THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

APRIL 2008

What is Maintenance of Certification?

ON JAN 1, 2008, THE AMERICAN BOARD OF OBSTETRICS and Gynecology initiated Maintenance of Certification. MOC is designed to ensure that physicians who are board certified continue to remain up-to-date and practice evidence-based medicine according to the most recent guidelines for best practice.

MOC is a requirement for board certification for diplomates with time-limited certificates and is optional for all others. Since the program began, ACOG has received numerous communications from Fellows with concerns and questions about why all of this is necessary. To explain the reason for this program, a brief review of history is required.

In 2000, the Institute of Medicine published its landmark book *To Err is Human*. The essence of the report was that errors were harming patients. Congress and regulatory bodies immediately began to ask medicine "why?" In 2001, the follow-up IOM report, *Crossing the Quality Chasm*, was published. A key issue that was identified was that physicians were not practicing the most current and up-to-date evidence-based medicine. Finally, in 2003, the IOM published *Health Professions Education: A Bridge to Quality*. All of this led Congress and regulatory bodies to ask specialty boards how they were ensuring that their

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Provocative ACM session to examine solutions to medical liability crisis

ADVOCATING SOLELY FOR tort reform in the legislative arena does not get to the root of the medical liability crisis, according to Richard Boothman, JD, chief risk officer for the University of Michigan Health Systems. Mr. Boothman contends that the health care system needs to address the reason that patients sue doctors in the first place and focus on key patient safety and communication issues.

"Study after study suggests that patients see lawyers primarily because they feel they haven't gotten answers. They feel that no one is accountable when an error has caused injury, and they feel a huge, underappreciated sense of responsibility to protect others, to make sure what happened to them won't happen to other patients," Mr. Boothman said. "Blaming lawyers and imposing caps and other hurdles to litigation simply doesn't get to what is actu-

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EXECUTIVE DESK

AMA membership for residents

ACOG IS CONSTANTLY SEEKING ways to generate more membership benefits for our Junior Fellow residents. In the past, we have been able to offer $100,000 of term life insurance to fourth-year residents. Beginning in July, this will extend to third-year residents as well. We were also recently able to add up to $10,000 in identity theft insurance for all Junior Fellow residents.

ACOG also has a loan program for residents who have at least one year of their program completed or, upon completion of their residency, are in an approved subspecialty fellowship program. We continue to look for other benefits of membership for our residents in our constant efforts to improve recruitment into our specialty of the best and brightest.

Recently, another opportunity has surfaced that ACOG believes will be a benefit to our Junior Fellow residents: resident membership in the American Medical Association. In multiple Executive Desk articles in the past, I have emphasized the importance of ACOG members becoming members of the AMA. This is important primarily because ob-gyn representation and input are needed as the AMA battles Congress and regulatory bodies on issues such as physician payment reform, medical liability concerns, and other advocacy issues. However, this is not all the AMA does for its members. The AMA's other educational efforts include the *Journal of the American Medical Association*, the largest medical journal in the world and one of the most respected.

The AMA also produces *AMA News*, a weekly update on the state of medicine in the US with in-depth presentations on issues critical to all physicians. There are also prep materials for practice as well as many other educational programs. These are areas that we believe will benefit our residents most and will allow them to determine later whether they want to belong to the AMA.

We are aware at ACOG that often the residency that a bright student selects may be decided by small factors. Because large populations of students belong to the AMA, it is our hope that, besides the educational benefits offered to residents, the opportunity to continue membership during residency at no cost will tip the scales in favor of the ob-gyn program. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

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***Obstetrics & Gynecology* HIGHLIGHTS**

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

End-of-Life Decision Making
(Ethics Committee Opinion #403, revised)

Late-Preterm Infants
(Obstetric Committee Opinion #404, new)
For more information, see page 13.

Use of Psychiatric Medications During Pregnancy and Lactation
(Obstetric Practice Bulletin #92, revised)

Members support ACOG through donations

THROUGH PERSONAL CONTRIBUTIONS, ACOG MEMBERS ARE ENSURING that ACOG will continue to promote and maintain the highest standards for ob-gyn care. ACOG recognizes and thanks the following individuals for their financial contribution and personal commitment to ACOG:

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Past President Dr. Evans dies

ACOG PAST PRESIDENT Tommy N. Evans, of Scottsdale, AZ, died in January. Dr. Evans, a former member of District V, served as the College's president from 1976 to 1977.

Dr. Evans received his medical degree from Vanderbilt University, Nashville, TN, in 1945. After two years as a US Navy medical officer, he completed his ob-gyn residency at the University of Michigan, where he remained as a professor for two decades. In 1965, he joined the faculty at Wayne State University in Detroit, where he also became the dean of the school of medicine from 1970 to 1972. At Wayne State, he founded and served as director of the C.S. Mott Center for Human Growth and Development.

Dr. Evans's research interests included the prevention of birth defects, and his work earned him the March of Dimes National Foundation Humanitarian of the Year award in 1974.

Dr. Evans was an ABOG examiner and president of the American Gynecologic Society, the Central Association of Obstetricians and Gynecologists, and the Michigan Society of Obstetricians and Gynecologists, according to the *Arizona Republic* newspaper. ♀

ACOG Today Correction

ACOG Today listed the wrong district for Dane M. Shipp, MD, ACOG's fellow-at-large nominee, in the March issue. Dr. Shipp is a member of District IX, not District II. We apologize for this error. ♀

New Indian health award established

THE ACOG COMMITTEE ON American Indian Affairs is raising money for a new award that would recognize an individual who has made a major contribution to improving the health care of American Indians/Alaska Natives.

The William H.J. Haffner American Indian/Alaska Native Women's Health Award is named after ACOG Fellow Dr. Haffner, an ob-gyn professor at the Uniformed Services University of the Health Sciences, Bethesda, MD. Dr. Haffner worked for the federal Indian Health Service for many years and has been involved with ACOG's Indian health programs since their inception.

The committee aims to raise $50,000, which would be matched by ACOG's Development Fund, creating a $100,000 endowment to sustain the award.

To qualify for the award, clinicians do not have to be ob-gyns. In fact, many of the practitioners in Indian Health facilities are not ob-gyns. Any health care professional, including family physicians, certified-nurse midwives, nurse practitioners, and registered nurses, are eligible. The awardee must hold an IHS or Tribal staff position or be recently retired.

