

Front desk staff presents the face of your practice

WHEN SHE WAS A MEDICAL STUDENT, JUNIOR Fellow Brandy R. Patterson, MD, switched ob-gyns because of difficulty scheduling appointments and attitude from the front desk staff. She was tired of her doctor's staff making it difficult to get an appointment, and when she arrived, they didn't make her feel welcome as they sighed, showed obvious frustration, and even rolled their eyes.

"The attitude and helpfulness of the front desk staff is a very important aspect of care," said Dr. Patterson, now chief ob-gyn resident at the University of Alabama at Birmingham. "I changed ob-gyn practices because of difficulty with staff—not my doctor! I think this is a key facet of our patients' care."

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"We need to model the idea that you need to take care of yourself as a physician, and art is one way to do that. It can make us better physicians and act as a stress reliever at the same time."

—Jeffrey M. Rothenberg, MD

Ob-gyn finds more than a hobby in art of glassblowing

ABOUT 10 YEARS AGO, Fellow Jeffrey M. Rothenberg, MD, Indiana Section chair, suffered the loss of three infants under his care in one week. Disheartened, he confided in his wife, Joani, an art therapist, who immediately bought him a ticket to a glassblowing class at the Indianapolis Art Center to help him cope.

Today, what started as a therapeutic escape has turned into more than just a hobby for Dr. Rothenberg. Not only does he still blow glass at least twice a week, but he has made one of his missions as associate professor at the Indiana University School of Medicine to incorporate more humanities into the curriculum.

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EXECUTIVE DESK

ACOG moves forward with the creation of a Congress

FOLLOWING ACOG'S ANNUAL Clinical Meeting this month, we will be turning our attention to activities to implement the bylaw amendments approved at the Annual Business Meeting.

The College is now creating an additional professional nonprofit organization, with a 501(c)(6) Internal Revenue Service designation, that will be called The American Congress of Obstetricians and Gynecologists. The Congress will work parallel to the College, a 501(c)(3) nonprofit.

As with other important issues, the decision to develop a 501(c)(6) Congress was not made overnight. The College's Executive Board first considered a change to a 501(c)(6) business league in the mid-'80s. It was again reconsidered twice in the 1990s and finally in 2007. This reflects the Board's careful consideration of the impact of such a change as well as the alterations in the legal environment in which we exist. It is also an example of the careful deliberations that are the hallmark of the Executive Board and reflects positively on the members you elect to serve in this important capacity.

Now that the vote is in and the Congress can become a reality, there is much work ahead as we address the activities of two separate organizations. The vote to revise the 501(c)(3) bylaws was overwhelmingly in favor of the changes. However, there were also a small number who opposed. I want to assure those who opposed that their objections, many of which were emailed to me prior to the vote, are understood and will be given serious consideration. First and foremost, the College is not going to forget its educational mission. This is key to who we are. Furthermore, we are going to continue to develop our Practice Bulletins and Committee Opinions to enable our members to continue to keep practicing at the forefront of ob-gyn.

What we will be able to do with the Congress is get more involved in developing business help for the practice of ob-gyn. We will also be better positioned for peer review and grievance activities. In the future, our business activities can take many routes; the Congress will now explore other activities prohibited for 501(c)(3) organizations.

One concern voiced by some was the fear that the Congress would use their dues money to support candidates or parties that were in opposition to their personal position. As with the 501(c)(3), the 501(c)(6) Congress cannot use dues for these types of support. What the Congress can do is form a Political Action Committee. Contributions to the PAC must come from personal contributions and not from the Congress or any corporation. If you disagree with decisions of the PAC, then you can withhold any contributions. This same situation exists today with the Ob-Gyns for Women's Health PAC.

The Executive Board of the College and the Congress will be nearly identical, and the two Boards are very aware of the limitations of what can and cannot be done. As I indicated at the start, the Executive Board is a very dedicated and responsible body. The decisions these members make are made after thorough investigation and careful deliberations. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President



Obstetrics & Gynecology HIGHLIGHTS

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

Antibiotic Prophylaxis for Gynecologic Procedures
(Gynecologic Practice Bulletin #104, revised)

Routine Pelvic Examination and Cervical Cytology Screening
(Gynecologic Committee Opinion #431, new)

Spinal Muscular Atrophy
(Genetics Committee Opinion #432, new)
For more information, see page 12.

Optimal Goals for Anesthesia Care in Obstetrics
(Obstetric Committee Opinion #433, revised)
For more information, see page 14.

Two Fellows snag patient-safety Issue of the Year award



Dr. Gala will develop a toolkit to help ob-gyn practices plan, implement, and perfect the art of office-based procedures.



Dr. Curtis will examine the initiation, maintenance, and ongoing evaluation of a successful patient safety program.

FOR THE 2008-09 ISSUE OF THE YEAR, “ESTABLISHING AN OFFICE-Based Patient Safety Program,” ACOG has selected two winners: Rajiv B. Gala, MD, clinical faculty at Ochsner Medical Center in New Orleans, and Michele G. Curtis, MD, MPH, associate professor of ob-gyn at the University of Texas, Houston. The two Fellows are each required to develop a thoroughly researched and referenced background paper of 50–100 pages.

Dr. Gala’s efforts will focus on developing a toolkit to help ob-gyn practices to plan, implement, and perfect the art of office-based procedures.

“Effective and safe implementation of office-based surgical procedures involves proper patient selection, appropriate equipment, and a firm understanding of anesthesia techniques,” Dr. Gala said. “The transition from performing a procedure in the operating room to the office is not as simple as just moving equipment. . . . Unfortunately, because of a lack of standard, evidence-based protocols, physician groups have turned to industry in search of a starting point.”

Practices should first conduct a standard needs assessment of their office environment that does more than create a list of hardware necessary for office-based procedures. Subsequently, practices can use simulation to conduct a virtual implementation to troubleshoot complications and minimize real-time errors. Finally, well-designed outcomes research is needed to refine and improve patient safety for office-based surgical procedures, Dr. Gala added.

In her research paper, Dr. Curtis plans to first examine the inextricable link between quality and patient safety, discussing performance measures, peer review, and maintenance of certification. Next, she will offer a

nuts-and-bolts approach to defining, discussing, and determining what an effective office-based patient safety program would require, including initiation, maintenance, ongoing evaluation, and success.

“The way the health care system is structured is going to change in a lot of ways, and one of those ways is a structure that will offer a safer health care system with quality of care that is being delivered consistently,” Dr. Curtis said. “Medicine has been so hierarchical and autonomous for a millennium so it’s hard to get people to change their thinking.”

Despite all the time and attention spent on patient safety and quality improvement in the US, much of it has been focused on hospitals, Dr. Curtis said.

“This is a rather myopic view given that most health care in the United States is delivered in the ambulatory setting, which is fundamentally different than hospital-based care.”

Ambulatory care is harder to coordinate, with off-site lab and pharmacy services, and often relies on poorly coordinated and unintegrated use of referrals to specialty services and providers, she said.

