

Fellows leading the way in public health

Dr. Emeterio Gonzalez Jr treats a patient at a free medical clinic in Baja California, Mexico. Volunteering at the clinic in the late 1980s was one of his first introductions to public health.



WHETHER THEY ENTERED THE PUBLIC HEALTH FIELD intentionally or stumbled into it accidentally, several ACOG Fellows hold key public health positions in state health departments and federal agencies.

Moving from clinical practice to a government position can be quite an adjustment, but these ob-gyns say they appreciate the ability to contribute to women's health on a broader scale.

Their experience as clinicians also allows them to understand the needs and issues of the medical community.

"Because I have a strong clinical perspective, I feel like I can act as a bridge between the clinical community and the public health community," said ACOG Fellow William M. Callaghan, MD, MPH, a senior scientist at the Centers for Disease Control and Prevention. "My perspective can help form the questions that we ask in public health. Clinical decisions are made one at a time, but the net effect of those decisions is what is measured in public health."

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ACOG book addresses underserved women

ACOG HAS DEVELOPED A NEW BOOK, *Special Issues in Women's Health*, that focuses on the health care needs of underserved women. These women often suffer health care disparities from barriers created by poverty, cultural differences, race and ethnicity, geography, and other factors.

Underserved issues and populations may not be receiving proper attention because physicians are not adequately trained to handle such groups, are afraid of offending patients, feel powerless in addressing the problem, have insufficient support, or face time constraints, according to *Special Issues*.

"This book focuses on many underserved groups of women, including women with disabilities, incarcerated women, lesbian and bisexual women, and transgendered individuals," said Kurt T. Barnhart, MD, chair of the ACOG Committee on Health

"Because we do not care for these women every day, this book can serve as a valuable resource."



Care for Underserved Women. "Because we do not care for these women every day, this book can serve as a valuable resource."

Special Issues also presents information on patient communication, cultural competency, and topics such as substance abuse, smoking, domestic violence, sexual assault, and adult manifestations of childhood sexual abuse.

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EXECUTIVE DESK

Strategic plan charts ACOG's course

AT ACOG'S NATIONAL OFFICE, we often receive inquiries about ACOG's goals and plans for the future. Some members believe that the Executive Board simply goes from one issue to the next without a forward-looking plan. This could not be further from the truth.

As with any large organization, ACOG has an evolving plan of action. This strategic plan is reviewed every year to ensure that it is relevant to the current health care environment. Based on the strategic plan, ACOG has specific goals to attain. We do not always succeed, but we are cognizant of what we need and where to go.

At the February meeting of the Executive Board, a new operational mission statement and strategic plan for ACOG were reviewed, discussed, and approved. They will be presented to the fellowship at the Annual Business Meeting at the Annual Clinical Meeting in May.

The plan's goals fall under four main categories:

- ▶ Advocate for women's health
- ▶ Assess and evaluate the breadth, depth, and practice of the discipline
- ▶ Expand and strengthen membership support
- ▶ Nurture and improve the obstetric and gynecologic community

Next step: developing an operational plan

The document is the culmination of many hours of work by a task force appointed by ACOG President Vivian M. Dickerson, MD, and the efforts of the Executive Board at its November strategic planning

Operational Mission Statement

The American College of Obstetricians and Gynecologists, the pre-eminent authority on women's health, is a professional membership organization dedicated to advancing women's health by building and sustaining the obstetric and gynecologic community and actively supporting its members. The College pursues this mission through education, practice, research, and advocacy. ACOG will emphasize life-long learning, incorporate new knowledge and information technology, and evolve its governance structure. To achieve its strategic goals, ACOG will develop an operational plan that includes appropriate metrics.

meeting. College staff will now develop an operational plan to accomplish the goals of the strategic plan.

I hope each of you will review the new operational mission statement and let your district chair know if you have concerns, constructive improvements, appreciation, or suggestions.

As with any plan or mission, this is not a plan "fixed in concrete." It is a plan that is designed to be flexible to meet your needs for the next five to seven years. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

James William Gay, MD
Atlanta

J. A. Karsh, MD
Middlebury, CT

Ronald Alan Koval, MD
East Amherst, NY ✉ 2/05

Philip Novina, MD
Oceanside, CA

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Fairfield, CT ✉ 2/05

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Howard A. Spindler, MD
Rochester, NY

Daniel R. Taffe, MD
Haverhill, MA ✉ 2/05

Obstetrics & Gynecology
HIGHLIGHTS

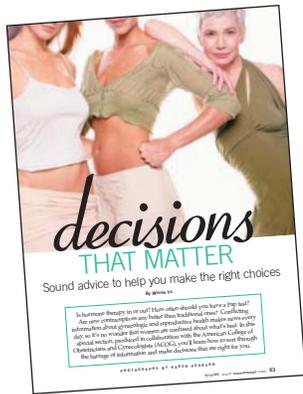
The May issue of
the Green Journal
includes the
following ACOG
document:

**Intrapartum Fetal Heart
Rate Monitoring**

(Practice Bulletin #62, revised)
For more information, see article
on page 11.

ACOG teams up again with *Woman's Day* magazine

ACOG HAS PARTNERED with *Woman's Day* magazine for the second consecutive year to present important health information to more than 19 million women in the US.



ACOG's Office of Communications collaborated with *Woman's Day* on a special supplement in the May 10 issue. *Decisions that Matter: Sound Advice to Help You Make the Right Choices* promotes College guidelines and includes interviews with ACOG Fellows and a message from newly inducted ACOG President Michael T. Mennuti, MD.

"Many strides in women's health care have been made during the last decade, including breakthroughs in contraception choices, gynecologic surgery, screening tests, and earlier cancer detection," Dr. Mennuti writes. "Having options can be confusing. Gather facts [and] educate yourself. ... Knowledge will empower you to be an

active partner with your physician in making the right decisions about your health."

The supplement includes sections on hormone therapy, cervical cancer screening, fibroids, low sex drive, elective cesarean sections, and birth control options. ♀

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- www.womansday.com/acog
- Copies of the supplement are available through ACOG's Office of Communications: 800-673-8444, ext 2560



Drs. Laughead and Wah run for AMA office

Two ACOG Fellows are running for office in the American Medical Association. ACOG urges its members to support these candidates.

Robert M. Wah, MD, Capt, MC, USN, is running for a seat on the AMA Board of Trustees. Dr. Wah is the associate chief information officer and practices at Walter Reed Hospital in Bethesda, MD.

Marilyn K. Laughead, MD, is running for a seat on the AMA Council on Constitution and Bylaws. Dr. Laughead practices ob-gyn in Scottsdale, AZ. ♀



Correction

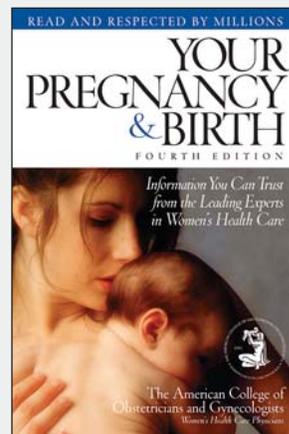
The obituary for Past President George W. Morley, MD, in the April issue of *ACOG Today* listed the wrong middle initial for Dr. Morley. We apologize for the error.

