HEALTH CARE REFORM:
What it means to you and your patients
As ob-gyns, each of us improves the world daily through our dedication to our specialty. But today we face several hard realities: The medical liability crisis is hurting our society, our patients, and our nation; a future potential shortage of obstetrical providers looms before us; and the cesarean delivery rate is at an all-time high with the maternal mortality rate headed in the wrong direction. These issues all demand our immediate attention.

First, medical liability is the elephant in the room that has begun to define our specialty and use up our oxygen. This must change. In 2007 the direct cost of the U.S. tort system was $252 billion. But, reforming the liability system is about much more than lowering costs as measured in dollars. It’s about alleviating the huge toll on physicians and their families and on the entire health care system. We will continue to make medical liability reform a top priority of ACOG while I am in office.

Second, the future ob-gyn workforce shortage is a serious threat to our nation. To respond, we must address this now, and work toward building a collaborative health care community. Our workforce is aging and physicians are leaving the delivery room on average 10 years earlier than previous generations. Right now, nearly half of the more than 3,000 counties in this country lack an ob-gyn physician, and nearly 9.5 million Americans live in these predominantly rural areas.

The ability to improve and extend medical care to all women and their newborns, a clear goal of health care reform, will depend in part on the quality of our collaborative efforts to work with all organizations that provide women’s health care.

As the third component of my presidential initiative, I will take a hard look at birth issues and how to improve maternity care into the next decade and beyond. ACOG has the ability and a responsibility to play a strong role in guiding maternity care. I plan to appoint a work group to focus on such issues as the lack of a uniform method of recording birth statistics in the US; the increasing rate of maternal deaths in the US; the record high rate of cesarean deliveries; too many premature births; racial disparity in access and outcomes; and patient safety.

I welcome our new ACOG Fellows just inducted at the ACM! At this time of new beginnings, let’s all remind ourselves that as we practice our profession, we have an obligation to empower women and their families through the birth process. Our goal must be to protect not only their health, but their dignity, and to treat them with the utmost respect.

I look forward to working together with you during the coming year. Thank you.

Richard N. Waldman, MD
President
The College and Congress: moving forward together

As the American Congress (ACOG) completes its first six months of existence, members are still asking, “Are we a Congress, or are we a College?” The answer is simple. We are both, not one or the other. The American Congress and The American College of Obstetricians and Gynecologists are companion organizations that combined allow for more support for our members. As a 501(c)(6) not-for-profit business league, ACOG is allowed to spend more time and activity working to improve the practice environment. This includes more involvement in certain areas of practice, such as reimbursement and professional liability. As a 501(c) (6), ACOG is allowed to have a Political Action Committee (PAC) and thus support those legislators who support women’s health issues and the practice of obstetrics and gynecology.

On the other hand, the College, a 501(c)(3), can expand our educational efforts in practice guidelines and development of practice-related activities. In addition, we can continue all of our current educational activities such as the ACM, educational publications, and educational courses both online and on-site. The College can also increase its educational efforts directed toward all women.

As members of both the Congress and College, our Fellows can take advantage of both tax exempt organizations as we enter a new era of health care reform. By having both a (c)(3) and a (c)(6) organization to represent our profession, we can work to adjust to the changes. We will continue to work tirelessly through the Congress for liability reform, a critical objective for our members.

THE BIRTH CONTROL PILL, the most studied medication in the world, reached its 50-year milestone in May. Since the introduction of the pill in the US, numerous types of hormonal and nonhormonal contraceptives have been developed, all greatly expanding women’s birth control options. Originally intended solely for pregnancy prevention, decades of research have shown a host of health benefits from the birth control pill and other forms of hormonal contraception, including cancer prevention and relief from menstruation disorders. Hear what your colleagues have to say about the pill. Go to: www.youtube.com/user/ACOGNews. Read more at www.acog.org under News Releases.
A milestone in US health care history, the newly-enacted Patient Protection and Affordable Care Act may result in better access to care for women and ultimately lead to improvements in women’s health. But several key measures are missing, and thus ACOG reluctantly opposed its enactment. The law will directly affect ACOG Fellows and their patients.

“Our patients will have better health care coverage. In the private insurance market, this law will result in direct access for all women to their ob-gyns, no insurance denials for pregnancies, fewer uninsured women, guaranteed maternity coverage, and guaranteed preventive and well-women’s care,” said Gerald F. Joseph, Jr, MD, past president of ACOG. “In Medicaid, which today covers the care for 41 percent of all US births, more women will have access to affordable family planning. These provisions are important to our women’s health mission and to our practices.”

ACOG achieved a number of goals including bringing issues to the attention of the House speaker and Senate majority leader, and solidifying the women’s health community which adopted and echoed ACOG’s views.

These reforms will also mean changes and challenges in how Fellows currently manage, deliver, and document health care. Hal C. Lawrence, III, MD, ACOG vice president, Practice Activities, describes the law:

“There are several important issues not included in this legislation. There’s been no meaningful action to deal with the medical liability crisis, and the sustainable growth rate (SGR) was not repealed. It is a major problem that is growing annually. If the SGR is not corrected, and cuts go into effect, the initial impact for Medicare recipients and ob-gyns caring for Medicare patients will be dramatic. The potential of having reimbursement be less than the cost for Medicare services is real. Many insurers use multiples of Medicare reimbursement to establish their reimbursement criteria, so new limits could extend to all patients,” he says.