“I think we’re at the tipping point. All the right players are here—a coalition of forces—ready to make some changes,” Dr. Curtis said. ♀



REAWAKEN YOUR LOVE FOR OB-GYN AT AUGUST POSTGRADUATE COURSE

POSTGRADUATE COURSE director Tod C. Aeby, MD, wants ob-gyns to become reenergized about their specialty and to learn new concepts in a collaborative and interactive environment. Dr. Aeby will lead the ACOG postgraduate course “Reawakening the Excitement of Obstetrics and Gynecology,” Aug 27–29, 2009, in La Jolla, CA. The course will cover issues such as:

- ▶ The challenges of the medical marriage
- ▶ How to apply time, stress, and practice management principles
- ▶ Management of personal finances
- ▶ How to handle challenging patients

The course is designed around adult-learning theory. Rather than providing only lectures, the course will use small-group sessions to stimulate discussion. Part of the instruction will be determined by the participants, who are asked to register early. Then, they will be asked to submit suggested course topics.

The three-day course is organized so that the first half of the morning focuses primarily on medical issues, leaving the second half of the morning for more personal topics such as finances and relationships. Spouses and partners are encouraged to attend these latter discussions. ♀

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→ www.acog.org/postgrad/pgpage.cfm?recno=470

California Section 2 honored for prenatal drug abuse program

CALIFORNIA SECTION 2, which represents the Bay Area, is the 2008 Wyeth Pharmaceuticals Section Award winner for its efforts in establishing Early Start, a drug screening, evaluation, and treatment program for prenatal patients.

The main goals of Early Start are to decrease substance abuse in pregnant women, reduce negative birth outcomes and medical costs, improve access to substance abuse services for pregnant women, and enhance provider satisfaction and efficiency. More than 40,000 women have been screened with the program, and 14,000 have been assessed and given treatment. The cost savings per mother entered into a treatment program through

Early Start is more than \$1,500, based solely on calculations of hospital-related costs.

“There is an unmeasured value in the emotional and physical savings reflected by a reduction of fetal death,” said District IX Chair Jeanne A. Conry, MD, PhD. According to Dr. Conry, the rate of fetal death in patients who declined treatment through the Early Start program is seven times higher and the rate of placental abruption is six times higher than for those who accept treatment. There was no difference in outcome for patients with a treated drug and alcohol problem and those with no history of drug use.

The success of the program is attributed to five key components:

- ▶ Educating all pregnant women about the

ACOG RECOGNIZES THE HARD WORK and determination of all the sections nominated for the section award:

District I: Maine Section, Maternal and Infant Mortality Review

District II: New York Section 9, Enhancing Early Identification, Diagnosis, and Treatment of Perinatal Depression

District IV: Florida Section, Update on HPV—Epidemiology, Treatment, and Immunology Symposium

District VI: Wisconsin Section, Management of Unipolar Depression in Pregnant and Postpartum Women

District VII: Tennessee Section, Reduction of New Human Papillomavirus Infections in Davidson County

- risks of prenatal substance abuse
- ▶ Universally screening all pregnant women by urine toxicology and questionnaires
- ▶ Locating a substance abuse specialist in the prenatal clinic
- ▶ Linking Early Start counseling visits with routine prenatal care visits
- ▶ The ongoing education of ob-gyns about prenatal substance abuse ♀

GREEN JOURNAL ANNOUNCES RESEARCH PAPER WINNERS

OBSTETRICS & GYNECOLOGY HAS ANNOUNCED the winners of the 2008 Roy M. Pitkin Award, which honors 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 most outstanding articles 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.

University of California, San Francisco

Department of Obstetrics, Gynecology & Reproductive Sciences; Linda C. Giudice, MD, PhD, MSc, chair

Sawaya GF, Chirenje MZ, Magure MT, Tuveson JL, Ma Y, Shiboski SC, Da Costa MM, Palefsky JM, Moscicki A-B, Mutasa RM, Chipato T, Smith-McCune KK. *Effect of Diaphragm and Lubricant Gel Provision on Human Papillomavirus Infection among Women Provided with Condoms: A Randomized Controlled Trial.* Obstet Gynecol 2008;112:990-7.

Kaiser Permanente San Francisco

Department of Obstetrics and Gynecology; Steven J. Masters, MD, chair

Longinotti MK, Jacobson GF, Hung Y-Y, Learman LA. *Probability of Hysterectomy after Endometrial Ablation.* Obstet Gynecol 2008;112:1214-20.

Stanford University

Department of Obstetrics and Gynecology; Jonathan S. Berek, MD, MMS, chair

Lyell DJ, Pullen KM, Mannan J, Chitkara U, Druzin ML, Caughey AB, El-Sayed YY. *Maintenance Nifedipine Tocolysis Compared with Placebo: A Randomized Controlled Trial.* Obstet Gynecol 2008;112:1221-6.

The George Washington University

Department of Obstetrics and Gynecology; John W. Larsen, MD, chair

Toso L, Cameroni I, Roberson R, Abebe D, Bissell S, Spong CY. *Prevention of Developmental Delays in a Down Syndrome Mouse Model.* Obstet Gynecol 2008;112:1242-51.

New award created

ACOG and the Green Journal have established the Harold A. Kaminetzky Prize Paper to recognize the best paper from a non-US researcher. The 2008 winner is:

Radboud University Nijmegen Medical Centre, The Netherlands

Siebers AG, Klinkhamer PJJM, Arbyn M, Raifu AO, Massuger LFAG, Bulten J. *Cytologic Detection of Cervical Abnormalities Using Liquid-Based Compared with Conventional Cytology: A Randomized Controlled Trial.* Obstet Gynecol 2008;112:1327-34.



ACOG Fellow William F. Rayburn, MD, MBA, is gathering data to analyze the future of the ob-gyn workforce.

Website articles explain the 'how to' of EMR implementation

ACOG WILL BE PRESENTING a series of articles throughout the year to help practicing Fellows evaluate the benefits of implementing electronic medical record systems. These articles, published on the ACOG website, will cover essentials that should be considered before a practice begins selecting vendors. Articles will address:

- ▶ Readiness assessment and the value to you and your practice
- ▶ Change management and process redesign
- ▶ Vendor selection and the most appropriate type of IT support
- ▶ Implementation process and education
- ▶ Optimizing workflows after an EMR system is implemented

The articles are not designed to recommend any specific vendor or product but to educate ob-gyn practices about the process and how to get started. The first article, "Readiness Assessment," provides an overview of the EMR process and offers some basic tools that can reveal overall readiness and obstacles a practice is likely to encounter. The second article, "Return on Investment," discusses how to perform a return on investment analysis, aimed at improving returns by reductions in



costs, increases in expected gains, or acceleration of the timing of when gains may occur.

Fellow Michael J. McCoy, MD, authored the articles. Dr. McCoy used an EMR in his previous practice and has been a hospital system chief medical information officer and has held executive positions with both enterprise/hospital EMR vendors and ambulatory/office EMR vendors. He has been involved in several national health care standards panels and groups. ♀

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→ A new article will be published on the ACOG website each month. At www.acog.org, under "Practice Management," click on "Health Information Technology"

Fellow examines ob-gyn workforce data

ALL OB-GYNS HAVE HEARD of a Fellow who has dropped obstetrics, retired early, or begun working only part-time. And as the Baby Boomers get older, more ob-gyns will reach retirement age, as will more women in the general population, increasing the demands for gynecologic services.

