THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

MAY/JUNE 2007

Expanding geriatric training as population ages

WITH THE NUMBER OF OLDER PEOPLE IN THE US skyrocketing, are ob-gyns prepared for the influx of older patients in the coming years? Americans age 65 and older numbered 36.3 million in 2004—58% of them women, according to federal statistics. With the first Baby Boomers turning 65 in 2011, the older population will surge, doubling from 35 million in 2000 to 72 million by 2030.

"The demographics in this country are exploding in terms of our older population, and ob-gyns better be ready to deal with these older women," said ACOG Fellow Michael R. Petriella, MD, vice chair of ob-gyn at Hackensack University Medical Center, Hackensack, NJ. "There will be an increasing need for physicians with specialty training in geriatrics, and all medical specialists will need to be prepared to carry some of that responsibility."

➤PAGE 6

Too few young women being screened for chlamydia

ACOG GUIDELINES RECOMMEND THAT ALL sexually active women 25 and younger be screened for chlamydia, but study after study has shown that these guidelines are not being followed. The Centers for Disease Control and Prevention and the US Preventive Services Task Force also recommend routine screening of this population.

"We have got to get physicians to do the age-based testing," said ACOG Fellow Jill S. Huppert, MD, MPH, assistant professor of pediatrics and ob-gyn in the division of adolescent medicine at Cincinnati Children's Hospital Medical Center. "Everyone 25 and younger should be screened annually if they're having sex—and by the time females reach 25, over 90% of them are having sex."

➤PAGE 8

acogTODAY

Volume 51, Issue 5

Executive Vice President
Ralph W. Hale, MD, FACOG

Director of Communications
Penelope Murphy, MS

Editor
Melanie Padgett

Contributors
Joni Weber
Nonda Wilson
Marian Wiseman, MA

Design and Production
Marcotte Wagner
Communications

Advertising
Greg Phillips
202-863-2529
gphillips@acog.org

Letters to the Editor
Melanie Padgett, Editor
ACOG Today
PO Box 96920
Washington DC
20090-6920

Fax: 202-863-5473
Email: mpadgett@acog.org
Letters may be edited for length.

Permission to Photocopy or Reprint
Melanie Padgett, Editor
Email: mpadgett@acog.org

Main Phone
800-673-8444 or
202-638-5577

Resource Center
202-863-2518
toll free for members only
800-410-ACOG (2264)

Address Changes
800-673-8444, ext 2427,
or 202-863-2427
Fax: 202-479-0054
Email: membership@acog.org

Order Publications
Online at sales.acog.org
or call 800-762-2264 or
770-280-4184

(ISSN 0400-048X)
Published 10 times a year

EXECUTIVE DESK

Even small amounts of alcohol can lead to fetal alcohol syndrome

I RECENTLY RECEIVED A LETTER FROM a father whose daughter-in-law had just delivered an infant with fetal alcohol syndrome. He reported that the ob-gyn had said that moderate alcohol intake during pregnancy was permissible—a statement that ACOG does not agree with.

Fetal alcohol spectrum disorders can present in a variety of ways and with varying degrees of severity—the most severe is fetal alcohol syndrome or FAS. The more common findings are low weight and reduced height. The infant may also have a small head, abnormal facial features, a heart defect, and mental retardation.

The degree of severity increases with greater amounts of alcohol intake, but even a small amount of alcohol can put a baby at risk for FAS. There is no way to correlate the actual alcohol intake with the severity of FASD because there are too many variables.

No acceptable risk

ACOG Committee Opinion *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice* (#294, May 2004) states, "There is no level of alcohol use, even the most minimal drinking, that has been determined to be absolutely safe."

In other words, even an occasional drink of alcohol may result in FAS. For this reason, pregnant women should avoid drinking any alcohol. As part of good reproductive and prenatal health care, patients should be informed about the risk to their fetus from alcohol consumption.

Once FAS occurs there is no cure. These infants and their family will live with their problems the rest of their lives. The financial costs and toll in angst and emotional stress will be far greater than those caused by abstaining from alcohol while pregnant.

Ask patients about alcohol intake

As part of every initial obstetric or preconception health care visit, ob-gyns should ask the patient about her current alcohol intake and explain the risks to the fetus from even an occasional drink. Stopping is just good preventive medicine.

ACOG has an excellent Patient Education Pamphlet, *Alcohol and Pregnancy* (AP132), that can be given to the patient. Also helpful are the Patient Education Pamphlets *You and Your Baby: Prenatal Care, Labor and Delivery, and Postpartum Care* (AB005), and *Birth Defects* (AP146). ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

info

➜ ACOG has developed a free toolkit, called *Drinking and Reproductive Health*, for physicians to properly screen and advise their patients about risky drinking, including drinking during pregnancy. Download a copy at www.acog.org/departments/healthissues/FASDToolkit.pdf (case sensitive) or email jmahoney@acog.org for a hard copy

IN MEMORIAM

Hugh R.K. Barber, MD
New York City • 12/06

Arthur Howard Bearon, MD
Minneapolis

Elliott C. Leonhardt, MD
Northridge, CA • 12/06

George S. Zarou, MD
Brooklyn, NY

Obstetrics & Gynecology HIGHLIGHTS

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

Endometrial Ablation
(Practice Bulletin #81, revised)

Patents, Medicine, and the Interests of Patients
(Committee Opinion #364, revised)

Seeking and Giving Consultation
(Committee Opinion #365, revised)
For more information, see page 9

Disruptive Behavior
(Committee Opinion #366, new)
For more information, see page 9

ACOG launches colorectal cancer awareness campaign

PREVENTABLE. TREATABLE. Beatable! That's the message of a new education campaign ACOG is launching at the Annual Clinical Meeting in May about the importance of regular colorectal cancer screening.

An ACOG packet will arrive in your mailbox containing a patient education fact sheet on colorectal cancer, posters for your exam rooms (see right), and the Committee Opinion *Routine Cancer Screening* (#356, December 2006), which lists ACOG's colorectal cancer screening guidelines.

Colorectal cancer is the second leading cause of cancer death in the US. Each year, it takes the lives of nearly as many women as do ovarian, cervical, and uterine cancers combined. But colorectal cancer is largely preventable and curable with regular screening and early detection. ACOG recommends that all women age 50 and older be screened for colorectal cancer.

Because ob-gyns are the only physicians many women see on a regular basis, they can help increase colorectal cancer screening rates and, thereby, help reduce deaths from this disease. The campaign encourages physicians to counsel their patients about colorectal cancer and the appropriate screening recommendations, including when to begin screening and the benefits, limitations, and frequency of the different testing options.

ACOG's partners in the campaign are the Jay Monahan Center for Gastrointestinal Health, the American Society for Gastrointestinal Endoscopy, and the American College of Gastroenterology. The posters featuring Katie Couric were developed by the Centers for Disease Control and Prevention's Screen for Life: National Colorectal Cancer Action Campaign, in collaboration with the Entertainment Industry Foundation's National Colorectal Cancer Research Alliance. ♀

info

➜ Campaign materials are available on the ACOG website, www.acog.org

Newest *Clinical Updates* available

THE NEWEST BOOK AVAILABLE from the *Clinical Updates in Women's Health Care* series is *Primary and Preventive Care*. The monograph defines the role of the ob-gyn in the prevention of serious morbidity and mortality and helps physicians plan preventive strategies to apply in their practice.

Two other recent *Clinical Updates* monographs are *Weight Control: Assessment and Management* and *Chest Pain and Heart Disease*.

