THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

ACOG TODAY

MARCH 2011

WORKFORCE CHANGES

CLOSING THE GAP

Medical liability a chronic crisis

Richard N. Waldman, MD, President

President Obama's federal 2012 budget includes $250 million in grants over the next three years to fund state efforts to overhaul medical liability laws. This proposal authorizes the US Department of Justice, in consultation with the Department of Health and Human Services, to award grants to states for implementing innovative reform measures such as health courts, "safe harbor" laws, and early disclosure and compensation programs.

ACOG has long endorsed measures to make health care safer for patients while also protecting access to the physicians who care for them. The president's proposal is an important step in the right direction toward fostering a reliable system of medical justice and enacting common sense reforms that protect patients, halt lawsuit abuse, and keep doctors in practice. The medical liability situation for ob-gyns remains a chronic crisis and continues to deprive women of all ages—especially pregnant women—of experienced ob-gyns.

Women's health care suffers as ob-gyns further decrease obstetric services, reduce gynecologic procedures, and are forced to practice defensive medicine. According to an ACOG survey, 90% of ob-gyns have been sued at least once during their professional careers. Currently, the average age at which physicians cease practicing obstetrics is 48, an age once considered the midpoint of an ob-gyn's career. More than 63% of ob-gyns have changed their practices due to the risk or fear of liability claims or litigation, and one in 12 obstetricians who have changed their practice has stopped delivering babies.

ACOG is fully committed to the enactment of a national law patterned on the HEALTH Act, HR 5, and the Texas and California medical liability reforms. While ACOG works to attain this goal, we support interim measures and alternatives that address the long delays, excessive costs, and the unpredictability and inequality of compensation in our current system. Successful alternatives could help guarantee that injured patients are compensated fairly and quickly while promoting quality of care and patient safety. One alternative highlighted in President Obama's budget is health care courts. These special courts would take injury claims out of the adversarial tort system, where facts are often poorly understood, and put them into the hands of experts whose goals are fairness and patient safety. Other promising alternatives include early offer systems and expert witness qualification programs.

Without reform of America's broken liability system, women will increasingly find they cannot get the prenatal and obstetric care they need, and many pregnant women will not be able to find doctors to deliver their babies. Women deserve better.

ACOG TODAY
MARCH 2011 VOLUME 55, ISSUE 2

Find this issue online at
www.acog.org/goto/acogToday

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ACOG Today's mission is to keep members apprised of activities of both The American Congress of Obstetricians and Gynecologists and The American College of Obstetricians and Gynecologists.

COVER: ISTOCKPHOTO

<39 WEEKS TOOLKIT

To support hospitals in eliminating non-medically indicated deliveries before 39 weeks, the March of Dimes, California Maternal Quality of Care Collaborative, and California Department of Health have collaborated to develop a toolkit. This resource is meant to guide providers, obstetricians, clinical staff, and hospitals across the nation in eliminating non-medically indicated deliveries before 39 weeks gestation. Hospital partners in New York, California, Florida, Illinois, and Texas are piloting the toolkit program. With support from the March of Dimes, ACOG District IX, through its Patient Safety and Quality Improvement Committee, has also trained a speakers' bureau to offer training and ongoing mentorship to California hospitals wishing to implement a program to eliminate non-medically indicated deliveries before 39 weeks.

The robust toolkit, available at no cost, provides all the tools a clinician might need to implement the initiative in his or her hospital. Find the toolkit online at: http://ca.acog.org

Electronic voting and board changes

Ralph W. Hale, MD,
Executive Vice President

Each year ACOG elects new officers to our Executive Board, and 2011 is no exception. This year, however, we have discontinued the use of paper ballots and we are conducting our national election electronically from March 7–April 27. ACOG has conducted electronic elections for Junior Fellow and District Fellow officers for several years. Those experiences indicate we will increase involvement in the national election process.Watch for a notice on how to vote electronically.

Electronic voting is just one new advance our Executive Board has made. The Board continually reviews its governance structure. When The Congress became operational, we decided the transition presented an opportune time to consider other changes. For the past few years, our Board has consisted of officers, district chairs, subspecialty representatives, young Fellows, the Junior Fellow chair, and a public member. Recently the Board voted to create two new positions to be called "Fellows-at-Large." For the 2012-13 election cycle, which begins this year, one new Fellow-at-Large will be added. The other Fellow-at-Large will be added in the 2013-14 cycle. This will allow for staggered terms. These positions were created to increase access to the governance process by a broader spectrum of individuals. Any Fellow of the Congress who has been a Fellow for more than eight years is eligible to serve.

The Board renamed the current two Fellow-at-Large positions "Young Physicians-at-Large" and added a third Young Physician-at-Large. Candidates for these positions must have been a Fellow for eight years or less.

Nominations for the eligible Board positions will be accepted until April 1, 2011. A letter with specific information on the nominations process was sent to Fellows in February. For nominations information, visit www.acog.org and view National Officer Nominations Process under Membership.

These new opportunities and processes are examples of how ACOG continues to evolve as we address today's changing medical, economic, and political environments.

Ralph W. Hale MD

inside

DID YOU KNOW?

Colorectal cancer is the third leading cause of cancer death among US women. More than 70,000 women are diagnosed with it each year. Research shows that regular screening saves lives, but an estimated 45% of the target population forgo screening.