Indian health contract renewed

Recently, ACOG's Indian Health Service contract was renewed for five years. The contract funds ACOG's three primary Indian health projects:

- The Committee on American Indian Affairs, which conducts site visits to Indian Health Service hospitals and clinics and is a consultant for Indian health programs
- A four-day postgraduate course covering a broad spectrum of maternal and infant health for family physicians, nurse practitioners, nurses, and other health professionals who provide care to women in Indian health programs but who are not necessarily specially trained in maternal and child health
- The Fellows Serving Native American Women program, which allows ACOG Fellows and Junior Fellows to volunteer their services for at least three weeks at an Indian Health Service or Tribal hospital ♀

David Yost, MD (far right), clinical director of Whiteriver PHS Indian Hospital in Whiteriver, AZ, gives a tour of the hospital to ACOG's Committee on American Indian Affairs during its November site visit.

info

- To donate to the Haffner Award Fund, please make checks out to "ACOG" and mail to Yvonne Malloy, ACOG, 409 12th St. SW, Washington, DC 20024
- For more information on the award or other Indian health programs: ymalloy@acog.org; 800-673-8444, ext 2580; or visit the ACOG website, www.acog.org; under "Women's Issues," click on "Indian Health Service"

GRIEVANCE COMMITTEE REPORTS ON ACTIONS

SANDRA A. CARSON, MD, CHAIR of ACOG's Grievance Committee, provides this report to the Fellowship in accordance with the College's grievance 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 committee reviews complaints submitted by Fellows of the College against other Fellows, severe disciplinary actions taken by state medical boards, and any adverse actions taken against a Fellow's medical license in any jurisdiction on the basis of sexual misconduct.

Executive Board final actions

One Fellow was expelled from the College. The Executive Board took this action on the basis of one state placing this Fellow's medical license on probation for 10 years. As required, the College reported this expulsion to the National Practitioner Data Bank.

The College suspended one Fellow. The Executive Board took this action on the basis of one state's indefinite restriction of the Fellow's medical license and another state's suspension of the Fellow's medical license. As required, the College reported the suspension to the National Practitioner Data Bank.

The College also issued one censure and four warnings to ACOG Fellows.

Grievance Committee activities

The Grievance Committee reviewed 11 complaints and conducted 15 hearings in 2007. ♀

info

- www.acog.org/goto/grievance
- Office of the General Counsel: 202-863-2584; grievance@acog.org

E-prescribing rules changing

UPCOMING CHANGES TO THE Medicare Modernization Act may affect the way you prepare prescriptions for patients covered by the Medicare Part D program.

Electronic medical record users are likely unaware that their computer-generated prescriptions are showing up as faxes at the pharmacy. Beginning Jan 1, 2009, all computer-generated prescriptions for Medicare Part D patients must comply with the SCRIPT standard defined by the National Council for Prescription Drug Program. If the SCRIPT standard is not used, prescriptions must be printed and then manually faxed.

To determine if your current technology is compliant and to take the steps to request pharmacy connectivity from your vendor, visit www.GetRxConnected.com/ACOG for a free e-prescribing readiness assessment. ♀

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diplomates were practicing contemporary, evidence-based quality medicine.

The parent organization for ABOG and 23 other specialties is the American Board of Medical Specialties. ABMS reacted to these questions and concerns by convening a working group to address how the boards should respond. The working group presented a plan to ABMS for its approval that covered four key areas, which became the four parts of MOC: professionalism, life-long learning, cognitive knowledge, and self-assessment.

ABOG had major concerns with the cognitive knowledge part, Part III of MOC, which requires diplomates to pass a secure written examination. However, ABOG was outvoted by the other member boards, resulting in the adoption of the current MOC process with all four required components.

Although ACOG supported ABOG in its objection to the current MOC program, especially the Part III examination, the College did not have a vote and was at no time involved in the decision by ABMS. Because MOC has now been adopted by all 24 member boards of ABMS, ACOG and ABOG have now agreed to work together to make MOC as least intrusive and expensive to a physician's practice as possible.

ACOG will oversee only Part IV

ABOG will be responsible for Parts I, II, and III. For Part IV, self assessment, ABOG asked ACOG to participate in its development, and the College was very appreciative of this request. ACOG's goal was to ensure that practicing physicians were involved in developing self-assessment modules and that such modules were as minimally intrusive to the physician's practice as possible.

Moreover, Part IV of MOC, "the modules," is provided at no cost to ACOG Fellows. There is no charge for Part I, "professionalism," and the cost of Part II, "the ABC articles," is the same as last year. Part III, "the secure written exam," is a work in progress and will not be available until 2012 at the earliest.

All of the ABMS-approved specialties (internal medicine, surgery, pediatrics, radiology, etc) now have an MOC program, so we are not alone as a specialty. While the actual program may vary, all of the programs must include the four components (including a secure written examination). Now, the Federation of State Medical Boards is recommending that all state boards institute a program similar to MOC for relicensure. There is every reason to hope that our MOC program will meet that requirement.

So what is MOC? MOC is an attempt to reassure the public that board-certified physicians are practicing safe, up-to-date medicine.

By participating in MOC, it is hoped that we can regain our patients' trust from an intellectual and moral standpoint. MOC is not a punishment, nor a mechanism to remove a physician's certification. ♀

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- A free archived ABOG webcast that explains the MOC process is available on the ACOG website: look under "Announcements" on the home page, www.acog.org
- MOC guidelines, FAQs, and slideshow: www.abog.org/main/faqmoc.html
- ACOG's portion of MOC, the Road to Maintaining Excellence modules, is now available online: www.acog.org/from_home/misc/mocinfo.cfm

Fellow to trace evolution of cesarean delivery

Dr. Baskett

CESAREAN DELIVERY HAS become one of the most common and safest surgical procedures, yet there are no recent publications tracing the history of cesareans in the US, according to ACOG's newest history fellow.

Thomas F. Baskett, MB, was selected as the recipient of the 2008 ACOG Fellowship in the History of American Obstetrics and Gynecology. Dr. Baskett, professor of ob-gyn at Dalhousie University in Halifax, NS, will research the evolution of cesarean delivery in the US at the ACOG History Library in Washington, DC.