Fourth edition of pregnancy guide now available

ACOG's complete guide to childbirth, *Your Pregnancy & Birth*, has been thoroughly revised and redesigned and is now available for your patients.

Now in its fourth edition, the book has undergone extensive revisions to reflect the latest scientific advances and practice guidelines. Updates include information on genetic disorders and available screening tests. New tests and approaches to monitoring the health of the mother and baby are described to help parents understand the screening techniques they may encounter.

There is also more information about women



with certain medical conditions and how such conditions affect pregnancy as well as the latest recommendations on what foods pregnant women should and should not consume.

As more and more attention is focused on leading a healthy lifestyle—and not just during pregnancy—a new chapter on how to

stay healthy throughout life has been added and includes information on nutrition, exercise, family planning, and tests that are recommended at certain ages.

Your Pregnancy & Birth also provides advice on finding a doctor and a facility that meets a woman's needs best and offers advice on how to cope with the physical and emotional changes a woman encounters during pregnancy.

The book continues to include a complete subject index, a personal pregnancy diary, and an extensive glossary. ♀

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- Order at <http://sales.acog.org>; 800-762-2264, ext 192

The following profiles show just a few o

Emeterio Gonzalez Jr, MD

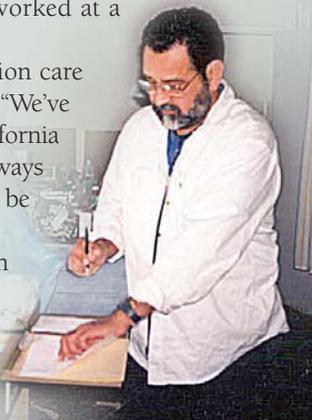
Public Health Medical Officer II ■ Maternal, Child, and Adolescent Health Branch
California Department of Health Services

DR. GONZALEZ WAS A PRACTICING OB-GYN FOR 22 YEARS before joining the California Department of Health Services almost five years ago. “They needed an ob-gyn in the Maternal, Child, and Adolescent Health Branch, Office of Family Planning, plus I had a desire to help people who are not being taken care of, who just don’t have any access to care,” he explained.

Dr. Gonzalez had worked with underserved populations throughout his career in California and Washington. He was a member of the Flying Samaritans, a volunteer organization that operates free medical clinics in Baja California, Mexico. In Washington, where he practiced for five years, he worked at a clinic that served primarily migrant workers.

Dr. Gonzalez’s branch is developing a preconception care program as well as a pregnancy-related mortality review. “We’ve had a slight trend upward in maternal mortality in California so we’re establishing a review to develop more effective ways to address medical and psychosocial factors that can be linked to the causes of death.”

Dr. Gonzalez continues to treat patients and teach residents. Twice a month he volunteers as an assistant clinical professor at the University of California, Davis, and he also volunteers at two free clinics for uninsured people.



Diana Cheng, MD

Medical Director, Women’s Health
Center for Maternal and Child Health
Maryland Department of Health and Mental Hygiene

“I ACTUALLY APPLIED TO MEDICAL SCHOOL WITH THE GOAL of going into public health,” Dr. Cheng said, “but I got seduced by clinical medicine.”

At one point, Dr. Cheng was practicing in Seattle where she consulted on many different community health projects. “That drew me back into public health to do something more population oriented.” She accepted a position at the Maryland Department of Health and Mental Hygiene, where she’s been about 10 years.

Dr. Cheng’s division is working on a pilot project at three local health department centers that provide care to underserved women. The project is integrating comprehensive preventive women’s health services into the family planning program to improve availability of quality services.

“This project is really getting at the whole mission of public health: prevention of disease and promotion of health. It’s been a very fulfilling project to work on.”

One disorder Dr. Cheng finds that is particularly underdiagnosed and undertreated in women is depression. She recently helped develop a postpartum depression brochure to distribute to women before they leave the hospital after delivery.

William M. Callaghan, MD, MPH

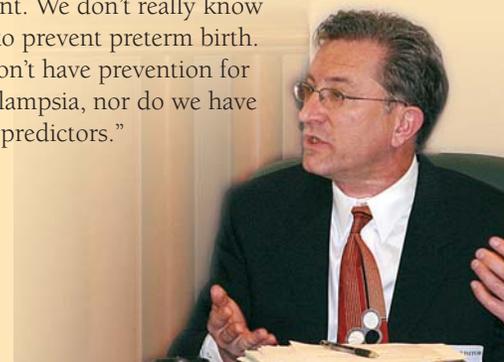
Senior Scientist, Maternal and Infant Health Branch
Division of Reproductive Health
Centers for Disease Control and Prevention

DR. CALLAGHAN PRACTICED IN A LARGE private practice for 14 years before leaving in 1999 to do a second residency in preventive medicine and obtain a master’s degree in public health. During his second residency, he spent seven months at the CDC and was later offered a position as a medical epidemiologist in the Division of Reproductive Health. He’s been at the CDC for four years.

“While I very much enjoyed private practice and the contact with my patients, I was seeing many of the same determinants of problems they presented with over and over and over again,” Dr. Callaghan said. “I became very interested in the health of populations and that led me into a research role. It’s extremely gratifying. Much of what I enjoy is looking at data, finding the hidden patterns, and interpreting the patterns correctly.”

Many of Dr. Callaghan’s surveillance projects focus on maternal mortality and preterm birth. He was an author of a CDC research paper that examined maternal mortality in women 35 and older. The research showed that these women had a higher risk of mortality but that they were dying from the same conditions as younger women: hemorrhage, amniotic fluid embolism, pulmonary embolism, hypertensive disorders, and chronic medical conditions.

While disease prevention interventions can be difficult to initiate in a clinical setting, they’re still important, Dr. Callaghan said. “We know a lot about the effects and importance of some preventive methods, such as not smoking during pregnancy, but there are many things we don’t know how to prevent. We don’t really know how to prevent preterm birth. We don’t have prevention for preeclampsia, nor do we have good predictors.”



f the ACOG Fellows working in public health



C. Michael Riddell, MD

Chief Physician Consultant
Women's Health Team
Arkansas Department of Health

DR. RIDDELL HAD A BUSY private practice in Arkansas, when, in 1998, he was suddenly diagnosed with multiple sclerosis. Although it turned out that he has a mild form of the disease, it led to physical disabilities and forced him to discontinue his private practice at age 43. Later, he accepted a part-time position at the Arkansas Department of Health in the perinatal health unit. Subsequently, the perinatal health and family planning departments were combined into a new "women's health team," with Dr. Riddell as its first chief, the position he holds today.

"Although I miss the close rapport I had with my patients in private practice, I realized I could be much more effective contributing an ob-gyn's perspective and experience regarding population-based health concerns," Dr. Riddell said.

In 2002, the health department received an award from the state March of Dimes for a program Dr. Riddell created that immunized seronegative postpartum women for rubella before they are discharged from the hospital.

Dr. Riddell also developed a program to train registered nurse practitioners to insert intrauterine devices and has personally trained more than 25 RNPs and physicians one-on-one.

"Access to IUDs for indigent women in Arkansas was very limited before," he said. "Now, women have much shorter waiting periods for an IUD, and there has been a greater demand for this type of contraception due to a high level of patient satisfaction."