What does all this mean for the ob-gyn workforce? Will the current shortage of ob-gyns in some areas increase? Will faculty positions be filled? Will there be enough ob-gyn researchers?

ACOG Fellow William F. Rayburn, MD, MBA, is looking into these and other workforce questions in a series of projects examining the changing landscape of ob-gyn and the anticipated increase in demands on academic faculty and community-based physicians. Dr. Rayburn is the Randolph V. Seligman Professor and Chair of the ob-gyn department at the University of New Mexico, which is partly sponsoring a mini sabbatical for his efforts.

Throughout 2009, Dr. Rayburn will conduct research at ACOG headquarters and at the research offices of the Association of American Medical Colleges, both in Washington, DC.

"As we look to the future, we must first look at our academic centers involved in the training of future women's health care providers," Dr. Rayburn said. "There's going to be more of a turnover of leadership positions and the need to train more leaders."

It's been several years since a large amount of ob-gyn workforce data and analyses was published, and "there have been dramatic changes in subspecialization and in women going into medical school and ob-gyn since then," said Dr. Rayburn, who plans to develop comprehensive workforce analyses and publish his data in ob-gyn journals later this year. ♀



More medical students choosing ob-gyn

THE PERCENTAGE OF OB-GYN POSITIONS FILLED IN this year's residency match continued to improve to 99.5%, leaving only six ob-gyn slots unfilled. The percentage of US seniors filling these slots also increased to 74.2%, up from 72.1% last year. Moreover, the number of slots available—1,185—was 22 more than last year and 41 more than were available in 2005.

The ob-gyn residency match numbers have improved in each of the last five years. ACOG medical student recruitment efforts include hosting an ob-gyn residency fair and offering a medical student course, booth, reception, and hands-on courses at the Annual Clinical Meeting. ♀

Ob-gyn finds more than a hobby in art of glassblowing

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“The things we deal with as physicians can be so emotionally heavy that if you take them home with you, you will get smothered,” Dr. Rothenberg said. “Having art or some other sort of passion to take part in can really help us take our minds off of everything.”

Dr. Rothenberg believes that, in addition to being therapeutic, the practice of art heightens a person’s senses and focus on detail and that reflection on creating art and its products and processes can increase a person’s awareness of self and others.

“Art can aid physicians as healers and also help patients in their coping with symptoms, stress, and traumatic experiences,” Dr. Rothenberg said.

Dr. Rothenberg has seen a hunger in his students for incorporating humanities into medical education. He believes that it is equally important for physicians to practice humanistic principles to set an example for students and residents.

“In medicine, there is a lot of burnout,” Dr. Rothenberg said. “We need to model the idea that you need to take care of yourself as a physician, and art is one way to do that. It can make us better physicians and act as a stress reliever at the same time.”

Dr. Rothenberg’s award-winning artwork is featured in many public and private col-

“Art can aid physicians as healers and also help patients in their coping with symptoms, stress, and traumatic experiences.”



Dr. Jeffrey M. Rothenberg glassblowing at the Indianapolis Art Center



Dr. Rothenberg with some of his work displayed in the Indiana University library

lections. Recently, he donated an installation to the newly built Riley Mother and Baby Hospital at the Moi University Medical Center in Eldoret, Kenya. Indiana University and Moi University have had a partnership since 1989, linking US physicians, residents, and medical students with Kenyan counterparts to help develop leaders in health care for both the US and Africa.

When Dr. Rothenberg first saw the Riley Mother and Baby Hospital, he noticed the spaciousness of the lobby and thought he could use art to help fill it. Eight months later, he had created 192 glass globes, one for every country of the United Nations, each unique in size, color, and style (see cover photo).

In September 2008, Dr. Rothenberg traveled to Kenya to sus-

pend each of the globes from the lobby’s ceiling and found help from the local community.

“It was an amazing transformation from an open space to this installation, working with the Kenyans as a team,” Dr. Rothenberg said. “When they look at it, they can take ownership and feel that they created part of it too.”

Dr. Rothenberg incorporated local artwork by using 1,000 beads from women at the Imani Workshop, another part of the university partnership that produces and sells quality crafts by HIV-positive Kenyan artisans, while promoting economic self-sufficiency to its workers.

“The Riley Mother and Baby Hospital in Kenya sends a very strong message to the local communities about the importance we put on women’s and children’s health care,” Dr. Rothenberg said. “Having art inside augments that concept and makes the space feel special. It is one of the things I am most proud of in my career so far.” ♀

Patient safety experts export concepts to China

TWO OF ACOG'S LEADING patient safety advocates took their message overseas in February, teaching Chinese ob-gyns patient safety and peer review concepts.

John S. Wachtel, MD, chair of ACOG's Committee on Patient Safety and Quality Improvement, and Paul A. Gluck, MD, current member and past chair of the patient safety committee, taught a three-day patient safety course in Beijing for 65 leaders from 26 tertiary care maternity hospitals representing 20 Chinese provinces. They also taught a one-day course in Shanghai.

Chinese maternal-fetal medicine specialist Tao Duan, MD, PhD, invited the two US ob-gyns to present the seminars after Dr. Duan attended Drs. Wachtel and Gluck's patient safety course at ACOG's 2008 Annual Clinical Meeting in New Orleans.

"They wanted an introduction to patient safety. There's no developed patient safety

system in China right now," Dr. Wachtel said. "The audience was very engaged. They asked a lot of appropriate and pertinent questions, and they were very excited."

The courses began with an introduction to patient safety that included information on the incidence of and reasons for medical errors. Course sessions covered:

- ▶ Disclosure of adverse events
- ▶ Communication
- ▶ Team function to improve safety
- ▶ Medication safety
- ▶ ACOG's Voluntary Review of Quality of Care Program
- ▶ The emotional impact of adverse events on clinicians
- ▶ The concept of just culture

The peer review and quality improvement concepts were new to most attendees, and many later asked the US Fellows how they could begin to set up peer review programs in their hospitals in China. The idea of just



Patient safety advocates John S. Wachtel, MD; Tao Duan, MD, PhD; and Paul A. Gluck, MD, in China

culture was also new, but "they were very energized and ... the just culture idea seemed to resonate with them," Dr. Wachtel said.

Many of the attendees were interested in collaborating with the two US Fellows on patient safety initiatives, and both hope to help their Chinese counterparts with future projects.

"We are planning to organize lecture tours about patient safety in China," Dr. Duan said, "first letting ob-gyn doctors in China know what is patient safety and then cooperating with ACOG to develop patient safety programs for China."

