

## Military ob-gyns prove versatility of specialty



Army Lieutenant Colonel G. Scott Rose, MD, an ACOG Fellow, visits with patient Bianca Rendon, a member of the US military, at a hospital in Baghdad

**S**PLENECTOMIES, bowel surgery, and reconstructive skin grafting may not be a typical part of ob-gyn practice, but such trauma surgery was common for ACOG Fellow and Army Lieutenant Colonel G. Scott Rose, MD, during a six-month stint in Iraq.

Dr. Rose is just one of many ob-gyns and ACOG Fellows caring for both men and women in Iraq through their service in the US military.

Dr. Rose volunteered for deployment, temporarily leaving his position as director of the gyn oncology fellowship training program at Walter Reed Army Medical Center in Washington, DC. He returned home in January.

In Iraq, Dr. Rose was attached to the 31st Combat Support Hospital in Baghdad. Located within the heavily fortified Green Zone, the hospital is fully staffed with physicians in most specialties, from neurosurgery to psychiatry to hematology.

“Usually combat support hospitals are run out of temper tents, **▶ PAGE 11**

This month, *ACOG Today* examines how ob-gyns are providing skills and knowledge caring for patients in Iraq and Afghanistan through military service or volunteer work. To read more, see pages 10-12.

## EC use doesn't lead to more unsafe sex

**W**HEN TEENAGERS and young women are provided with easy access to emergency contraception, they do not increase their frequency of unsafe sex or abandon their regular contraception, a new study in the *Journal of the American Medical Association* shows.

The Food and Drug Administration rejected over-the-counter status for Barr Pharmaceuticals' Plan B

emergency contraception last May, stating that Barr did not provide adequate data to support the safe use of Plan B among teenagers without intervention of a physician.

“The research supports the contention that the leadership of the FDA shortchanged and underestimated women last year by failing to approve OTC status for EC,” said ACOG President Vivian M. Dickerson, MD. “The study demonstrates that ready avail-

ability of EC does not negate the ability of women to act responsibly, despite erroneous claims to the contrary by some EC opponents.”

At press time, Barr was waiting to hear from the FDA on a supplemental application that, if approved, would allow Plan B to be sold over the counter to women ages 16 and older but would still require a prescription for teenagers ages 15 and younger. **▶ PAGE 14**



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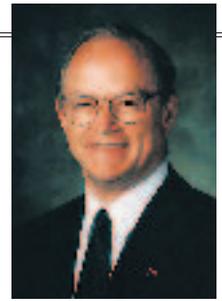
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EXECUTIVE DESK

# Fellows part of team serving in Iraq



EVERY NIGHT ON THE EVENING NEWS, we hear about US soldiers serving in Iraq. We see these young soldiers going on patrols, looking for insurgents, and securing areas. But did you ever stop and think who takes care of them? ACOG Fellows are part of the team of physicians delivering that care.

That's right, as members of the US military, many ACOG Fellows are providing medical care to American soldiers serving in Iraq. These ob-gyns provide gynecological care to female soldiers but also treat male soldiers and serve as trauma surgeons.

In this issue of *ACOG Today*, we highlight some of these Fellows—who've since returned home safely—as they share their unique experiences with you. We also let you know about ob-gyns who have volunteered their time in Iraq and Afghanistan, helping the citizens rebuild their medical system and improve women's health care.

I'm proud of all of these Fellows as they serve their country and their patients and help rebuild medical systems on the other side of the globe. In fact, I have a physician son who is in Iraq today

as part of the US Army.

I'm also proud to announce that a very active ACOG Fellow, Lieutenant General Kevin C. Kiley, MD, has been named as the new surgeon general of the US Army. LTG Kiley has been promoted to a three-star general, and I had the opportunity to attend his promotion ceremony last fall with several other ACOG representatives (see page 10).

In addition, the current chair of the Armed Forces District, Brigadier General Carla G. Hawley-Bowland, MD, has become the first female physician to become an Army general. BG Hawley-Bowland took command of the US Army's Europe Regional Medical Command and became the command surgeon for the US Army Europe and 7th Army in July 2004.

So remember, the next time you're watching the news and they show physicians treating soldiers, you may just be looking at an ACOG Fellow.



BG Hawley-Bowland

Ralph W. Hale, MD, FACOG  
Executive Vice President

**Obstetrics & Gynecology HIGHLIGHTS**

**The March issue of the Green Journal includes the following ACOG document:**

**Pregestational Diabetes Mellitus**  
(Practice Bulletin #60, new)

Each month, *ACOG Today* will list the titles of ACOG documents that were published in the corresponding month's *Obstetrics & Gynecology*.

**IN MEMORIAM**

**Leonard H. Boggs, MD**  
Sioux City, IA

**A. F. Forster, MD**  
Long Beach, CA | 12/04

**Charles Harrison Gartner, MD**  
Denver | 11/04

**Robert Bridger Hunt, MD**  
Dover, MA | 12/04

**Alan King, MD**  
Loma Linda, CA | 10/04

**Rodolfo Niccoli, MD**  
Rimini, Italy

**E. Y. Strawn Sr, MD**  
Milwaukee

**Charles E. Wood, MD**  
Rogers, AR | 10/04

## ACOG Today unveils new look

WELCOME TO THE NEW ACOG TODAY! ACOG's Office of Communications is pleased to present a fresh, new look to the award-winning newsletter, featuring an eye-catching nameplate on the cover and a new format. We hope you find this modern look pleasing to the eye and easy to navigate.

As always, *ACOG Today* will continue to bring you the latest information in areas that include College news, professional liability reform, ACM sessions and events, clinical issues, patient safety, practice management, Junior Fellows, and much more.

We will continue to strive to improve the newsletter with special features, such as the package of articles on ob-gyns serving or volunteering in Iraq and Afghanistan, which begins on this month's cover page.

If you have any questions or comments about the newsletter, please email Editor Melanie Padgett at [mpadgett@acog.org](mailto:mpadgett@acog.org). ♀

## ACOG responds to new IRS code

LAST YEAR the Internal Revenue Service informed the public and Congress that it would begin active investigation based on new IRS rules governing nonprofit organizations.

In 1996, Congress passed a new law designed to more closely regulate the activities of nonprofits. The regulations for implementation of Internal Revenue Code 4958 were finally completed in 2002.

Now known as Intermediate Sanctions, the new regulations are aimed at preventing those in positions of authority in a nonprofit organization from taking unfair advantage or receiving excess benefit from the organization by virtue of their position.

The rules are extremely complex, and the punishments for failure to comply are substantial. ACOG's Executive Board has been working closely with the firm Grant Thornton

to ensure ACOG's compliance.

All officers of the Executive Board, District Advisory Councils, and Sections are considered "insiders" or "disqualified persons," terms the IRS uses to define those who could unfairly benefit from their position. One concept in the regulations is that once you are an insider or disqualified person, you remain such for five years after leaving the position.

ACOG has developed an educational program to explain IRC 4958. If you meet the definition of an insider or disqualified person and have not received the educational program as a CD at a District meeting or other presentation, please contact Ginny Satterfield in the ACOG Office of the Executive Vice President for a copy. ♀

### info

- [gsatterfield@acog.org](mailto:gsatterfield@acog.org)
- 800-673-8444, ext 2516

## Dr. Mennuti to be sworn in as new president at ACM

MICHAEL T. MENNUTI, MD, of Philadelphia, will be sworn in as the College's 56th president on May 11 in San Francisco, where he will deliver his inaugural address. Dr. Mennuti is professor and chair of the department of ob-gyn and professor of human genetics and pediatrics at the University of Pennsylvania, Philadelphia.

"While seeking resolutions to the medical liability crisis will continue to be our highest priority, I also plan to work on implementing the new strategic plan that the Executive Board is developing," Dr. Mennuti said. "This plan, being developed under Dr. Vivian Dickerson's leadership, is very forward-looking. It will incorporate renewed commitment to and emphasis on many of our existing goals. It will also lead us in exciting new directions for the future development of our specialty.

