Today.

Asked if in the future the CF testing panel might be expanded, Dr. Grody said, “In 10 years the testing technology will be more efficient—you will be able to screen for more and keep the price down. Most importantly, we will have more information to help us predict clinical severity for our patients. Changes in the recommendations or in practice must be based on scientific evidence rather than being driven by commercial competition.” ♀

info

- ACOG CF guidelines: www.acog.org/publications/taskforcereports/cysticfibrosis.pdf
- Slide presentation: *CF Screening: What to Order for and Tell Your Patients*: www.acog.org/departments/download/ACOGCFslides.ppt
- Patient Education Pamphlets: www.acog.org/bookstore/Cystic_Fibrosis_C47.cfm
- ACOG Committee Opinion *Update on Carrier Screening for Cystic Fibrosis*: www.acog.org/publications/committee_opinions/co325.cfm

Many patients embrace alternative medicine

► PAGE 1

Regardless of what primary care physicians think of CAM treatments, experts say it's important they discuss CAM use with their patients.

"As a physician, I would assume that every patient is using some alternative therapy, and don't think that you can categorize who that person is because you'd be surprised," Dr. Chambliss said. "As an example, studies have shown that those with chronic illnesses are more likely to use alternative medicines, so patients with chronic pelvic pain may be seeking it out. Conventional therapy hasn't treated their problems, so they're looking for answers."

Bringing up the subject

It can be difficult to delve into the alternative treatments patients are using. Patients may not divulge that they take mega doses of vitamins every day, or they may not mention that they routinely go to the chiropractor.

"CAM is such a general term, and it encompasses so much," said Annekathryn Goodman, MD, interim chief of the division of gynecologic oncology at Massachusetts General Hospital and a licensed acupuncturist. "Patients may not think what they're doing is in the same realm or necessary to mention. For example, you don't tell your doctor if you took an aspirin last night for a headache.

"To get answers from your patients, be more specific and try to say it in a fairly value-neutral way. Instead of saying 'Do you take any complementary and alternative medication or treatments?' ask if they have been taking any herbal remedies or multivitamins and whether they've been seeing any other practitioners."

Follow-up questions can include asking patients when they decided to use CAM, what results they were expecting, how they chose the method, and how it has worked, according to ACOG's *Guidelines for Women's Health Care: A Resource Manual*.

Helping patients understand CAM treatments

Some treatments face less skepticism than others, such as chiropractics or acupuncture, and some treatments seem to work even though modern medicine cannot explain why or how.

"There are things that make patients feel good, but you can't really prove it. There is a lot of stuff in alternative medicine that's claimed, but there are no randomized, controlled, double-blinded studies to prove those claims," Dr. Goodman said. "Our job is to be advocates for our patients, but don't be afraid to question some methods or treatments."

Physicians may find that patients are unaware that herbal medicines and dietary supplements are not regulated by the US Food and Drug Administration. Patients likely don't know that there is no standardization of doses and a potential for drug interactions.

"Our job is to be advocates for our patients, but don't be afraid to question some methods or treatments."

"If a treatment has a drug-like effect, it can also have a drug-like adverse effect. I don't think patients appreciate that. These things get marketed, and there's a presumption they're safe," Dr. Chambliss said.

Some ob-gyns may be uncomfortable discussing CAM with their patients because allopathic physicians may not have training in or knowledge of certain CAM treatments. Dr. Goodman suggests asking your patients to bring in the information they have on the particular treatment so you can do some research on it. She uses websites such as that of the National Center for Complementary and Alternative Medicine at the National Institutes of Health, <http://nccam.nih.gov>, and the physician discussion forums on Medhelp.org. ♀

info

- *Guidelines for Women's Health Care: A Resource Manual*: ACOG Bookstore, <http://sales.acog.org>
- *Clinical Updates in Women's Health Care: Complementary and Alternative Medicine* (October



Free CAM toolkit for physicians



Order a free "Time to Talk" toolkit that helps encourage discussion with your patients about their use of complementary and alternative medicine.

Developed by the National Center for Complementary and Alternative Medicine at the National Institutes of Health, the kit includes posters, tip sheets, patient wallet cards, and other resources.