"Although there's been a fair amount written on the development of cesareans in the US, there hasn't been a comprehensive look in the last 70–80 years," Dr. Baskett said.

Cesareans were first done as a last resort on women who had prolonged and septic labor.

"It was carried out when the woman was exhausted and infected, and the mother succumbed soon after the cesarean," Dr. Baskett said. "Robert Harris and Charles Noble, both from Philadelphia, realized by the 1890s that in women who had a narrow pelvis doing a cesarean early in labor, or before labor, improved both maternal and baby survival."

One telling fact was that women who suffered traumatic "cattle-horn" cesareans, in which they were gored or sliced open by cattle in farming accidents, had better survival rates than women who underwent medical cesareans. The reason was because doctors performed cesareans when women were infected, after hours of obstructed labor, according to Dr. Baskett.

"It really went from an operation that was almost invariably fatal to the mother, and, over a century, became one of the most common and safest surgeries," he said.

Dr. Baskett is particularly looking forward to reviewing all the editions of the textbook *Williams Obstetrics*, which is unique in that it has been published continuously for more than a century, since 1903.

"Through a standard text like that you can see how the standard position of the day evolved over a century," he said. "All of those editions are in the ACOG History Library." ♀

ACOG Congressional Leadership Conference

Fellows and Junior Fellows attended ACOG's 26th Annual Congressional Leadership Conference in February.

Audience members during the ACOG President's Luncheon on the second day of the conference

ACOG President Kenneth L. Noller, MD, MS (on the left), with Immediate Past President Douglas W. Laube, MD, MEd

Dr. Noller leads the discussion during his President's Luncheon on the topic "Is an Individual Mandate Necessary?"

Legislative primer now available

"GET INVOLVED." OFTEN, ob-gyns are encouraged to become active in state and federal legislative health issues, but many physicians new to the legislative arena may not know how to start. The new *ACOG Legislative Primer: Your Practice, Your Priorities, Your Future* explains the legislative process, discusses how to get involved, and outlines ACOG's top legislative issues and how they affect your practice.

The primer was developed by the Government Relations and Outreach Committee, which aimed to provide advocacy tools to ACOG members, particularly Junior Fellows and young Fellows.

ACOG members can pick up their free primer at the ACOG Booth during the Annual Clinical Meeting in New Orleans in May or by contacting govtrel@acog.org. ♀

New campaign outlines ACOG's health care reform agenda

ACOG LAUNCHED ITS NEW *Health Care for Women, Health Care for All* campaign during the College's 26th Annual Congressional Leadership Conference in February. The campaign outlines ACOG's national health care reform agenda, calling for universal access to maternity care and reform of the US health care system.

The agenda calls for a system that covers everyone in the US, regardless of citizenship or residency status, and states that universal coverage of pregnant women and infants should be a priority if reforms are phased in. ACOG supports employer contribution requirements and individual health insurance mandates, provided that coverage is affordable and includes essential benefits, along with expansion of existing public programs.

Campaign materials include a chart that provides a side-by-side comparison of ACOG's proposals with those of the Democratic and Republican presidential candidates; information on the core package of essential benefits

that ACOG believes should be available nationwide to all women; a list of specific services ACOG believes should be covered in the outpatient, hospital, or home setting; statistics on the number of uninsured and underinsured women, disparities in health coverage and outcomes, and costs for women and their families; and a glossary of health care reform acronyms and terms.

ACOG will update and supplement campaign materials as the US continues to deliberate health care reform. ♀

info

- To access the campaign online, go to www.acog.org/goto/healthcarereform
- For more information or to order campaign kits: govtrel@acog.org

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ally driving patients to lawyers."

Mr. Boothman will be a presenter during the Annual Clinical Meeting's 6th Scientific Session—The Donald F. Richardson International Symposium, "Medical Malpractice Reform: Beyond Caps." Also presenting will be Dr. Robert C. Lyneham, chair of the Medicolegal Committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Dr. Lyneham will discuss the government and health care sector's response to the medical liability crisis in Australia a few years ago and will outline the Royal College's initiatives to improve the quality of expert testimony. The session will be held from 2:30 to 5:15 pm on Tuesday, May 6.

In 2001, the University of Michigan aimed to reduce its medical liability claims with a new effort based on three principles:

1. We will compensate quickly and fairly when inappropriate medical care causes injury
2. We will defend medically appropriate care vigorously
3. We will reduce patient injuries (and therefore, claims) by learning from mistakes

In August 2001, the university had 262 claims. By August 2007, there were only 83 cases pending. Processing time dropped from 20.3 months to 9.5 months, total reserves for claims decreased by more than two-thirds, and average litigation costs were cut in half.

"Michigan instituted a rigorous process to answer the core question 'Was the care reasonable or not?'" Mr. Boothman said. "If a mistake was made, the patient gets an apology quickly and an offer of compensation. If we haven't made a mistake, we give a full explanation to the patient."

The university placed more emphasis on patient communication and patient safety, which included improving the informed consent process, instituting a strong peer review system, improving clinical care, responding to complaints quickly, helping patients deal with unanticipated outcomes, and setting realistic patient expectations.

Mr. Boothman advocates for a system with quality clinical indicators and good data collection so hospitals can identify and act on outliers and patterns of problems. Furthermore, hospitals need to institute a "real, honest, robust" peer review system.

"Way too often, doctors fall into the trap of the 'There but for the grace of God go I' syndrome, when in fact, if they used a different test—'Would I want that colleague operating/delivering/treating my wife?'—the answer would be more honest and objective," Mr. Boothman said. "Peer review is alive only in rare pockets in this country."

Australia's medical liability crisis

In his presentation, Dr. Lyneham will describe Australia's response to its 2002 medical liability crisis, which caused physicians to threaten to walk off the job.

"The response from government, business, and the medical profession was swift and effective," Dr. Lyneham said.

Among the solutions, legislation was passed that reduced the amount of damages available to plaintiffs injured by negligent defendants and modified the test to determine the standard of care in cases in which the practitioner was accused of negligence. Most jurisdictions also introduced an expert witness code of conduct. The federal government also helped physicians with rising premiums by underwriting "incurred but not reported liabilities," covering part of very high claims, and subsidizing premiums.