Weight Control, which has been updated from the 2003 version, addresses the ongoing obesity epidemic in the US, presenting new research and prevention and treatment strategies. *Chest Pain and Heart Disease* will help ob-gyns evaluate patients who present with chest pain so that appropriate treatment and referral can be provided. ♀

info

➜ www.clinicalupdates.org

FIGO seeks chief executive

FIGO, THE INTERNATIONAL Federation of Gynecology & Obstetrics is seeking to recruit a chief executive to be responsible, in conjunction with the current administrative director, for leading and directing all aspects of the day-to-day business of FIGO, including personnel and finance.

In addition to being responsible for the coordination of all of FIGO's business activities, the chief executive will also develop, with the officers and executive board, strategies, policies, and plans for the future development of the organization.

The chief executive will be responsible for representing the federation at the national and international level, for preparation of plans for the funding of FIGO activities, and for production of the related grant applications and reports to donors.

Qualifications

The successful candidate will be:

- A senior ob-gyn with experience in international or public health
- The holder of an MBA or have similar widespread administrative experience
- Based in, or willing to relocate to, the United Kingdom
- In possession of good personal skills—a team player

A personal network in international reproductive health would be an asset. The position is full time, and the initial contract will be for a fixed term of three years renewable. Salary will be by negotiation commensurate with experience. ♀

info

➜ More details and a provisional job description are available on the FIGO website: www.figo.org

➜ Applications, accompanied by a full CV, should be sent to: figo@figo.org or Professor I Fraser, Honorary Secretary; FIGO; FIGO House; Suite 3, Waterloo Court; 10 Theed Street; London SE1 8ST; United Kingdom

Florida Section receives Wyeth Section Award for heart disease education efforts

CARDIOVASCULAR HEALTH for women has become an important issue in ACOG's Florida Section. Because of its efforts to increase awareness of heart disease, the section has been awarded the 2006 Wyeth Pharmaceuticals Section Award.

"As primary care physicians to women, we can offer many remedies to women that can have an impact on this deadly and most serious problem," said Edward Carney, MD, chair of the Florida Section. "Many ob-gyns are knowledgeable and prepared to treat uncomplicated hypertension, diabetes, and thyroid disease, but are less likely to initiate pharmacologic therapy that lessens cardiovascular disease risk in women."

Heart disease is the No. 1 killer of women. It is responsible for more deaths among women—more than 460,000 deaths every year—than the next five leading causes of death combined, according to the American Heart Association. But many women still do not appreciate that they are at risk.

Developing educational CD-ROM

The Florida Section received funding to hold a cardiovascular symposium during the section's annual meeting, held in conjunction with the Florida Obstetric and Gynecologic Society. The symposium presentations were recorded to create an educational CD-ROM that was distributed to more than 2,400 Florida Section members. The CD-ROM includes a risk calculator and clinical guidelines, including the latest guidelines for lipid analysis and intervention.

The section placed a special emphasis on resident education, providing the CD-ROM to all 10 of the state residency training programs.

"We believe the recognized problem of cardiovascular health in women will be improved by earlier and more frequent intervention by the obstetrician-gynecologists that comprise our membership," Dr. Carney said. "I believe that we are getting a greater understanding of this disease, but there is, of course, continued room for improvement."

District IV and the Florida Section are pleased to have contributed to heart disease education among their Fellows, according to Dr. Carney, and hope that the CD-ROM helps increase the medical evaluation and treatment of heart disease in women.

"We as clinicians should be comfortable with the recognition of the cardiovascular risks in women and their treatment," Dr. Carney said. "This disease is too important for an obstetrician-gynecologist not to be educated and comfortable in appropriate therapies, including diet, exercise, and pharmacologic agents when indicated." ♀

Four ob-gyn departments receive Pitkin Awards

OBSTETRICS & GYNECOLOGY has announced the four winners of the 2006 Roy M. Pitkin Awards, which honor ob-gyn departments that promote and demonstrate excellence in research. The award provides a $5,000 unrestricted 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. Both the authors and the departments are recognized for the quality of research and publication of the results.

The editors selected 22 finalists from all the articles published in 2006, and a panel of former *Obstetrics & Gynecology* editorial board members selected the winners by ranking the papers on the basis of scientific merit, importance to the specialty, study design, methodology, presentation of results, soundness of conclusions, and writing style. ♀

NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

Botros SM, Abramov Y, Miller JJ, Sand PK, Gandhi S, Nickolov A, Goldberg RP. *Effect of Parity on Sexual Function: An Identical Twin Study*. Obstet Gynecol 2006;107:765–70. From the Division of Urogynecology, Evanston Continence Center, Evanston Northwestern Healthcare, Northwestern University, Feinberg School of Medicine (Sherman Elias, MD, chair).

UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS

Alexander JM, McIntire DD, Leveno KJ, Cunningham FG. *Selective Magnesium Sulfate Prophylaxis for the Prevention of Eclampsia in Women with Gestational Hypertension*. Obstet Gynecol 2006;108:826–32. From the Department of Obstetrics and Gynecology, University of Texas Southwestern Medical Center at Dallas (Steven L. Bloom, MD, chair).

UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY

Reddy SY, Warner H, Guttuso T Jr, Messing S, DiGrazio W, Thornburg L, Guzick DS. *Gabapentin, Estrogen, and Placebo for Treating Hot Flushes: A Randomized Controlled Trial*. Obstet Gynecol 2006;108:41–8. From the Department of Obstetrics and Gynecology, University of Rochester School of Medicine and Dentistry (James R. Woods Jr, MD, chair).

UNIVERSITY OF PITTSBURGH AND MAGEE-WOMENS RESEARCH INSTITUTE

Creinin MD, Schlaff W, Archer DF, Wan L, Frezieres R, Thomas M, Rosenberg M, Higgins J. *Progesterone Receptor Modulator for Emergency Contraception: A Randomized Controlled Trial*. Obstet Gynecol 2006;108:1089–97. From the Department of Obstetrics, Gynecology, and Reproductive Sciences, University of Pittsburgh and Magee-Womens Research Institute (W. Allen Hogge, MD, chair).

Physicians must begin using National Provider Identifiers

IF YOU HAVE NOT APPLIED FOR your National Provider Identifier, you need to do so immediately to avoid significant interruptions in claims processing and cash flow. All health care providers must begin using their NPIs on May 23. Once physicians obtain their NPI, it will take approximately 120 days for them to complete the rest of the work necessary to use the NPI, according to the Centers for Medicare and Medicaid Services.

This spring, reports circulated that CMS had extended the deadline for physicians until next year. That was incorrect—at press time, the May 23 deadline still stood for physicians. CMS has, however, instituted a contigency plan for health plans that won't be able to meet the deadline. Physicians should check with their health plans to see what the companies' contigency plans are and how such plans will affect billing.

As part of the Health Insurance Portability and Accountability Act, or HIPAA, all providers are required to have unique individual identifiers for billing and can no longer use other identifiers such as Medicare PINs and proprietary commercial identifiers.

Although HIPAA applies only to physicians who do business electronically, Medicare is requiring paper billers to use NPIs as well, and commercial payers may follow suit for paper billers.

Medicare has extended the deadline to June 1 for requiring paper billers to use the new CMS 1500 paper form. The form was modified to allow space to report the NPI number. ♀

info

➜ https://nppes.cms.hhs.gov
➜ www.cms.hhs.gov/nationalprovidentstand

Apply for history fellowship

APPLY NOW FOR THE 2008 ACOG Fellowship in the History of American Obstetrics and Gynecology. Applications are due by October 1. The award carries a $5,000 stipend for expenses while the fellow spends a month in Washington, DC, working full time on the fellow's specific historical research project.