- **To order a toolkit:**
888-644-6226; ask for D393
- **Toolkit materials online:**
<http://nccam.nih.gov/timetotalk>

02004): www.clinicalupdates.org

- Practice Bulletin *Use of Botanicals for Management of Menopausal Symptoms* (#28, June 2001): www.acog.org/member_access/lists/practbul.cfm
- Patient Education Pamphlet *Herbal Products for Menopause* (AP158) and Patient Education Pamphlet *Morning Sickness* (AP126): ACOG Bookstore, <http://sales.acog.org>

Pregnant women left out of disaster plans



WHEN DISASTERS STRIKE, whether they're hurricanes, earthquakes, or forest fires, evacuated and displaced people continue to need their everyday medical services. Particularly vulnerable are pregnant and postpartum women and their infants. Previous disasters have shown that states don't always have a plan in place for pregnant women and new moms, leaving families and relief workers scrambling to provide services.

ACOG wants to ensure that city, state, and national emergency disaster plans take into account pregnant and postpartum women and their babies. The College's Committee on Health Care for Underserved Women has been evaluating ways to help government agencies and communities plan for the needs of this vulnerable population during an emergency.

ACOG participated in the White Ribbon Alliance for Safe Motherhood's development of the Women and Infants Service Package,

which presents a framework for the minimum and initial actions needed to respond to the health care needs of this vulnerable group.

The College's Executive Board has endorsed the guidelines, and the underserved committee is also developing an online resource guide to help practitioners and patients find information during disasters.

"Hurricane Katrina made it all too clear that pregnant women and new mothers and their infants—already a vulnerable population—become more vulnerable and especially unprotected during a disaster," said New Orleans ob-gyn Juan Acuna, MD, a liaison member of the Committee on Health Care for Underserved Women. "ACOG wants to make sure pregnant and postpartum women aren't forgotten when emergency plans go into effect." ♀

info

→ www.whiteribbonalliance.org

Efforts under way to standardize newborn screening

ADVANCES IN TECHNOLOGY and new information about genetics have contributed to an expansion in newborn screening. What hasn't changed is the fragmentation of the screening structure.

Because systems are developed and funded by each state's public health agencies, the diseases and conditions that newborns are screened for can vary dramatically from state to state. But that may improve in the near future.

The US Health and Human Resources Services Administration/Maternal Child and Health Bureau is leading a national effort to standardize the system. HRSA/MCHB com-

missioned the American College of Medical Genetics to develop a uniform panel of core conditions appropriate for newborn screening. The panel includes 29 core conditions, which are listed in a new ACOG Committee Opinion, *Newborn Screening*, published in the December issue of *Obstetrics & Gynecology*.

For state-specific information, visit <http://genes-r-us.uthscsa.edu>.

"ACOG encourages ob-gyns to be familiar with screening in their state and prepared for questions from their patients," said Anthony R. Gregg, MD, chair of ACOG's Committee on Genetics. "Physicians can provide brochures, website links, or videos to patients to inform them about newborn screening."



Free patient and provider fact sheets can be downloaded from the ACOG website. Look under "Newborn Screening" at www.acog.org/from_home/misc/dept_pubs.cfm. ♀

Not too late to give—and get—flu vaccines

FLU SEASON USUALLY PEAKS in February, and ACOG reminds ob-gyns that all pregnant women should get a flu shot.

The College recommends that an intramuscular, inactivated flu vaccine be given in any trimester to women who will be pregnant during any part of the flu season, which can run through mid-May. Therefore, if a pregnant woman has not yet been vaccinated, it is not too late to immunize her in April or May.

Unlike past years, there is no shortage of flu vaccines this flu season. However, estimated vaccination coverage remains low, at less than 50%, among pregnant women, health care personnel, and other groups for which routine annual vaccination is recommended, according to the Centers for Disease Control and Prevention.

Thimerosal-free vaccines

Some pregnant patients may be concerned about the safety of flu vaccines because most flu vaccines contain thimerosal, a mercury-containing antibacterial compound. ACOG supports the recommendations and findings of the federal Advisory Committee on Immunization Practices, which has determined that there is no evidence showing that thimerosal is a danger to the health of the mother or her fetus.

However, the federal advisory committee recognizes that patient concerns about thimer-

osal are a potential barrier to achieving higher vaccine coverage levels, and, therefore, supports efforts to provide thimerosal-free vaccine options.