Dr. Riddell also promotes a successful state project, the Campaign for Healthier Babies, which encourages expectant mothers to get first-trimester and continual prenatal care, with the ultimate goal of reducing the percentage of preterm and low-birth-weight babies. The program distributes to pregnant women *The Happy Birthday Baby Book*, which provides a variety of prenatal information, a monthly planner, and coupons. Since the program was initiated, Arkansas has seen a 16% increase in first-trimester prenatal care visits.



Janet D. Lawson, MD

Clinical Support ■ Preventive and Primary Care Unit
Texas Department of State Health Services

AFTER RESIDENCY while a faculty member at the University of Texas Medical Branch, Dr. Lawson had a small private practice and was the medical director of the UTMB teenage pregnancy clinic and pediatric and adolescent gynecology clinic. Later, she fulfilled the obligation of a medical school public health scholarship by practicing general ob-gyn for 18 months at the Brownsville Community Health Clinic in Brownsville, TX.

After working in private practice in Oregon, she returned to academia, becoming a faculty member at Louisiana State University Medical Center in New Orleans. While there, she staffed the Children's Hospital pediatric and adolescent gynecology clinic and was the medical director of an innovative clinic for women with developmental disabilities. After returning to Texas, she accepted a position at the then-Texas Health Department.

Dr. Lawson now serves as a subject matter expert for the Preventive and Primary Care Unit in the renamed Texas Department of State Health Services. Her unit includes family planning, maternal health, indigent health care, epilepsy, breast and cervical cancer control, and primary care health services.

Dr. Lawson admitted she didn't fully grasp the concept of public health until she began working at the Texas Health Department.

"Many physicians think of public health as simply a safety net for poor people, and that's not what it is. It was quite an education for me," Dr. Lawson said. "Public health involves looking after the general health of the public—all of us—making sure you've got clean water to drink, your food is not contaminated, looking at epidemics and the extent of disease, trying to make sure the polices from the state and the federal government are reasonable and keeping in step with the evidence-based medicine. It's so much broader than what I thought it was."

"There are many bright people here dedicated to public health. If they weren't here, all of us would be a lot sicker." ♀



Work in public health through federal health corps

The National Health Service Corps is actively recruiting primary care clinicians, including ob-gyns, to provide care to underserved people throughout the US.

NHSC, part of the US Health Resources and Services Administration, provides comprehensive team-based health care.

NHSC clinicians are part of primary health care teams, interdisciplinary groups that use their combined skills to maximize their ability to meet patients' health care needs. Team members vary based on the specific needs of each community. NHSC clinicians practice with a community focus and treat the whole patient through health promotion, disease prevention, and continuity of care. ♀

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→ <http://nhsc.bhpr.hrsa.gov>



New teaching resource unveiled at CREOG and APGO Annual Meeting

By Leah A. Kaufman, JFCAC chair

CREOG AND APGO ARE currently developing online educational modules to “teach the teacher” through a new program called REFEREE (Resident Educators/Faculty Educators: Recommendations for Educational Excellence).

REFEREE was just one of the many topics covered at the CREOG and APGO Annual Meeting in March in Salt Lake City. The meeting, as always, was filled with many opportunities for educators of both ob-gyn residents and medical students to share ideas for content and the approach to learning.

REFEREE program

REFEREE is a resident training and faculty development program that will help faculty and residents excel as educators. A CD-ROM demonstration of the pilot module, “Providing Feedback to Your Learner,” will be shown at the CREOG and APGO booths at this month’s Annual Clinical Meeting. Residents, faculty, and medical students who test the demo will be asked to fill out an evaluation form.

Future modules may include topics such as:

- ▶ Writing educational goals and objectives
- ▶ The microskills of teaching
- ▶ Large- and small-group instruction
- ▶ Leading a discussion
- ▶ Ambulatory teaching

The JFCAC requested that professional liability education be included as one of the module topics. Also related to professional liability, CREOG has agreed to include at least one presentation about teaching liability issues to residents at all future CREOG meetings.

In other CREOG news, the release of the eighth edition of *Educational Objectives: Core Curriculum in Obstetrics and Gynecology* was highlighted.

The resource, which will be sent to all ob-gyn residency programs and their residents, provides clear, concise descriptions of exactly what a graduating resident should know or be able to do.

ABOG and ACGME updates

In ABOG news, effective July 1, prospective residents with experience in other specialties who transfer to an ob-gyn program may receive credit for their prior experience.

Up to six months of credit may be given at the program director’s discretion to prospective residents who have successfully completed 12 months of an ACGME-approved program. The change is in response to requests by program directors and Junior Fellows.

During presentations by the ACGME’s Ob-Gyn Residency Review Committee, meeting attendees were able to take part in a mock RRC site-review evaluation meeting, which served to demystify the process for new educators and program directors.

Residency programs have been asked to have a minimum of 70% of their residents complete the online ACGME Resident Survey, which will provide feedback on issues such as compliance and implementation of the 80-hour work week.

Changes to the ob-gyn data collection were announced. Effective July 1, residents will no longer be tracking low-birth-weight deliveries, vaginal breeches, or antepartum surgeries. It was stressed that although tracking has changed, the education in such principles should not.

Multifetal deliveries will now include vaginal deliveries as well as cesarean deliveries. And the category for urogynecology will be eliminated; incontinence and pelvic floor surgery should now be logged under the pelvic surgery/reconstruction heading.

Please contact me with any questions or suggestions for Junior Fellows. ♀

info

→ lkaufman@nshs.edu

Number of US seniors choosing ob-gyn increases

THE PERCENTAGE OF OB-GYN residency programs filled by US medical students in this year’s Match increased slightly compared with last year’s.

In 2005, 67.5% of ob-gyn programs were filled by US medical school seniors, compared with 65.1% last year, according to the National Resident Matching Program. The remaining matched positions were filled by previous graduates and osteopathic and foreign applicants. The percentage of US medical student seniors filling ob-gyn residencies was still below the 75% in 2000 through 2002.

In ob-gyn programs, both the overall number of applicants and the number of US applicants increased from last year. This year, 1,083 of the 1,144 ob-gyn available positions were filled, for a 95% total ob-gyn match.

Overall, more than 14,700 US medical school seniors applied for residency positions, the highest number in almost 20 years. Among the most competitive fields were dermatology, emergency medicine, general surgery, orthopedic surgery, and plastic surgery. ♀

info

→ www.nrmp.org



Personal tale captures ‘What’s Write’ essay contest

No one believed her story. She was a graduate student studying landscape architecture. She wanted to design public gardens in big, urban spaces. When the resident-physician walked into the emergency room, she looked up. “I’m pregnant,” she said, “and I’ve had this pain in my abdomen and going up to my shoulders since 5 am this morning.” Their conversation covered the required ground: menstrual and sexual history, onset and duration of symptoms, exacerbations and ameliorations. And then something happened. The third-year ob-gyn resident asked her about her hopes, her parents, her education, the fiancé who’d abandoned her when he found out she was pregnant. The physical abuse she’d encountered from him. And the resident stroked her hair when she started to cry retelling these stories.

I was that patient. And my decision to apply to medical school was formed that night in a county hospital room. Though I knew I was pregnant, I did not know it was ectopic. The third-year ob-gyn resident that walked through the door of that room where I sat became my inspiration to become a doctor. I couldn’t have predicted the influence she would have on the shape of my life. And she had no idea of the power behind her kindness. ...