"To position us for the future, I hope to strengthen genetics education for our members and to facilitate the incorporation of the explosion of scientific developments in genetics into ob-gyn practice," Dr. Mennuti continued. ♀



Michael T. Mennuti, MD

### EDUCATION

**MD:** Georgetown University, Washington, DC

**RESIDENCY:** Hospital of the University of Pennsylvania

**FELLOWSHIPS:** maternal fetal medicine and human genetics, Hospital of the University of Pennsylvania

### ACOG ACTIVITIES

#### NATIONAL:

▶ Secretary; assistant secretary; currently on the Committee on Government Relations; has chaired the Committee on Obstetric Practice, Committee on Credentials, and task forces on the ACOG nominations process, Internet initiatives, governance of ACOG, and establishing a 501(c)(6) organization

▶ Chaired the Cystic Fibrosis Steering Committee and the Genetics Subcommittee of the Committee on Obstetrics; served on the Committee on Long-Range Planning, Committee on Nominations, Grievance Committee, and the Health Care Commission and as liaison to the American Academy of Pediatrics' Committee on Genetics and AAP Committee on the Fetus and Newborn

▶ Recently chaired a National Institutes of Health conference on First-Trimester Screening for Down Syndrome

**DISTRICT III:** chair, vice-chair, secretary, assistant secretary, and program chair for four Annual District Meetings. Received the Outstanding District Service Award

**ABOG:** Served as director and vice-president, and director of the Division of Maternal Fetal Medicine

# clinical seminars

## MONDAY, MAY 9

11 am-12:15 pm

Laparoscopic Hysteroscopy CMA01  
Surgical Options for Stress Urinary Incontinence CMA02

VBAC in the New Millennium: Where Do We Go from Here? CMA03

\* Diagnostico y Manejo del Crecimiento Intrauterino Restringido CMA04

Advances in Ovarian Cancer Detection and Treatment: Update for the Generalist CMA05

Minimally Invasive Approaches to the Diagnosis and Management of Submucosal Leiomyomas CMA06

The Changing Practice of Obstetric Anesthesia: Current Controversies and Future Trends CMA07

Tales from the Witness Chair CMA08

Nausea and Vomiting During Pregnancy CMA09

Adapting to the New Environment: Re-defining the Annual Visit CMA10

Emergency Contraception: A Well-Kept Secret CMA11

Ovulation Induction for the Generalists: Optimizing Clomiphene Citrate and Beyond CMA12

An Update on Sexually Transmitted Diseases and Vaginitis CMA13

First-Trimester Screening and Prenatal Diagnosis CMA14

## MONDAY, MAY 9

2:30-4 pm

How to Get Published—Pearls for Authors CMP15

Course and Treatment of Depression During Pregnancy, Postpartum, and Lactation CMP16

Surviving the Despair of Liability Litigation CMP17

Facing Ethical Challenges in Ob-Gyn Clinical Practice CMP18

Female Sexual Dysfunction: The Challenge of Diagnosis and Treatment CMP19

Current Evaluation and Management of Benign Breast Conditions for the Practicing Gynecologist CMP20

Evidence-Based Infertility Care CMP21

\* Parto Prematuro: Nuevo Conceptos en Diagnostico, Prevencion, y Tratamiento CMP22

Obesity: A Weighty Problem for the Ob-Gyn Practice CMP23

Complementary and Alternative Medicine in Ob-Gyn CMP24

Cervical Cerclage: An Evidence-Based Review CMP25

Myths and Truths of Cesarean Delivery Technique CMP26

Incorporating Industry-Sponsored Clinical Trials into Your Practice CMP27

What's New and Upcoming in Pediatric and Adolescent Gynecology CMP28

Meeting the Needs of Your Lesbian Patients CMP29

## TUESDAY, MAY 10

2:30-4 pm

Treatment of Uterine Fibroids: Non-Invasive Therapy for the 21st Century CTP30

Managing Abnormal Pap Tests Today and Tomorrow: A Case-Based Review CTP31

Disclosure of Unanticipated Outcomes and Medical Errors CTP32

Team Training in Labor and Delivery: An Innovative Approach for Improving Patient Safety CTP33

Hypertension, Pregnancy, and Beyond CTP34

Providing Gynecologic Care to Women with Disabilities CMP35

Key Moments in the History of Obstetrics and Gynecology CTP36

Choosing Incision and Wound Closure Techniques CTP37

Colon Cancer Screening and Prevention: An Ob-Gyn's Perspective CTP38

Tap into the Information Age: How to Identify and Access High-Quality Clinical Information at the Point of Care CTP39

"State-of-the-Art" Examination of the Adult Female Sexual Assault Victim CTP40

Recent Advances in Bariatric and Robotic Surgery CTP41

\* Marcadores Bioquimicos de Anomalias Cromosomicas CTP42

\*Three sessions in Spanish

## Compare cases with Fellows at ACM interactive sessions

**A**TTEND AN INTERACTIVE SESSION at the Annual Clinical Meeting and see how your management of a case compares with that of other ob-gyns in the audience.

In these lively and popular sessions, the faculty outline patient cases and offer options for management or diagnosis decisions. Each member of the audience then registers his or her own choice, using individual key-pads. Within 30 seconds the tally of everyone's answers is shown on the screen at the front of the room. The faculty uses the audience answers to steer the discussion and respond to audience questions.

In the session "Caring for Women with Challenging Menopausal Problems," participants will be asked to consider several difficult cases such as an oophorectomized woman with a low libido who has been married for several years or a woman who has heart disease and menopausal symptoms. The session will be offered on both Tuesday and Wednesday.

"At the end of the session, we hope that participants will be able to individualize care for difficult cases," said Robert W. Rebar, MD, executive director for the American Society for Reproductive Medicine, who will be teaching the course along with Karen Bradshaw, MD, professor at the University of Texas, Southwestern Medical Center. ♀

### INTERACTIVE SESSIONS

#### MONDAY

**Abnormal Pap Smears—2005**

11 am-12:30 pm

**Ultrasound in Ob-Gyn**  
2:30-4 pm

#### TUESDAY

**Caring for Women with Challenging Menopausal Problems**

3-4:30 pm

#### WEDNESDAY

**Caring for Women with Challenging Menopausal Problems**

11 am-12:30 pm

**Management Dilemmas in Intrapartum FHR Monitoring**  
1:30-3 pm

#### TUESDAY

**Management Dilemmas in Intrapartum FHR Monitoring**

9:15-10:45 am

**Management of Pelvic Mass**  
11 am-12:30 pm

**Your Diagnosis Is? Testing Your Knowledge of Various Vulvovaginal Conditions**

1:30-2:30 pm

# Putting your skills to the test

## Practice techniques with hands-on postgraduate courses

FOUR HANDS-ON COURSES will be offered at this year's ACM, giving participants the opportunity to learn new techniques through lectures and then practice what they have learned.

**Saturday, May 7, or Sunday, May 8 | 8:15 am–5 pm**

### Hands-On Operative Hysteroscopy

As the emphasis on minimally invasive surgery has increased, hysteroscopy has become a more important part of gynecologic practice. The role of hysteroscopy in the diagnosis and treatment of abnormal uterine bleeding and infertility will be discussed, and techniques will cover hysteroscopic myomectomy, endometrial ablation, and hysteroscopic sterilization. Participants will be able to practice techniques, using a combination of virtual reality simulators and/or inanimate models, in the afternoon sessions with the course faculty.

### OB Ultrasound: A Hands-On Look at the Basics

This course will cover aspects of second- and third-trimester obstetrical ultrasound.

All of the components of a basic exam will be covered, including biometry and a thorough survey of fetal anatomy. Live models will be available, and faculty will go through exams with participants.

### Minimally Invasive Treatment Options for the Surgical Correction of Stress Urinary Incontinence: A Hands-On Tutorial

Participants will learn the basic office evaluation and urodynamic principles for the evaluation of genuine stress urinary incontinence by means of didactic lecture and hands-on training of both retropubic and transobturator minimally invasive mid-urethral sling procedures.