Ob-gyns may encounter patients who desire thimerosal-free flu vaccines. In addition, some states have banned flu vaccines containing thimerosal for children and/or pregnant women. However, ob-gyns and patients should be aware that thimerosal-free flu vaccines can be hard to obtain and tend to be more expensive.

Most patients should get vaccinated

Most patients, not just those who are pregnant, can benefit from the flu vaccine. ACIP recommends that vaccine providers give the vaccine to anyone who wishes to reduce his or her likelihood of getting the flu or transmitting the flu to others, while specifically targeting patients 50 and older for vaccination. The vaccine is also recommended for child caregivers and people living in the same house as children age four and younger, with a special emphasis on those caring for children younger than six months because flu vaccines are not recommended for these infants.

It's also vitally important for all health care personnel—physicians and their staff, hospital employees, and even medical students who have contact with patients—to be vaccinated to protect patients and themselves.

FLU RESOURCES

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

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

The FDA expanded its FluMist recommendations in September to include children ages two to four, as long as they don't have a history of recurrent wheezing.

Breastfeeding mothers can choose either type of vaccine. ♀

ENCOURAGING HEART HEALTH



COMMUNITIES ACROSS the US will be hosting heart healthy educational programs and fitness activities this month. February is National Heart Disease Awareness Month, a perfect time to discuss steps patients can take to decrease their risk of developing heart disease.

Heart disease kills more women—about 480,000 every year—than the next four most common causes of death combined. ♀

ACOG Resources

Order at <http://sales.acog.org>; 800-762-2264:

- ▶ *Guidelines for Women's Health Care: A Resource Manual, third edition*
- ▶ *Clinical Updates in Women's Care: Management of Dyslipidemia* (CU005)
- ▶ *Clinical Updates in Women's Health Care: Hypertension* (CU018)
- ▶ *Clinical Updates in Women's Health Care: Weight Control* (CU023)

Patient Education Pamphlets

- ▶ *Cholesterol and Your Health* (AP101)
- ▶ *Keeping Your Heart Healthy* (AP122)

- ▶ *Managing High Blood Pressure* (AP123)
- ▶ *Weight Control: Eating Right and Keeping Fit* (AP064)

More Resources

- ▶ Exercise tips, an online heart health assessment tool, and healthy recipes: www.goredforwomen.org
- ▶ Body mass index online tool: www.nhlbisupport.com/bmi
- ▶ Patient education brochures and fact sheets:
 - www.americanheart.org/presenter.jhtml?identifier=1200021
 - www.nhlbi.nih.gov/health/public/heart

professional liability lessons

Common terms and definitions

Insurance policies

Consent to settle: A provision that requires an insurer to get the physician's consent to settle a claim. Without this clause, an insurer can settle a claim without consent.

Exclusions: The component of an insurance policy that sets forth the circumstances under which the physician will not be covered.

Experience rating: The practice of basing insurance premiums on past loss history.

Extended reporting endorsement ("tail" coverage): A supplement to a claims-made policy that provides coverage for any incident that occurred while the claims-made insurance was in effect but was not brought as a claim by the time the insurer-policyholder relationship ended.

Layering: The process of putting together a primary policy with excess or umbrella coverage to ensure comprehensive coverage.

Prior acts coverage ("nose" coverage): A supplement to a claims-made insurance policy that may be purchased from a new carrier when a physician changes carriers and had claims-made coverage with the previous carrier. Covers incidents that occurred before the beginning of the new insurance policy but for which no claim has yet been made.

Slot coverage: Group insurance policy that covers a certain number of positions in an entity, rather than individuals. If a physician resigns, another physician may be able to fill the vacated slot.

Unearned premium: The portion of a premium that applies to the time that an insurance policy has yet to run.

YOU ASKED, WE ANSWERED

Obtaining tail coverage when switching practices

Q I JUST CHANGED PRACTICE locations and have learned that my current employer won't provide tail coverage. My contract doesn't address the issue. Is this typical?

A ONE OF THE MOST IMPORTANT things to understand about a claims-made medical professional liability insurance policy is that when you leave the insurer that issued that policy, you are not covered for future claims.

When terminating a claims-made policy, physicians should obtain "tail" coverage, also known as an "extended reporting endorsement," from their old carrier or "nose" or "prior acts" coverage from their new carrier. Both of these insure against claims reported after the end of the original policy period for alleged incidents that occurred while that policy was in effect.