“The third-year ob-gyn resident that walked through the door of that room where I sat became my inspiration to become a doctor.”

—Jane van Dis, MD

And so begins the deeply personal essay by Junior Fellow Jane van Dis, MD, of Los Angeles, a second-year resident in District IX, that captured first place in ACOG’s “What’s Write with Ob-Gyn” contest.

The contest was developed by the Junior Fellow College Advisory Council to rejuvenate Junior Fellows as well as motivate medical students to choose the ob-gyn specialty. There was an overwhelming response, with more than 100 essays submitted. A winner was selected in each district to receive \$500 and compete in the national competition. As the national winner, Dr. van Dis received an additional \$500 and a trip to the ACM this month.

“My essay is very personal, and for better or worse, it’s the story I have to tell,” Dr. van Dis said in an interview. “I think it’s easy to forget—in our busy, frantic, long hours and days—that we can have an incredible influence on the way patients feel about their circumstances, their health, and their fears. [The resident] cared enough to listen to my story, and that made all the difference.”

get—in our busy, frantic, long hours and days—that we can have an incredible influence on the way patients feel about their circumstances, their health, and their fears. [The resident] cared enough to listen to my story, and that made all the difference.”

Honored to be their doctor

Dr. van Dis’ essay explains how touched she is to share a family’s personal moments and how honored she is to be



The winning essays from each district can be read in their entirety in the May issue of *Obstetrics & Gynecology*.

entrusted with a woman’s greatest reproductive hopes and fears.

“When the door to the exam room closes, I am honored to be the one listening as a woman tells me about an unplanned pregnancy: her ambivalence and fears, her desire for fertility, for family, however she chooses to define it,” Dr. van Dis writes. “And, like every doctor, I am always in awe of the strength I witness when taking care of a woman near the end of her life or struggling with a diagnosis of cancer. These are some of the most privileged conversations in medicine.”

Dr. van Dis wants medical students to recognize how rewarding the ob-gyn specialty is.

“Medical students need to hear that there are variables other than medical liability, reimbursement, and work hours when considering specialty choice—namely, there’s the incredible satisfaction and connection one has with their patients as an ob-gyn,” Dr. van Dis told *ACOG Today*. “It’s truly an honor to take care of women’s reproductive health, and that’s what I most wanted to share with medical students.” ♀

District essay winners

- District I:Tania Day, MD
- District II:Taraneh Shirazian, MD
- District III:Frederick L. Dutton, MD
- District IV:Randy A. Fink, MD
- District V:Laura A. Hunter, MD
- District VI:Sogol Jahedi, MD
- District VII:Charles W. Gibbs, MD
- District VIII:Jennifer M. Nicholson, MD
- District IX:Jane van Dis, MD
- Armed Forces District:Maureen E. Farrell, MD

Fellows take tort reform fight to Capitol Hill

ACOG PRESIDENT VIVIAN M. Dickerson, MD, and approximately 100 Fellows and Junior Fellows delivered more than 200,000 petitions to Capitol Hill in March, calling for medical liability reform. Dr. Dickerson spoke at a news conference led by Senate Majority Leader Bill Frist (R-TN) about the urgent need for meaningful medical liability reform.

“We are witnessing the slow but sure demise of our specialty because of the medical liability crisis,” Dr. Dickerson said. “Medical students are turning away from the specialty, good doctors are leaving practice, and pregnant women are finding it harder to get care when they need it the most. The future of women’s health is in serious jeopardy.”

The event came during ACOG’s annual Congressional Leadership Conference (for-

merly the Legislative Workshop), in which 140 ACOG members attended sessions about the College’s legislative priorities and advocacy efforts. They also visited their congressional representatives at the US Capitol to urge them to vote for medical liability reform and to stop cutting Medicare physician payments. ♀

Participants at ACOG’s Congressional Leadership Conference listen to keynote speaker Rep. Tom Price (R-GA), an orthopedic surgeon.



ACOG President Vivian M. Dickerson, MD, urges the Senate to pass medical liability reform at a news conference in March. On the left of the photo are Sen. Elizabeth Dole (R-NC) and Incoming ACOG President Michael T. Mennuti, MD. On the far right of the photo is Sen. John Ensign (R-NV), with ACOG Fellows behind him.

McCain Fellow urges ob-gyns to be advocates

ACOG FELLOW VINCENT A. Culotta Jr, MD, has been an advocate for ob-gyns in Louisiana for many years. He helped establish the preferred Medicaid drug list and has helped the Louisiana State Medical Society beat back challenges to its medical liability reform law enacted in 1975. Currently, he serves as chair of the Council on Legislation for the state medical society.

But recently he expanded his advocacy efforts to the national level as an ACOG McCain Fellow, spending four weeks as part of the College’s Government Relations staff in Washington, DC.

“This fellowship has been rewarding, informative, and humbling,” said Dr. Culotta, who practices with a large group practice in



Dr. Culotta

New Orleans. “I arrived here full of ideas and hubris. I leave knowing how much more there is to learn and accomplish.”

Fellows must become active in the legislative process

For Dr. Culotta, the experience underscored how crucial it is for ACOG Fellows to become involved in legislative activities and advocate for ob-gyn issues, including medical

“The impact of an individual physician talking to a legislator is enormous and should never be discounted.”

liability reform, adequate Medicare physician payments, and continued Medicaid coverage for vulnerable populations.

“It really is important that physicians participate and become visible to legislators and the staff of legislators,” Dr. Culotta said. “The impact of an individual physician talking to a legislator is enormous and should never be discounted.”

As part of his experience, Dr. Culotta attended briefings and public hearings on Capitol Hill and met with several members of Congress and their staffs to discuss medical liability reform and other issues.

Dr. Culotta plans to develop a list of political axioms for Fellows new to the legislative process so they can understand the process, pitfalls, and challenges. ♀



Dr. Veltman

Reducing the risk of obstetrical lawsuits

OB-GYNS ARE WELL AWARE of the fact that obstetrics has a higher risk of liability claims than do most other medical specialties. Ob-gyns have an average of 2.6 claims filed against them during their career, and obstetric claims account for 61% of claims against ob-gyns.

But there are steps ob-gyns can take to reduce the chance that they'll be sued. Larry L. Veltman, MD, chair of the ACOG Committee on Professional Liability, offers five key strategies to reduce obstetric liability.

1. Practice high quality medicine—from the patient's perspective

It's important that ob-gyns recognize that patients and physicians don't judge quality in the same way.

"Patients use personal interaction between the physician and the entire health care team to judge quality," Dr. Veltman said. "It may not have anything to do with competency, skill, or training. A very important question to ask ourselves is 'How's my bedside manner?' because that is how patients often judge quality of care."

2. Perfect the art of establishing realistic expectations

The informed consent process is the foundation for establishing realistic expectations. The physician should discuss with the patient how care will be delivered, the alternatives, and the potential outcomes.

This is the time to establish realistic expectations about how the care will be delivered. Important information could include the nature of the call group, who is allowed in the operating room if a cesarean delivery is necessary, when the patient can receive an epidural, and what are the physician's vacation days and days off from work.