The fellow will have access to the ACOG History Library and is encouraged to use other national, historical, and medical collections in the Washington area. The research results must be disseminated through publication or presentation at a professional meeting. ♀

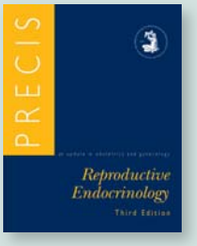
info

➜ 800-410-2264; dscarborough@acog.org

New edition of *Precis: Reproductive Endocrinology*

THE THIRD EDITION OF *Precis: Reproductive Endocrinology* includes numerous revisions to reflect the rapid advances in the field.

The section on infertility has been revised substantially to offer a general overview of evaluation and management, focus on factors affecting treatment success rates, and discuss the newest advances in ovulation induction, preimplantation genetic diagnosis, ethical issues, and emerging technologies.



The section on complementary and alternative medicine has been reorganized and expanded, and the menopause section has been updated, reflecting results from the Women's Health Initiative trials.

The endocrine assays section emphasizes the role of the physician in interpreting results and recognizing the reliability, clinical usefulness, and pitfalls of assays performed and interpreted by different labs.

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, Oncology, Obstetrics,* and *Gynecology*. ♀

info

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

Expanding geriatric training as population ages

➤PAGE 1

Blending geriatrics into ob-gyn

Dr. Petriella is one of several ACOG Fellows emphasizing the importance of incorporating geriatrics into ob-gyn, through medical school education, residency training, and research. Dr. Petriella implemented geriatrics residency training at Hackensack thanks to a grant from the American Geriatrics Society's Geriatrics Education for Specialty Residents Program.

"A one-month experience with geriatrics is not enough," Dr. Petriella said. "Physicians are procedure-oriented, but geriatric education has to be blended into the fabric of the four-year ob-gyn residency."

As part of Hackensack's ob-gyn residency training, geriatricians are available for consultation, and a geriatrician joins residents for didactic rounds, where residents and the geriatrician discuss issues such as pain management; preventive medicine strategies, including prevention of falls; preoperative evaluation of an elderly patient; delirium; thromboembolism; pressure ulcers; bladder conditions; medication errors; and depression.

"We want our doctors to realize that elderly patients have some unique issues that are different from younger individuals," Dr. Petriella said. "Physicians need to appreciate the physiology of aging and how to interpret lab data. When you admit an 85-year-old woman for a same-day surgical procedure, you need to think about who is at home to help her, how you are going to manage her pain, and how you are going to reduce her risk of falls."

Hosting monthly lectures at UAB

ACOG Fellow Holly E. Richter, PhD, MD, professor and director of the division of women's pelvic medicine and reconstructive surgery at the University of Alabama at Birmingham, also received a grant from the Geriatrics Education for Specialty Residents Program to improve geriatrics residency training. One of the primary components is a monthly didactic lecture on geriatric issues, open to all residents but required for first- and second-year residents.

"If we can get them the geriatric knowledge base early in their residency, they can hopefully utilize it to care for their patients through their four years," Dr. Richter said.

During the lecture, a geriatrics expert discusses issues such as cognitive and functional assessment of patients, physiological changes with aging, use of medications, risk assessment, hospice care, and Medicare guidelines.

Residents present cases of patients 70 and older for the group to discuss the perioperative management of each patient as it relates to that month's topic.

"Geriatric education has to be blended into the fabric of the four-year ob-gyn residency."

Getting rid of stereotypes

ACOG Fellow Stacy Tessler Lindau, MD, an ob-gyn professor at the University of Chicago, is aiming to break down stereotypes of elderly patients while improving the research base through her research on sexuality and the elderly.

"When we were medical students, our preceptors impressed upon us the importance of the patient's sexual history. Yet, I quickly observed that most people, even our teachers, skipped the sexual history when interviewing older patients," Dr. Lindau said. "I was curious as to why we avoided talking to older people about these issues. When I chose ob-gyn, I thought there was a real opportunity to start to change the way we think about and take care of older women."

Dr. Lindau pointed to several reasons that ob-gyns might not discuss sexuality with their older patients: "Physicians are people, and we are subject to the same stereotypes as the general public, and, for the most part, the general public sees older people as asexual, particularly older women. Doctors may not feel comfortable talking about sexuality with older women, who remind them of their mothers and grandmothers. In addition, doctors are not well trained to talk about these issues or to treat problems stemming from discussions of sexuality."

Furthermore, physicians may think they would offend or embarrass their patients, but Dr. Lindau said she found just the opposite, that patients tended to open up when asked about their sexual history.

To illustrate the importance of sexual history taking in older patients, Dr. Lindau pointed out that in seven years of generalist ob-gyn practice, she has had only two patients who tested positive for HIV, and both were women older than 50.

"Both felt they were at risk, but a physician had never talked to them about HIV or offered them testing, and so, they were never tested," she said.

"The first Baby Boomers have turned 60, and the older part of our population has expanded in a significant way," Dr. Lindau said. "Gynecologists have an obligation to take care of the health needs of our older women and an opportunity to set the standard for how older women should be treated by their physicians." ♀

info

- *The State of Aging and Health in America 2007*: www.cdc.gov/aging/saha.htm
- *65+ in the United States: 2005*: www.census.gov/prod/2006pubs/p23-209.pdf
- American Geriatrics Society: www.americangeriatrics.org

Diagnosing and managing patients with dementia

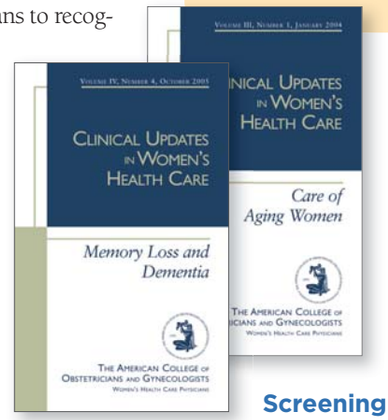
AS THE POPULATION GETS increasingly older, more and more women will suffer from dementia. What signs might your patients show and how can you help them manage this progressive disease?

"It's important for physicians to recognize that, by age 85, there is a greater than 50% chance a person's going to have a cognitive disease that causes dementia," said Evelyn C. Granieri, MD, MPH, MSEd, cochief of the division of geriatric medicine and aging at Columbia University College of Physicians and Surgeons in New York City and a member of ACOG's Geriatrics Working Group. "You really must pay attention to a disorder that could affect so many of your patients."

ACOG's *Clinical Updates in Women's Health Care*

- *Memory Loss and Dementia*
- *Care of Aging Women*

www.clinicalupdates.org



The most common initial presenting feature of dementia may be memory impairment, although memory impairment alone does not define dementia. (Dementia includes memory loss and impairment in at least one other cognitive area.)

"A lot of physicians think memory loss is a consequence of aging, and it isn't. It's a consequence of pathology in the brain that can be caused by many things," Dr. Granieri said.

Symptoms to watch for

As dementia progresses, it will tend to involve language ability, according to Myron Miller, MD, director of the division of geriatric medicine at Sinai Hospital of Baltimore and a member of the editorial board for ACOG's *Clinical Updates in Women's Health Care*.

"People may have difficulty finding the right words to describe things, and rather than describe them in specific terms, they may use general words or explanations such as 'that thing you eat with' instead of saying 'fork,'" he said.

Other signs may include trouble with spatial ability and orientation, weight loss, personality changes, sadness or depression, forgetting doctor's appointments, repeatedly calling the doctor's office with questions, and a sudden unkempt appearance.

Screening tests

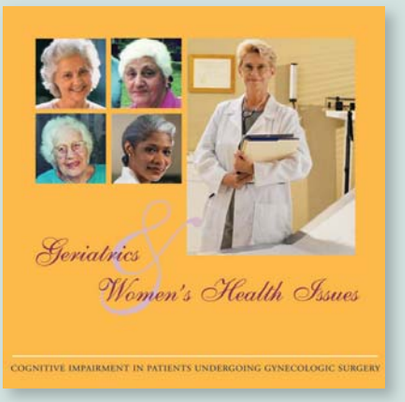
To screen for dementia, physicians can ask a few simple questions about whether a patient is having trouble with her memory. Dr. Miller also advocates the Folstein Mini-Mental Status Examination, which measures cognitive ability in adults.