Unfortunately for ob-gyns, the cost of tail coverage can come at a painfully high price. Premiums for tail coverage are determined by medical specialty, practice location, limits of liability, and length of continuous claims-made coverage.

If you have had your claims-made policy with the same insurer for many years and are retiring, you may qualify for free tail coverage. If you are not planning to retire soon and are relocating, ask your current carrier if it is licensed to do business in your new location. Assuming that you are paying for your own insurance now, you won't need tail coverage at all if you simply stay with the same insurer and keep the same policy while you transition to your new practice.

If your policy is not portable, some physicians can successfully negotiate with practices or hospitals that recruit them to pay all or part of the premium.

Another cost saver is to try to get your new policy with a carrier that offers prior acts coverage. This serves the same purpose as tail coverage, but you do not have to pay a separate premium for it. Instead, you begin paying



premiums for a new policy of similar maturity to the one you had with your old carrier, which factors in the risk that the new carrier is assuming.

Financing tail coverage

Physicians sometimes have no choice but to pay for the cost of tail coverage themselves. When this happens, try contacting your current insurer to see if you can finance your payments, with interest, over time so that you are not hit with a big payment up front. Some insurance companies have options for financing tail coverage, but they choose not to advertise them. Always check to see if this option is available.

If you are using a commercial lender to finance the cost of your tail coverage and you are having trouble finding a lender to provide this service, try networking with the colleagues in your group practice or hospital for the names of lenders. Your state insurance commission or state medical association may also be able to provide you with the names of some lenders in your area.

Review your policy periodically

Even if you don't have to think about tail coverage for many years, now is the time to review your policy or practice agreement. Many contracts simply do not address the issue of tail coverage. If your current insurance contract or practice agreement is silent on this subject, you should negotiate to have your agreement amended.

By planning early, you can help to ease the financial burden of the high cost of tail coverage when it is needed. ♀

2008 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

FEBRUARY

12

ACOG WEBCAST:
Evaluation and Management Consultation Coding
1-2:30 pm ET
800-673-8444, ext 2498

19

ACOG WEBCAST:
Junior Fellows—Business of Medicine
1-2 pm ET
Click on "Junior Fellows" in the "Quick Links" box on the left side of the ACOG home page, www.acog.org

24-26

ACOG's Congressional Leadership Conference
Washington, DC
www.acog.org
800-673-8444, ext 2509

MARCH

4-8

20th European Congress of Obstetrics and Gynaecology
Lisbon, Portugal
www.mundiconvenius.pt/2008/ebcog

5-8

CREOG and APGO Annual Meeting
Lake Buena Vista, FL
www.apgo.org
CREOG: 202-863-2558
APGO: 410-451-9560

9-12

Society of Gynecologic Oncologists 39th Annual Meeting on Women's Cancer
Tampa, FL
www.sgo.org
312-235-4060

11

ACOG WEBCAST:
Preconception Counseling and Prenatal Testing for the Generalist Ob-Gyn
1-2:30 pm ET
800-673-8444, ext 2498

12-16

American College of Medical Genetics 15th Annual Clinical Genetics Meeting
Phoenix
www.acmgmeeting.net

17-21

American Society for Colposcopy and Cervical Pathology Biennial Meeting
Lake Buena Vista, FL
www.asccp.org

25-29

American College of Osteopathic Obstetricians & Gynecologists 75th Annual Conference
Orlando, FL
www.aooog.org/events.html

26-29

Society for Gynecologic Investigation 55th Annual Scientific Meeting
San Diego
www.sgionline.org

APRIL

8

ACOG WEBCAST:
Pursuing Excellence in Perinatal Safety and Quality: Meeting the Challenge and Maintaining Engagement
1-2:30 pm ET
800-673-8444, ext 2498

9-13

Pacific Coast Reproductive Society 56th Annual Meeting
Rancho Mirage, CA
www.pcrsonline.org
562-947-7068

16-18

North American Society for Pediatric and Adolescent Gynecology Annual Clinical Meeting
Newport Beach, CA
www.naspag.org/ACM/geninfo.html

30-May 3

10th Congress of the European Society of Contraception "Noncontraceptive Impact of Contraception and Family Planning"
Prague, Czech Republic
www.contraception-esc.com