For its part, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists addressed expert witness testimony.

"There were anecdotal complaints against experts made by Fellows involved with cases, judicial criticism in certain judgments, and well-defined criticisms in a detailed survey of all 478 Australian judges," Dr. Lyneham said. "Our College's first step was to introduce an 'Expert Witness Register,' with certain criteria requiring fullfilment for Fellows to be on the register. The next step was to develop an expert witness training program. Eventually, completion of this program will be a requirement for being on the register." ♀

ACM session: IUDs good choice for many women

ONLY 2% OF WOMEN WHO use contraception in the US choose an intrauterine device, despite the proven safety and effectiveness of this long-term contraception. In contrast, IUDs are the most widely used reversible contraceptive worldwide, according to David A. Grimes, MD, vice president of biomedical affairs at Family Health International, Research Triangle Park, NC, and a clinical professor of ob-gyn at the University of North Carolina.

IUDs offer a safe and effective choice for many women seeking a reversible contraceptive and an alternative to tubal sterilization. In the 3rd Current Issues Update at the Annual Clinical Meeting in May in New Orleans, Dr. Grimes will present "New Uses for IUDs: Contraception and Beyond." The update will be held from 2 to 3 pm on Tuesday, May 6.

"The cloud of suspicion has been lifted off IUDs in recent years by reassuring studies, and there's a rekindled interest in what I like to call 'forgettable' contraception," Dr. Grimes said. "IUDs are an attractive option for many women. They're tantamount to tubal sterilization, offering the same contraceptive effectiveness with a simple office procedure."

Some IUDs can be appropriate for nulligravid women and those with a history of ectopic pregnancy. Furthermore, studies have shown that the risk of PID is negligible and limited to the first month. The World Health Organization gives nulliparity a category 2 rating, meaning that the benefits of IUDs generally outweigh the risks. WHO notes that the risk of expulsion may be higher in such women, presumably due to the smaller uterine cavity. A landmark case-control study of tubal infertility from Mexico City that included nulliparous women showed that copper IUD use was unrelated to tubal infertility. In contrast, women with prior exposure to *C. trachomatis* had a significant increase in the risk of infertility.

During his session, Dr. Grimes will discuss emerging noncontraceptive benefits of IUDs as well.

"In more than 80 countries around the world, the levonorgestrel system is approved for heavy menstrual bleeding and for protecting the endometrium during hormone therapy in menopause," he said. "Plastic and copper IUDs are associated with a 40% reduction in the risk of endometrial cancer. It is similar to the protection provided by oral contraceptives, and many clinicians are not yet aware of that. For treating endometriosis, the levonorgestrel system is an alternative to 'watch and wait' or leuprolide acetate injections. Another emerging use for the hormonal system is treating endometrial hyperplasia." ♀

2008 ACM history sessions

THE J. BAY JACOBS, MD, LIBRARY FOR the History of Obstetrics and Gynecology in America is sponsoring three events at the 2008 Annual Clinical Meeting, May 3–7, in New Orleans.

The 12th Annual Breakfast of the History Special Interest Group

Wednesday, May 7, 6:30–8 am
Hilton New Orleans Riverside Hotel

Mary A. Hyde, MSLS, AHIP, and Debra G. Scarborough, MLS, AHIP, will detail the resources and services available from the ACOG Resource Center/History Library & Archives. In addition, they plan to discuss the creation of the new Ralph W. Hale, MD, History Museum at ACOG headquarters, which was dedicated in February. Ms. Hyde and Ms. Scarborough's careers as medical librarians span more than 20 years, and both have expertise as former hospital librarians. The breakfast is free, but space is limited, so be sure to register at the ACOG Booth in the ACM Exhibit Hall.

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

Tuesday, May 6, 2:30–4 pm

Carol A. Stamm, MD, associate clinical professor at the University of Colorado Health Sciences Center and the 2007 ACOG History Fellow, will discuss the history of emergency contraception, reviewing ancient methods and botanicals previously used and developed in other countries. Tickets are required. Register when you register for the ACM.

Oral History Project

For each of the past 24 years, with support from Wyeth Pharmaceuticals, the History Library has recorded interviews with two individuals of importance to the College and the specialty. The aim of the project is to capture recollections of ob-gyns, nurses, and ACOG staff, including the early leaders of ACOG.

This year, the library will interview Gerald B. Holzman, MD, a former ACOG vice president for education, and John T. Queenan, MD, deputy editor of *Obstetrics & Gynecology* and editor of the ACOG publication *High-Risk Pregnancy*. Fellows are welcome to suggest topics to discuss or individuals to interview in the future. Email suggestions to history@acog.org.

Past interviews are available for viewing at the History Library at ACOG headquarters in Washington, DC, and a complete list is available upon request. ♀

info

➜ history@acog.org

Research paper winner studies BMI and sexual behavior

WINNING PAPERS

FIRST PRIZE

The Relationship between Body Mass Index and Sexual Behavior

- Bliss Kaneshiro, MD, University of Hawaii
- Alison B. Edelman, MD, MPH
- Jeffrey T. Jensen, MD, MPH
- Mark D. Nichols, MD

SECOND PRIZE

Risk Factors Associated with Rising Contraception Non-Use Between 1995 and 2002

- Lauren A. Robertson, Oregon Health & Science University, Portland, OR
- Jeffrey T. Jensen, MD, MPH
- Garnett McMillan, PhD
- Marie Harvey, DrPH, MPH

THIRD PRIZE

Efficacy of an Automated PCR Assay for GBS Determination in Pregnant Women

- Lori L. Goranson, MD, Dartmouth-Hitchcock Medical Center, Lebanon, NH
- Claudine L. Bartels, PhD
- Gregory J. Tsongalis, PhD
- E. Rebecca Pschirrer, MD, MPH

RECOGNIZING THAT THE majority of Americans are overweight or obese, University of Hawaii researcher Bliss Kaneshiro, MD, studied the relationship between BMI and sexual behavior, including sexual orientation, age at first intercourse, number of partners, and frequency of intercourse.

Relationship between Body Mass Index and Sexual Behavior won first place among research papers to be presented at the Annual Clinical Meeting, May 3–7, in New Orleans. Dr. Kaneshiro, assistant professor at the University of Hawaii, will present her winning paper on Monday afternoon of the ACM.