3. Be there—before, during, and especially, after

It's important that ob-gyns realize the importance of being available to come when they are called to the labor and delivery department, Dr. Veltman said. A patient is more reassured when her physician is there, especially if a complication arises.

4. Get credit for good care: write it down

Physicians can have good communication, set realistic expectations, and be there, but if they don't document well, they may not get credit for good care. A patient's chart needs to have timed, contemporaneous progress notes of labor with comments on fetal well-being and notes whenever intervention is necessary.

5. Work toward a high reliability perinatal unit

Ob-gyns should see themselves as part of a team, develop good intra-professional communications, and strive toward a multidisciplinary approach to patient care. ♀

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

Tips on physician-patient communication

Make the patient feel welcome

- ▶ Meet the patient, especially a new patient, while she is still fully clothed. "I find that shaking hands with a patient is helpful; there needs to be an invitation of warmth," Dr. Veltman said
- ▶ Try not to have a barrier, such as a desk, between the two of you
- ▶ Don't write or type at the computer when she's talking
- ▶ Elicit information from the patient, and give her time to talk. Studies show that many doctors interrupt their patients after just a few seconds

Keep it simple

- ▶ A patient may feel bewildered or nervous during a visit, which means she may not remember every instruction you give her. Keep the regimen simple, and write it down for the patient
- ▶ Describe benefits of treatment and a timetable for carrying out the treatment
- ▶ Describe side effects and risks of medications and procedures



FDA issues warning for antidepressants

Ob-gyns may want to familiarize themselves with the Food and Drug Administration's new "black box warning" for patients taking antidepressant medication.

The FDA has directed drug companies to add a black box warning to all antidepressants because of the increased risk of suicidal thoughts and behavior among children and adolescents.

However, it's important to recognize that untreated depression may pose a greater suicide risk than antidepressants do. As stated in ACOG's *Health Care for Adolescents*, all adolescents should be asked annually about behaviors or emotions that indicate recurrent or severe depression and a risk of suicide.

In part, the black box warns: "Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of [insert established name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need."

The warning also states that "patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber." ♀

info

- "Depression in Adolescents" fact sheet in ACOG's Tool Kit for Teen Care: www.acog.org/goto/teens
- *Health Care for Adolescents*: Online at www.acog.org/publications/adolescents or order a copy at <http://sales.acog.org>; 800-762-2264, ext 192

► PAGE 1

Being aware and sensitive to different cultures

In the chapter "Cultural Competency, Sensitivity, and Awareness in the Delivery of Health Care," the authors point out that culture is not limited to race or ethnicity. It includes age, gender, faith, class, profession, sexual orientation, and more.

In addition, women from similar racial and ethnic groups may have different cultures, and an individual's culture may change over time, according to ACOG Fellow Francisco Arredondo, MD, MPH, one of the authors and a former member of ACOG's Committee on Health Care for Underserved Women.

Health care providers should develop an understanding of the cultures represented in the communities they serve. They need to be objective and nonjudgmental toward the actions, practices, and lifestyles of their patients.

"It's impossible to be knowledgeable about all cultures, but you have to have certain rules in how you approach your patient, and No. 1 is to listen and listen properly," Dr. Arredondo said. "We also need to positively incorporate cultural differences into the provision of health care measures for our diverse patients and populations."



Most people with disabilities have experienced physical, financial, attitudinal, communication, and knowledge barriers to obtaining quality medical care.

Treating patients with disabilities

Approximately 17 million noninstitutionalized girls and women in the US are living with disabilities, and many of them may be facing significant difficulties in meeting their reproductive health needs. According to *Special Issues*, most people with disabilities have experienced physical, financial, attitudinal, communication, and knowledge barriers to obtaining quality medical care.

Women with disabilities may often be seen as asexual although they have the same sexual desires, needs, and reproductive abilities as nondisabled peers. Ob-gyns should not neglect contraceptive issues.

Physicians need to be aware of the mobility needs of their patients. Offices may have obstacles that are difficult to maneuver around. Alternative positioning may be required for examination.

Patients with disabilities may also need longer appointments and more staff assistance than other patients do, and if the extra time is not built into the schedule, it can be frustrating for both the physician and patient, according to *Special Issues*.

Caring for lesbian and bisexual women

Special Issues stresses that practitioners have the responsibility to provide quality care to all women, regardless of their sexual orientation.

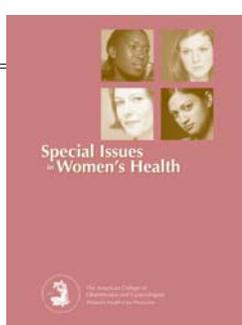
According to *Special Issues*, many physicians conclude that lesbians don't need Pap tests because they don't have sex with men. However, studies have shown that most lesbians have been sexually active with men at some point. The book recommends standard comprehensive gynecologic care for lesbian and bisexual women, including family planning and STD screening and prevention counseling.

Physicians should also be aware that teenage girls and young women may be questioning their sexual orientation and experimenting with lesbian behavior.

Lesbian teenagers face social stigma, hostility, hatred, and isolation, and are at higher risk for suicide, victimization, sexual risk behaviors, substance use, tobacco use, and eating disorders. Therefore, it is important for practitioners to ask about sexual activity with males or females, attraction to males or females, and self-identification as lesbian or bisexual, according to *Special Issues*. ♀

info

- Order at <http://sales@acog.org>; 800-762-2264, ext 192



Standard terminology recommended for fetal heart rate monitoring

A NEW ACOG PRACTICE BULLETIN encourages ob-gyns to use the same, established terminology when evaluating fetal heart rate patterns.

Electronic fetal monitoring is the most common OB procedure, with approximately 3.4 million fetuses in 2002 assessed with the technology. Practice Bulletin *Intrapartum Fetal Heart Rate Monitoring (#62)*, which was published in the May issue of *Obstetrics & Gynecology*, lists definitions developed in 1997 by the National Institute of Child Health and Human Development Research Planning Workshop.

“The language needed to be standardized,” said ACOG Fellow George Macones, MD, who helped draft the Practice Bulletin. “There can be a lot of variation in how physicians read fetal heart tracings, and this variation could lead to miscommunication between health care providers in the course of patient care. We believe that if everyone uses the same language, such miscommunication will be minimized.”

The document also reviews the data on the efficacy of electronic fetal monitoring, delineates the strengths and weaknesses of electronic fetal monitoring, and describes the management of nonreassuring fetal heart rate patterns. ♀



NIH issues new guidelines on asthma and pregnancy

A NATIONAL INSTITUTES OF HEALTH PROGRAM has issued the first new guidelines in more than a decade for managing asthma during pregnancy. The report includes new medications that have emerged as useful in pregnancy and updates treatment recommendations for pregnant women with asthma.

Managing Asthma During Pregnancy: Recommendations for Pharmacologic Treatment—Update 2004 was developed by the National Asthma Education and Prevention Program, which is administered by the National Heart, Lung, and Blood Institute.

Because asthma severity changes during pregnancy for most women, the guidelines recommend that ob-gyns monitor asthma severity during prenatal visits and work with the patient's asthma care provider

to adjust her medications as needed.