**Sunday, May 8 | 8:15 am–5 pm**

### Mobilizing Your Practice with the Latest Handheld Devices, Wireless Technologies, and Software

With the government initiative to have all doctors and hospitals paperless by 2014, this hands-on course is designed to introduce the practicing physician to the latest handheld technologies, software, and techniques to mobilize a paperless practice efficiently. Hardware overviews will be given, covering pagers, Blackberry devices, personal digital assistants, "intelligent" phones, cameras, personal computers, and other technologies of today and the future. Additionally, the course will introduce the participant to several medical software solutions, including electronic health records and practice management systems. ♀



## ACM History Sessions

THE J. BAY JACOBS, MD, LIBRARY for the History of Obstetrics and Gynecology in America is sponsoring three events at the 2005 Annual Clinical Meeting, May 7-11, in San Francisco.

### Videotaped accounts of ob-gyn history

For the past 21 years, with support from Wyeth Pharmaceuticals, the History Library has coordinated videotaped interviews with two individuals of importance to the College and the specialty. The aim of the project is to capture recollections of ob-gyns and nurses, including the early leaders of ACOG.

This year, former ACOG Executive Director Warren H. Pearse, MD, will interview two past presidents: Richard F. Jones III, MD, and Robert C. Park, MD. Suggestions of topics to discuss are always welcome. Email suggestions to [history@acog.org](mailto:history@acog.org).

Past interviews are available for viewing at the History Library at ACOG head-

quarters in Washington, DC, and a complete list is available upon request.

### The 9th Annual Breakfast of the History Special Interest Group Wednesday, May 11, 6:30–8 am San Francisco Marriott

Ronald E. Batt, MD, 2004 ACOG History Fellowship recipient, will speak on the scientific, social, and cultural perspectives of endometriosis. Dr. Batt is currently pursuing a doctorate in the history of sciences and medicine at SUNY Buffalo and plans to use his career-long research interest to publish a comprehensive history of the subject.

The breakfast is free, but space is limited. Preregister at the ACOG booth in the Exhibit Hall.

### "Key Moments in the History of Obstetrics and Gynecology" Clinical Seminar

Tuesday, May 10, 2:30–4 pm

Lawrence D. Longo, MD, director of the Center for Perinatal Biology at Loma Linda School of Medicine in Loma Linda, CA, will discuss Robert Patterson Harris, a 19th century physician from Philadelphia, and his role in developing medical statistics and persuading practitioners to institute changes in obstetrical management, especially in the use of cesarean section, which helped to improve operative results for both mothers and infants.

Please register for the seminar when you register for the ACM. ♀

### info

→ For more information on these and other History Library activities, email [history@acog.org](mailto:history@acog.org)

# Nominees for 2005–06 ACOG officers

The following slate will be voted on at the 2005 Annual Business Meeting in San Francisco on May 9. Fellows and Senior Fellows who cannot attend should vote by proxy, using the card sent in a separate mailing in March.

## President-Elect Nominee



**Douglas W. Laube, MD, MEd**  
*Madison, WI*

**Professional Position**

Chair, ob-gyn department, University of Wisconsin

**Education**

- **MD:** University of Iowa
- **RESIDENCY:** University of Iowa Hospital and Clinics

**ACOG Activities**

- **NATIONAL:** vice president; assistant secretary; CREOG chair; chair, Committee on Grievance; chair, Presidential Task Force on Student Recruitment; member, committees on primary care, nominations, technical bulletins; member, *Precis* and *Clinical Updates* editorial boards; member, Task Force on Primary Care in Ob-Gyn; member, Female Circumcision/Genital Mutilation Task Force; vice chair, Education Commission
- **DISTRICT VI:** scientific program chair; Wisconsin Section chair and vice chair

## Vice President Nominee



**Richard P. Green, MD**  
*Washington, DC*

**Professional Position**

Private solo practice; senior attending physician in ob-gyn, Washington Hospital Center

**Education**

- **MD:** Howard University, Washington, DC
- **RESIDENCY:** Howard University Hospital

**ACOG Activities**

- **NATIONAL:** assistant secretary; chair, Council of District Chairs; chair, National College Advisory Council Meeting; chair, Committee on Credentials; member, committees on professional liability, grievance, nominations; member, Subcommittee for Development; member, Task Force on Neonatal Encephalopathy & Cerebral Palsy; reviewer, Voluntary Review of Quality of Care Program; peer reviewer, ACM postgraduate course
- **DISTRICT IV:** chair; vice chair; secretary; newsletter editor; chair, committees on site selection and perinatal mortality; chair and vice chair of District of Columbia Section

## Assistant Secretary Nominee



**Paul G. Tomich, MD**  
*Omaha, NE*

**Professional Position**

Director, Division of Maternal Fetal Medicine, and director of obstetrics, University of Nebraska School of Medicine, Nebraska Medical Center

**Education**

- **MD:** Loyola University, Chicago
- **RESIDENCY:** Mayo Clinic, Rochester, MN

**ACOG Activities**

- **NATIONAL:** chair, Council of District Chairs; McCain Fellow; chair, task forces on district & section activities and meetings management; member, committees on obstetric practice, continuing medical education; member, Subcommittee for Development; advisor, JFCAC; member, Task Force on Nominations
- **DISTRICT VI:** chair; vice chair; program chair; member, Legislative Committee; program chair, Annual District Meeting; Junior Fellow secretary-treasurer and assistant secretary; vice chair, Illinois Section

## Fellow-at-Large Nominee (two-year term)



**Laura A. Dean, MD**  
*Stillwater, MN*

**Professional Position**

Private group practice

**Education**

- **MD:** Mayo Medical School, Rochester, MN
- **RESIDENCY:** University of Minnesota

**ACOG Activities**

- **NATIONAL:** member, committees on quality improvement and patient safety, nominations, and coding and nomenclature; member, Steering Committee on Women's Health Care into the 21st Century; member, Task Force on Women and Younger Fellows in ACOG Leadership; member, Leadership Program in Women's Health Policy; participant, ACOG Legislative Workshop
- **DISTRICT VI:** Minnesota Section vice chair; Minnesota scientific meeting chair; Minnesota council member; Junior Fellow chair and vice chair

## Children reap rewards of ACM also

ALTHOUGH MOST of the scientific and educational information at the Annual Clinical Meeting will be way over the heads of children, they don't need to feel left out. The children of ACM participants are again invited to take part in Camp ACOG and youth field trips.

Camp ACOG, which is run by ACCENT on Arrangements Inc, is available each day of the meeting from 7:30 am–5:30 pm for children ages six months to 12 years. Youth field trips are available for kids ages 6–12.

Thanks to a grant from Berlex Laboratories—which is sponsoring the camp for the 11th year—parents need only pay a one-time registration fee of \$20 per child for the camp and \$5 per child for each field trip.

### info

- Registration forms are in the Preliminary Program: [www.acog.org/acm2005](http://www.acog.org/acm2005)
- Registration forms must be received by April 22
- 504-524-0188

### YOUTH FIELD TRIPS

#### SATURDAY, MAY 7

Six Flags Marine World  
9 am–5 pm

#### SUNDAY, MAY 8

Paramount's Great America  
9 am–5 pm

#### MONDAY, MAY 9

Muir Woods National Park  
and California Academy  
of Sciences  
9 am–4 pm

#### TUESDAY, MAY 10

Tech Museum of Innovation  
and Rosicrutian Museum  
9 am–4 pm

#### WEDNESDAY, MAY 11

A Visit to the  
Exploratorium  
9 am–1 pm

# 2005 ACM

MAY 7-11, SAN FRANCISCO



**Register online now! [www.acog.org/acm2005](http://www.acog.org/acm2005)**

- Select from postgraduate courses, clinical seminars, interactive sessions, and many other courses when you register online for the 2005 ACM
- Registering online is the easiest way to select courses because you will know immediately if a course is available, making it unnecessary to list second and third choices
- San Francisco hotel reservations can also be made on the ACM website

## Annual Business Meeting May 9

ACOG members in all categories of membership should check their mailbox for the March ACOG Resource Packet, which will include the minutes of the 2004 Annual Business Meeting. In addition, Fellows will receive a special mailing in March that includes proposed bylaw amendments and a proxy card to vote for the 2005–06 national officers, the fellow-at-large, and the proposed amendments.