READ MORE ON PAGE 5

JUNIOR FELLOW NEWS

2010-2011 Junior Fellow Congress Advisory Council members met in January in Washington, DC.

Junior Fellow leaders gather for orientation

Newly-elected Junior Fellow officers reviewed the services, programs, and educational benefits for ACOG members at the Junior Fellow orientation at ACOG National Headquarters in Washington, DC, in January. The meeting provided a forum for the officers to exchange ideas with other Junior Fellow district officers and ACOG staff. Ralph W. Hale, MD, ACOG's executive vice president, presented an overview of ACOG's structure and history. Hal C. Lawrence, III, MD, vice president of practice activities, Albert L. Strunk, MD, JD, deputy executive vice president and vice president of fellowship activities, and other ACOG staff updated the group on activities of each division and the services they offer. JFCAC Vice Chair Ravi P. Gada, MD, explained officer duties in detail, and JFCAC officers met with their district managers.

Cynthia A. Brincat, MD, PhD, JFCAC chair, Luke A. Newton, MD, District XI Junior Fellow chair, Jessica A. Shepherd, MD, District V Junior Fellow chair, and Diane Horvath-Cosper, MD, District VI Junior Fellow chair, discussed plans for the JFCAC meeting on April 30 at the ACM.

Junior Fellow ACM Course: *Transitioning from residency to practice*

BE THERE!
MAY 2, 12:45–5 PM

The 2011 Junior Fellow ACM course on Monday, May 2, will offer insights from a variety of experts. "This year's program is really star-studded, and it offers something for every Junior Fellow. Come join us, everyone!" said Cynthia A. Brincat, MD, PhD, chair of the Junior Fellow Congress Advisory Council (JFCAC).

The program will take place from 12:30–5 pm and will feature presentations by Victoria L. Green, MD, JD, MBA, on medical liability, Patrice M. Weiss, MD, on handling adverse outcomes, Scott D. Hayworth, MD, on the business of medicine, and Dee E. Fenner, MD, on finding the right job. A special roundtable discussion from 4–5 pm will focus on the ob-gyn generalist and the "ABCs" of our specialty. "Plus, there will be ample opportunity for networking with medical students during the break and the evening reception afterward," noted Dr. Brincat.

To learn more about the ACM, visit www.acog.org/acm or call 800-686-7295.

Inspire us

Junior Fellows, submit your entry to the Junior Fellow Essay Contest before June 1. The topic is *Inspirations and Lessons Learned From My Patients*. Visit www.acog.org and click on Junior Fellows for entry instructions. The winning essay will be published in the Green Journal.

International opportunities

Junior Fellows continue to be committed to international involvement. JFCAC members will host a booth at the ACM Medical Student Ob-Gyn Residency Fair highlighting international opportunities in ob-gyn at the Renaissance Washington Downtown Hotel on May 3 from 1–4 pm. JFCAC leadership has also been invited to participate in the Annual European Network of Trainees of Obstetrics and Gynaecology in May in London.

Jeannine W. Miranne, MD, District I Junior Fellow chair, Rebecca I. Epstein, MD, District V Junior Fellow vice chair, and Jill M. Krapf, MD, District IV Junior Fellow vice chair, caught up during a break.

Women have options for colorectal cancer screenings

Although colonoscopy is the preferred method of screening for colorectal cancer, physicians should discuss all screening options with their patients, according to a new Committee Opinion released by The College. Women should be screened using the method that they are most comfortable with and most likely to complete.

Colorectal cancer is the third leading cause of cancer death—after lung cancer and breast cancer—among women in the US. More than 70,000 women are diagnosed with colon cancer each year. Screening exams for colorectal cancer reduce mortality by detecting precancerous growths and cancers at an early stage when they are most treatable. Research has shown that regular screening saves lives, yet an estimated 45% of the target population forgo screening.

"Many women have anxiety about colorectal cancer screenings. They fear that the advance prep will be miserable and that the test itself will be uncomfortable. Some women also underestimate their risk and assume that they can put off testing until a later time," said Cheryl B. Iglesia, MD, chair of The College's Committee on Gynecologic Practice. "But even though colon cancer is relatively slow-growing, time is of the essence and the sooner that abnormalities are detected, the better."

All women should be screened regularly for colon cancer beginning at age 50, or earlier for African-American women and those at high risk. Women at increased risk include those who have a first-degree relative younger than age 60 or two or more first-degree relatives of any age with colorectal cancer or polyps; had colorectal cancer or polyps themselves; had bowel disease, such as chronic ulcerative colitis, inflammatory bowel disease, or Crohn's disease; or a family history of certain types of colon problems or colon cancer.

"It's important that ob-gyns be familiar with the various forms of screening exams for colon cancer," Dr. Iglesia said. The new Committee Opinion reviews five common screening tests and two newer tests that are currently available. "No one screening method will work for every woman, so we must lay out the options for patients, help them understand the benefits and drawbacks of each, and let them select the test that best suits them," Dr. Iglesia added.

According to the Committee Opinion, tests that detect both polyps and early colorectal cancer should be encouraged, but all methods described in the document are suitable for cancer screening.

Tests that detect polyps and cancer

The College recommends colonoscopy as the preferred method of colorectal cancer screening. Colonoscopy allows for the visualization of the whole colon, including the right side of the colon—an area where 65% of advanced cancers are found and that other screening exams can miss.