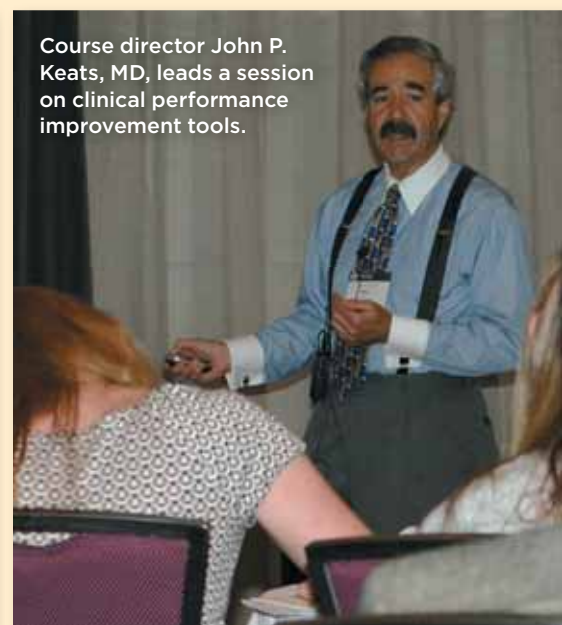
About 15 to 20 ob-gyns from China plan to attend ACOG's Annual Clinical Meeting this month in Chicago. ♀

POSTGRADUATE COURSE TEACHES PATIENT SAFETY TECHNIQUES

Participants in the sold-out ACOG course "Quality and Safety for Leaders in Women's Health Care" learned key patient safety and quality improvement principles and techniques. The course was held March 26–28 in Washington, DC.



In a leadership exercise involving Tinkertoys, course participants work out a solution.



Course director John P. Keats, MD, leads a session on clinical performance improvement tools.



Dr. Hunt

Essay recalls lessons in letting go

MEDICAL SCHOOL TRAINS students to become life savers. But sometimes saving a life isn't an option.

The day Junior Fellow Jennifer Hunt, MD, learned this, she believes, was the day her true education of medicine began. She was assessing a patient with a history of ovarian cancer who was surrounded by concerned family members and struggling to breathe. Instinctively, Dr. Hunt tried to save the patient's life with a diagnosis, ordering a blur of tests, wondering what she could be missing.

In mid-dial to radiology to order another test, Dr. Hunt stopped herself and thought, "What am I doing?" She knew the patient's diagnosis was staring her in the face.

"More tests wasn't what she needed right now," Dr. Hunt writes in an essay about the experience. "What she needed was to be surrounded by the people who loved her most and to make peace with the journey that led

DISTRICT ESSAY WINNERS

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

District I: Elena Tunitsky-Bitton, MD

District II: Rachel S. Weirnerman, MD

District III: Khanh-Ha D. Nguyen, MD

District IV: Nisha Bansal, MD

District V: Mark A. Zakaria, MD

District VI: Jennifer Hunt, MD

District VII: Damaris M. Olagundoye, MD

District VIII: Joy K. Zia, MD

District IX: Minako Watabe, MD

Armed Forces District: Alta J. DeRoo, MD

District XI: Heather L. Danson Straub, MD

her to this moment."

Dr. Hunt approached the patient's family—one of whom was a gynecologist at the hospital—and the family members decided it was best to let her go peacefully. For the next two hours, Dr. Hunt sat at the patient's bedside, holding her hand and talking with her family until she passed away. Dr. Hunt realized that night that sometimes to save a life physicians have to let it go.

Dr. Hunt's essay on her experience was selected as the national winner from the 11 district winners in the Junior Fellow essay contest, "Ob-Gyn ... The Day I Made a Difference." Dr. Hunt is a fifth-year resident at the Women's Hospital in Winnipeg, Manitoba, in District VI. Each district winner received \$500, and Dr. Hunt was given an additional \$500 plus a trip to ACOG's Annual Clinical Meeting in May to present her essay. ♀

A look back at 2008–09 achievements

By Eric J. Hodgson, MD, JFCAC chair

IT IS WITH MIXED FEELINGS OF excitement and sadness that I write this final article as chair of the Junior Fellow College Advisory Council. It has been a terrific year in the life of ACOG's Junior Fellows, and I'm pleased to report on a few highlights of the past year.

The Junior Fellow leadership remains committed to encouraging the best and brightest medical students to enter our specialty. The completion of "Choose Ob-Gyn for Women's Health," our new ob-gyn recruitment video, was our major contribution toward that goal.

As advocates for ob-gyns in training, the national Junior Fellow leaders participated in ACOG's Chantilly II retreat and presented our

data from the Junior Fellow Practice Pattern Survey. The JFCAC will continue to serve as the voice for young physician input in defining and reshaping the next generation of our specialty.

This was the inaugural year for our Junior Fellow Section Officer Training Program, a new leadership training program designed to teach practical skills to ACOG's newest leaders. The program was held in conjunction with ACOG's Congressional Leadership Conference, The President's Conference, in Washington, DC, to maximize participation of Junior Fellows in legislative advocacy. The position of Junior Fellow section legislative chair was created to enhance state-based legislative

advocacy efforts.

Although it is impossible to thank each person who has helped make this year such a success, I want say a special word of thanks to Dr. Rajiv B. Gala, JFCAC immediate past chair; ACOG Executive Vice President Ralph W. Hale, MD; Junior Fellow Advisor Owen C. Montgomery, MD; and ACOG Vice President of Fellowship Activities Albert L. Strunk, MD, as well as the awesome Junior Fellow staff at ACOG and the fantastic Junior Fellow district leadership. They made this year a joy and a pleasure.

I look forward to supporting Taraneh Shirazian, MD, as she assumes her new role as chair. ♀



YOU ASKED, WE ANSWERED

Managing your stress during a lawsuit is crucial

Q I AM IN THE MIDST OF A liability lawsuit. How can I maintain my stamina during this seemingly interminable process?

A THE LITIGATION PROCESS is very unpredictable, with many stops and starts. Most physicians prefer to confront a problem, deal with it promptly, and move on, but an ob-gyn medical liability case can take an average of three to four years to be resolved. Managing the stress that comes with litigation is not only essential to your health and a successful defense, but it is also a risk management issue. Difficulty in concentrating, irritability, or anger can make you more vulnerable to incidents likely to trigger another claim. In fact, physicians who are sued are at twice the usual risk for an additional claim within the next year.

Even while you devote energy and time to your defense, you must continue to function as a physician. Doing whatever you can to

gain a greater sense of control over your work should help to reduce your stress, such as:

- ▶ Cutting back on work hours or the number of patients you see, if possible
- ▶ Reducing your involvement in areas of practice you find stressful or anxiety producing
- ▶ Focusing more time and energy on the areas of practice you enjoy
- ▶ Not getting involved in activities that compromise your standards
- ▶ Finding time for activities that improve your skills and bolster your confidence

The most difficult task of all may be to compartmentalize, to prevent worries about your liability case from invading other areas of your life. If your case is typical, a few years could pass before the case is resolved, so you will need to find ways to put it out of your mind, at least temporarily, in order to function effectively.