If you do not plan to attend the Annual Business Meeting in San Francisco on May 9, please mail your proxy as soon as you receive it.

### Notice of annual meeting

Notice is hereby given, in accordance with the Bylaws of the American College of Obstetricians and Gynecologists and the provisions of the General Not-for-Profit Corporation Act of the State of Illinois, that the Annual Meeting of the Fellows of said College will convene at 11 am, Monday, May 9, 2005, in the Moscone Convention Center in San Francisco, for the purpose of electing officers of the College and transacting such other business as may come before the meeting. ♀

James N. Martin Jr, MD  
Secretary  
Dated: March 14, 2005

### Dr. Hale invites questions to be answered at the Annual Business Meeting

At the upcoming Annual Business Meeting on Monday, May 9, in San Francisco, ACOG Executive Vice President Ralph W. Hale, MD, will answer questions submitted by Fellows about ACOG or ob-gyn issues.

### Please mail or fax your questions by April 4 to:

Ralph W. Hale, MD  
Executive Vice President  
ACOG, PO Box 96920  
Washington, DC 20090-6920  
Fax: 202-863-1643

## How to seek a practice position after residency

Junior Fellow leaders who recently completed their residency and are now in academic and practice settings share their job-hunting experiences and advice with residents

**S**EARCHING FOR THE PERFECT ob-gyn position for life after residency may seem like a daunting task, but with proper planning and research, residents may just land their dream job.

### Decide what type of practice you want to work in—academic, group, or solo—and consider your future goals

“Having an idea of long-term career aspirations is of great importance,” said Patrick S. Ramsey, MD, MSPH, District VII Junior Fellow chair. “For instance, issues that face residents looking at private practices often are substantially different from those facing individuals looking at academic-type positions. Issues such as starting salary; percentage of protected time for administrative efforts and research; vacation time; practice partnership options; noncompete clauses; and medical liability coverage may vary substantially among practice types and settings.”

Know the type of characteristics you want in a practice and don’t waste time interviewing with low-priority opportunities, added Dr. Ramsey, assistant professor of ob-gyn at the University of Alabama at Birmingham.

### Network, network, network

“Don’t be afraid to talk to people,” advised Meredith B. Loveless, MD, District IV Junior Fellow chair. “Network and find as many people as you can in the area you are interested in who can help.”

Dr. Loveless, who is in her first year as a full-time faculty member at Johns Hopkins Bayview Medical Center in Baltimore, recommends using ACOG resources to aid your job search.

“Practices in regions with a large number of training programs tend to fill their positions from the many residencies nearby,” she said. “If you are moving into an area with lots of training programs, contact someone in the region to get information about groups that

are recruiting. Your ACOG Fellows are an excellent resource, and other Junior Fellows may also know who is hiring. Also, ask your faculty if they know anyone in the region.”

Once you begin looking at specific practices, your contacts can also provide invaluable advice.

“If you are moving to an area where you did not train, it helps to talk to residents who have worked with doctors in your prospective practice,” said Stella M. Dantas, MD, District VIII Junior Fellow chair. “They might be able to give you some ‘behind-the-scenes’ information.”

### Learn about a practice

“It is helpful for applicants to meet as many people as they can in a practice,” said Dr. Dantas, who is in her fourth year of practice with Northwest Permanente/Kaiser in Portland, OR. “It is very important to get a feel for how the doctors in the practice work together and get along, so take as many opportunities to meet with people (interviews, dinners, second looks) as you can.”

Learning about the practice is also important to show you’re interested during the interview process. “Make sure you know something about the practice before your interview so you can ask well-thought-out questions and be able to define for yourself what your ideal job would be,” Dr. Dantas continued.

### Get faculty support for an academic position

“In academics it is most important to have people on the faculty of your residency program who support and recommend you,” Dr. Loveless said. “Be prepared for a longer interview process, and keep in mind second interviews are often requested. Also for a faculty position, I think you should be very clear about what your interests, goals, and long-term plans are and if they mesh with the needs of the department.”



### Contract negotiations: hire a lawyer

Once negotiations begin, it’s important to hire a lawyer in the same state as the job position. When Shelly Holmstrom, MD, past Junior Fellow chair of District IV, was negotiating with a group practice, her attorney sent her a detailed critique of the contract she was offered, which became helpful in her decision.

“I spoke to the partners in the practice and sent them the detailed critique,” she said. “The partners were unable to change most of what I requested due to a standardized contract situation. The tail coverage for professional liability insurance with that practice was also extremely high and another factor in my not joining that group.”

Dr. Holmstrom, an assistant professor in ob-gyn at the University of South Florida in Tampa, was able to get a sense of regional salaries by talking to several different employers in the area where she wanted to practice.

“Salary was usually not terribly negotiable, but benefits were,” she said. “Time off, CME money, and other perks were sometimes negotiable.” ♀

### More help on seeking practice opportunities

- ▶ Search the ACOG Career Connection job bank at no charge. Click on the Career Connection logo on the ACOG homepage, [www.acog.org](http://www.acog.org)
- ▶ A new ACOG business of medicine primer, which will include information on finding a job after residency, will be available in May and distributed at no charge to all current residents.

## Colorectal cancer screenings cause confusion

**A**COG RECOMMENDS that all women of average risk undergo colorectal cancer screening beginning at age 50. But which tests to use and how to administer them can be confusing to some ob-gyns.

“Fellows have an important role to play in suggesting that women get screened for colorectal cancer, and they need to know which tests are recommended,” said Stanley Zinberg, MD, MS, ACOG vice president of practice activities.

As outlined in the College’s Committee Opinion #292, *Primary and Preventive Care: Periodic Assessments*, ACOG recommends that women age 50 and older be screened by:

- ▶ Fecal occult blood testing every year or
- ▶ A flexible sigmoidoscopy every five years or
- ▶ FOBT every year plus a flexible sigmoidoscopy every five years or
- ▶ A double-contrast barium enema every five years or
- ▶ A colonoscopy every 10 years

In a survey by the National Cancer Institute on providers’ colorectal cancer screening knowledge and practices (*Preventive Medicine*,



March 2003), researchers discovered that awareness of colorectal cancer screening was high, with 98% reporting that they recommend screening to average-risk patients.

When recommending screening, more than 80% of providers, including ob-gyns, most often recommended FOBT and/or flexible sigmoidoscopy. However, nearly two-thirds of ob-gyns reported conducting FOBT in the office with a digital rectal exam, which is not the recommended method.

The American Cancer Society recommends that FOBT be conducted with a home-testing kit that instructs patients to collect stool samples to be returned for laboratory testing.

A study released in January found that less than 5% of patients with advanced neoplasia tested positive through a single in-office

FOBT. Twenty-one percent tested positive with a 6-sample take-home test but negative with an in-office test. The study, in the January 18 issue of *Annals of Internal Medicine*, studied 3,121 asymptomatic mostly male patients ages 50 to 75.

### New technologies

Researchers are studying the effectiveness of virtual colonoscopy, which is still considered experimental. Neither the cancer society nor ACOG recommends it currently. The virtual colonoscopy is thought to be faster and cheaper than a regular colonoscopy and doesn’t require sedation, according to the cancer society. However, if a polyp or growth is found, a biopsy or polyp removal will need to be done later during a colonoscopy.

Researchers are also studying the effectiveness of fecal DNA testing, particularly in comparison with FOBT. ♀

### info

- *Reducing Your Risk of Cancer* Patient Education Pamphlet; order at <http://sales.acog.org>
- [www.preventcancer.org/colorectal](http://www.preventcancer.org/colorectal); 877-35-COLON

## More women pass up contraception

**T**HE PERCENTAGE of sexually active women in the US who are not using any form of contraception has increased, leading to concerns about an increase in unintended pregnancy.