Colonoscopy, recommended every 10 years, carries a higher risk of serious complications, such as perforation, hemorrhage, and severe abdominal pain, than other methods. Some women may find colonoscopy to be more inconvenient because it requires advanced bowel preparation, a missed day at work, and chaperoned transportation following the procedure because of sedation. But having a colonoscopy to start may save time in the long run. According to Dr. Iglesia, "positive test results from one of the other invasive or non-invasive exams almost always necessitate a follow-up diagnostic colonoscopy. A patient may wind up having two tests at the end of the day."

Flexible sigmoidoscopy can also detect certain types of polyps found in the rectum that may signal a higher risk of cancer in other parts of the colon. Flexible sigmoidoscopy is limited to the lowest part of the colon and may miss a significant number of right-sided lesions, particularly in women and African Americans. Colonoscopy is usually required if test results come back positive. This screening is recommended every five years.

In a double contrast barium enema, the entire colon is stained using a contrast dye enema, and then x-rayed. If polyps of more than 6 mm are discovered, a follow-up colonoscopy will be recommended. This procedure requires a complete bowel prep.

Virtual colonoscopy is an emerging, non-invasive technique that is currently being evaluated as an additional option for colorectal cancer screening. The exam uses computed tomography imaging to detect polyps and cancerous lesions. It can drastically reduce the risk of perforation, but if polyps are found, a standard colonoscopy is needed. Access to this newer test may be limited.

Colonoscopy allows for the visualization of the whole colon, including the right side of the colon—an area where 65% of advanced cancers are found and that other screening exams can miss.

Tests that detect cancer only

Guaiac fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) are non-invasive tests that detect hidden blood in the stool caused by large polyps (greater than 1 cm) or cancer. For both tests, patients collect stool samples at home for several days. Samples are sent to a lab to be checked for hidden blood. Research suggests that gFOBT and FIT testing lead to detection of cancer at an early and more curable stage. These screenings must be performed annually. A follow-up colonoscopy will be recommended if the test comes back positive.

Fecal DNA testing is a newer, still-evolving screening exam that detects genetic mutations in the stool associated with colorectal cancer. A single, home-collected stool sample is required for this screening test. A recent study found fecal DNA testing to be more effective in detecting hidden blood than FOBT testing.

Committee Opinion #482, *Colonoscopy and Colorectal Cancer Screening Strategies*, is published in the March 2011 issue of the Green Journal.

OB-GYN WORKFO

The ob-gyn workforce is undergoing fundamental changes that have important implications for future practice. Population trends, medical education, physician preferences, and practice patterns are all contributing to workforce changes. How might these changes affect your practice?

Workforce shortages growing

The gap between the supply of ob-gyns and the demand for women's health care services is believed to be widening, with one report projecting a shortage of 9,000–14,000 ob-gyns in 20 years. Beyond 2030, a shortfall may be even larger, as the US population of women is projected to grow 36% between 2010 and 2050, but the number of ob-gyns will likely remain constant.

"Obtaining and monitoring data about the workforce is critical for us to address the relevant issues," said William F. Rayburn, MD, MBA, Randolph V. Seligman Professor and Chair in the Department of Ob-Gyn, University of New Mexico Health Sciences Center and School of Medicine, and consultant to ACOG on workforce studies and planning. "We need data on workforce trends and dynamics to help make decisions about practice, training, and health care policy." Dr. Rayburn is the author of *The Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications,* to be released by ACOG this spring.

Echoing the importance of data analysis is Albert L. Strunk, JD, MD, ACOG deputy executive vice president: "We need thoughtful examination of trends. The data underpins everything we do from an advocacy and policy perspective."

Now is a critical time to monitor trends, as more than a third of ACOG Fellows are beyond age 55 and will reach retirement age in the next 10 years. Of those already retired, nearly 60% said they quit practice earlier than they had expected, according to a 2006 survey conducted by the American Association of Medical Colleges in conjunction with ACOG. Rising liability insurance premiums and insufficient reimbursements were cited as the top two reasons for early retirement. Significantly, more than 72% of ob-gyns beyond age 50, whether retired or still in practice, said that the availability of part-time work or more flexible scheduling affected their willingness to continue practice past their expected retirement age.

Practicing ob-gyns are already in short supply. While the population of women in the US has increased 26% since 1980, there has essentially been no net increase in the number of ob-gyns trained. Empirical data also reflect an ob-gyn shortage and point to its effect on practice. Practices often use excessive wait times for patient appointments as a sign that the practice needs another associate. A survey by Merritt, Hawkins and Associates found that the average

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AFFECT PRACTICES, PATIENTS

wait time for an ob-gyn appointment was more than 14 days in 13 of 15 metropolitan areas, and the wait time was more than 21 days in nearly half of the metropolitan areas surveyed.

Recruiting challenges are also among the ways the ob-gyn shortage is felt. Women in small town and rural America face the greatest challenges in having access to ob-gyns. Currently, approximately half of all US counties do not have an ob-gyn, while 17% of US women live in rural America. By 2030, rural areas will have an even greater shortage of ob-gyns, researchers estimate. "Positions in rural and nonmetropolitan areas are really more difficult to fill," said Mary Barber, vice president of Cejka Search, a national search firm. "Physicians usually want to join a group with at least three physicians to share call and deliveries."

The supply side: new ob-gyns

Medical schools have tackled the need for more physicians, so that enrollment is expected to increase 30% by 2015. Existing schools have expanded their class size, and more than two dozen new schools have been started or planned since 2007, according to the American Medical Association.