"The obesity epidemic in the US has resulted in serious health consequences for many individuals and for the health care system as a whole," Dr. Kaneshiro said. "Physicians of all specialties must factor body weight into their clinical decision-making process on a daily basis. In addition to being a risk factor for multiple chronic diseases, obesity can affect emotional health, as well as psychosocial functioning. Our analysis of the National Survey of Family Growth, Cycle 6 demonstrated that obese and overweight women do not have a significant difference in some of the objective measures of sexual behavior compared to women of normal weight."

Hear latest research

Learn about new ob-gyn research when clinical and basic research papers are presented at the ACM. Papers will be presented from 2 to 4 pm on Monday and Tuesday in the New Orleans Morial Convention Center. Each researcher will present his or her findings in seven minutes, and the audience will have three minutes to ask questions. The session will be moderated by a prominent specialist in the field. The prize-winning papers will be presented on Monday afternoon. ♀

Connect with employers, job candidates at ACM

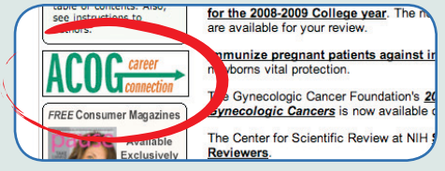
ACOG'S CAREER CONNECTION Job Center at the Annual Clinical Meeting allows visitors to post resumes, search the online job database, and respond to job postings, while employers can post job opportunities and search the database for qualified candidates.

The center, which features ACOG's online career site for women's health care professionals, will be open Saturday through Tuesday from 8 am to 4 pm and on Wednesday from 8 am to 1 pm. The center will be in Hall D in the New Orleans Morial Convention Center.

"Conference Connection," a feature of the Career Connection website, allows both candidates and employers to indicate online that they are attending the ACM and set up face-to-face interviews ahead of time.

Employers are encouraged to post all of their available opportunities online prior to the ACM, while those searching for a new position should post their resumes. Both employers and candidates can then indicate online whether they will be an ACM attendee or exhibitor and provide their local contact information (cell phone, booth number, hotel number, etc).

Career Connection is free to job seekers and allows them to search by position type, location, and keywords. Candidates can also



email a CV and cover letter online and receive email notifications of new listings. ACOG Career Connection is a part of HEALTHeCAREERS Network. ♀

info

➜ Click on the ACOG Career Connection logo on the ACOG home page, www.acog.org

➜ 888-884-8242; info@healthecareers.com

Junior Fellow prize paper winners announced

THE WINNERS OF THE 2007–08 DONALD F. RICHARDSON MEMORIAL PRIZE PAPERS ARE JUNIOR FELLOWS Sarit O. Aschkenazi, MD, of District VI, and Micah J. Hill, DO, Junior Fellow chair of the Army Section in the Armed Forces District. Their papers were selected from Junior Fellow papers nominated by each district and will be presented on Tuesday, May 6, at the Annual Clinical Meeting.

Dr. Aschkenazi

Use of the PISQ-12 to assess sexual function in a general female population

Dr. Aschkenazi's paper is "Use of the Short Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire for Female Sexual Dysfunction in a General Population."

A cross-sectional survey of 557 twin sisters showed that the shorter, user-friendly version of the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire, known as the PISQ-12, can be used as a general sexual function questionnaire in a sexually active female population. In fact, just nine of the 12 questions were needed to reliably and accurately assess sexual function in a general sexually active female population.

Both the PISQ-12 and the modified shorter version, the PISQ-9, have good validity, reliability, and responsiveness in a general population of sexually active women, according to Dr. Aschkenazi.

Dr. Aschkenazi is a urogynecology fellow at Evanston Northwestern Healthcare, McGaw Medical Center, Northwestern University, Chicago. She received her MD from the Sackler Faculty of Medicine, Tel Aviv University, Israel, and completed her residency at North Shore University Hospital, Long Island Jewish Health System, Manhasset, NY.

Dr. Hill

Membrane sweeping's association with prelabor rupture of membranes

Dr. Hill's paper is "The Effect of Membrane Sweeping in Uncomplicated Pregnancies on Prelabor Rupture of Membranes: A Prospective Randomized Controlled Trial."

Membrane sweeping is a common practice for term pregnancies, but a Cochrane review suggests that the procedure provides little clinical benefit.

Three hundred pregnant women were enrolled in a prospective, blinded, randomized controlled trial. The study showed no overall difference in PROM rates between the no-sweep group and the sweep group. There were no differences in PROM between the two groups in women with 0–1 cm dilation. However, those who were greater than 1 cm dilated were more likely to have PROM if they underwent membrane sweeping, compared with 0% in the no-sweep group. This finding requires verification in a study designed to address this specific issue, according to the study.

Dr. Hill is a new attending physician at Blanchfield Army Community Hospital at Fort Campbell, KY. He received his DO from the Oklahoma State College of Osteopathic Medicine and completed his residency at Triple Army Medical Center in Honolulu. ♀

RRC UPDATE

By Tamara Chao, MD, resident representative, Ob-Gyn Residency Review Committee of the Accreditation Council for Graduate Medical Education

Changes in primary care

The Residency Review Committee program requirements for education in primary care are being revised. A primary care task force met in July 2007 to come up with recommendations for defining primary care in the context of our field and to discuss how this definition fits in with residency training requirements.

Several shortcomings were identified that need to be addressed, including the lack of standardized education in primary care, ill-defined assessment tools, lack of agreement on expectations for education in the management of nonreproductive illnesses, and lack of qualification requirements for ob-gyn faculty to serve as primary care experts.

In the future, primary care data will not be tracked in a "numbers" fashion. Counting encounters in each primary care category on the ACGME case log system is a faulty method and does not reveal reliable information about a resident's primary care experience. Instead, the RRC is developing a method of evaluating this experience that will include a representative chart review from the continuity clinics at the time of each program's site visit.

Tracking

With an increasing number of residents applying for subspecialty fellowships, the RRC is discussing the possibility of adopting a tracking system during residency. This may allow those residents who know early on what subspecialty they want to pursue to focus their training.