In the government’s latest report on contraception and family planning, researchers at the National Center for Health Statistics found that in 2002, 7.4% of sexually active women ages 15 to 44 were not using contraception, a jump from 5.2% in 1995. This translates into 4.6 million women—an increase of 1.43 million women since 1995—who may be at risk for unintended pregnancy, according to the report.

The report points out that this increase is statistically significant and that the change merits further study.

“The explanation for declining contraceptive use among women not desiring pregnancy is unclear; this preliminary report had few

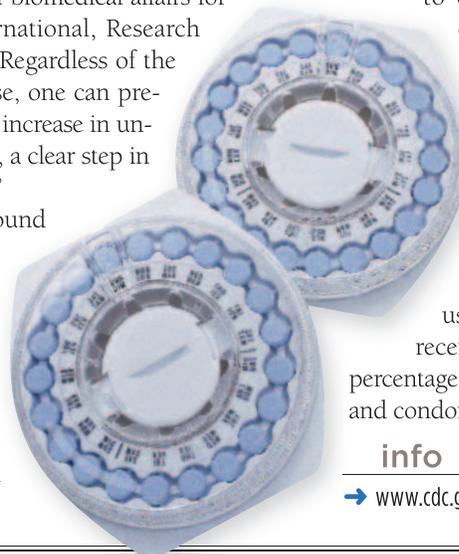
details,” said David A. Grimes, MD, clinical professor in the Department of Obstetrics and Gynecology at the University of North Carolina at Chapel Hill School of Medicine and vice president of biomedical affairs for Family Health International, Research Triangle Park, NC. “Regardless of the cause of this decrease, one can predict a corresponding increase in unplanned pregnancies, a clear step in the wrong direction.”

The report also found that:

- ▶ Black and Hispanic women were less likely than white women to have ever used the contraceptive pill but more likely to have used Depo-Provera.

▶ Few women still use diaphragms or intrauterine devices. In 1982, 8% of women using contraception used diaphragms; that dropped to less than 2% in 1995 and to 0.3% in 2002. IUD use dropped from 7% in 1982 to 0.8% in 1995 but increased slightly in 2002 to 2%.

▶ Since 1995, teenagers are more likely to use contraception, usually condoms, at first intercourse, and more teens use condoms at their most recent intercourse. A growing percentage of adolescents use the pill and condoms at first intercourse. ♀



### info

- [www.cdc.gov/nchs/data/ad/ad350.pdf](http://www.cdc.gov/nchs/data/ad/ad350.pdf)

## 'We're very hopeful'

ACOG Fellow part of project to open interchange with Iraqi physicians

**T**HE IRAQI PHYSICIANS are incredibly courageous and dedicated," says Fellow Randall W. Williams, MD. "They are a wonderful, thankful, gracious people who long for collegiality with their American and British and world counterparts."

Dr. Williams traveled to Baghdad in February 2004 to help Iraqi physicians create specialty societies, an impartial medical licensure system, and a residency review and accreditation process. He was one of 30 American and British volunteer physicians, each representing a different specialty, to take part in a four-day medical forum. Dr. Williams is part of a gynecology and infertility practice in Raleigh, NC.

### Open exchange of ideas

Approximately 500 Iraqi physicians attended the forum. Dr. Williams gave presentations to about 50 ob-gyns on endometrial ablation and new techniques in operative laparoscopy.

Dr. Williams described the reaction by the Iraqi physicians as a "Rip Van Winkle effect."

"For 25 years they've had no innovation. They practice rudimentary medicine—no Pap smears, no mammography units. This was the first time in 25 years they'd been exposed to new ideas and technology or had the chance to complain and ask questions."

### Shortages in medicine

"One of the obstetricians told me she would start the week out with one ampule of Methergine—for the whole week," Dr. Williams said. "If someone came in bleeding really heavily on Monday, the doctor would have to decide whether to use it. If she did, and then another patient came in on Wednesday bleeding even more heavily, that patient



Dr. Randall W. Williams, far right, with Iraqi ob-gyns at the Iraqi Medical Specialty Forum in Baghdad

would die. On the other hand, if she didn't use the Methergine on Monday, and the woman died, and then no one else came in ..." He paused, the implications obvious. "And yet at the end of the week, she couldn't complain about the shortage."

Although the volunteer physicians were warned about the dangers of going outside the compound, Dr. Williams and other phy-

sicians did visit area hospitals with their new Iraqi friends. What he saw stunned him.

"I had a sense that things were bad, but I didn't have a clue until I saw them with my own eyes. Many hospitals have problems with electricity and clean water. They don't have autoclaves, and lack of sterile conditions accounts for much of the perinatal morbidity."

### 'We're very hopeful'

The delegation plans to follow up the visit by helping the Iraqi physicians organize specialty societies and develop licensure and accreditation processes. However, plans have been put on hold because of the wave of attacks on Iraqi civilians and international volunteers.

"Everything has come to a grinding halt because the people who would be the leaders could be targeted as collaborators, and they would be killed," Dr. Williams said.

But Dr. Williams connects with his friends in Iraq regularly via email.

"We're very hopeful that with the election in January and the Iraqis taking on more responsibility that a true Iraqi government will come into play."

He and others hope to return in April, sponsored by the US Department of State, to reconnect with their Iraqi colleagues and formally arrange for the transfer of physicians and technology. ♀



At LTG Kiley's promotion ceremony: Past ACOG President Frank C. Miller, MD; ACOG Executive Vice President Ralph W. Hale, MD; and LTG Kiley

## ACOG Fellow serves as surgeon general of the Army

**A**COG FELLOW Lieutenant General Kevin C. Kiley, MD, was named the new surgeon general of the Army and promoted to a three-star general last fall.

Formerly the commanding general of Walter Reed Army Medical Center and the North Atlantic Regional Medical Command in Washington, DC, LTG Kiley now commands all Army hospitals, dental clinics, and veterinary facilities in the US and Europe, as well as the US Army Medical Research and Material Command, Fort Detrick, MD, and the AMEDD Center and School at Fort Sam Houston, San Antonio.

As the senior ranking medical person in

the Army, he oversees all of the health care for the Army and advises the chief of staff of the Army and the secretary of the Army on medical matters, including ongoing operations in Iraq.

"This is a tremendous honor and responsibility for me, particularly in light of our ongoing global war on terrorism and the rapidly changing landscape of modern American medicine," LTG Kiley said.

LTG Kiley is the former chair of the Armed Forces District and current chair of ACOG's Committee on Finance. Last year, he received the Outstanding District Service Award. ♀

# Military ob-gyns prove versatility

► PAGE 1 with an attached OR suite,” Dr. Rose explained in a phone call from Baghdad. “But we happen to be in an 85-bed hospital that Saddam Hussein had built for himself and other elite members of the Baathist party.”

Trauma patients—from 1 to 15 at a time—are brought to the hospital by ground ambulance or helicopter. The patients are US military and coalition forces, some Iraqi civilians, and even wounded insurgents.

Most of Dr. Rose’s patients were men—only about 20,000 of the approximately 150,000 soldiers in Iraq are women.

Urogynecologist Jerome L. Buller, MD, an Army major, also served as a trauma surgeon in Iraq. During his final month of deployment, Dr. Buller was one of two physicians on a Forward Surgical Team, a medical unit that moves with the infantry into combat. His FST moved just south of Baghdad to an area called “the death triangle,” where the team did everything from orthopedics to general surgery.

Dr. Buller returned to the US in May 2004 to resume his duties as director of the Division of Female Pelvic Medicine and Reconstructive Surgery at Walter Reed. He had been deployed for nine months, mostly with a reserve unit that provided care to combat support units at Camp Doha, Kuwait.

## Heat, stress, poor hygiene

Because combat support units have many women and Dr. Buller was the only ob-gyn available to provide the full spectrum of rou-

tine and emergency gynecology, he stayed very busy. The most common cases concerned vaginal discharge, irregular bleeding, pregnancy, pelvic pain, and the need for Pap tests.