Dr. Granieri suggests screening with a quick and simple "clock test." Ask the patient to draw a clock and to put the numbers on the face of it and put the hands at 2:45.

"You will be surprised at who can do it and who can't do it," Dr. Granieri said. "If she makes any mistake on that test, that's really a cause to refer to a geriatrician because if it is dementia, the patient will continue to decline. Addressing dementia is a very constant, nuanced, time-consuming approach so ob-gyns should find a geriatrician who can direct the patient's care or co-manage with you."

Although dementia has no cure, a diagnosis is important to help patients and family members prepare for the future, as patients will require more assistance as time goes on.

"Women over the age of 85 are the fastest growing segment of the population," Dr. Granieri said. "All of us in clinical care should make sure our most vulnerable patients receive the care they need and deserve." ♀



ACOG develops geriatrics residency training tool

ACOG HAS DEVELOPED A four-part CD-ROM residency education series on geriatrics. The series, which was developed under the guidance of the ACOG Geriatrics Working Group, will be mailed to all US residency program directors.

Each CD includes a multimedia slide presentation, comprehensive speaker's notes, and a bibliography. The first CD is "Cognitive Impairment in Patients Undergoing Gynecologic Surgery." Three more CDs will be available later this year:

- "Pharmacologic Issues in Older Patients Undergoing Gynecologic Surgery"
- "Geriatric Physiology and the Older Person's Response to Stress: Implications for Surgical Intervention"
- "Functional Assessment of Older Patients"

The series was funded by the American Geriatrics Society with a grant from the John A. Hartford Foundation.

ACOG has been collaborating with the American Geriatrics Society and is represented on the society's Council of the Section of Surgical and Related Medical Specialties, a working unit of national specialty leaders committed to improving the care of geriatric patients. ♀

info

➜ For a copy of the series, email jchapin@acog.org

Too few young women being screened for chlamydia

➤PAGE 1

Cases going undiagnosed

Chlamydia is the most commonly reported infectious disease in the US. In 2005, 976,445 diagnoses were reported, but because many cases go undiagnosed, it's estimated that there are about 2.8 million new cases of chlamydia in the US each year, according to CDC. Infection is highest among girls ages 15–19. If left untreated, chlamydia can cause lifelong reproductive problems. According to CDC, up to 40% of untreated females develop pelvic inflammatory disease, and 20% of those may become infertile.

Yet surveys of primary care physicians have indicated that only 29% to 54% routinely screen asymptomatic sexually active young women for chlamydia, according to Dr. Huppert's research.

"When the CDC comes out with a recommendation for universal testing for HIV and we're not even to the point of universal testing for chlamydia, that's a problem," she said. "There's just some real resistance and some reluctance to test for STIs."

Barriers to testing

Why are young women and teenagers not being screened routinely for chlamydia? Experts point to several reasons.

"I think the biggest obstacle for ob-gyns in private practice is that they don't believe they ever see the disease—but the problem with that line of thinking is that if they don't test for chlamydia, they'll never find it," said ACOG Fellow David E. Soper, MD, ob-gyn professor at the Medical University of South Carolina in Charleston. "Although we're taught in medical school to look for symptoms of disease, the vast majority of women infected with an STI don't have symptoms. They don't have them for herpes; they don't have them for gonorrhea or for any STI you can name.

"Another obstacle is that physicians believe the prevalence is low in their patient population, so they don't think it justifies the cost of the test," Dr. Soper said.

While there may be a lower prevalence of chlamydia in private practice when compared with other settings such as STD clinics, even a 2% prevalence in nulliparous females is significant in terms of the potential to spread the disease and cause reproductive problems, according to ACOG's *Health Care for Adolescents*. A 2006 study from the nonprofit Partnership for Prevention showed that chlamydia screening is one of the top most effective but underutilized preventive health services.

For a recent research study, Dr. Huppert and her colleagues surveyed internists, pediatricians, and family medicine physicians in the Cincinnati area to learn if and when they were screening for chlamydia. Some said they weren't screening because they didn't have pelvic exam tables or couldn't store the test kits. But, Dr. Huppert points out, new urine-based testing doesn't require a pelvic exam or test kit and can be done at any health care visit.

She suggests one simple way to implement universal screening for sexually active patients 25 and younger: have nurses collect urine samples at the start of the visit, just as they always check a patient's weight and blood pressure. Then, if the physician determines that the patient has ever had sex, it's a simple matter to send the urine sample for testing.

"Patients accept it when you tell them we do this for everyone their age. If you say that this is the norm, that you test everyone, it's reassuring to them," Dr. Huppert said.

Another barrier to testing is the stereotypes that go along with sexually transmitted diseases. Some studies have shown that patients are more likely to be screened on the basis of race or socioeconomic level, rather than their age.

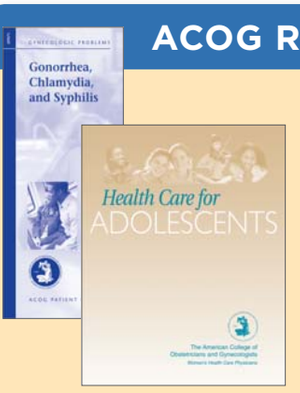
In Dr. Huppert's Cincinnati survey, some respondents who practice in the suburbs said they don't screen but that they would if they worked "downtown," reflecting a provider bias of urban women vs. suburban women, according to Dr. Huppert.

Because of stereotypes, some physicians have a hard time believing their patient would be infected with this disease, Dr. Soper said.

"That stigma still exists. It's still a scarlet letter," he said. But, he points out, "serial monogamy" is common nowadays among young people.

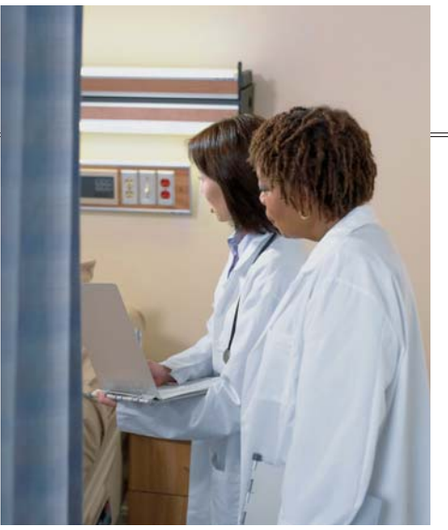
"We need to work to dispel the bias. STIs are diseases of humanity. Humans become infected doing what normal humans do, have sex," Dr. Soper said. "We need to grow up in our approach to STIs." ♀

ACOG Resources on STDs



- ACOG Committee Opinions *Sexually Transmitted Diseases in Adolescents* (#301, October 2004) and *Primary and Preventive Care: Periodic Assessments* (#357, December 2006): www.acog.org/member_access/lists/commopin.cfm
- "Screening for Chlamydia and Gonorrhea in Adolescents," a chapter in ACOG's *Health Care for Adolescents*: www.acog.org/publications/adolescents/adol07.cfm
- Patient Education Pamphlet *Gonorrhea, Chlamydia, and Syphilis*: www.acog.org/publications/patient_education

ACOG: Establish formal consultation protocol



A NEW COMMITTEE OPINION revises ACOG recommendations for physicians seeking and giving consultations. The document outlines the purpose for consultation and referral, states the principles of consultation as outlined in ACOG's Code of Professional Ethics, and elaborates on the responsibilities of both those who seek and provide consultation.