But residency training, restrained by limits on federal funding, is not keeping pace. "Without sufficient Medicare funding for graduate medical education, certain ob-gyn residency programs are at risk of being overwhelmed with service obligations," Dr. Rayburn noted. He added that ob-gyn residents are especially needed in states where there is a shortage of ob-gyns or where a significant population increase is anticipated.

While the number of residency slots needs to expand, that would be only a partial solution, according to Dr. Strunk. "Even if we were able to increase to 1,300 residency graduates a year [currently about 1,200], we would still be looking at a shortfall of ob-gyns by 2030 or 2035."

A changing profile of ob-gyns

The profile of physicians who will be taking the place of the 15,000 ob-gyns likely to retire in the next 10 years is "way different"—as those younger physicians might say—from the majority currently in practice. For starters, 80% of them—maybe more—will be women. That is the current percentage of women ob-gyn residents.

Another big change, as shown by survey after survey of physicians in training, is their expectation of greater work-life balance. Two-career marriages are now the norm. "That's a major driver for needing more time for home and child care responsibilities," Dr. Rayburn commented. Young physicians plan to work fewer hours, and they want flexibility in practice, including the option for part-time practice and combining academic interests with private practice.

Addressing the shortage

ACOG and workforce researchers offer a number of strategies for diminishing the shortfall of ob-gyns or alleviating its negative effects:

Number of ob-gyn residents: Encourage more medical students to pursue careers in women's health, through mentoring or offering a clerkship in your practice. Encourage your members of Congress to support federal funding for a selective increase in residency slots.

Flexibility in practice: Create part-time work schedules and retirement plans for part-time ob-gyns, and structure compensation methods to accommodate different overhead costs. Job sharing is also an approach to explore.

Rural areas: Encourage policy makers to provide incentives to make rural practice more attractive. Federal incentives might include increased Medicare payments and an enhanced loan forgiveness program for residency graduates. States can also offer incentives. Oregon, for instance, offers state income tax credit to rural practitioners and assists rural obstetricians with medical liability insurance premiums. Both federal and state incentives could help establish residency programs in rural hospitals and encourage existing programs to develop rural training tracks and rotations.

Telemedicine consultation is another mechanism to address access to care in rural areas. For example, the University of New Mexico Health Sciences Center offers a high-risk pregnancy telemedicine clinic every other week, and the University of Arkansas for Medical Sciences offers a statewide telemedicine system for maternal-fetal medicine consultations.

Collaborative practice: Broaden physician-only practices to include collaboration with qualified nonphysician clinicians. Such collaborative physician-led practices allow ob-gyns to devote more of their time to using procedural or surgical skills and treating high-risk conditions.

Use of ob-gyn hospitalists: The use of ob-gyn hospitalists has the potential to reduce time pressures on ob-gyns by eliminating interruptions during the workday, including discussing cases with nurses in hospital and leaving the office to attend labor and delivery.

Both Dr. Rayburn and Dr. Strunk noted that this is a period of transition, as practice models are changing and use of information technology to coordinate care is not yet universal. Dr. Rayburn commented, "During this time there is a critical need for workforce investigation and monitoring, so that we can determine more effective, data-driven ways to address career satisfaction, training, and practice alternatives in this changing environment."

William F. Rayburn, MD, MBA, and Albert L. Strunk, JD, MD, ACOG's deputy executive vice president, review ob-gyn workforce data included in a new book authored by Dr. Rayburn to be released this spring by ACOG.



Family health history is important screening tool

All women should have a family health history on file and it should be reviewed and updated regularly, according to The College. Family history screening is especially important in reproductive planning.

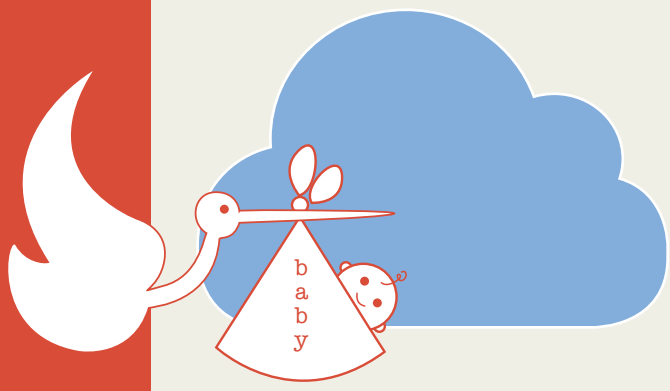
"Our goal is to help improve our patients' health by promoting family history as a screening tool," said W. Allen Hogge, MD, chair of The College's Committee on Genetics. Certain diseases and conditions run in families, such as breast and colon cancer, heart disease, type 2 diabetes, depression, and thrombophilias. "If we know about the family history, we can better help our patients identify their own risk factors, decide on certain screenings, and modify their lifestyle to prevent or minimize the problem.

"When a woman is planning a pregnancy, it's an ideal time to review her family history as well as her partner's," said Dr. Hogge. In addition to obtaining the family and medical history of the woman and her partner, it's also important to include their ethnic backgrounds, any family or personal negative pregnancy outcomes they've had separately or together, such as miscarriages, preterm birth, or birth defects, and any known causes for infertility. Some couples may decide against pregnancy after genetic counseling and testing, choose to use donor sperm or eggs, or opt for preimplantation genetic testing of the embryos.