MAY

3-7

ACOG 56th Annual Clinical Meeting
New Orleans
www.acog.org/acm

13

ACOG WEBCAST:
Coding with Modifiers
1-2:30 pm ET
800-673-8444, ext 2498

15-17

American College of Physicians Internal Medicine Meeting
Washington, DC
www.acponline.org
800-523-1546, ext 2600

23-29

American College of Nurse-Midwives 53rd Annual Meeting & Exposition
Boston
www.acnm.org
240-485-7800

JUNE

10

ACOG WEBCAST:
Pay for Call
1-2:30 pm ET
800-673-8444, ext 2498

14-18

American Medical Association Annual Meeting
Chicago
www.ama-assn.org
202-863-2515

25-29

Society of Obstetricians and Gynaecologists of Canada 64th Annual Clinical Meeting
Calgary, AB
www.sogc.org
613-730-4192, ext 347

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.

FEBRUARY

7-9

Complex Gynecologic Surgery: Prevention and Management of Complications
Phoenix

14-16

Twenty-First Century Obstetrics and Gynecology
Rose Hall, Jamaica

29-Mar 2

ICD-9-CM and CPT Coding Workshop
Orlando, FL

SOLD OUT

MARCH

7-9

ICD-9-CM and CPT Coding Workshop
Philadelphia

28-30

ICD-9-CM and CPT Coding Workshop
Washington, DC

APRIL

4-6

ICD-9-CM and CPT Coding Workshop
Albuquerque, NM

MAY

8-10

ICD-9-CM and CPT Coding Workshop
New Orleans

JUNE

5-7

Quality and Safety for Leaders in Women's Health Care
Chicago

7-8

"No Frills" Emerging Issues in Office Practice: Sexuality, Body Image, and Psychologic Well-Being
Chicago

20-22

ICD-9-CM and CPT Coding Workshop
Portland, OR

26-28

Reawakening the Excitement of Obstetrics and Gynecology
Kohala Coast, HI

27-29

ICD-9-CM and CPT Coding Workshop
San Francisco

JULY

11-13

ICD-9-CM and CPT Coding Workshop
Memphis, TN

17-19

Concepts and Controversies in the Treatment of Perimenopausal and Postmenopausal Women
Vancouver, BC

AUGUST

15-17

ICD-9-CM and CPT Coding Workshop
Richmond, VA

21-23

Practical Obstetrics and Gynecology (in conjunction with the ACOG District III, VI, and IX Annual Meeting)
Banff, AB

Monograph on gastrointestinal disorders and pregnancy

THE AMERICAN COLLEGE OF GASTROENTEROLOGY has a new monograph, available on its website, that addresses gastrointestinal disorders during pregnancy, including heartburn, nausea, constipation, diarrhea, hemorrhoids, and more.

Pregnancy in Gastrointestinal Disorders explores the physiologic changes during pregnancy that may contribute to GI disorders, addresses the challenges physicians face in treating and managing chronic digestive disorders in pregnancy, and discusses safe pharmacologic and alternative therapies for pregnant women. ♀

info

→ www.acg.gi.org/physicians/pdfs/pregnancymonograph.pdf

Diabetes and pregnancy online resources



APATIENT EDUCATION TOOL ABOUT diabetes and pregnancy is available online from the National Center on Birth Defects and Developmental Disabilities. The website answers common questions and presents general information about diabetes: www.cdc.gov/features/diabetespregnancy.

The site also offers a link to the Diabetes Public Health Resource, which is available in both English and Spanish and offers information for the public and professionals, including research, statistics, and educational publications.

In addition, NCBDDD has released a podcast called “Diabetes and Pregnancy: Gestational Diabetes” available at www2a.cdc.gov/podcasts/player.asp?f=7235. ♀

ACOG PATIENT EDUCATION

Information you and your patients can trust

Save 20% for a limited time. Take advantage of this special offer on ACOG’s revised pamphlets.



Mammography (AP076)

- ▶ How the test is done
- ▶ What the test results mean
- ▶ When a woman should have mammography



Skin Conditions During Pregnancy (AP169)

- ▶ Common skin, hair, and nail changes that may occur during pregnancy
- ▶ What treatment, if any, will ease these changes

info

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



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