"The focal point of this opinion was to differentiate professional dialogue from formal consultation in order to guide practitioners in deciding the best level of collegial participation for their patients," said John K. Jain, MD, of ACOG's Committee on Ethics.

Relationships with other physicians often lead to "professional dialogue," in which clinicians share their opinions and knowledge. Professional dialogue is not formal consultation and does not establish a patient-consultant relationship. Often, one physician is asking another physician a question, but the second physician does not talk with or examine the patient, nor make an entry in the medical record. The first clinician should not attribute an opinion to the second clinician, according to the document.

The Committee Opinion recommends that a formal consultation protocol be developed to maximize prompt, effective consultation and collegial relationships. This may be particularly helpful for family physicians who provide ob-gyn care and for collaborative practice between ob-gyns and nurse practitioners, certified nurse-midwives, and other health care professionals, according to the Committee Opinion.

Email can be used as long as both physicians agree to it, have established systems to confirm receipt and transfer of reports to the medical chart, and communicate in a way that protects patient confidentiality.

The document, *Seeking and Giving Consultation*, was published in the May issue of *Obstetrics & Gynecology* and revises and updates the consultation chapter in *Ethics in Obstetrics and Gynecology*, second edition. ACOG is updating all chapters in this book and reissuing them as Committee Opinions. ♀

info

➜ www.acog.org/from_home/publications/ethics

Dealing with a physician's disruptive behavior

YELLING AT OR BULLYING nurses, slamming down charts, criticizing colleagues in front of patients. Unfortunately, studies have shown that many physicians have witnessed or know of other physicians who display disturbing, disruptive behavior on a regular basis.

ACOG's Committee on Patient Safety and Quality Improvement is speaking out against such behavior in a new Committee Opinion, *Disruptive Behavior,* published in the May issue of *Obstetrics & Gynecology*.

The American Medical Association's Report of the Council on Ethical and Judicial Affairs defines disruptive behavior as "a style of interaction … that interferes with patient care … [and] that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care."

According to the Committee Opinion, disruptive behavior can include:

- Profane or disrespectful language
- Yelling at or insulting others
- Throwing charts or other objects
- Bullying or demeaning behavior
- Criticizing other caregivers in front of patients or other staff
- Sexual comments or innuendo

"Staff may refrain from asking for help or clarification and hesitate to make suggestions about care to the disruptive physician," according to the Committee Opinion. "Additionally, patients who witness the behavior may lose confidence in the health care provider as well as the institution."

Make a commitment to addressing problems

The patient safety committee recommends that institutions develop a multifaceted approach to deal with disruptive behavior and that an institution's administration commit itself to addressing these issues. The committee recommends that institutions establish a code of conduct that stipulates behavioral standards and the consequences for failure to comply. Institutions should also work to resolve problems, establishing thresholds for taking action, developing appropriate disciplinary actions, and informing department chairs about individuals with persistent problem behaviors.

"Disruptive physician behavior creates a difficult working environment for all staff and threatens the quality of patient care and, ultimately, patient safety," the Committee Opinion states. "Colleagues often find confronting these individuals difficult. Therefore, it is important that clear standards of behavior are established and all staff are informed of such standards, as well as the consequences of persistent disruptive behavior." ♀

Are you really communicating with your patients?

CONSIDER THIS SCENARIO: Your patient is nodding as you explain the treatment plan, the risks, and the benefits. When you are done, you make a point of asking "Do you understand?" and she says that she does.

Is there anything wrong with this communication? Yes, according to consultant Wendy Leebov, EdD, who specializes in strategies that enhance patient satisfaction and health care communication. She points out two problems in this situation: "First, the question about understanding was 'closed'—asking for a yes/no answer. Second, the doctor didn't check for understanding but just accepted the patient's word for it."

Dr. Leebov advises physicians to ask open-ended questions throughout the patient visit.

"It takes some thought to ask 'what' and 'how' questions, but if you don't find out how the patient is thinking, you're going to end up with mistakes and safety issues because you don't know how they are processing what you are saying," she said.

Similar advice comes from Fellow Paul G. Stumpf, MD, who chairs ACOG's Committee on Patient Safety and Quality Improvement: "The doctor-patient relationship is inherently a little lop-sided, and the patient may feel awkward, embarrassed, or hesitant to ask questions," he said. "We should ask our patients to repeat back to us what their understanding is of what we told them."

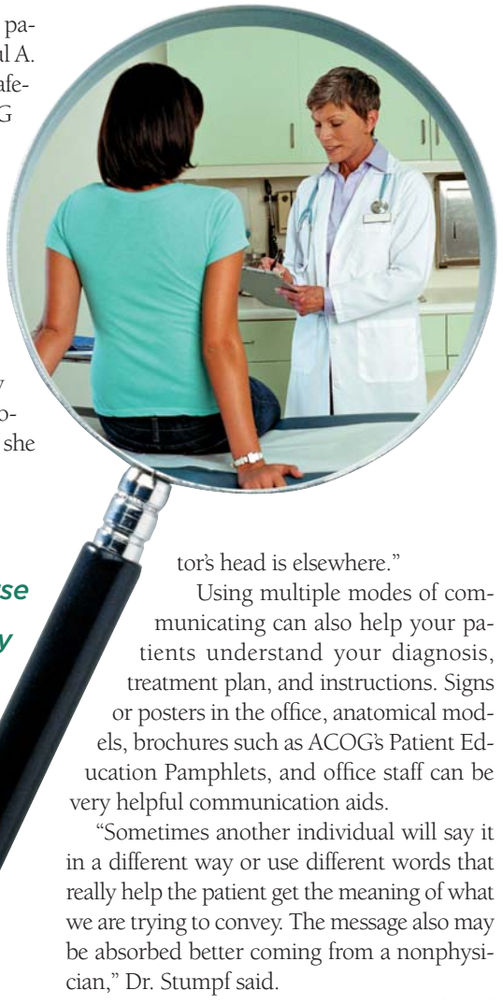
Be 'present' with your patient

"Doctors often feel so overloaded while they are with the patient—thinking about the next things they need to do—that they are not fully tuned in to cues coming from the patient," Dr. Leebov said. "They have a high degree of task orientation, and they miss cues because their heads are elsewhere."

Dr. Leebov encourages physicians to put a premium on the importance of presence, of mindfulness: "Start with a deep breath. Let go of that 'to do' list racing through your head. Create a mental tunnel between you and the patient. Notice the color of her eyes or something else to get yourself to tune in to the patient."

Spending a few extra minutes with a patient pays off later, according to Fellow Paul A. Gluck, MD, chair of the National Patient Safety Foundation and past chair of the ACOG Committee on Patient Safety and Quality Improvement. Dr. Gluck urges ob-gyns to allow time for the patient to talk, noting that studies have shown that the average time before a physician interrupts a patient is 18 seconds.

"The patient feels much more satisfied if you let her tell her story," he said. "In addition, when we interrupt it's usually because we're already working on a diagnosis, and if we had let the patient continue she might have led us in another direction."



"Another minute or two to explain a recommended course of action or treatment will pay dividends many times over."

Dr. Gluck acknowledges that physicians feel pressed for time, but counters, "Another minute or two to explain a recommended course of action or treatment will pay dividends many times over. You won't have to remediate a situation down the road if the patient didn't comply with recommended therapy, and, in my experience, my night calls have gone down dramatically as I communicate more because the patient knows what to expect—what is normal and what is not."

What is your body language saying to your patient?

Your nonverbal behavior speaks volumes to the patient. Lack of eye contact. Looking at your watch. A hand on the doorknob. Writing without explaining that you need a moment to jot down your notes.