There are a couple of standard methods that physicians can use to obtain family health histories: a questionnaire or checklist, and a family pedigree. A common screening tool is the family history questionnaire. Patients can fill them out at home which gives them extra time to contact family members and provide more accurate information. The other family history tool is known as a "pedigree" that ideally goes back three generations. The pedigree indicates the ages, health histories, and ethnicities of each family member, as well as dates and causes of death. Of course, family history screening tools can be difficult or impossible to obtain for adopted individuals and their usefulness may be limited for people with very small families.

Although many adult-onset health problems have complex genetic and environmental interactions, obtaining that information in a family history can help patients modify their diet, lose weight, or exercise to improve their outcome or delay the onset of symptoms. "For instance, if you are at high risk for developing heart disease, then you need to watch your blood pressure and keep your cholesterol levels in the healthy range," said Dr. Hogge.

Committee Opinion #478, *Family History as a Risk Assessment Tool,* is published in the March 2011 issue of the Green Journal.



When patients ask about planned home birth

Although The College believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. Importantly, women should be informed that the appropriate selection of candidates for home birth; the availability of a certified nurse-midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes.

Committee Opinion #476, *Planned Home Birth,* is published in the February 2011 issue of the Green Journal and online under Publications at www.acog.org.

Medical liability reform update

"Without reform of America's broken liability system, women will increasingly find that they cannot get the prenatal and obstetric care they need," ACOG told the House Judiciary Committee in recent testimony on medical liability reform legislation, HR 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act. "Many pregnant women will not be able to find doctors to deliver their babies. Women will lose care that will help detect and treat cancer early," stated ACOG witness Stuart R. Weinstein, MD, University of Iowa professor of orthopaedic surgery and pediatrics, who presented testimony on behalf of ACOG and other member organizations of the Health Coalition on Liability and Access. HR. 5, introduced by Reps. Phil Gingrey, MD, FACOG (R-GA), Lamar Smith (R-TX), and David Scott (D-GA), includes caps on non-economic damages, and other reforms like those found in Texas and California.


Rep. Phil Gingrey, MD, FACOG

Previously, ACOG and 100 organizations jointly expressed strong support for HR 5 in a letter to its sponsors, stating the bill would "help reduce costs, while ensuring that patients who have been injured due to negligence receive just compensation." The letter said the bill provides the right balance of reforms by "promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting non-economic damages to a quarter million dollars." Read about ACOG's legislative activity under Advocacy at www.acog.org.

Nonobstetric surgery during pregnancy calls for team approach

The College acknowledges that the issue of nonobstetric surgery during pregnancy is an important concern for physicians who are caring for women. It is important for a physician to obtain an obstetric consultation before performing nonobstetric surgery and some invasive procedures, such as cardiac catheterization or colonoscopy, because obstetricians are uniquely qualified to discuss aspects of maternal physiology and anatomy that may affect intraoperative maternal-fetal well-being. Ultimately, each case warrants a team approach involving anesthesia and obstetric care providers, surgeons, pediatricians, and nurses.

Committee Opinion #474, *Nonobstetric Surgery During Pregnancy,* is published in the February 2011 issue of the Green Journal and online under Publications at www.acog.org.

Worth noting

CDC has launched a new website with information on medications and pregnancy. The site includes easy-to-read information for patients, a compilation of data and scientific publications, and an overview of the work CDC and its partners are doing on medications and pregnancy. Visit **www.cdc.gov/ncbddd/pregnancy_gateway/meds/index.html**

USDA and HHS announced the 2010 Dietary Guidelines for Americans to promote health, reduce the risk of chronic diseases, and reduce the prevalence of overweight and obesity. The guidelines include specific ACOG recommendations for pregnant women, including folic acid intake for women of reproductive age, encouraging pregnant women and women trying to become pregnant to abstain from alcohol, and recommending appropriate levels of seafood consumption for pregnant women. Visit **www.dietaryguidelines.gov**

Gestational weight gain in overweight and obese women is the focus of grant opportunities from NIDDK, NICHD, NCCAM, and NHLBI. Applications for two funding opportunities are due March 24. Visit **http://grants.nih.gov** (search "gestational weight") or contact Mary E. Evans, PhD, NIDDK director of Special Projects in Nutrition at 301-594-4578 or **evansmary@mail.nih.gov.**

Nominees for 2011–12 ACOG officers

The following slate of three nominees will be voted on at the Annual Business Meeting on May 2 during the Annual Clinical Meeting in Washington, DC. Fellows who are unable to attend the meeting will vote online beginning in early March.