In a recent study by the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network, asthma worsened in about 30% of women who had mild asthma at the start of their pregnancy and improved in 23% of women who initially had moderate or severe asthma. ♀

info

→ www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg.htm

Watch pregnant women for West Nile Virus signs

As summer—and mosquito season—grows nearer, the Centers for Disease Control and Prevention reminds ob-gyns to be aware of the West Nile Virus risk to their pregnant patients.

CDC encourages physicians to consider WNV infection in the differential diagnosis of women presenting with unexplained fever and/or neurologic illness during pregnancy in areas of WNV transmission.

The agency requests that physicians report any such cases to their local or state health department and also asks that ob-gyns seek consent from their patients to enroll them in the national WNV pregnancy registry (see info below).

The likelihood of transmission from mother to baby is unknown, as is the chance of clinical abnormalities. CDC is tracking pregnant women infected with the disease to see if it can be transmitted to the fetus and to determine birth outcomes.

Treating pregnant women with West Nile Virus

CDC released interim guidelines last year on WNV and pregnancy. The guidelines state that:

- ▶ Screening of asymptomatic pregnant women for the disease is not recommended because the consequences of infection during pregnancy have not been well-defined and there is no treatment for infection
- ▶ Pregnant women who have meningitis, encephalitis, acute flaccid paralysis, or unexplained fever in an area of ongoing WNV transmission should have serum tested for antibody to WNV
- ▶ If the illness is diagnosed in pregnancy, a detailed ultrasound to evaluate for structural abnormalities in the fetus should be considered no sooner than two to four weeks after onset of WNV illness unless an earlier examination is otherwise indicated

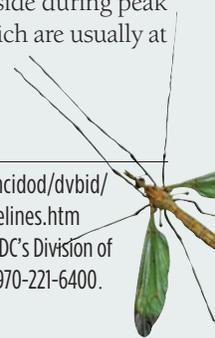
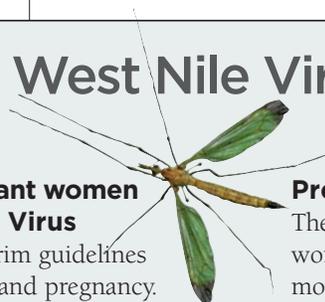
Preventing WNV infection

The guidelines also recommend that pregnant women who are exposed to WNV-infected mosquitoes should use insect repellent that contains DEET on skin and clothes and wear clothing that protects from mosquito bites.

When used according to the product label, DEET can be used by pregnant women without harming the fetus. Pregnant women should also avoid being outside during peak mosquito-feeding times, which are usually at dawn and dusk. ♀

info

- WNV guidelines: www.cdc.gov/ncidod/dvbid/westnile/congenitalinterimguidelines.htm
- To enroll patients in registry: Call CDC's Division of Vector-Borne Infectious Diseases, 970-221-6400.



National partnership committed to improving patient safety after surgery

A NEW NATIONAL PARTNERSHIP is striving to improve surgical care through the reduction of post-operative complications. The Surgical Care Improvement Project's goal is to reduce the national incidence of surgical complications by 25% by 2010. The project plans to launch a national campaign in mid-2005 addressing four target areas:

- ▶ Surgical-site infections
- ▶ Adverse cardiac events
- ▶ Deep-vein thrombosis
- ▶ Postoperative pneumonia

"Because ob-gyns interact with other specialties and health care staff as we care for our patients, we need to address patient safety issues from a multidisciplinary approach," said Vanessa K. Dalton, MD, a member of ACOG's Committee on Quality Improvement and Patient Safety who represents the College on the technical expert panel of the national partnership. "Furthermore, because system



problems are the root cause of many medical errors, we need to be consistent with our solutions across disciplines and health care settings. ACOG's participation in the SCIP project is one example of the College's commitment to health care quality and patient safety."

The partnership was initiated by the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services in 2003. Last year, the partnership released an advisory statement on surgical infection prevention. ♀

info

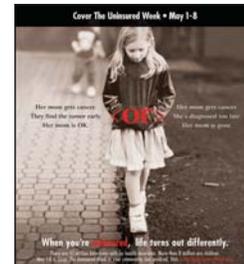
- SCIP: www.medqic.org/scip
- Surgical infection prevention advisory statement: Click on the June 15, 2004, issue of *Clinical Infectious Diseases* at www.journals.uchicago.edu/CID/journal/available.html

CoverThe
UninsuredWeek 2005
MAY 1-8
Let's Get America Covered

ACOG MEMBERS ARE HELPING

call attention to Cover the Uninsured Week, the first week of May, by distributing materials to their patients and taking part in events around the country.

ACOG is a supporter of Cover the Uninsured Week, and universal health care is a legislative priority for the College.



The official kickoff event was April 27, but more events will be held throughout May. Hundreds of thousands of individuals are

participating in events such as health fairs, business seminars, campus activities, and faith-based meetings.

Materials and a list of events can be found on the Cover the Uninsured Week website. ♀

info

- <http://covertheuninsuredweek.org>



Recognizing endometriosis among teens

ENDOMETRIOSIS is often recognized as a disease affecting women in their 30s and 40s. However, the disease is increasingly being seen in adolescents and young adults, a fact addressed in a new ACOG Committee Opinion, *Endometriosis in Adolescents* (#310).

Published in the April issue of *Obstetrics & Gynecology*, the Committee Opinion highlights the differences between adolescent and adult endometriosis.

"It is important for health care providers of adolescent women to understand that endometriosis can occur in this age group and is a common cause of chronic pelvic pain," said Marc R. Laufer, MD, chair of ACOG's Committee on Adolescent Health Care.

Teenagers and adults present differently

Adolescents may be more likely than adults to seek medical treatment because of pain rather than a concern about infertility, according to the document. In addition, adult women with endometriosis may bring in their teen daughters for evaluation and early diagnosis.

Published studies have shown that acquired or progressive dysmenorrhea is the most common symptom, followed by acyclic pain, dysuria, and gastrointestinal complaints.

"In contrast to adult women, adolescents tend to have both acyclic and cyclic pain instead of predominately cyclic pain," Dr. Laufer said.

The Committee Opinion recommends that when ob-gyns evaluate an adolescent

for endometriosis, they rule out a pelvic mass or a congenital anomaly of the reproductive tract.

The document also notes that a bimanual exam may not be necessary to evaluate pelvic pain, especially in teenagers who have never had intercourse.

Treatment of symptomatic teens is based on the knowledge that the disease is progressive and without a known cure.

Treatment should be multidimensional, considering surgery, hormonal manipulation, pain medications, mental health support, and complementary and alternative therapies.

"With early diagnosis and treatment of endometriosis we can hopefully improve adolescent women's quality of life and preserve their future fertility," Dr. Laufer said. ♀

Two innovative programs receive Wyeth Section Award

TWO PROJECTS—and four ACOG sections—are recipients of the 2004 Wyeth Pharmaceuticals Section Award, which will be presented at the Annual Industry and Awards Luncheon at the Annual Clinical Meeting on May 8.

Both the Army and Air Force sections are being recognized for instituting a comprehensive cystic fibrosis screening program in the US Army, and the New Hampshire and Vermont sections are being honored for their collaborative effort in developing emergency cesarean delivery simulation and performance guidelines for hospitals.