For most medical families, a lawsuit results in a significant personal crisis for everyone in-

involved—physician, spouse/partner, and other family members. Communicating as much as you can with family members about the non-confidential aspects of the lawsuit—the allegations, possible publicity, and expected testimony—can help to reduce feelings of isolation. Remember that discussions of the details involved in the case should be limited to conversations with your attorney. The purpose of talking with family or friends is to get emotional support, not legal advice. Your children may have questions and concerns about the case. Answer questions as honestly as you can, keeping in mind your child's age and ability to understand the information. ♀

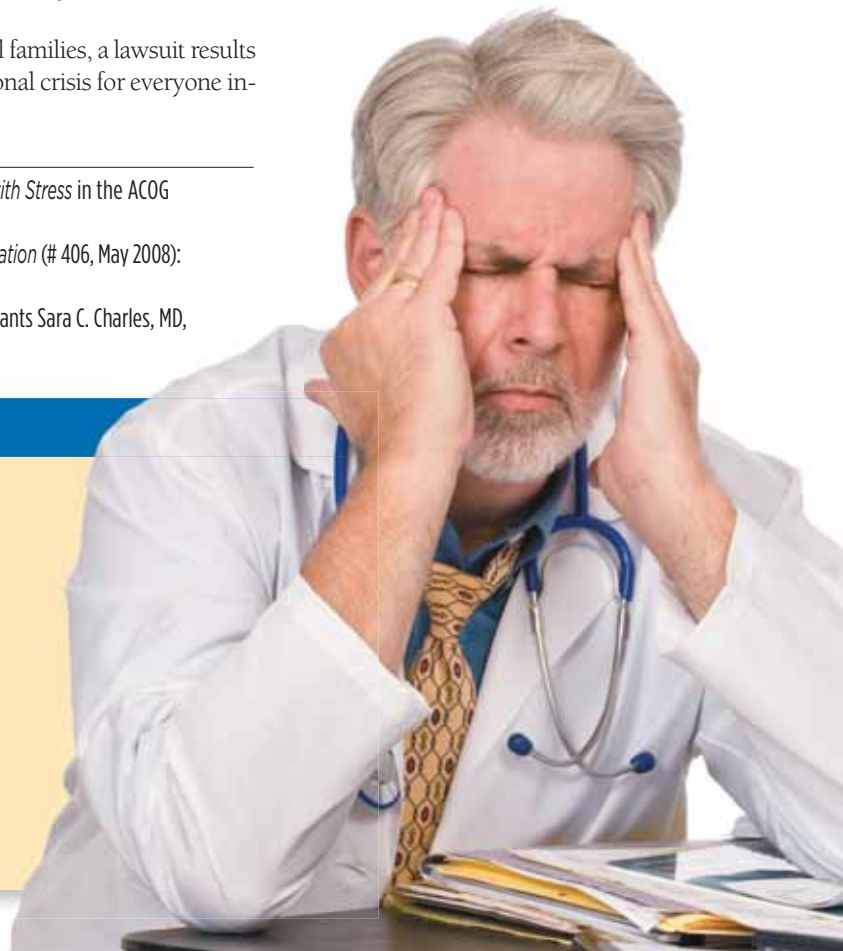
The information in this article should not be construed as legal advice. As always, physicians should consult their personal attorney about legal requirements in their jurisdiction and for legal advice on a particular matter.

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- ACOG's CD-ROM *From Exam Room to Courtroom: Navigating Litigation and Coping with Stress* in the ACOG Bookstore: <http://sales.acog.org>; 800-762-2264
- ACOG Committee Opinion *Coping with the Stress of Medical Professional Liability Litigation* (# 406, May 2008): www.acog.org/publications/Committee_Opinions/co406.cfm
- *Adverse Events, Stress, and Litigation: A Physician's Guide*, a book by ACOG consultants Sara C. Charles, MD, and Paul R. Frish, JD

STRESS MANAGEMENT TACTICS

- ▶ Schedule more leisure time. Take a vacation if possible
- ▶ Spend more time with your family and friends
- ▶ Get regular exercise
- ▶ Limit chemical or alcohol use
- ▶ If you have neglected financial planning, address this; it will help relieve some worries about your family's future
- ▶ Ask for help in dealing with the stress of litigation; this is not an admission of weakness or professional incompetence
- ▶ Do not try to diagnose and treat your own symptoms, even "just" insomnia
- ▶ See your primary care physician for a thorough evaluation of any symptoms you experience. If you do not have a primary care physician, find one



How to properly code for IUDs

TO HELP OB-GYN PRACTICES SEEK APPROPRIATE COMPENSATION for the provision of intrauterine devices the ACOG Coding Department, in collaboration with ACOG's Long-Acting Reversible Contraception Program, has provided the following coding recommendations.

“Correct coding for contraceptive services is essential to obtaining appropriate compensation for physician time and effort devoted to contraceptive counseling and method selection.”

—Eve Espey, MD, chair of ACOG's work group on long-acting reversible contraception

IUD insertion, removal, and supply

CPT code 58300 is reported for the insertion of IUDs, while code 58301 is assigned for the removal. The cost of the IUD is not included in these codes and should be reported separately using HCPCS code J7300 for the ParaGard copper IUD and J7302 for the hormonal Mirena IUD.

The ICD-9-CM diagnosis codes for IUD placement and removal depend on the circumstance. Most IUD services will be linked to a diagnosis code from the V25 series, “encounter for contraceptive management.”

Coding for the office visit with or without IUD insertion

A visit to discuss the use of an IUD involves counseling the patient about her choice and the different options available to her. In addition, the physician will conduct a review of the patient's history and perform a physical exam. When more than 50% of the visit is spent counseling the patient, report the evaluation and management code based on the entire encounter. For example, if the entire encounter was 30 minutes, with 20 minutes devoted to counseling a new patient, code 99203 would be assigned. For new patient services, codes are:

- ▶ 99201, 10 minutes
- ▶ 99202, 20 minutes
- ▶ 99203, 30 minutes

- ▶ 99204, 45 minutes

- ▶ 99205, 60 minutes

For established patient services, codes are:

- ▶ 99211, 5 minutes supervision (physician must be in the office)
- ▶ 99212, 10 minutes
- ▶ 99213, 15 minutes
- ▶ 99214, 25 minutes
- ▶ 99215, 40 minutes

If the office visit is conducted without insertion of the IUD, report the appropriate E/M service code at the correct level. Link the E/M code to ICD-9-CM diagnosis code V25.02, “general counseling and advice, initiation of other contraceptives.”

If counseling and IUD insertion occur on the same day, add modifier 25, “significant and separately identifiable E/M service on the day of another service,” to the E/M service to indicate that the service(s) was distinct from the IUD insertion procedure. Code 58300, “insertion of IUD,” should be linked to V25.1, “insertion of intrauterine contraceptive device.”

Same day removal and insertion

When a patient sees the clinician to have an IUD removed and a new one inserted during the same visit, report both the IUD removal (58301) and insertion (58300) separately. The E/M service, if performed, and the supply are also reported separately.



Discontinued IUD insertion

If you were unable to insert the IUD because of extenuating circumstances or a threat to the well-being of the patient, add modifier 53, “discontinued procedure,” to code 58300, “insertion of IUD.” This modifier is used when a procedure is started but discontinued, not when the procedure is electively canceled prior to surgical preparation. Modifier 53 offers a way for ob-gyns to seek partial payment for the work performed. It is not necessary for physicians to reduce their fee; this will be determined by the payor.

IUD reassessment

A follow-up visit in the office to check the proper placement of the IUD is reported as V25.42, “surveillance of previously prescribed contraceptive method, intrauterine contraceptive device.” If ultrasound is used, assign these codes:

- ▶ Code 76857, “ultrasound, pelvic [non-obstetric], real time with image documentation limited or follow-up,” with V25.42 or
- ▶ Code 76830, “ultrasound, transvaginal,” with V25.42 ♀

info

- ➔ On the ACOG website, in the “Quick Links” box on the left side of the home page, click on “Coding”
- ➔ Questions: coding@acog.org or fax to 202-484-7480

Front desk staff presents the face of your practice

► PAGE 1

Before accepting a position at a group practice in Mississippi, which she will join after she finishes her residency in June, Dr. Patterson called around to inquire about the efficiency and attitude of the staff, which received positive reviews.