"These behaviors are all perceived by patients as inattention," Dr. Leebov said. "And these behaviors usually *do* mean that the doctor's head is elsewhere."

Using multiple modes of communicating can also help your patients understand your diagnosis, treatment plan, and instructions. Signs or posters in the office, anatomical models, brochures such as ACOG's Patient Education Pamphlets, and office staff can be very helpful communication aids.

"Sometimes another individual will say it in a different way or use different words that really help the patient get the meaning of what we are trying to convey. The message also may be absorbed better coming from a nonphysician," Dr. Stumpf said.

Dr. Leebov adds that "jotting down a few of the key points" and giving the patient a written summary is also valuable. "Everyone—no matter how educated or how old—needs multiple methods. People just don't retain information as well as we wish they would, so help them with another prop." ♀

info

- Institute for Healthcare Communication: www.healthcarecomm.org
- National Patient Safety Foundation: www.npsf.org
- Agency for Healthcare Research and Quality: www.ahrq.gov
- Dr. Leebov: wleebov@wendyleebov.com; 215-413-1969

The 1-800-HOW'S MY DRIVING approach to reducing liability risk

HOW DO YOU KNOW YOUR risk of being sued? And what can you do about it? Gerald B. Hickson, MD, director of the Vanderbilt Center for Patient and Professional Advocacy at Vanderbilt University in Tennessee, offers two practical suggestions for ob-gyns.

Build a credit balance of good will

"The patient's inclination to sue is built up over time," Dr. Hickson said. "The patient who perceives the doctor as caring throughout her entire pregnancy is much less likely to call an attorney than the patient who has been sent very negative messages."

Dr. Hickson stresses that all practice staff must be dedicated to making the patient feel she is valued.

"Any time a practice creates barriers that make the patient hesitant to call back for help, it is just a lawsuit waiting to happen," he said.

Not receiving test results is another hot button. "I can't tell you how badly it irritates patients not to hear back about test results.The approach of 'if the lab results are abnormal, I'll call; otherwise, you won't hear from me,' does not add to the credit side of the ledger."

Collect and review complaints

Physicians need data to change their risk of being sued, and a feedback loop is critical, according to Dr. Hickson.

Dr. Hickson suggests monitoring patient complaints. He found that lawsuits were significantly related to the total number of patient complaints (*JAMA* 2002 Jun 12: 187[22]:3003–5).

Dr. Hickson suggests that a practicing ob-gyn group maintain a file of complaints—every call or letter—and encourage the hospital to send the complaints they have received. As a group, review them quarterly. ♀

info

➜ Dr. Hickson: gerald.hickson@vanderbilt.edu

How to improve your communication with patients

- ✔ In the waiting room, offer a patient a blank paper to list her questions for that day
- ✔ Be "present" and focused on the patient during her visit
- ✔ Sit down to talk, whether in the office or the hospital
- ✔ Let her tell her story; don't interrupt or break in with your conclusion or even your questions
- ✔ Use plain language
- ✔ Use visual aids to illustrate a procedure or a condition
- ✔ Ask her to tell you in her own words what she is to do
- ✔ Give her a written summary of key points

Assessing the health literacy of your patients is crucial

KNOWING YOUR PATIENTS' "health literacy"—the ability to read, understand, and act upon health information—is a critical aspect of enhancing patient safety, according to patient safety experts.

"I think the most basic and important thing we can do is to speak in plain language and not use overly technical or medical terms," said Fellow Paul G. Stumpf, MD, who chairs ACOG's Committee on Patient Safety and Quality Improvement.

According to an Institute of Medicine report, nearly half of all American adults have difficulty understanding and using health information. Patients are often embarrassed or ashamed to admit they don't understand. This embarrassment has led to their use of well-practiced coping mechanisms to mask their problem.

Fellow Paul A. Gluck, MD, chair of the National Patient Safety Foundation, recommends using the approach advocated by a health literacy initiative called "Ask Me 3," which encourages patients to ask these questions:

1 What is my main problem?
2 What do I need to do to get better?
3 Why is it important for me to do this?

"As ob-gyns, we need to be sure patients understand the answers to these questions—even if the patient doesn't ask them directly," Dr. Gluck said. "That third question is often the one omitted and is the most important one for patient compliance. When we prescribe a treatment, if we don't tell them why, they don't understand, and they won't comply." ♀

info

➜ www.askme3.org

Humanistic side of medicine important to national essay winner

IN HER AWARD-WINNING ESSAY, Junior Fellow Stacie Herndon Elfrink, MD, expresses the humanistic side of medicine, explaining why it is important for ob-gyns to "give something" of themselves when caring for patients.


Dr. Elfrink

Dr. Elfrink, a second-year resident in District VII, was selected the national winner from the 10 district-winning essays in the 2006 Junior Fellow Essay contest, "The Ob-Gyn Doctor-Patient Relationship: What it Means to Me." District winners received $500 each, and, as the national winner, Dr. Elfrink received an extra $500 and a trip to the Annual Clinical Meeting in May.

As a medical student at the University of Oklahoma, Dr. Elfrink attended classes on "literature and medicine," where she read poetry, short stories, and novels that taught her a lot about working with patients. She fell in love with the ob-gyn specialty and has embraced the idea of medicine as both a science and an art.

"Patients often present us with problems that are very worrisome or embarrassing to them, and we need to not only be aware of their vulnerability but to also help them fully understand what is going on," Dr. Elfrink said. "Patient education is a vital part of the doctor-patient relationship. Helping patients understand how their body works can empower them to take more control over their health."

Connecting with a patient

In her essay, Dr. Elfrink described a particular patient who meant a lot to her. The first time the patient saw her, she told her she didn't like doctors. The patient's CT scan and ultrasound showed a large abdominal mass, consistent with a large uterine fibroid. Dr. Elfrink spent over an hour with her during that visit discussing the options for management and their implications. The decision was made to remove her uterus, which was a convoluted mess of multiple fibroids.

In her essay Dr. Elfrink writes, "I held her hand as we came to the decision for a hysterectomy. ... She later told me that maybe she liked some doctors after all."

Dr. Elfrink continues, "It is relationships like this one and others where a true connection occurs that makes my job so meaningful and reaffirms the humanistic nature of medicine and caring for others."

Dr. Elfrink believes that one of the most important concepts an ob-gyn should recognize is that he or she is often the only physician a woman will see, especially during her reproductive years, and therefore, it is an ob-gyn's job to look at the woman as a whole, not just focus on her reproductive system.

"We need to be cognizant of her blood pressure, family history, disease screening, and overall health so that we can give her the best possible health care. This also means encouraging her to see another physician if need be," she told *ACOG Today*.

She writes in her essay, "Medicine is both a science and an art. I believe this is especially true in the field of ob-gyn where the physician must combine surgical and clinical acumen with compassionate and insightful care. I have laughed with patients, cried with patients, shared moments of joy and moments of sorrow. A doctor-patient relationship will always be stronger when the physician gives something of him or herself as well." ♀

District essay winners

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

- **District I:** Ila D. Dayananda, MD
- **District II:** Shana K. Dowell, MD
- **District III:** Chiara Ghetti, MD
- **District IV:** Millie A. Behera, MD
- **District V:** Laura K.P. Vricella, MD
- **District VI:** Heather B. Kerrick, DO
- **District VII:** Stacie Herndon Elfrink, MD
- **District VIII:** Gweneth B. Lazenby, MD
- **District IX:** Kathleen M. Brennan, MD
- **Armed Forces District:** Toby J. Genrich, MD

Match numbers continue to increase

THE PERCENTAGE OF OB-GYN residency positions filled by US medical students increased again this year. In the 2007 National Resident Matching Program Residency Match, 99.5% of ob-gyn residency positions were filled, with 72.5% filled by US medical students, compared with 72% last year and 65% in 2004.