This idea would create logistical dilemmas for residency programs. A couple of schemata have been proposed, but one has not gained universal acceptance by the Residency Review Committee yet. ♀

Elder abuse more common than you may think

DO YOU SCREEN EVERY older patient for abuse? The potential for abuse increases with age, and ob-gyns are a key part of the network to help identify victims and refer them for help.

Asking *every* patient screening questions is critical because there is no typical victim—elder abuse occurs in all racial, social, educational, and economic groups. Moreover, the anticipated burgeoning of the elderly population is beginning, as the baby boomers enter their 60s. Between 2010 and 2030, the number of people over age 65 is expected to grow by 75%.

Effective screening tips

For effective screening, Fellow Ronald Chez, MD, advises being attentive and using simple, open-ended questions when you are alone with the patient. Face her, make eye contact when possible, and wait for her answer without filling the silence. Dr. Chez is associated with the Center of Excellence on Elder Abuse and Neglect at the University of California Irvine School of Medicine.

He suggests preceding your screening questions with a general statement such as "I don't know if this is a problem for you, but because so many patients I see are dealing with abusive relationships, I have started asking about it routinely."

"The value of the ubiquity statement is to let the patient know you are not singling her out," Dr. Chez said.

Two important screening questions to ask are "Do you feel safe where you live?" and "Are you afraid of someone?" Other questions you may wish to include, depending on your patient's condition and situation, are "Has your caregiver ever refused to help take care of you when you asked for help?" and "Have you been forced to do something sexually that you don't want to do?"

Studies have shown that although physicians know they should screen their patients for abuse, they don't do it consistently, according to Georgia J. Anetzberger, PhD, a consultant in elder abuse and editor of the *Journal of Elder Abuse and Neglect*.

Among the reasons given are that it's too time-consuming; they don't have confidence in the agency that would look into the case; they don't want to be pulled into court; they believe it's someone else's responsibility; and they fear losing rapport with the patient, perhaps leaving the patient more isolated and vulnerable than ever.

But including screening in your practice may be saving a life.

"It is always easier to prevent the problem from escalating if intervention is done earlier rather than later," Dr. Anetzberger said. "In addition, research has shown that an older person is more likely to tell a physician about abuse than any other professional."

Finally, most state laws identify physicians as mandatory reporters of suspected instances of abuse and neglect.

If you do find your patient is a victim of abuse, Dr. Chez said, "The first thing to do is indicate to her that it's not her fault. She has a right to be safe. Then, document it in the chart and make a referral to your local Adult Protective Services agency. As physicians, we don't have the resources for handling elder abuse, so the team approach is essential. APS does a fantastic job and is linked to all the resources."

Dr. Anetzberger cautions that it's not the responsibility of the physician to investigate what happened or to determine who caused the abuse. "The physician can just focus on seeking assistance for the patient."

Tip of the iceberg

How prevalent is elder abuse?

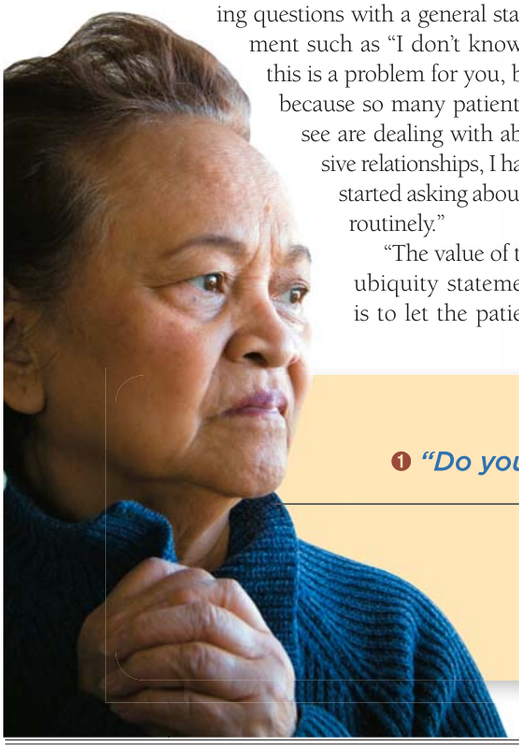
"It is far more common than most people think," Dr. Anetzberger said. Although there is no national uniform data collection method, local studies suggest that 3% to 6% of the elderly who live outside of institutions are abused.

Calling it the "iceberg phenomenon," Dr. Chez said that it is estimated that only one out of six cases of elder abuse is reported. As an example, he notes that in Orange County, CA, where 500 suspected cases of abuse are reported for investigation each month, there could be as many as 3,000 cases of alleged elder abuse.

According to a survey of APS agencies in 2004, 89% of the alleged cases of elder abuse occurred in a domestic setting, and two out of three victims were women. ♀

info

➜ National Center on Elder Abuse: www.ncea.aoa.gov



Two important screening questions to ask:

❶ "Do you feel safe where you live?" ❷ "Are you afraid of someone?"

A SURVEY ON ELDER ABUSE SHOWED THAT:*

- In 20 of the states, 43% of victims were 80 or older
- 2 out of 3 elder abuse victims were women
- 89% of the alleged abuse occurred in a domestic setting

2004 SURVEY OF STATE ADULT PROTECTIVE SERVICES, NATIONAL CENTER ON ELDER ABUSE

Don't deliver late-preterm infants unless medically indicated

LATE-PRETERM INFANTS should not be delivered unless there is an accepted maternal or fetal indication for delivery, according to a new ACOG Committee Opinion.

Late-preterm infants—those born between 34 weeks and zero days and 36 weeks and six days of gestation—are often mistakenly believed to be as physiologically and metabolically mature as term infants. However, late-preterm infants are at higher risk than term infants are of developing numerous substantial medical complications, resulting in higher rates of infant mortality, morbidity before initial hospital discharge, and hospital readmission in the first months of life.

"In the last decade, the proportion of births that were late-preterm births increased by 16%," said Ann R. Stark, MD, the American Academy of Pediatrics liaison to the ACOG Committee on Obstetric Practice. "Women and physicians need to be careful that when scheduling cesarean deliveries or inductions, they do so only when maternal or fetal indications exist, such as preeclampsia or a nonreassuring fetal status."