President Elect Nominee

James T. Breeden, MD, Carson City, NV

PROFESSIONAL POSITION

President, Carson Medical Group

EDUCATION

MD: Marquette School of Medicine, Milwaukee

RESIDENCY: Mercy Hospital, San Diego, CA

ACOG ACTIVITIES

NATIONAL: vice president; treasurer; member, Executive Boards; chair, Council of District Chairs; vice chair, Grievance Committee; member, Ob-Gyn PAC Governing Committee; member, Appeals Panel Committee; member, Task Forces on Establishing a 501(c)(6) Organization, Strategic Planning; member, Audit Committee; member, committees on Finance, Credentials, Coding and Nomenclature, Nominations, Compensation; participant, Leadership Institute

DISTRICT VIII: chair; vice chair; treasurer; member, Advisory Council; Outstanding District Service Award; Junior Fellow "Top Fellow" Award; Nevada Section chair, vice chair; *Gazette* editor

Vice President Nominee

John C. Jennings, MD, Odessa, TX

PROFESSIONAL POSITION

Regional Dean, School of Medicine, Ted Roden Endowed Chair, professor of ob-gyn, Texas Tech University Health Sciences Center

EDUCATION

MD: University of Tennessee, College of Medicine

RESIDENCY: University of Tennessee, City of Memphis Hospitals; University of Texas Health Sciences Center, Houston, TX

ACOG ACTIVITIES

NATIONAL: member, Executive Boards; member, Council of District Chairs; chair, Working Group on Midwifery; member, Committee on Government Affairs, State Legislative Subcommittee, Task Force on Strategic Planning, Ob-Gyn PAC Committee; Ob-Gyn PAC MVP Award; participant, Chantilly II Conference on "Future of Residency Training"; representative, AMA State Legislative Conference; formal discussant, National Maternal Mortality Committee; ACM prize paper

DISTRICT XI: chair; member, Advisory Council; Educator of the Year; Texas Section chair, vice chair, legislative chair, Advisory Council member

Assistant Secretary Nominee

Thomas M. Gellhaus, MD, Bettendorf, IA

PROFESSIONAL POSITION

Clinical Associate Professor, Department of Obstetrics and Gynecology, Carver College of Medicine, University of Iowa Hospitals and Clinics, Iowa City, IA

EDUCATION

MD: University of Oklahoma, College of Medicine, Oklahoma City, OK

RESIDENCY: Ob-gyn, University of Iowa Hospitals and Clinics; Pathology, University of South Dakota School of Medicine Affiliated Hospitals

ACOG ACTIVITIES

NATIONAL: member, Executive Boards; member, Council of District Chairs; member, Ob-Gyn PAC Committee; member, committees on Government Affairs, International Affairs; McCain Fellow; Primary Care Policy Fellow

DISTRICT VI: chair; vice chair, treasurer; member, Advisory Council; Iowa Section chair, vice chair; Junior Fellows vice chair; District Legislative Committee chair; Junior Fellow section advisor

Annual Business Meeting May 2 in Washington, DC

ACOG members in all categories of membership should check ACOG's website, www.acog.org, in March for the Monthly Member Info link, which will include the minutes of the 2010 Annual Business Meeting. In addition, Fellows who are eligible to vote will receive an email in March about ACOG's first electronic ballot for national elections, and for the first time, will be able to vote for the slate of 2011–12 national officers online.

Notice of annual meeting

Notice is hereby given, in accordance with the Bylaws of The American Congress 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 Congress will convene at 11 am, Monday, May 2, 2011, in the Washington Convention Center in Washington, DC, for the purpose of electing officers of the Congress and transacting such other business as may come before the meeting.

Mark S. DeFrancesco, MD, MBA
Secretary
Dated: March 7, 2011

MAKING the Rounds
MARCH 2011

Practice updates

The following appear in the Green Journal and are online under Publications at www.acog.org.

Practice bulletin

- 118 *Antiphospholipid Syndrome* (January 2011) (Replaces Practice Bulletin #68, November 2005)

Committee opinions

- 482 *Colonoscopy and Colorectal Cancer Screening Strategies* (March 2011)
- 481 *Newborn Screening* (March 2011)
- 480 *Empathy in Women's Health Care* (March 2011)
- 479 *Methamphetamine Abuse in Women of Reproductive Age* (March 2011)
- 478 *Family History as a Risk Assessment Tool* (March 2011)
- 477 *The Role of the Obstetrician–Gynecologist in the Early Detection of Epithelial Ovarian Cancer* (March 2011)
- 476 *Planned Home Birth* (February 2011)
- 475 *Antenatal Corticosteroid Therapy for Fetal Maturation* (February 2011)
- 474 *Nonobstetric Surgery During Pregnancy* (February 2011)
- 473 *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist* (January 2011)

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

At the Annual Business Meeting on Monday, May 2, in Washington, DC, 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

ACOG's Voluntary Review of Quality of Care Program

Established 25 years ago, the Voluntary Review of Quality of Care (VRQC) Program provides peer consultations to departments of ob-gyn to assess the quality of care provided and suggest possible alternative actions for improvement. This is accomplished through a site visit, typically conducted by three board-certified practicing ob-gyns, and a nurse with experience in ob-gyn, who use various quality assessment techniques, including an evaluation based on The College guidelines.

BY THE NUMBERS

10% The approximate percentage of hospitals providing obstetrics services in the US that have been reviewed by the VRQC Program.

31 The number of members of the VRQC Review Panel, which serves as a pool from which individual teams are selected for site visits. The panel includes seven team leaders and 16 team associates who are ACOG Fellows, one certified nurse-midwife, one anesthesiologist, one board-certified family physician who practices obstetrics, and five nurse reviewers with expertise in ob-gyn.

43 The number of states where VRQC site visits have occurred. States that have had the most site visits are Illinois (25), Texas (21), Florida (22), Ohio (19), California (13), and Massachusetts (10). States that have had no site visits are Connecticut, Maine, Missouri, North Dakota, Oklahoma, Rhode Island, and Utah.

The total number of site visits conducted to date. Hospitals range from rural to urban locations and from community-based hospitals to academic teaching hospitals. **276**

1985 The year William Mixson, MD, then ACOG president, founded the VRQC program. The first site visit was conducted in 1986.