Dr. Buller said many women had gynecologic problems resulting from a combination of relatively poor hygiene in some outlying camps, extremely high temperatures (120-130°), and increased stress. Many of the women were transportation specialists who were in convoys that were getting shot at or ambushed on a regular basis, he said.

Army Captain Laura Lee Joiner, MD, was also attached to the 31st Combat Support Hospital where Dr. Rose worked. Based mostly in the outpatient clinic, Dr. Joiner’s first priority was caring for women, but she sometimes treated men as well.

“We see all sorts of patients, mostly military, but also Department of Defense contractors, and occasionally Iraqi civilians. I also serve as back-up surgeon and have done several appendectomies and minor treatments like washouts from gunshot wounds.”

## Leaving family behind

Dr. Joiner’s Iraq assignment came suddenly after residency. She had just started practice at Reynolds Army Community Hospital at Ft. Sill, OK, when she learned she was to be deployed to Iraq. In two weeks she was on her way, leaving her 10-month-old son and 2-year-old daughter behind with her husband.



ACOG Fellows Army Captain Laura Lee Joiner, MD, and Lieutenant Colonel G. Scott Rose, MD, with Major Bridget Brandt, a certified nurse midwife, at a hospital in Baghdad

“I miss my family terribly,” Dr. Joiner said. “My son learned to walk the week after I left. My daughter has learned to count, say the alphabet, her colors—so many things I have missed.”

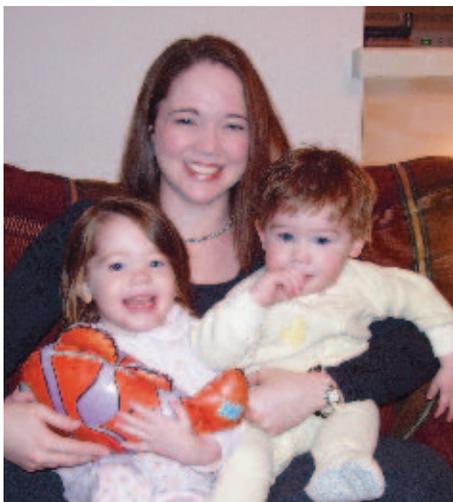
Her husband, Brad, a history teacher turned stay-at-home dad during her final year of residency, continued in that role until Dr. Joiner returned home in January.

## Committed to service

All of the ob-gyns expressed their commitment to service.

“I honestly feel as though I am doing the most important thing I have ever done, or will ever do—save for the birth of my children—especially if we can get things turned around in the Middle East for the sake of the people and especially the women,” Dr. Joiner said.

“The chance to take care of these young soldiers is truly an honor,” Dr. Rose said. “Every military physician will tell you that. These soldiers are some of the most patriotic young men and women you’ll ever meet. Everyone misses their family, but that’s just part of being in the military.” ♀



Dr. Joiner with her two children, Allison, now 2½, and Brad Jr, now 18 months old, at home in January

## Iraq-US email discussion group started

ACOG’s Tennessee Section has established an Internet discussion group between physicians in Iraqi Kurdistan and the US. The project follows up on a three-week visit by ACOG Fellow Martin E. Olsen, MD, to Iraqi Kurdistan in 2004. Dr. Olsen made the trip as part of an East Tennessee University program to help develop a medical school system in the region.

The discussion group gives Iraq physicians the opportunity to discuss patient management and other issues with US physicians.

Questions and responses are sent to a group email address and automatically forwarded to

all individuals who have joined the group.

### To join the discussion group:

1. Visit [http://health.groups.yahoo.com/group/Iraq\\_TN\\_Womens\\_Health](http://health.groups.yahoo.com/group/Iraq_TN_Womens_Health)
2. Sign up for a Yahoo account (if you don’t already have one)
3. Click on the “join this group” button
4. Complete the group membership form
5. Once your application is verified, you will receive a confirmation message and you may join the discussion

## US ob-gyns helping to create residency program in Kabul

**A**S PART OF THE EFFORT to reconstruct Afghanistan's medical infrastructure, nine ACOG Fellows have gone to Afghanistan since 2003 to work at Rabia Balkhi Hospital, one of four women's hospitals in Kabul. Each ob-gyn works at Rabia Balkhi for at least three months, as part of a project to train female Afghan ob-gyns, nurses, midwives, and hospital staff.

Launched in November 2002, the program is run by the nongovernmental organization International Medical Corps and funded by the US Department of Health and Human Services.

The program began under the leadership of Fellow William H.J. Haffner, MD, immediate past chair of ACOG's Committee on Health Care for Underserved Women, and was continued by ACOG president-elect nominee Douglas W. Laube, MD, MEd. Dr. Laube developed the initial curriculum outline after a site visit to Kabul in 2003, in anticipation of developing a more formal US-style residency program.

ACOG Fellow Jeanette E. Akhter, MD, immediate past chair of ACOG's Maryland Section, worked at the hospital from Novem-

**Dr. Jeanette E. Akhter during a forceps training session at Rabia Balkhi Hospital in Kabul, Afghanistan. Dr. Akhter is in the middle with the blue scarf.**

**Dr. John J. Ryan with ob-gyn residents in Afghanistan**

ber 2004 through January 2005. Dr. Akhter described the complexity of the project: "In addition to training residents and establishing a four-year curriculum, we train other hospital personnel—nurses, midwives, OR staff, administrators, equipment handlers, and so on. And support services need to be set up for a residency—lab, X-ray, sonogram, medical records, cleaning services, etc. Definitely, it's all about teamwork."

### Saving mothers' lives

In 2002 Afghanistan's nationwide maternal mortality rate was 1,600 out of every 100,000 live births, according to the Centers for Disease Control and Prevention. The IMC reports that for deliveries at Rabia Balkhi Hospital, the maternal mortality was about 600 per 100,000 when the US project began. The ma-



**An ob-gyn resident checks out a textbook in the new hospital library.**

ternal mortality rate at the hospital has now dropped to about 200 per 100,000, and some months have had no maternal deaths.

"On average there are 35–50 deliveries a day," Dr. Akhter said. "About 70% of the deliveries are normal, and the woman goes home in a few hours. Women who have had a cesarean delivery, about 10%, stay at the hospital a week."

### Establishing a medical library

California Fellow John J. Ryan, MD, worked at Rabia Balkhi Hospital for six months beginning in August 2004. Working with two US librarians, he created a medical library at the hospital after noticing that medical books and journals were kept locked up because hoarding and theft were common.

"It's good to see residents and the staff carrying books now," he said.

Dr. Ryan summed up the Kabul project: "Progress has been made, thanks to the help of volunteer ACOG physicians, midwives, nurses, and IMC staff, who have taught and helped the Afghanistan residents to join the modern age. Very many countries, large and small, have been contributing to Afghanistan. It is truly a world effort." ♀

### info

- International Medical Corps is seeking ob-gyns to volunteer at Rabia Balkhi Hospital for a minimum of six months. For more information, contact Theresa Phung at 310-828-7800 or [tphung@imcworldwide.org](mailto:tphung@imcworldwide.org)
- For donations to IMC, contact Margaret Owing at the number above
- [www.imcworldwide.org](http://www.imcworldwide.org)

## YOU ASKED, WE ANSWERED

# Defining a physician-patient relationship

**Q** **WHAT CONSTITUTES** the beginning of a physician-patient relationship? Is it the act of scheduling a patient for an appointment in my office, or does the relationship begin when the patient actually appears for her first appointment? At what point is a doctor obligated to see the patient in the emergency room or on labor and delivery if there has been no prior contact?

**A** **DETERMINING WHETHER** a physician-patient relationship exists can be difficult. As a general rule, direct contact with a patient is required by most courts to establish a physician-patient relationship. However, there are numerous exceptions.

At one time, the existence of a physician-patient relationship was an essential prerequisite to whether a physician might be held legally liable for a patient injury or a bad outcome. Thus, a good deal of emphasis was placed on the character of the physician-patient relationship and various indications of its existence.