Collaborative counseling by both obstetric and neonatal clinicians about the outcomes of late-preterm births is warranted unless precluded by emergent conditions, according to the Committee Opinion *Late-Preterm Infants*, which was published in the April issue of *Obstetrics & Gynecology*. Much of the Committee Opinion contains information on the health risks these infants face, as outlined in guidelines by the American Academy of Pediatrics.

Late-preterm infants are four times more likely than term infants are to have at least one medical condition diagnosed and three and a half times more likely to have two or more conditions diagnosed, according to the Committee Opinion. Late-preterm infants are more likely to be diagnosed with temperature instability, hypoglycemia, respiratory distress, apnea, jaundice, and feeding difficulties. ♀

NATIONAL DAY TO PREVENT TEEN PREGNANCY

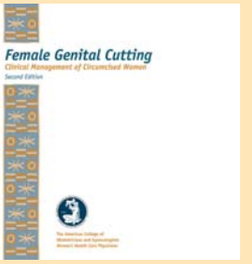
PROMOTIONAL MATERIALS AND IDEAS ON how to promote the National Day to Prevent Teen Pregnancy on May 7 are now available. ACOG is a partner in the annual event, organized by the newly renamed National Campaign to Prevent Teen and Unplanned Pregnancy.

On the day, teens will be asked to visit a new website, www.stayteen.org, to take a short, scenario-based quiz that asks them what they would do in a number of risky sexual situations. Online, the campaign offers National Day promotional materials (pens, rubber bracelets, headphone cord charms), web banners, sample press releases, and a list of local community events.

Recently, the campaign expanded its mission—and its name—to include unplanned pregnancies among 20-somethings, launching a new website, www.thenationalcampaign.org. ♀

info

➜ www.thenationalcampaign.org/national



New CD-ROM educates clinicians about female genital cutting

APPROXIMATELY 228,000 women and girls in the US have undergone or are at risk for female genital cutting, according to the African Women's Health Center at Brigham and Women's Hospital in Boston. While the procedure is illegal in the US, your patient population may include immigrants who have undergone the procedure or girls at risk because family members intend to take the girls back to their family's home country to undergo the procedure.

ACOG has revised its slide lecture kit on female genital cutting, providing a presentation that can be used to teach residents or other clinicians about the procedure. The kit is now available as a CD-ROM that includes a slide presentation with speaker notes and a short video by primary author Nawal M. Nour, MD, MPH.

"It's much more user-friendly now, and the video can educate the presenter on how to use the information for grand rounds or it can be used as a method to teach residents directly," said Dr. Nour, founder and director of the African Women's Health Center at Brigham and Women's Hospital.

The practice is sometimes called female genital mutilation, but most of these women do not see themselves as "mutilated" and may be offended by that term, according to Dr. Nour. ACOG recommends that practitioners use whatever terminology their patient uses. ♀

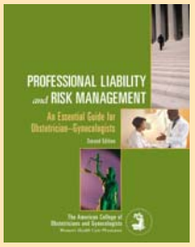
info

➜ *Female Genital Cutting: Clinical Management of Circumcised Women*, second edition: http://sales.acog.org; 800-762-2264

ACOG book serves as guide to professional liability, risk management

THE NEWEST EDITION OF ACOG's popular guide *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists* is now available. This second edition has been updated with the latest professional liability statistics and information.

The guide offers a wide array of professional liability and risk management issues, concepts, and strategies in an easily accessible format. Chapters are devoted to such topics as emerging legal theories, the role of the expert witness, consent issues, risk management, liability insurance, high-risk areas for ob-gyns, special liability issues for residents, and litigation stress. The book also contains a glossary of insurance and medical-legal terms and a new checklist for tracking systems. The guide is available through the ACOG Bookstore (see "info" below).



Brochures featuring select content from the book are also available at no charge. Brochure titles are:

- *Coping with a Crisis in Your Professional Liability Coverage*
- *Informed Consent and Informed Refusal*
- *Medical Record Retention*
- *Reducing the Risk of Obstetrical Lawsuits*
- *Risk Management and Patient Follow-Up*
- *Shopping for a Professional Liability Insurance Policy*
- *Terminating a Physician-Patient Relationship* ♀

info

➜ Book: http://sales.acog.org; 800-762-2264
➜ To request brochures: nwilson@acog.org

Federal program protects physicians who give vaccines

PHYSICIANS WHO ADMINISTER vaccines to their patients can be protected from medical liability through the National Vaccine Injury Compensation Program.

"VICP provides reassurance to ob-gyns administering important vaccines to their patients," said Stella M. Dantas, MD, a member of ACOG's Committee on Professional Liability. "Ob-gyns should be aware of this program—and how to comply—so if a patient has a serious vaccine complication, we can steer them in the right direction."

The VICP was established 20 years ago as a no-fault alternative to the adversarial tort system by providing compensation to people who are found to be injured by certain vaccines.

Only certain vaccines are covered by the program. HPV was recently added to the coverage list.

To comply with the program, vaccine providers need to properly distribute and document the vaccination. The American Academy of Pediatrics encourages vaccine providers to follow the four "D"s: distribute, discuss, document, and dialogue. Federal law requires vaccine providers to distribute a federal Vaccine Information Statement, or VIS, each time the vaccine is given, even if the statement was provided for a previous dose of the same vaccine.

According to AAP, physicians need to be sure they properly document the name, address, and title of the person administering the vaccine; the date of vaccine administration; and the vaccine manufacturer and lot number of the vaccine used. Physicians should also document when the VIS was provided and discussed with the patient.

Only certain vaccines are covered by the program. HPV was recently added to the coverage list.

Also covered are the following types of vaccines: diphtheria, tetanus, pertussis; haemophilus influenza type b; Hepatitis A and B; trivalent influenza; measles, mumps, rubella; meningococcal; polio; pneumococcal conjugate; rotavirus; and varicella. Patients or their families can file a claim if the effects of the injury lasted for more than six months after the vaccine was given or resulted in a hospital stay and surgery or resulted in death.

When a claim is filed, a medical review is conducted, followed by a legal review by the US Department of Justice. The US Court of Federal Claims makes the final decision on whether compensation will be awarded and how much.