The year the program began offering comprehensive site visits only. Previously, the VRQC program offered both focused reviews and comprehensive reviews. Focused reviews were eliminated because program participants recognized the importance of reviewing entire systems and processes rather than focusing on just one provider. **2004**

To learn more about the VRQC Program, visit www.acog.org/goto/vrqc or e-mail the program manager at vrqc@acog.org or call (800) 266-8043.

VRQC Voluntary Review of Quality of Care

In Memoriam

Amy L. Abt, MD
Pinetop, AZ
4/10

O. Karlis Adamsons, MD, PhD
San Juan, Puerto Rico
1/10

Morton J. Adels, MD
Houston, TX
3/10

Glenn S. Aggerup, MD
Cary, NC
3/09

John G. Baker, MD
Niskayuna, NY
7/09

Maurice Barney, MD
New Canaan, CT
2/10

Philip T. Bennett, MD
Aptos, CA

Ronald C. Boden, MD
Claremore, OK
12/09

Edmund J. Brennan, MD
Waterbury, CT
3/05

Stanley Brunn, MD
Port Jervis, NY
4/10

Robert Burstein, MD
St. Louis, MO
11/09

Robert M. Campbell, MD
Medina, WA
3/10

Edward N. Cartnick, MD
Vero Beach, FL
10/10

Ralph P. Caschetta, MD
Pittsford, NY
4/09

William R. Claytor, MD
Washington, DC
10/09

Melvin R. Cohen, MD
Chicago, IL
12/10

George T. Conger, MD
Akron, OH
3/10

Charles E. Couch, MD
Memphis, TN
8/09

Clifford H. Curtis, MD
San Carlos, CA
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Baaba Dadson, MD
Salisbury, MD
3/10

William S. Davis, MD
Austell, GA
9/09

James T. Dawsey, MD
Fernandina Beach, FL
12/10

Everett S. Diggs, MD
Towson, MD
1/10

Donald L. Dunlop, MD
Edmonton, Alberta, Canada
1/09

John S. Dunlop, MD
Port Orchard, WA
11/09

M. Fernandez Duran, MD
San German, Puerto Rico
8/10

Edward M. Eisenbrey, MD
Waldorf, MD
7/10

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Fort Smith, AR
11/09

Herman C. Ensor, MD
Cullman, AL
10/09

Wilson C. Everhart, MD
Mechanicsburg, PA
12/09

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Peoria, IL
8/09

Michelle Fedewa, RN
Lansing, MI
10/09

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Greensboro, NC
8/09

Ted H. Forsythe, MD
Lubbock, TX
8/10

James F. Fortune, MD
Sacramento, CA
8/10

Uwe E. Freese, MD
Chicago, IL
8/10

Donald G. Gallup, MD
Savannah, GA
1/11

William A. Gannon, MD
Arcadia, CA

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Grays Knob, KY
6/10

Larry L. Gossack, MD
San Jose, CA
11/10

Steven V. Grady, MD
South Windsor, CT
1/10

John J. Graham, MD
Williamsburg, VA
4/10

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Nashville, TN

Richard K. Green, MD
Council Bluffs, IA
10/09

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Portland, OR
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Lexington, KY
4/10

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Edinburg, VA
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Victoria, TX
9/10

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Rocheport, MO
7/10

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Galveston, TX
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Lake Wales, FL
4/10

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Clearwater, FL
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6/10

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Gary D. Helmbrecht
Charlottesville, VA
02/11

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Westbury, NY

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Williamsport, PA
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Memphis, TN
9/10

Manuel Jacobs, MD
LaJolla, CA
9/09

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Houston, TX
9/10

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10/10

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Portsmouth, VA

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Durango, CO
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Rock Springs, WY
5/10

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Dayton, OH
5/10

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Bethesda, MD
1/10

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Bartlesville, OK
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Guaynabo, Puerto Rico
4/10

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Franklin, MI
2/10

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Charleston, SC
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Wayne, PA
3/10

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Phoenix, AZ
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Tucson, AZ
4/09

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G. Virginia Upton, PhD
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Lyndhurst, OH
10/10