"This year's match comes with more good news for women's health, as ob-gyn numbers continue to increase," said ACOG President Douglas W. Laube, MD, MEd, former chair of ACOG's student recruitment task force. "In the last three years, ACOG has focused intently on medical student recruitment, and we will continue to create new initiatives that mentor and attract med students into the specialty."

Medical student initiatives have included a medical student course, lounge, reception, and booth at the Annual Clinical Meeting and an Ob-Gyn Residency Fair, held at the 2007 ACM for the first time. ♀

JFCAC developed several successful initiatives in 2006

By Patrick S. Ramsey, MD, MSPH, JFCAC chair

BY THE TIME you read this, we will have just finished another Annual Clinical Meeting, and my term as chair of the Junior Fellow College Advisory Council will have come to an end.

The past year has been immensely productive for the JFCAC. Many initiatives have come to fruition, and many more are under development. Hallmarks of recent JFCAC projects have been:

- Assessing the impact of the duty-hour regulations
- Assessing the impact of medical liability on Junior Fellows' career choices
- Preparing young physicians for the business of medicine
- Improving communication among Junior Fellows
- Enhancing service to all Junior Fellow members

Medical student recruitment has also been an area of great emphasis throughout my term as JFCAC chair. To this end, we have developed many exciting programs, including an ACM medical student course, an ACM obgyn residency fair, and we have established a formal JFCAC standing committee for medical student initiatives and recruitment. While too early to formally assess the impact of these projects, results from this year's residency match—which showed an increase in US applicants—is encouraging! (See match article, page 12.)

Panelists at the ACM medical student course

As my term as chair ends, the JFCAC is poised to continue many of these efforts and is prepared to launch a number of additional projects in the areas of advocacy, professionalism, patient safety, and many more, diversifying our service to Junior Fellows and medical students.

This truly has been a great year, and it has been an honor to serve as your chair. I look forward to continue to work with the new JFCAC chair, Rajiv B. Gala, MD, as he carries us forward. ♀

CREOG UPDATE

By Tamera J. Hatfield, MD, PhD, and Whitney B. You, MD, resident representatives to the CREOG Council

New *Educational Objectives*

At the CREOG Council meeting in March, it was announced that writing assignments for the 9th edition of CREOG's *Educational Objectives: Core Curriculum in Obstetrics and Gynecology* will be completed this summer.

The current goal is to release the new *Educational Objectives* in 2009. If adequate funding can be obtained, the document will be available in hard copy as well as electronically. It will include many new concepts and will place more emphasis on patient safety and biomedical ethics.

CREOG exam format

The 2007 CREOG exam was administered in a different format this year, with distribution of four different test booklets distinguished by color. Overall, this new format was a success. The Council will stress to examination proctors that it is imperative that they review completely the directions for the exam each year in case there are changes in the test administration instructions.

CREOG Education Committee

The CREOG Education Committee announced that it will now offer educational services to residents and those members who are in fellowship training programs.

The committee will have two subcommittees: eight members will focus on residency education, while four members will address fellowship education issues that can be supported by ACOG.

Surgical simulation centers

Sterling B. Williams, MD, MS, ACOG vice president for education, announced that the new ACOG Simulations Consortium will have its first meeting in May.

These simulation centers will provide an excellent resource for residents to enhance their surgical skills training, especially with the constraints of the 80-hour work week. Initially, there will be eight simulation centers in the consortium with plans to add other centers in the future to ensure that residents will have short travel distances and, thus, cheaper costs and less time away from their residency programs.

Resident workshops

CREOG's *Workshop for Ob-Gyn Residents: Preparing to be Teachers & Leaders* provides great tips about teaching and adult learning that residents can incorporate into their individual training programs.

There will be three resident workshops this year. One was held in Chicago in April, and another is scheduled during the ACM in May. A third will be held in New York City, May 18–20. ♀

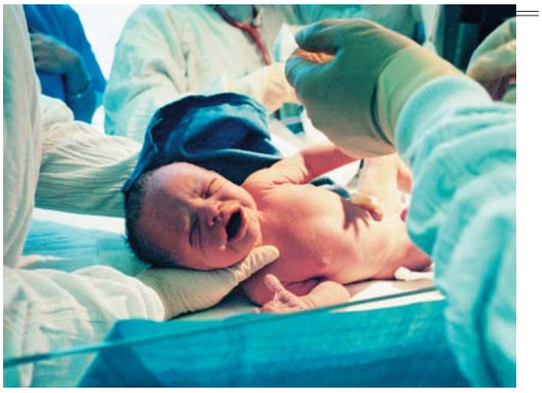
Properly documenting shoulder dystocia

MANY OBSTETRIC LAWSUITS involve allegations of brachial plexus injury stemming from a shoulder dystocia. To demonstrate that they handled a shoulder dystocia case appropriately, it's important for ob-gyns to provide proper documentation in the chart.

"Ob-gyns need to document the case in detail and do so immediately after the delivery," said Richard L. Berkowitz, MD, a member of ACOG's Committee on Professional Liability and a professor of ob-gyn at Columbia University Medical Center, New York City. "The thing that gets physicians sued with a shoulder dystocia case is the occurrence of a brachial plexus injury, and the question in all the malpractice suits is 'Did the injury occur because the obstetrician was too forceful in his or her maneuvers?' The only defense for that is to go to the chart and say 'This is precisely what was done.' Without good documentation, you have trouble proving you did the right thing."

Dr. Berkowitz offers a list of the information that ob-gyns need to document. According to Berkowitz, the chart should include:

1. A list and identification of all personnel present at the delivery
2. Whether it was a spontaneous or operative delivery; if operative, provide the indication for using the instrument and describe the station of the fetal head at the time of application of the forceps or vacuum
3. The position of the fetal head in order to identify whether it was the anterior or posterior fetal shoulder that became stuck
4. An estimation of the force of traction that was applied to the fetal head while attempting to deliver the anterior shoulder should be described. For example, "At no time in the delivery process was any force, traction, or rotation applied to the baby's head greater than that employed in a normal delivery"
5. If an episiotomy was used, a description of the type performed
6. The maneuvers performed, the sequence in which they were employed, and, if possible, the time it took for each maneuver
7. The total time elapsed following delivery of the head to delivery of the body
8. The condition of the neonate after its delivery; note any evidence of bruising, fractures, obvious nerve palsy, etc



9. Cord gases, if able to obtain them

Dr. Berkowitz also stresses, "Don't confuse fundal and suprapubic pressure. Fundal pressure should never be applied [for shoulder dystocia], but sometimes doctors write 'fundal' when what they used and what they mean is 'suprapubic.'" ♀

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.

YOU ASKED, WE ANSWERED

Addressing insurance coverage when you join a practice

Q I RECENTLY COMPLETED MY residency and am considering joining a group practice. What elements regarding medical liability insurance coverage should be addressed in the employment agreement?

A SILENCE IS ANYTHING BUT golden when it comes to professional liability terms in employment agreements. Medical groups and member physicians must use clear and specific contract terms regarding the purchase, maintenance, and termination of insurance coverage. Those who do will have more amicable partings and spend more time practicing medicine and less time in court.

Most professional liability policies are written on a claims-made or claims-reported basis. An employee covered through a group's claims-made policy is insured for claims arising from his or her actions on behalf of the group as long as the claims are made within the policy period. But, when an employee leaves a group, he or she is not covered under the group's policy for work on behalf of the group unless an extended reporting endorsement or "tail coverage" is added to the policy.

The group itself is usually not covered for the prior acts of a physician who leaves the group unless that physician obtains tail or nose coverage. Extended reporting endorsement or tail coverage can be a particularly controversial issue because it is expensive.