“That was something very important to me in my decision process of choosing a practice, a close second to my colleagues in that practice,” Dr. Patterson said.

When Utah Fellow Robert J. Fagnant, MD, started a previous practice, it took him a while before he was listed in the phone book or on the local hospital’s list of ob-gyns available to patients. However, that didn’t stop new patients from finding his office.

“A common comment was that it was still easier to find me than deal with another group in town that had developed a bad reputation for their front office,” he said.

“It can be extremely difficult for patients to get appointments at some ob-gyn practices, and it just should not be that hard. Sometimes ob-gyns forget that patients are the lifeblood of their practice,” said Fellow Holly S. Puritz, MD, managing partner at The Group for Women in Norfolk, VA, which has 13 clinicians, including nine ob-gyns. “If a patient didn’t have a good encounter when she came in, the whole rest of the appointment is really colored by that.”

Dr. Puritz points to an adage that is behind the practice’s “customer service” philosophy: You don’t get a second chance to make a first impression.

“I can teach you functions in your job description; I can’t train you on how to be nice,” said The Group for Women’s administrator, Eric Preuss, MS. “I can’t train you on tact and diplomacy. I can’t train you to say ‘please’ and ‘thank you.’ That’s stuff you have or you don’t.”

That said, as part of their initial training, staff members are instructed on how to answer the phone and how to greet patients when they come in the door. Some practices conduct ongoing training with the help of videos showing patient encounter scenarios. Mr. Preuss holds weekly manager meetings to discuss issues and constantly reinforces the

philosophy of customer service and patient satisfaction.

Dr. Puritz added that physicians set the tone for their entire practice. Their mood and personality can establish the type of culture a practice is going to have.



“It can be extremely difficult for patients to get appointments at some ob-gyn practices, and it just should not be that hard.”

—Holly S. Puritz, MD

“It does trickle down to staff. The way you behave and the way you act absolutely gives permission to the staff to behave and act that way,” Dr. Puritz said.

Handling phone calls

With the phone system often the first encounter a patient has with a practice, these physicians believe it’s important that a human being answer the phone. While computerized phone systems can be helpful in a busy practice, “press 1 if you’re a new patient,” “press 2 if this is for your annual exam,” and “press 3 for billing” can be a turnoff.

Fellow Lynda J. Wolf, MD, a partner of Reproductive Medicine Associates of Michigan in Troy, MI, said that when she calls any business,

if a computer system answers instead of a person, she simply hangs up. She didn’t want her patients to do the same, so when she and two other REIs started their practice nearly three years ago, they decided it was important for a person to answer the phone. Dr. Wolf admits it can be challenging when the phone lines keep ringing and the two people at the front desk are already on other lines with patients.

“I don’t want someone who’s making their first encounter with us to go to voicemail,” she said. “We’ve been getting more phone lines and creating a back-up system.”

Surveying patients and recognizing staff

To determine which areas of their practice are strong and which may need work, both Dr. Wolf’s and Dr. Puritz’s practices conduct patient surveys. The surveys ask patients to rate particular aspects of the practice and leave blank space for patients to share what they feel the practice is doing well and what needs improvement.

Recognizing staff for being extra kind or helpful to a patient is also important to foster a professional, courteous environment.

When Mr. Preuss hears of or witnesses staff members being extra helpful to a patient, he recognizes them on the spot, with more than a “thank you”—he presents them with movie gift certificates, enough for their entire family. Mr. Preuss organizes potlucks once a quarter and surprises staff with periodic barbecues. Every month, he writes thank you cards to different staff members about a patient encounter in which they went above and beyond—and mails the cards to their home for a welcome surprise.

“You’ve got to get the right people in the front,” Mr. Preuss said. “You have to recognize them, and you have to compensate them correctly.”

Adds Dr. Wolf, “Your front desk people are your face to the patient. Before their first appointment, that’s the only image they have of your practice. It’s very important that they are professional, courteous, and go above and beyond. . . . We really try to stress that the patient comes first.” ♀

Widespread screening for spinal muscular atrophy not recommended

PRECONCEPTION AND PRE-natal screening for the genetic disease spinal muscular atrophy is not recommended for the general population, according to a new Committee Opinion from ACOG's Committee on Genetics.

Spinal Muscular Atrophy, which was published in the May issue of *Obstetrics & Gynecology*, addresses the debate over population-based screening for SMA—also known as Werdnig-Hoffman disease—an autosomal recessive disease that leads to atrophy of skeletal muscle and overall weakness from degeneration of spinal cord motor neurons. The incidence is approximately 1 in 10,000 births, and, depending on the form of the disease, affected children may die as infants or during adolescence, often from respiratory failure.

Genetic counseling and carrier screening should be offered to women and couples with a family history of SMA or SMA-like disease, according to the new Committee Opinion. SMA carrier screening should also be provided to patients aware of the test who request screening after they've had genetic counseling that included discussion of the sensitivity, specificity, and limitations of screening.

ACOG recommendations differ from ACMG's

Recent public awareness campaigns and marketing of improved diagnostic assays for gene mutation have included calls for preconception and prenatal SMA carrier testing, regardless of family history. In November 2008, the American College of Medical Genetics issued a new practice guideline that recommended offering carrier testing to all families, regardless of race or ethnicity.

"There are certain conditions that should be met before recommending widespread population screening, and at this point in time, several of these conditions haven't been addressed," said Thomas J. Musci, MD, chair of ACOG's Committee on Genetics. "There's zero data on the cost-effectiveness of screening in the entire population, and no studies have



"There's zero data on the cost-effectiveness of screening in the entire population, and no studies have been completed in the US that would determine how best to provide pretest and posttest education and counseling."

—Thomas J. Musci, MD, chair of ACOG's Committee on Genetics

been completed in the US that would determine how best to provide pretest and posttest education and counseling."

SMA patient advocates compare the SMA carrier rate to that of cystic fibrosis, which has a 1 in 25 carrier rate for non-Hispanic Caucasians, or Tay-Sachs, which has a 1 in 31 carrier rate. SMA carrier frequencies are estimated at 1 in 40 to 1 in 60.

"Recommending population-based screening for SMA widens the circle of the carrier frequency for offering disease screening to everyone," Dr. Musci said. "Geneticists and policymakers in general haven't sat down to decide if there is a carrier frequency threshold that must be hit before it makes policy sense to recommend screening for everyone."

Dr. Musci believes geneticists need to address this as patient advocates and test manufacturers continue to call for widespread

screening for particular genetic diseases.

"For newborn screening, as an example, there's a process in place that each candidate disease goes through. There are forums and committee meetings where experts evaluate each disease. . . . It's a great model to consider adopting to determine which tests should be included in prenatal carrier screening panels," Dr. Musci said.