Today, however, a more useful question is whether the relationship, however great or small, between physician and patient is one

that creates a duty by the physician to exercise his or her professional skills on behalf of the patient. If such a relationship exists and the duty arises, a court will most likely find the existence of a physician-patient relationship.

There are many circumstances in which relationships between physicians and patients may be established without face-to-face contact. For example, providing advice over the telephone or through email can mark the establishment of the physician-patient relationship.

### Provider contracts may govern

In some circumstances—for example, if the patient is a member of a managed care plan or a capitated patient list—the physician-patient relationship might begin when the patient makes her appointment for examination.

In addition, some courts have found that the physician-patient relationship is established when a third party obtains medical care on behalf of a patient, such as when a physician makes an appointment on behalf of a patient or gives advice to a patient through another physician or health care professional.

Hospital-employed physicians, resident

physicians, independent contractor physicians, and even those physicians required by a hospital's bylaws to provide emergency room or labor and delivery coverage are contractually obligated to respond to a patient admitted to their hospital.

In general, a physician is not obligated to treat every individual who presents for care, and he or she has the option of refusing to treat a prospective patient if the following apply:

- ▶ There has been no prior contact of any type with the patient
- ▶ There is no institutional or other contractual obligation in force
- ▶ There is no statutory requirement
- ▶ The patient's life is not in immediate jeopardy ♀

### info

→ [liability@acog.org](mailto:liability@acog.org)

*The information in this article should not be construed as legal advice. As always, physicians should consult their personal attorneys about legal requirements in their jurisdiction and for legal advice on a particular matter.*

# HIPAA security deadline nears

**T**WO IMPORTANT HIPAA DATES are fast approaching. By April, health care providers must be in compliance with the HIPAA Security Rule, which governs the security of patients' electronic health information.

Required safeguards include the development of clearance procedures, implementation of automatic log-off processes, and installation of encryption technology and firewalls. While many ob-gyn practices may have security procedures already in place, such procedures must be in writing.

ACOG members can download a free guide to complying with the security rule

on the College website (see info below). The guide offers step-by-step approaches to help physicians and practice managers understand the regulations and make the changes that are required. It also includes electronic versions of policies and forms that can be customized for individual practices.

### Begin applying for the National Provider Identifier in May

Another important upcoming HIPAA date that practices need to prepare for is May 23. At that time, health care providers can begin applying for the National Provider Identifier as the standard unique health identifier to use

when filing and processing health care claims and other transactions.

All HIPAA-covered entities must use NPIs by the compliance dates: May 23, 2007, for all but small health plans and May 23, 2008, for small health plans. ♀

### info

→ ACOG's *HIPAA Security Rule Manual: A How-To Guide for Your Medical Practice* is available free to ACOG members at [www.acog.org/departments/practice/securitymanual.doc](http://www.acog.org/departments/practice/securitymanual.doc)

→ Order ACOG's *HIPAA Privacy Manual*, second edition (AA411), at <http://sales.acog.org> or 800-762-2264, ext 192

→ More HIPAA materials: click on "HIPAA" under the "Practice Management" link on the ACOG website, [www.acog.org](http://www.acog.org)

# EC use doesn't lead to more unsafe sex

► PAGE 1 The FDA was expected to rule on the application by January 21 but delayed its decision, informing Barr that it was unable to complete its review by the deadline but was committed to completing it in the near future.

## Better EC access, higher use

In the JAMA study, researchers conducted a randomized, single-blind, controlled trial of 2,117 women ages 15 to 24 who visited four family planning clinics in the San Francisco area.

The women were divided into three groups:

- One group was given three packets of EC
- One group was given instructions on how to get EC directly from a pharmacy without a prescription. (California is one of six states that allows women to obtain EC from a pharmacist without a prescription.)
- The control group was given instructions to return to the clinic to obtain EC if needed

The study found no significant dif-

ferences in the amount of unprotected sex among the three groups. In addition, there was no difference in the frequency of sex or the number of partners among the three groups.

According to the study, the requirement to ask a pharmacist or clinic for EC appeared to be a barrier to women using EC. The women who were given advance access to EC were much more likely to use it, at 37%, than were women who had to go to a clinic to get it, at 21%.

ACOG, through its "Every Woman, Every Visit" campaign, continues to urge ob-gyns to provide advance prescriptions for EC to all reproductive-age women at every office visit. The College also continues to work with the media to remind women to ask their ob-gyns for advance prescriptions.

## Government guidelines ignore EC

In related news, ACOG joined more than 200 organizations in January in sending a letter to the Department of Justice after it made no mention of EC in a new national protocol for treating sexual assault victims.

The groups urged the DOJ to include the routine offering of emergency contraception to women who are at risk of pregnancy from rape. According to the letter, the 130-page protocol, which provides step-by-step medical treatment guidelines for sexual assault patients, includes only one vague sentence on pregnancy prevention: "Discuss treatment options with patients, including reproductive health services."

"The failure to include a specific discussion about emergency contraception in the first national protocol for sexual assault treatment is a glaring omission in an otherwise thorough document," the letter stated. "Including counseling about pregnancy prevention and the provision of emergency contraception would help rape victims prevent the trauma of unintended pregnancies, avoid abortions, and safeguard their reproductive and mental health." ♀

## info

→ *Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs*, JAMA, Jan 5, 2005: <http://jama.ama-assn.org>



# ACOG Grievance Committee reports on actions

**W**ILLIAM P. DILLON, MD, chair of ACOG's Grievance Committee, provides this report to the Fellowship in accordance with the College complaint process. Under ACOG's Code of Professional Ethics, a Fellow can be issued a warning, censured, suspended, or expelled from the College for unethical behavior.

To determine whether a Fellow has engaged in a violation of the ACOG Bylaws or Code of Professional Ethics, the Grievance Committee reviews complaints submitted by ACOG Fellows and reviews severe disciplinary actions taken by state medical boards.

The procedures for handling these complaints require that all voting Fellows be notified annually, by personal and confidential letter, of the names of the Fellows terminated and

the reasons for termination. A summary of all other disciplinary actions, without names, is also provided. However, the Executive Board revised the grievance process in July 2004, expanding the notification process to require that Fellows also be notified of the names of Fellows who had received suspensions and censures. This change took effect with the complaints submitted to the Grievance Committee at its October 2004 meeting and will be reflected in the 2006 annual report to Fellows.

## Executive Board final actions

One Fellow was expelled from the College. The Executive Board took this action based on the permanent limitations of the Fellow's medical license, precluding the Fellow from the practice of medicine in that state. As re-

quired, the College reported this expulsion to the National Practitioner Data Bank.

The College censured two ACOG Fellows based on Fellow complaints. The College also censured one Life Fellow based on the revocation of the Fellow's state medical board license.