Doris E. Wickman, MD
Glen Ellyn, IL
10/09

Robert D. Wiley, MD
Gilford, NH
4/10

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Oak Lawn, IL
6/09

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11/10

W. Donald Woodard, MD
Lander, WY

W. Steve Worthy, MD
Carrollton, GA

2011 MEETING DATES FOR OBSTETRICIAN–GYNECOLOGISTS

Diabetes in Pregnancy Study Group of North America	**April 1–2**	Washington, DC
American College of Physicians Internal Medicine 2011	**April 7–9**	San Diego, California
Society of Gynecologic Surgeons Annual Scientific Meeting	**April 11–13**	San Antonio, Texas
North American Society for Pediatric and Adolescent Gynecology Annual Clinical Meeting	**April 14–16**	Chicago, Illinois
The American College of Obstetricians and Gynecologists Annual Clinical Meeting	**April 30–May 4**	Washington, DC
American Medical Association House of Delegates	**June 18–22**	Chicago, Illinois
Society of Obstetricians and Gynaecologists of Canada Annual Clinical Meeting	**June 22–26**	Vancouver, BC, Canada
8th Singapore International Congress of Obstetrics and Gynaecology	**August 24-27, 2011**	Singapore www.sicog2011.com
American Urogynecologic Society Annual Scientific Meeting	**September 14–17**	Providence, Rhode Island
Society of Laparoendoscopic Surgeons Annual Meeting and Endo Expo	**September 14–17**	Los Angeles, California
American Academy of Family Physicians Scientific Assembly	**September 14–17**	Orlando, Florida
Pacific Coast Obstetrical and Gynecological Society	**September 14–19**	Sunriver, Oregon
International Society of Ultrasound in Obstetrics and Gynecology World Congress	**September 18–22**	Los Angeles, California
The North American Menopause Society Annual Meeting	**September 21–24**	Washington, DC
Society of Pelvic Reconstructive Surgeons International Conference	**September 21–24**	St. Louis, Missouri
ACOG District V	**September 22–24**	Detroit, Michigan
ACOG District VII	**September 23–25**	Kansas City, Missouri
ACOG District III and the American College of Osteopathic Obstetricians and Gynecologists	**October 13–16**	Philadelphia, Pennsylvania
ACOG District I	**October 14–16**	Halifax, NS, Canada
ACOG District XI	**October 14–16**	Plano, Texas
American Society for Reproductive Medicine Annual Meeting	**October 15–19**	Orlando, Florida
ACOG District IV	**October 21–23**	Naples, Florida
College Armed Forces District	**October 23–26**	San Diego, California
American College of Surgeons Clinical Congress	**October 23–27**	San Francisco, California
ACOG District VI and the Central Association of Obstetricians and Gynecologists	**October 26–29**	Nassau, Bahamas
ACOG Districts VIII and IX	**October 28–30**	Los Cabos, Mexico
ACOG District II	**October 28–30**	New York, New York
Association of American Medical Colleges Annual Meeting	**November 4–9**	Denver, Colorado
American Association of Gynecologic Laparoscopists Global Congress	**November 6–10**	Hollywood, Florida
The American Board of Obstetrics and Gynecology (Oral Examinations)	**November 7–11**	Dallas, Texas
Council of Medical Specialty Societies Annual Meeting	**November 18–19**	Washington, DC
The American Board of Obstetrics and Gynecology (Oral Examinations)	**December 5–9**	Dallas, Texas

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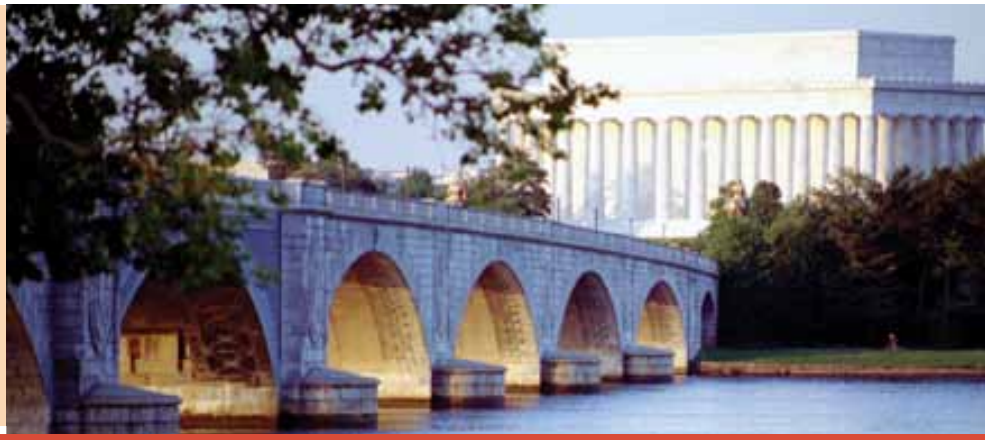

ELECTRONIC VOTING: March 7–April 27 » https://eBallot4.votenet.com/acognational

ACOG Courses and Coding Workshops

MARCH 8	ACOG Webcast: VBAC: What's New and What's Not
MARCH 10–12	Practical Ob-gyn Ultrasound: Preoperative Assessment of Patients
MARCH 11–13	Coding Workshop, Phoenix, AZ
APRIL 1–3	Coding Workshop, Atlanta, GA
APRIL 12	ACOG Webcast: Coding for Consultation Services
MAY 5–7	Coding Workshop, Washington, DC
MAY 10	ACOG Webcast: ACOG VRQC Program: Using Standardized Worksheets for Peer Review
JUNE 9–11	Quality and Safety for Leaders in Women's Health Care, Chicago, IL
JUNE 10–12	Coding Workshop, Indianapolis, IN
JUNE 14	ACOG Webcast: Coding for Wound Repair: Post-Operative and Postpartum
JULY 8–10	Coding Workshop, Los Angeles, CA
JULY 12	ACOG Webcast: Robotic Surgery in Gynecology
AUGUST 5–7	ACOG Coding Workshop, Dallas TX
AUGUST 9	ACOG Webcast: ICD-9 to ICD-10: What to Expect
AUGUST 26–28	ACOG Coding Workshop, Richmond, VA
SEPTEMBER 9–11	ACOG Coding Workshop, Las Vegas, NV
OCTOBER 21–23	ACOG Coding Workshop, Seattle, WA

Register online at www.acog.org/postgrad/index.cfm. To learn about freestanding postgraduate courses, email PGCourses@acog.org. To learn about coding courses and webcasts, call 202–863–2498 or email coding@acog.org.