Improving cystic fibrosis screening

In response to ACOG's new recommendations for cystic fibrosis screening in 2001, the US Army developed a multifaceted program that was implemented throughout the Army Obstetric Service in 2003–04. Because the cost of testing had been a major barrier to CF screening programs, a key element of the new program was the centralization of testing, with all testing conducted at the Armed Forces Institute of Pathology in Washington, DC.

“To ensure that patients were adequately selected and counseled prior to CF testing, it was clear that support for testing alone was meaningless unless there was also support for counseling,” said Air Force Colonel Melissa H. Fries, MD, chair of the ACOG Air Force Section. “Genetics counseling required both trained personnel, as well as an efficient means for patient education; both of these issues had been previously recognized as barriers. Our project was designed to provide a broad package of provider education, patient education, and testing performance and processing.”

The program trained 20 nurses in CF screening and test results counseling. At the four- and six-month follow-ups, approximately 50% of the nurses reported that they were being used in CF counseling programs.

After the program's implementation, testing increased at the AFIP from 60 tests a month to more than 1,000.

Preparing for emergency cesareans

After the New Hampshire and Vermont sections developed guidelines for the manage-

ment of VBAC—a project for which they received the Wyeth award last year—the hospitals involved in the project decided to form the Northern New England Perinatal Quality Improvement Network. The network's first project was to develop guidelines for hospitals to perform emergency cesarean delivery drills and performance evaluations.

Because emergency cesareans are uncommon for both hospitals and individual obstetric staff members, practice drills ensure optimal team performance when an emergency does occur.

“As physicians, we are primarily trained to work independently or as autonomous leaders,” said Michele R. Lauria, MD, a member of the New Hampshire Section and medical

director of NNEPQIN. “To do a timely cesarean delivery, we need to become a team member. Drills allow us to look at workflow and analyze the process. And, they permit us the opportunity to look for defects in the structures around us, without impairing patient care.”

At the beginning of the project, eight of nine hospitals surveyed in the two states had protocols for emergency cesarean delivery, but only four had defined roles for staff.

After the network developed and distributed simulation and performance guidelines, 12 of 15 hospitals surveyed had performed emergency cesarean section drills. This fall, the sections plan to track regional outcomes for emergency cesarean deliveries and VBAC. ♀



Four ob-gyn departments receive Pitkin Awards

OBSTETRICS & GYNECOLOGY has announced the four winners of the 2004 Roy M. Pitkin Awards, which honor ob-gyn departments that promote and demonstrate excellence in research. The award provides a \$5,000 un-

restricted grant to each department whose faculty, fellows, or residents published one of the four most outstanding manuscripts in the Green Journal in the past year. The top papers are selected by an independent panel of experts. This year's winners are:

New York University Medical Center

(John P. Curtin, MD, chair): Lee M-J, Davies J, Guinn D, Sullivan L, Atkinson MW, McGregor S, et al. *Single Versus Weekly Courses of Antenatal Corticosteroids in Preterm Premature Rupture of Membranes*. 2004; 103:274–81

University of California, San Francisco

(Elena Gates, MD, interim chair): Jackson RA, Gibson KA, Wu YW, Croughan MS. *Perinatal Outcomes in Singletons following In Vitro Fertilization: a Meta-Analysis*. 2004;103:551–63

University of Pittsburgh School of Medicine

(W. Allen Hogge, MD, interim chair): Creinin MD, Fox MC, Teal S, Chen A, Schaff EA, Meyn LA. *A Randomized Comparison of Misoprostol 6 to 8 Hours Versus 24 Hours after Mifepristone for Abortion*. 2004;103: 851–9

Columbia University Medical Center

(Mary E. D'Alton, MD, chair): Malone FD, Ball RH, Nyberg DA, Comstock CH, Saade G, Berkowitz RL, et al. *First-Trimester Nasal Bone Evaluation for Aneuploidy in the General Population*. 2004;104: 1222–8 ♀

Discipline by state medical boards creates ‘domino effect’

DISCIPLINARY ACTIONS, even minor ones, by a state medical board can have a tremendous impact on a physician’s ability to practice in other states. It’s important that ACOG members are aware that state medical boards stay updated on disciplinary actions in other states and that penalties vary greatly from state to state.

Being disciplined by a state medical board can have a domino effect on a physician’s license to practice in other states. Consider this scenario: An ob-gyn has medical licenses in four states and is given a short probation by one state’s medical board for a violation. A second state, where the physician hasn’t even practiced in 10 years, learns of the probation, and upon review, decides to revoke the physician’s license. The third and fourth states learn of the revocation and revoke the physician’s license in their states.

Now, the ob-gyn can no longer practice in three states and may have difficulty getting a medical license in other states, being offered a new job, or receiving hospital privileges.

In addition, the case will be brought before the ACOG Grievance Committee, which evaluates behavior that may violate the College’s Code of Professional Ethics or is inconsistent with the College’s bylaw requirements for fellowship. ACOG monitors state medical board actions, and all cases of license revocation are brought before the Grievance Committee. Other disciplinary actions may also be brought before the committee.

What can physicians do?

When ob-gyns receive a notice from a state that there are charges pending against them based on a disciplinary action taken by another state, they should take the notice seriously. Physicians may no longer practice in that state and may not feel it’s worth the time and money to show up for a disciplinary hearing, but ignoring the notice could have serious consequences. By not responding or appearing for a hearing, physicians may be leaving them-

selves vulnerable to a more severe discipline.

State medical boards vary greatly on the severity and number of disciplinary actions they take, and some states face political and public pressure to punish “bad doctors.” In a report released last year by the advocacy group Public Citizen, Kentucky was more likely to discipline doctors than other states. The state issued serious actions against 116 physicians in 2003 or 11.58 per 1,000 doctors in the state. (Serious actions were defined as revocations, surrenders, suspensions, and probations/restrictions.) New York and California disciplined the most doctors overall, but they have thousands more doctors than most other states.

Physicians may also want to evaluate whether they want to maintain their licenses in states where they no longer practice. However, some states do not allow physicians to “cancel” their license and can still discipline physicians even if their license is inactive. ♀

info

→ Questions? Contact ACOG’s General Counsel Office at 800-673-8444, ext 2584

YOU ASKED, WE ANSWERED

Destroying old patient records

Q If a patient has not been in the office for a number of years, when can obstetric or gynecologic records be destroyed? Are there ACOG or other national guidelines?

A Several factors must be taken into consideration before a physician should destroy any records. Many states have specific legal requirements for retaining medical records, and some states’ requirements for retaining business records might include medical records. Because laws vary from jurisdiction to jurisdiction, you should consult your state medical society for requirements. Records of Medicare or Medicaid patients must be kept at least five years, and immunization records must be kept permanently.

Statutes of limitations

The statute of limitations, which specifies the period after an incident in which a plaintiff may file a lawsuit, also determines how long medical records should be kept. The medical record can be the most important evidence in a medical liability trial.

Typically, the length of time begins either on the date the alleged injury occurred or on the date the patient should have reasonably discovered the injury. In most states, the statutes of limitations differ for actions involving adults and minors.