A health care business attorney is your best source for ensuring that your employment agreements have all the necessary elements. When creating a contract with your attorney, consider asking the following:

- Who selects the insurance policy limits and deductibles? Who pays the deductible?
- Who can request tail coverage?
- Who has the right to change or cancel the policy?
- Is payment required when the tail is selected?
- If the tail coverage is subject to a deductible, who is responsible for paying it? ♀

2007 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

MAY

1
ACOG WEBCAST:
Coding for Misadventures and Complications of Care
1–2:30 pm ET
800-673-8444, ext 2498

5–9
ACOG 55th Annual Clinical Meeting
San Diego
www.acog.org/acm
800-673-8444, ext 2460

JUNE

5–10
Western Association of Gynecologic Oncologists Annual Meeting
Sunriver, OR
www.wagogynonc.org
800-673-8444, ext 1648

12
ACOG WEBCAST:
Techniques for Improving Safety in Perinatal Care
1–2:30 pm ET
800-673-8444, ext 2498

21–26
Society of Obstetricians and Gynaecologists of Canada 63rd Annual Clinical Meeting
Ottawa, ON
www.sogc.org
613-730-4192

23–27
American Medical Association Annual Meeting
Chicago
www.ama-assn.org
800-673-8444, ext 2515

23–28
Teratology Society 47th Annual Meeting
Pittsburgh
www.teratology.org
703-438-3104

29–Jul 1
North American Society for the Study of Hypertension in Pregnancy
San Diego
www.nasshp.com
800-673-8444, ext 1648

JULY

10
ACOG WEBCAST:
Management of Adnexal Masses
1–2:30 pm ET
800-673-8444, ext 2498

20–22
Gynecologic Oncology Group Semi-Annual Meeting
Philadelphia
www.gog.org
215-854-0770

AUGUST

8–12
ACOG District VI Annual Meeting
Victoria, BC
800-673-8444, ext 2530

8–12
ACOG District VIII Annual Meeting
Victoria, BC
800-673-8444, ext 2530

8–12
ACOG District IX Annual Meeting
Victoria, BC
800-673-8444, ext 2530

9–11
Infectious Diseases Society for Obstetrics and Gynecology 34th Annual Scientific Meeting
Boston
www.idsog.org
800-673-8444, ext 2570

14
ACOG WEBCAST:
Coding for Medicare Preventive Care Visit
1–2:30 pm ET
800-673-8444, ext 2498

SEPTEMBER

5–8
Society of Laparoendoscopic Surgeons 16th Annual Meeting and Endo Expo
San Francisco
www.sls.org
305-665-9959

11
ACOG WEBCAST:
Coding for the Non-Medicare Preventive Care Visit
1–2:30 pm ET
800-673-8444, ext 2498

14–16
ACOG District IV Annual Meeting
Chicago
800-673-8444, ext 2488

16–19
ACOG District V Annual Meeting
Napa, CA
800-673-8444, ext 2574

26–29
American Gynecological and Obstetrical Society Annual Meeting
Chicago
www.agosonline.org
800-673-8444, ext 2648

26–29
Association of Reproductive Health Professionals 44th Annual Meeting
Minneapolis
www.arhp.org
202-466-3825

27–29
American Urogynecologic Society 28th Annual Scientific Meeting
Hollywood, FL
www.augs.org
202-367-1167

28–30
ACOG District I Annual Meeting
Newport, RI
800-673-8444, ext 2531

NOVEMBER

8–10
Society for Gynecologic Investigation 2nd International Summit on Reproductive Medicine
Valencia, Spain
www.sgionline.org

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.

MAY

10–12
ICD-9-CM a… Coding W…shop SOLD OUT
San Diego

JUNE

22–24
ICD-9-CM and CPT Coding Workshop
Baltimore

28–30
Practical Ob-Gyn Ultrasound: Spotlight on Chronic Pelvic Pain
Orlando, FL

JULY

13–15
ICD-9-CM and CPT Coding Workshop
Seattle

AUGUST

10–12
ICD-9-CM and CPT Coding Workshop
Atlantic City, NJ

16–18
The Art of Clinical Obstetrics
San Antonio

24–26
ICD-9-CM and CPT Coding Workshop
Charlotte, NC

SEPTEMBER

7–9
ICD-9-CM and CPT Coding Workshop
Houston

8–9
"No Frills" New Surgical Approaches to Incontinence and Prolapse
Atlanta

28–30
ICD-9-CM and CPT Coding Workshop
St. Louis

NOVEMBER

15–17
Ob-Gyn Pearls
Las Vegas

16–17
ICD-9-CM and CPT Coding Workshop
Los Angeles

29–Dec 1
Practical Obstetrics and Gynecology
New York City

30–Dec 2
ICD-9-CM and CPT Coding Workshop
Atlanta

DECEMBER

6–8
The Mature Woman: From Perimenopause to the Elderly Years
Chicago

RESOURCES

Earn CME credits through PROLOG

ASSESS YOUR KNOWLEDGE OF the most recent scientific advances in ob-gyn with the popular ACOG series Personal Review of Learning in Ob-Gyn—known as PROLOG.

Each unit of PROLOG covers a different major aspect of the specialty, presenting clinical evidence in case scenarios, and features a multiple-choice test plus a critique book that thoroughly discusses each answer. In January, the fifth edition of *Patient Management in the Office* was published.

ACOG is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. ACOG designates this educational activity for a maximum of 25 AMA *PRA category 1 credits*™ or up to a maximum of 25 Category 1 ACOG cognate credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

ACOG awards CME credit for each unit of PROLOG for its initial three years, including the year of publication. At the end of the three years, the College's content experts reevaluate the unit and, if appropriate, extend credit for an additional three years. An individual can request credit only once for each unit. ♀

info

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

New *High-Risk Pregnancy* book released

ACOG'S NEWEST PUBLICATION, *High-Risk Pregnancy*, is intended to serve as an authoritative guide on the management of high-risk pregnancies.

The book is a compilation of articles originally published as part of *Obstetric & Gynecology*'s Clinical Expert series. The authors—who represent a "Who's Who" of high-risk pregnancy experts—have revised and updated their original work for inclusion in *High-Risk Pregnancy*.

Some of the issues discussed are:

- Genetic issues
- Infections
- Medical complications such as thyroid disease, asthma, hypertension, and obesity
- Obstetric complications such as intrauterine growth restriction, preeclampsia, placenta previa, and placenta abruption
- Neonatal encephalopathy and cerebral palsy ♀

info

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

The American College of Obstetricians and Gynecologists
PO Box 96920
Washington, DC 20090-6920

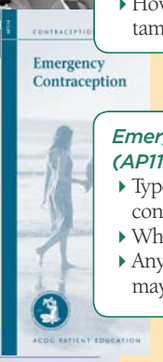
Nonprofit Org.
US Postage
PAID
Merrifield, VA
Permit No. 6418

ACOG PATIENT EDUCATION

Information you and your patients can trust

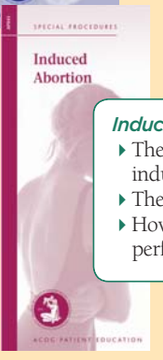
Save 20% for a limited time. Take advantage of this special offer on ACOG's revised pamphlets.

Menstruation
Especially for Teens ***(AP049)***
- The menstrual cycle
- What to expect each month
- How to use pads and tampons



Emergency Contraception (AP114)
- Types of emergency contraception
- When and how it is used
- Any follow-up care you may need

Polycystic Ovary Syndrome (AP121)
- What is PCOS
- How it is diagnosed
- How PCOS can be treated



Induced Abortion (AP043)
- The medical facts about induced abortion
- The types of abortion
- How abortions are performed

info

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