According to the ACOG Committee Opinion, "Before panethnic prenatal screening for SMA can be recommended there should be a variety of issues addressed which include, but may not be limited to, critical assessment of pilot screening programs, cost-effectiveness analysis, development of appropriate educational materials for both patients and primary obstetrician-gynecologists, and the development of laboratory assay standards and result reporting." ♀

Some Latin American patients may suffer from Chagas disease

PHYSICIANS IN THE US MAY encounter Chagas disease in their patients, particularly among Latin Americans, according to the Centers for Disease Control and Prevention.

Chagas disease, or American trypanosomiasis, is caused by the parasite *Trypanosoma cruzi* and spread by infected bugs called triatomines—or kissing bugs—blood-sucking insects that feed on humans and animals. The disease is endemic throughout much of Mexico and Central and South America. It has been estimated that 100,000 or more infected people are living in the US.

Chagas disease can also be transmitted by blood transfusion, organ transplantation, lab accidents, contaminated food or drink, and congenitally. Although the triatomine bugs are present in much of the southern US, vector-borne cases are rare. In December 2006, the US Food and Drug Administration approved a Chagas disease screening assay for donated blood.

What to look for in pregnant patients

According to the CDC, it is important to identify pregnant women who may be at risk for Chagas disease because it can be transmitted congenitally and can lead to severe disease in the newborn, even if the mother is asymptomatic. If untreated, infection is lifelong. In pregnant women, the disease should be suspected if the patient comes from a Chagas-endemic area and in cases of unexplained cardiac or gastrointestinal disease in patients from Mexico and Central and South America. Ob-gyns may be able to identify at-risk women by tak-

ing a detailed patient history that includes questions about:

- ▶ Having seen the triatomine bug (photographs are available on the CDC website at www.cdc.gov/Chagas)
- ▶ Having lived in poorly constructed and often rural housing in a country with known Chagas disease risk

Chagas disease is often asymptomatic for years to decades before people develop symptomatic disease, which may be characterized by cardiac disease (such as conduction abnormalities or apical aneurysm) or gastrointestinal manifestations (such as megacolon or megaesophagus). Having Chagas disease increases the risk of stroke and may be life-threatening in all phases of the infection.

There are several tests to detect Chagas disease. Serum samples may be sent to the CDC through state health departments. Two drugs, nifurtimox and benznidazole, are worldwide standard antiparasitic

treatments for Chagas disease and are available only from the CDC. The CDC recommends that treatment be postponed in pregnant women until after pregnancy, and though there are no reported data regarding breastfeeding, withholding treatment while breastfeeding is also recommended. ♀

info

- More information, including English and Spanish fact sheets for physicians and patients and an audio podcast: www.cdc.gov/Chagas
- “Clinician’s Corner: Evaluation and Treatment of Chagas Disease in the United States,” *Journal of the American Medical Association*, Nov 14, 2007 (Vol. 298 No. 18)



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Down syndrome screening guidelines adopted

THE MAJORITY OF OB-GYNS are following ACOG guidelines to offer Down syndrome screening to all pregnant patients, regardless of age, according to a new study conducted by Fellow Deborah A. Driscoll, MD, and Maria Morgan, PhD, and Jay Schulkin, PhD, both from ACOG’s research department.

“This survey shows that the majority of obstetricians have adopted this new paradigm for Down syndrome screening, including offering first-trimester screening tests,” said Dr. Driscoll, professor and chair of the ob-gyn department at the University of Pennsylvania and lead author of ACOG’s January 2007 Practice Bulletin *Screening of Fetal Chromosomal Abnormalities*, which recommended that age 35 no longer be used as a cut-off to determine which pregnant patients are offered aneuploidy screening vs. which are offered invasive testing.

Researchers mailed questionnaires in October 2007 to 968 ACOG Fellows and Junior Fellows practicing in the US. Ninety-five percent of the respondents were offering Down syndrome screening to all their pregnant patients. Seventy percent of general obstetricians were offering first-trimester screening. In the second trimester, the quad screen is now the preferred screening test, and 86% of respondents were offering the quad screen.

However, Dr. Driscoll pointed out, many are still using age 35 as a cutoff to offer invasive prenatal diagnostic testing. Ninety-two percent routinely offer all patients 35 and older amniocentesis, while only 15% routinely offer amniocentesis to all patients younger than 35.

The study was published in the April 2009 issue of the *American Journal of Obstetrics & Gynecology*. ♀



Chlamydia cases continue to increase

THE NUMBER OF REPORTED chlamydia cases in 2007 increased by about 77,000, according to the annual STD report from the Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance, 2007*. There were more than 1.1 million chlamydia cases reported.

Gonorrhea, the second most commonly reported infectious disease, had more than 350,000 reported cases, about the same as the previous year. However, it is estimated that more than half of all new infections of chlamydia and gonorrhea continue to go undiagnosed, underscoring the importance of increased screening.

ACOG guidelines recommend that all sexually active women 25 and younger be screened for chlamydia. ACOG also recommends that all sexually active adolescents be routinely screened for gonorrhea and that asymptomatic women 26 and older who are at high risk for infection be routinely screened for chlamydial infection and gonorrhea. The National Chlamydia Coalition, of which ACOG is a member, recently developed *Why Screen for Chlamydia? An Implementation Guide for Healthcare Providers* (see “info” below). ♀

info

→ www.cdc.gov/std/stats07

→ Screening guide: www.prevent.org/NCC

Hospitals should have written OB anesthesia policies

GOOD OBSTETRIC CARE requires the availability of qualified personnel and equipment to administer general or regional anesthesia both electively and emergently, says a Committee Opinion issued jointly by ACOG and the American Society of Anesthesiologists. *Optimal Goals for Anesthesia Care in Obstetrics*, which was first published by the two organizations in 2001, has been updated and published in the May issue of *Obstetrics & Gynecology*.

“ACOG and ASA have stood together for several years on how anesthesia services should be administered to obstetric patients. These updated recommendations, which have been approved by ASA’s House of Delegates also, reinforce that communication between ob-gyns and anesthesiologists is essential to optimal provision of care to patients,” said Craig M. Palmer, MD, ASA’s liaison to ACOG’s Committee on Obstetric Practice, who helped develop the document.

The recommendations recognize that the extent and degree to which anesthesia services are available varies widely among hospitals. However, according to the Committee Opinion, hospitals should have the following optimal anesthesia goals:

- ▶ Availability of a licensed practitioner who is credentialed to administer an appropriate anesthetic whenever necessary. For many women, regional anesthesia (epidural, spinal, or combined spinal epidural) will be the most appropriate anesthetic
- ▶ Availability of a licensed practitioner who is credentialed to maintain support of vital functions in any obstetric emergency
- ▶ Availability of anesthesia and surgical personnel to permit the start of a cesarean delivery within 30 minutes of the decision to perform the procedure
- ▶ Immediate availability of appropriate facilities and personnel, including obstetric anesthesia, nursing personnel, and a physician capable of monitoring labor and performing cesarean delivery, including an emer-



PHOTO COURTESY OF MANUEL VALLEJO, MD

gency cesarean delivery in cases of vaginal birth after cesarean delivery. The definition of immediately available personnel and facilities remains a local decision based on each institution’s available resources and geographic location

▶ Appointment of a qualified anesthesiologist to be responsible for all anesthetics administered. There are many obstetric units where obstetricians or obstetrician-supervised nurse anesthetists administer labor anesthetics. The administration of general or regional anesthesia requires both medical judgment and technical skills. Thus, a physician with privileges in anesthesiology should be readily available

In a joint survey, ACOG and ASA found that many US hospitals have not achieved these goals. The two organizations call for the hospital’s director of anesthesia services to develop and enforce written policies regarding obstetric anesthesia. The Committee Opinion details what those policies should include.