## Grievance Committee activities

The Grievance Committee reviewed 19 complaints and conducted 10 hearings in 2004. Of the 10 hearings, eight were complaints from 2003 and two were from 2004. The Grievance Committee continues to schedule hearings for 2005. ♀

## info

→ Questions about the complaint process of ACOG's Code of Professional Ethics? Contact the Office of the General Counsel at 202-863-2584 or [grievance@acog.org](mailto:grievance@acog.org)

# 2005 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

2-5

## CREOG and APGO Annual Meeting

Salt Lake City  
CREOG: 800-673-8444, ext 2558  
APGO: 410-451-9560

13-15

## ACOG Congressional Leadership Conference (formerly Legislative Workshop)

Washington, DC  
800-673-8444, ext 2505

18-19

## Council of Medical Specialty Societies Spring Meeting

Chicago  
847-295-3456

## APRIL

2-5

## JSOG: Congress of the Japan Society of Ob-Gyn

Kyoto, Japan  
<http://jsog.umin.ac.jp/IS/ISindex.htm>

5

## ACOG WEBCAST: Physician Employment Contracts

1-2:30 pm ET  
800-673-8444, ext 2498

6-10

## Sixth International Symposium on Osteoporosis

Sponsored by the National Osteoporosis Foundation  
Washington, DC  
[www.nof.org](http://www.nof.org)  
202-223-2226

7-10

## SSTAR Annual Meeting: Society for Sex Therapy and Research

Boston  
202-863-1644

## MAY

3

## ACOG WEBCAST: CPT Modifiers and the Global Surgical Package

1-2:30 pm ET  
800-673-8444, ext 2498

7-11

## ACOG Annual Clinical Meeting

San Francisco  
[www.acog.org/acm2005](http://www.acog.org/acm2005)

18-19

## Expecting Something Better: A Conference to Optimize Maternal Health Care

Sponsored by the Jacobs Institute of Women's Health  
Washington, DC  
[www.jiwh.org](http://www.jiwh.org)  
202-863-4990

## JUNE

7

## ACOG WEBCAST: Consent Issues—Informed Consent, Forms, and Informed Refusal

1-2:30 pm ET  
800-673-8444, ext 2498

15-18

## WAGO Annual Meeting: Western Association of Gynecologic Oncologists

Santa Fe, NM  
202-863-1648

19-21

## AIUM: Amer Institute of Ultrasound in Medicine

Orlando, FL  
301-498-4100 or  
800-638-5352  
[www.aium.org](http://www.aium.org)

## JULY

5

## ACOG WEBCAST: CPT Rules for Documenting Evaluation and Management Services

1-2:30 pm ET  
800-673-8444, ext 2498

## AUGUST

2

## ACOG WEBCAST: Medicare Rules for Documenting Evaluation and Management Services

1-2:30 pm ET  
800-673-8444, ext 2498

18-20

## IDSOG Annual Meeting: Infectious Diseases Society for Ob-Gyn

Charleston, SC  
202-863-2570

## SEPTEMBER

6

## ACOG WEBCAST: How to Survive an Audit

1-2:30 pm ET  
800-673-8444, ext 2498

27-30

## Royal College of Obstetricians and Gynaecologists 6th International Scientific Meeting

Cairo, Egypt  
[pioneerevents@yahoo.com](mailto:pioneerevents@yahoo.com)  
[www.rcog2005.com](http://www.rcog2005.com)

28-Oct 1

## NAMS: N American Menopause Society

San Diego  
[www.menopause.org](http://www.menopause.org)  
440-442-7550

29-Oct 1

## AGOS/AAOGF Annual Meeting: American Gyn-Ob Society and American Association of Ob-Gyns Foundation

Victoria, BC, Canada  
202-863-1648

## ACOG POSTGRADUATE COURSES

Two ways to register:

1. Call 800-673-8444, ext 2540/2541, or 202-863-2540/2541, weekdays 9 am-4:45 pm ET
  2. Go to [www.acog.org](http://www.acog.org) and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
- Registration must be received one week before the course. Onsite registration subject to availability.

## MARCH

3-5

## Practical Ob-Gyn Ultrasound: Spotlight on Chronic Pelvic Pain

Amelia Island, FL

11-13

## CPT and ICD-9-CM Coding Workshop

New York City

**SOLD OUT**

## APRIL

1-3

## CPT and ICD-9-CM Coding Workshop

Dallas

**SOLD OUT**

7-9

## Quality Improvement and Management Skills in Women's Health Care

Washington, DC

## MAY

12-14

## CPT and ICD-9-CM Coding Workshop

San Francisco

**SOLD OUT**

## JUNE

4-5

## No Frills—Controversies in Menopause

Washington, DC

16-18

## Office Procedures for the Clinician

Uncasville, CT

24-26

## CPT and ICD-9-CM Coding Workshop

Chicago

**SOLD OUT**

## JULY

8-10

## CPT and ICD-9-CM Coding Workshop

Indianapolis

## JULY

15-17

## CPT and ICD-9-CM Coding Workshop

Seattle

## AUGUST

5-7

## CPT and ICD-9-CM Coding Workshop

Dearborn, MI

## SEPTEMBER

6-8

## Special Problems for the Advanced Gynecologic Surgeon

Dana Point, CA

9-11

## Screening in Ob-Gyn

Dana Point, CA

16-18

## CPT and ICD-9-CM Coding Workshop

Atlanta

23-25

## CPT and ICD-9-CM Coding Workshop

Memphis, TN

## OCTOBER

7-9

## CPT and ICD-9-CM Coding Workshop

Las Vegas

## NOVEMBER

12-13

## No Frills—Operative Hysterectomy

Rosemont, IL

18-20

## CPT and ICD-9-CM Coding Workshop

Washington, DC

# Sections, districts seek officer nominations: June 1 deadline

**D**URING MARCH OR APRIL all Fellows eligible to vote in a section or district holding elections for the 2006 rotation will receive notice to nominate officers. Nominations must include a letter stating the office or offices being sought and a one-page summary of the individual's CV. Nominations are due June 1.

During the summer, all voting Fellows will receive a list of the individuals who were nominated by the June 1 deadline, along with the roster of the nominating committee and the date when the committee will meet. ACOG encourages Fellows to contact members of the nominating committee to offer comments about the candidates.

## Nominating committees determine slate of candidates

For section elections, the section nominating committee will meet before the Annual District Meeting and will name a slate of at least one candidate, but no more than two, for each office. The committee will not accept floor nominations but will choose candidates from the list mailed to all members during the summer.

For district elections, the same rules apply, but the committee meeting will occur either at the Annual District Meeting or within 30 days following it.

The slate adopted by the nominating committee will be sent to all Fellows for both district and section elections by the end of the

year. The results will be announced to candidates and District Advisory Councils on April 1, 2006, and publicly at ACOG's Annual Business Meeting in May 2006. ♀

### info

- Megan Willis: 800-782-1828
- Click on "District and Section Activities" under "Membership" at [www.acog.org](http://www.acog.org)

Timeline for election of district and section officers	
<b>MARCH 1</b>	Nominating committees formed with sections and districts
<b>MARCH-APRIL</b>	Voting Fellows invited to submit nominations
<b>JUNE 1</b>	Nominations for section and district officers due
<b>30 DAYS BEFORE ADM</b>	Voting Fellows receive list of candidates for office, roster of nominating committee members, and date the nominating committee will meet
<b>NOVEMBER</b>	Nominating committees select slates of candidates
<b>DECEMBER 30</b>	District/Section ballots to all voting Fellows
<b>FEBRUARY 1, 2006</b>	Section officer ballots due
<b>MARCH 1, 2006</b>	District officer ballots due
<b>ACOG ANNUAL BUSINESS MEETING (SPRING)</b>	Election results announced
<b>FOLLOWING ADM (FALL)</b>	New officers begin term

## OFFICER TERMS

Because all officers serve three years, to avoid having all College officers change at the same time, sections and districts hold elections on a three-year rotation. The following districts and sections will begin the new election process in 2005, with terms beginning after their Annual District Meeting in 2006.

### DISTRICTS

DISTRICT I  
DISTRICT IV  
DISTRICT VII

### SECTIONS (DISTRICT)

ARKANSAS (VII)  
ARMY (AFD)  
BRITISH COLUMBIA (VIII)  
CALIFORNIA SECTION 2 (IX)  
CALIFORNIA SECTION 3 (IX)  
CALIFORNIA SECTION 6 (IX)  
COLORADO (VIII)  
CONNECTICUT (I)  
GEORGIA (IV)  
HAWAII (VIII)  
INDIANA (V)  
IOWA (VI)  
MANITOBA (VI)  
MISSISSIPPI (VII)  
NEW HAMPSHIRE (I)  
NEW JERSEY (III)  
NEW MEXICO (VIII)  
NEW YORK SECTION 1 (II)  
NEW YORK SECTION 4 (II)  
NEW YORK SECTION 7 (II)  
NORTH DAKOTA (VI)  
ONTARIO (V)  
OREGON (VIII)  
PUERTO RICO (IV)  
TENNESSEE (VII)  
VIRGINIA (IV)



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