When requirements differ

Once you know the periods applicable to you for both the retention of business records and the statute of limitations, you will be in a good

position to develop your medical records retention policy. It’s best to keep your records for the longer time required. For example, with obstetric records, if the law on business records requires you to keep records for seven years, but the statute of limitations allows minors to bring a lawsuit for medical liability until age 16, you should keep your records for at least 16 years. ♀

info

→ liability@acog.org

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

2005 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

MAY

3
ACOG WEBCAST:
CPT Modifiers and the Global Surgical Package
 1-2:30 pm ET
 800-673-8444, ext 2498

7-11
ACOG Annual Clinical Meeting
 San Francisco
www.acog.org/acm2005

18-19
Expecting Something Better: A Conference to Optimize Maternal Health Care
 Sponsored by the Jacobs Institute of Women's Health
 Washington, DC
www.jiwh.org
 202-863-4990

19-22
4th International Conference on Cervical Cancer
 Sponsored by the University of Texas M.D. Anderson Cancer Center
 Houston
www.mdanderson.org
 800-392-1611

JUNE

7
ACOG WEBCAST:
Consent Issues—Informed Consent, Forms, and Informed Refusal
 1-2:30 pm ET
 800-673-8444, ext 2498

19-21
AIUM: Amer Institute of Ultrasound in Medicine
 Orlando, FL
www.aium.org
 301-498-4100 or
 800-638-5352

30-July 2
33rd Physicians Seminar on Breastfeeding
 Washington, DC
www.lalecheleague.org/ed/PhysSem05.html

JULY

5
ACOG WEBCAST:
CPT Rules for Documenting Evaluation and Management Services
 1-2:30 pm ET
 800-673-8444, ext 2498

AUGUST

2
ACOG WEBCAST:
Medicare Rules for Documenting Evaluation and Management Services
 1-2:30 pm ET
 800-673-8444, ext 2498

SEPTEMBER

6
ACOG WEBCAST:
How to Survive an Audit
 1-2:30 pm ET
 800-673-8444, ext 2498

25-29
15th World Congress on Ultrasound in Obstetrics & Gynecology
 Vancouver, Canada
www.isuog2005.com

27-30
Royal College of Obstetricians and Gynaecologists 6th International Scientific Meeting
 Cairo, Egypt
pioneerevents@yahoo.com
www.rcog2005.com

28-Oct 1
NAMS: North American Menopause Society
 San Diego
www.menopause.org
 440-442-7550

OCTOBER

4
ACOG WEBCAST:
Managing Adverse Outcomes
 1-2:30 pm ET
 800-673-8444, ext 2498

NOVEMBER

1
ACOG WEBCAST:
Complications of Laparoscopic Surgery
 1-2:30 pm ET
 800-673-8444, ext 2498

DECEMBER

6
ACOG WEBCAST:
Preview of New Codes for 2006
 1-2:30 pm ET
 800-673-8444, ext 2498

ACOG POSTGRADUATE COURSES

Two ways to register:

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

MAY

12-14
CPT and ICD-9-CM Coding Workshop
 San Francisco **SOLD OUT**

JUNE

4-5
No Frills—Controversies in Menopause
 Washington, DC

16-18
Office Procedures for the Clinician
 Uncasville, CT

24-26
CPT and ICD-9-CM Coding Workshop
 Chicago **SOLD OUT**

JULY

8-10
CPT and ICD-9-CM Coding Workshop
 Indianapolis

15-17
CPT and ICD-9-CM Coding Workshop
 Seattle

AUGUST

5-7
CPT and ICD-9-CM Coding Workshop
 Dearborn, MI

SEPTEMBER

6-8
Special Problems for the Advanced Gynecologic Surgeon
 Dana Point, CA

9-11
Screening in Ob-Gyn
 Dana Point, CA

16-18
CPT and ICD-9-CM Coding Workshop
 Atlanta

23-25
CPT and ICD-9-CM Coding Workshop
 Memphis, TN

OCTOBER

7-9
CPT and ICD-9-CM Coding Workshop
 Las Vegas

NOVEMBER

11-13
Practice Management Update for the Obstetrician-Gynecologist
 Coronado, CA

12-13
No Frills—Operative Hysterectomy
 Rosemont, IL

18-20
CPT and ICD-9-CM Coding Workshop
 Washington, DC

DECEMBER

1-3
Complications in Obstetrics
 New York City

2-4
CPT and ICD-9-CM Coding Workshop
 Sante Fe, NM

8-10
Ob-Gyn Pearls
 Chicago

New birth defects Patient Education Pamphlets available

ACOG'S PATIENT EDUCATION Pamphlets on birth defects have undergone extensive revision and are now available.

The new pamphlets are:

- ▶ *Birth Defects* (AP146)
- ▶ *Genetics Disorders* (AP094)
- ▶ *Screening Tests for Birth Defects* (AP165)
- ▶ *Diagnosing Birth Defects* (AP164)



Birth Defects is for patients who have general questions on the topic but have not been identified as being at increased risk. It gives a brief overview of the topic and describes how some defects can be detected and, in some cases, prevented.

Genetics Disorders is for patients who may be at increased risk. It covers advances in identifying women who may be at risk and includes information on genetic counseling and a brief overview of the types of screening and diagnostic tests available.

Screening Tests for Birth Defects replaces the pamphlet *Maternal Serum Screening for Birth Defects* and is for all women who are considering screening for birth defects or genetic disorders. It provides the latest information on what

screening tests are available, including first-trimester screening tests, what the results may or may not mean, and the next steps.

Diagnosing Birth Defects replaces the pamphlet *Amniocentesis and Chorionic Villus Sampling* and is for women who are at increased risk for birth defects, whether they already have known risk factors or received an abnormal result from a screening test. It covers amniocentesis, chorionic villus sampling, detailed ultrasound exams, and fetal blood sampling. ♀

info

→ Order at <http://sales.acog.org>; 800-762-2264, ext 192

Free online journal focuses on domestic violence



The Family Violence Prevention Fund has created a free online journal focusing solely on domestic violence in the health care context.

Family Violence Prevention and Health Practice will be published twice a year and include articles on engaging community clinics in violence prevention, evaluating health care-based family violence programs, and examining technology and family violence.

The premiere issue includes a guest editorial by John C. Nelson, MD, MPH, president of the American Medical Association and an ACOG Fellow.

The organization's managing director, Debbie Lee, said the journal will "fill a niche by showcasing emerging research, the experiences of providers and researchers, and clinical initiatives on family violence." ♀

info

→ To view the journal and subscribe at no cost, visit <http://endabuse.org/health/ejournal>

AHRQ: health care quality improved slightly in US

The Agency for Healthcare Research and Quality has released its second annual reports on disparities in health care and the quality of health care in the US.

The *2004 National Healthcare Quality Report* finds modest improvement in some quality measures and an overall improvement of 3% compared with data in the initial report from 2003. The greatest changes in quality included:

- ▶ A 34% decrease from 1996 to 2000 in elderly patients who were given potentially inappropriate medications
- ▶ A 34% decrease in the hospital admission rate for uncontrolled diabetes
- ▶ A 37% decrease in nursing home patients with moderate or severe pain

Two of the largest gains among the states were in Minnesota and Alabama. Minnesota improved its mammogram testing rates significantly, moving from 45th to 8th place among the 50 states, and Alabama was the only state to greatly increase screening rates for two recommended colorectal cancer tests, fecal occult blood testing and flexible sigmoidoscopy.

The *2004 National Healthcare Disparities Report* presents data on the same clinical conditions as the quality report but focuses on priority populations. ♀

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