Currently, about 34% of hospitals providing obstetric care have fewer than 500 deliveries a year. Providing comprehensive care to OB patients in these small hospital units is “extremely inefficient, not cost-effective, and frequently impossible,” according to the Committee Opinion, which recommends that whenever possible, small units should consolidate and that when geographic factors require the existence of smaller units, they should be part of a well-established regional perinatal system. ♀

2009 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

MAY

2-6
ACOG 57th Annual Clinical Meeting
 Chicago
www.acog.org/acm

8-9
Council of Medical Specialty Societies Spring Meeting
 Chicago
www.cmss.org

12
ACOG WEBCAST: Coding with Colposcopies
 1-2:30 pm ET
 800-673-8444, ext 2498

21-27
American College of Nurse-Midwives 54th Annual Meeting & Exposition
 Seattle
www.midwife.org/am
 240-485-1800

JUNE

9
ACOG WEBCAST: Quality and Safety in the Office Setting
 1-2:30 pm ET
 800-673-8444, ext 2498

13-17
American Medical Association Annual Meeting
 Chicago
www.ama-assn.org

17-21
Society of Obstetricians and Gynaecologists of Canada 65th Annual Clinical Meeting
 Halifax, NS
www.sogc.org
 800-561-2416

24-27
Western Association of Gynecologists and Oncologists Annual Meeting
 Vancouver, BC
www.wagogyononc.org/annualmeeting.cfm
 202-863-1648

JULY

14
ACOG WEBCAST: Patient Safety and Best Practices: New Issues in Perinatal Initiatives
 1-2:30 pm ET
 800-673-8444, ext 2498

17-19
Gynecologic Oncology Group Semi-Annual Meeting
 Baltimore
www.gog.org

AUGUST

11
ACOG WEBCAST: Coding for Multiple Services on the Same Day
 1-2:30 pm ET
 800-673-8444, ext 2498

SEPTEMBER

8
ACOG WEBCAST: Injection and Vaccination Coding
 1-2:30 pm ET
 800-673-8444, ext 2498

9-12
Society of Laparoendoscopic Surgeons 18th Annual Meeting and Endo Expo
 Boston
www.sls.org

10-12
American Gynecological and Obstetrical Society 2009 Meeting
 Chicago
www.agosonline.org
 212-305-0613

13-17
International Society of Ultrasound in Obstetrics and Gynecology 19th World Congress
 Hamburg, Germany
www.isuog.org/WorldCongress/2009

24-26
American Urogynecologic Society 30th Annual Scientific Meeting
 Hollywood, FL
www.augs.org
 202-367-1167

25
Society for Sex Therapy and Research Fall Clinical Meeting
 New York City
www.sstarnet.org
 202-863-1644

30-Oct 3
North American Menopause Society Annual Meeting
 San Diego
www.menopause.org
 440-442-7550

30-Oct 4
Pacific Coast Obstetrics and Gynecology Society
 La Jolla, CA
www.pcosg.org

OCTOBER

1-3
ACOG District V Annual Meeting
 Indianapolis
 202-863-2574

1-4
ACOG District VIII and IX Annual Meeting
 Napa, CA
 916-920-8100

4-9
International Federation of Gynecology and Obstetrics (FIGO) World Congress of Gynecology and Obstetrics
 Cape Town, South Africa
www.figo2009.org.za
figo@figo.org

9-11
ACOG District VII and XI Annual Meeting
 San Antonio
 202-863-2542

11-15
American College of Surgeons 95th Annual Clinical Congress
 Chicago
www.facs.org/clincon2009

13
ACOG WEBCAST Recovery Audit Contractors: How to Handle a Surprise Visit from Government Agents
 1-2:30 pm ET
 800-673-8444, ext 2498

14-17
American Academy of Family Physicians Scientific Assembly
 Boston
www.aafp.org

16-18
ACOG District IV Annual Meeting
 Asheville, NC
 202-863-2488

16-18
ACOG District I and III Annual Meeting
 Lake Buena Vista, FL
 202-863-2574

ACOG COURSES

- 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."
- 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

7-9
Coding Workshop
 Chicago **SOLD OUT**

JUNE

26-28
Coding Workshop
 Minneapolis

JULY

10-12
Coding Workshop
 Baltimore

AUGUST

7-9
Coding Workshop
 Kansas City, MO

27-29
Reawakening the Excitement of Obstetrics and Gynecology
 La Jolla, CA

28-30
Coding Workshop
 Seattle

OCTOBER

16-18
Twenty-First Century Obstetrics and Gynecology
 (In conjunction with the ACOG District I and III Annual Meeting)
 Lake Buena Vista (Orlando), FL

30-Nov 1
Coding Workshop
 Coronado, CA

NOVEMBER

12-14
Practical Obstetrics and Gynecology
 Las Vegas

13-15
Coding Workshop
 Atlanta

DECEMBER

3-5
Update on Cervical Diseases
 New York City

4-6
Coding Workshop
 Tampa, FL



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RESOURCES

Free mental health screening toolkit available

THIS YEAR ALONE, APPROXIMATELY 12 million women in the US will experience clinical depression. This spring, in conjunction with *May is Mental Health Month*, the organization Screening for Mental Health encourages clinicians to screen patients for depression.

Physicians can order free mental health screening kits from Screening for Mental Health that include screening forms, clinician diagnostic guides, and educational brochures. ♀

info

- Order online: www.mentalhealthscreening.org/acog
- Questions: 781-239-0071



ACOG PATIENT EDUCATION

Information you and your patients can trust

Save 20% for a limited time. Take advantage of this special offer on these revised patient education resources.



Laparoscopy (APO61)

- ▶ The reasons why laparoscopy is performed
- ▶ What happens during the procedure
- ▶ Recovery from laparoscopy
- ▶ Risks and benefits



Vaginal Birth after Cesarean Delivery (APO70)

- ▶ Benefits and risks of vaginal birth after cesarean delivery
- ▶ Why the type of uterine incision used for the previous cesarean birth is important
- ▶ Other factors involved in making the decision

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



New offerings in *Precis* and *PROLOG*

ASSESS YOUR KNOWLEDGE OF THE MOST RECENT scientific advances in ob-gyn with the popular ACOG series known as *PROLOG*. The sixth edition of *Gynecology and Surgery* (AA171) is now available. 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. ACOG awards CME credit for each unit of *PROLOG* for its initial three years.

Also new is *Precis: Primary and Preventive Care, Fourth Edition* (AA274), which reflects the expanding role of clinicians in optimizing women's health and preventing disease. The new edition includes areas that have undergone dramatic changes, such as patient safety, which has an entire new section devoted to it. Sections on information retrieval and evaluation of evidence-based medical literature have been updated. ♀

info

- <http://sales.acog.org>; 800-762-2264