"Ob-gyns are being called upon to implement vaccine programs into their practice," Dr. Dantas said. "To protect themselves and their patients, providers should be familiar with this federal program." ♀

info

➜ VICP: www.hrsa.gov/vaccinecompensation
➜ AAP's four "D"s: http://practice.aap.org/content.aspx?aid=1602&nodeID=3003
➜ Vaccine Information Statements: www.cdc.gov/vaccines/pubs/vis

2008 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

APRIL

8
ACOG WEBCAST:
Pursuing Excellence in Perinatal Safety and Quality: Meeting the Challenge and Maintaining Engagement
1—2:30 pm ET
800-673-8444, ext 2498

9–13
Pacific Coast Reproductive Society 56th Annual Meeting
Rancho Mirage, CA
www.pcrsonline.org
562-947-7068

16–18
North American Society for Pediatric and Adolescent Gynecology Annual Clinical Meeting
Newport Beach, CA
www.naspag.org/ACM/geninfo.html

30–May 3
10th Congress of the European Society of Contraception "Noncontraceptive Impact of Contraception and Family Planning"
Prague, Czech Republic
www.contraception-esc.com

MAY

3–7
ACOG 56th Annual Clinical Meeting
New Orleans
www.acog.org/acm

13
ACOG WEBCAST:
Coding with Modifiers
1–2:30 pm ET
800-673-8444, ext 2498

15–17
American College of Physicians Internal Medicine Meeting
Washington, DC
www.acponline.org
800-523-1546, ext 2600

23–29
American College of Nurse-Midwives 53rd Annual Meeting & Exposition
Boston
www.acnm.org
240-485-1800

JUNE

10
ACOG WEBCAST:
Pay for Call
1–2:30 pm ET
800-673-8444, ext 2498

11–14
Western Association of Gynecologic Oncologists Annual Meeting
Sonoma, CA
www.wagogynonc.org
202-863-1648

14–18
American Medical Association Annual Meeting
Chicago
www.ama-assn.org
202-863-2515

25–29
Society of Obstetricians and Gynaecologists of Canada 64th Annual Clinical Meeting
Calgary, AB
www.sogc.org
613-730-4192, ext 347

JULY

8
ACOG WEBCAST:
Ovarian Cancer: Information for the Generalist Ob-Gyn
1–2:30 pm ET
800-673-8444, ext 2498

18–20
Gynecologic Oncology Group Semi-Annual Meeting
Chicago
www.gog.org
215-854-0770

AUGUST

8–9
ACOG Future Leaders in Ob-Gyn Conference
Washington, DC
202-863-2515

12
ACOG WEBCAST:
Interrupted Pregnancy Coding
1–2:30 pm ET
800-673-8444, ext 2498

14–16
Infectious Diseases Society for Obstetrics and Gynecology 35th Annual Scientific Meeting
Seattle
www.idsog.org/AnnMtg.cfm
202-863-2570

21–23
ACOG District III, VI and IX Annual Meeting
Banff, AB
202-863-2530

24–28
18th World Congress on Ultrasound in Obstetrics and Gynecology
Chicago
www.isuog2008.com
info@isuog.org
+44(0) 20-7471-9955

SEPTEMBER

4–6
American Urogynecologic Society 29th Annual Scientific Meeting
Chicago
www.augs.org
202-367-1167

17–20
Royal College of Obstetricians and Gynaecologists 7th International Scientific Meeting
In conjunction with ACOG and the Society of Obstetricians and Gynaecologists of Canada
Montreal, QC
www.rcog2008.com

ACOG COURSES

1. For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
2. For Coding Workshops, visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Telephone registration is not accepted for Coding Workshops.

Registration must be received one week before the course. On-site registration subject to availability.

APRIL

4–6
ICD-9-CM and CPT Coding Workshop
Albuquerque, NM

MAY

8–10
ICD-9-CM and CPT Coding Workshop
New Orleans

JUNE

5–7
Quality and Safety for Leaders in Women's Health Care
Chicago

7–8
"No Frills" Emerging Issues in Office Practice: Sexuality, Body Image, and Psychologic Well-Being
Chicago

20–22
ICD-9-CM and CPT Coding Workshop
Portland, OR

26–28
Reawakening the Excitement of Obstetrics and Gynecology
Kohala Coast, HI

27–29
ICD-9-CM and CPT Coding Workshop
San Francisco

JULY

11–13
ICD-9-CM and CPT Coding Workshop
Memphis, TN

17–19
Concepts and Controversies in the Treatment of Perimenopausal and Postmenopausal Women
Vancouver, BC

AUGUST

15–17
ICD-9-CM and CPT Coding Workshop
Richmond, VA

21–23
Practical Obstetrics and Gynecology (in conjunction with the ACOG District III, VI, and IX Annual Meeting)
Banff, AB

SEPTEMBER

12–14
ICD-9-CM and CPT Coding Workshop
Chicago

18–20
Update on Cervical Diseases
Charleston, SC

26–28
ICD-9-CM and CPT Coding Workshop
Dallas

NOVEMBER

6–8
Practical Obstetric and Gynecologic Ultrasonography: Spotlight on Chronic Pelvic Pain
Naples, FL

14–16
ICD-9-CM and CPT Coding Workshop
Atlanta

New edition of *Precis: Oncology* available

THE THIRD EDITION OF *PRECIS: Oncology* encompasses the extraordinary increase in knowledge about cancer that has occurred in the past few years.

This new edition offers updated information on the role of genetics in cancer, preventive strategies, therapeutic modalities, supportive care, and psychosocial issues. An entire chapter focuses on screening and prevention strategies for all types of gynecologic and nongynecologic cancer. The chapter on breast cancer covers all forms of imaging and techniques for screening and diagnosis. The section on preinvasive cervical neoplasia has been expanded to highlight important new guidelines for screening and management.

The book also includes information on special topics, such as cancer in pregnancy, quality-of-life considerations, and integrative medicine, to present a balanced approach to patient care.

Precis helps ob-gyns stay current

The entire set of *Precis: An Update in Obstetrics and Gynecology* is a five-volume resource intended to meet the continuing educational needs of ob-gyns.

Precis offers a broad overview of information that focuses on new and emerging techniques. Each year, one volume of the set is revised. Other *Precis* volumes are *Primary and Preventive Care*, *Reproductive Endocrinology*, *Obstetrics*, and *Gynecology*. ♀

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