Dr. Lawrence also points out that the expansion of health care coverage, estimated to cover approximately 32 million additional people, will create a new group of insured patients who will need health care.

“This is only the beginning of health care reform,” says Dr. Joseph. “Huge areas of the law will be determined by regulations written by the US Department of Health and Human Services. ACOG is working to influence how these regulations are written, and will continue to fight for medical liability reform and repeal of the SGR.”

This new reform guarantees maternity coverage in all health insurance plans, a provision strongly supported by ACOG. ACOG worked against resistance to the measure in Congress, and its inclusion is a victory for ACOG.

“This is a positive step towards increasing access to prenatal care for all pregnant women,” says Maureen G. Phipps, MD, MPH, vice chair for Research, Department of Ob-Gyn and Associate Professor of Ob-Gyn and Community Health at Alpert Medical School of Brown University and Women and Infants Hospital of Rhode Island in Providence, RI. “Some of the most vulnerable women do not seek care early in pregnancy or do not seek prenatal care at all. This provision will encourage all women to
seek that care to achieve healthy pregnancies and births.”

Effective January 1, 2014, the new law states that women cannot be denied coverage due to pregnancy or prior medical history, such as previous C-sections or domestic violence, among many other conditions. Additionally, from now until that date, a temporary high-risk pool insurance program has been created for individuals who have been uninsured for six months and have a pre-existing condition.

“This provision enhances a patient’s potential for seeking appropriate and timely health care,” says Dr. Phipps. “If a 55-year-old woman, for example, with abnormal uterine bleeding was denied health insurance because of a pre-existing condition, she may not seek immediate care for her problem when she could have endometrial cancer. Delaying care puts patients at higher risk for poor outcomes.”

Beginning January 1, 2011, the new law requires guarantee issue and renewability of health insurance coverage, regardless of a patient’s gender. It allows premiums to vary based only on age, geographic location, family size, and tobacco use. The change may make private insurance coverage more affordable for women, but may not change the demand for ob-gyn services. The direct access to ob-gyn care mandate, a significant ACOG win, on the other hand, will protect women’s access and may lead to an increased patient load, so ob-gyns need to prepare for potentially greater patient numbers.

“This will require the practitioner to improve efficiency in order to handle an increased volume of patients. Improving outpatient and inpatient systems of care will become critical to ensure a safe environment for patients and health care workers,” says Raymond L. Cox, MD, MBA, chairman, department of OB/GYN at St. Agnes Hospital in Baltimore, MD. “Electronic health records, in the long run, may help to achieve that efficiency.”

Dr. Lawrence agrees that paying more attention to the administrative side of a practice, and establishing or enhancing electronic health record systems, will help ob-gyns manage the changes ahead. The new law includes standardization of health information technology to increase efficiencies and practice use.

“Fellows need to pay attention to their current practice demographics and finances, as well as payment reform and expanded coverage that will become available under health care reform,” he says. “They should recognize the need for careful administrative oversight for their practice, including the expanded use of electronic documentation.”

The new law also ensures that ultrasound for ob-gyn will remain covered, another ACOG win. This provision supports better and safer patient care, and protects ob-gyn ultrasound from any changes to imaging reimbursement. (Other changes for women’s health and the practicing ob-gyn will be reviewed in upcoming issues of ACOG Today.)

The Call for Liability Reform and SGR Repeal

The important changes in the law will only succeed if coupled with meaningful medical liability reform and a permanent repeal of the SGR formula, a formula ACOG believes must be replaced with a sensible reliable method of Medicare physician payment. Because neither was included, ACOG reluctantly opposed the package and will continue to lobby for these critical measures that affect both women’s health and our Fellows’ practices.

“At no time has it been more important for ob-gyns to use the resources provided by ACOG. Stay up-to-date on health care reform, read ACOG’s publications, including ‘How Health Care Reform Affects You,’ and use the ACOG Government Affairs’ website to understand changes,” says Dr. Hal C. Lawrence, ACOG vice president of Practice Activities.

Visit www.acog.org and click on Health Reform Center. Also read ACOG’s weekly e-newsletter, Legislative News, to stay informed of legislative activity and how to help.
New editions of Precis and PROLOG were among many offerings at the ACOG Bookstore.

ACOG President Elect James N. Martin, Jr, MD, records interview for home town radio program.

Fellows try new laparoscopic techniques in PG course.

Junior Fellows socialize at Monday reception.

Medical students practice delivery in hands-on workshop.

Exhibitor shares products with attendee.

Fellows try new laparoscopic techniques in PG course.
Attendees hit the dance floor at the welcome reception.

New inductees take oath to become Fellows.

Attendees hit the dance floor at the welcome reception.

Runners finish Sunday Fun Run.

Audience reacts as Junior Fellows “stump the professors.”

Cheryl B. Iglesia, MD, is a “Stump the Professors” panelist.

Roberto J. Romero, MD, speaks on late preterm birth.

Gerald F. Joseph Jr, MD, explains health care reform.

Isaac Schiff, MD, discusses hormone therapy.

---

**THE COLLEGE WOULD LIKE TO THANK...**

**PRESIDENT’S CABINET**

Bayer HealthCare Pharmaceuticals
Boehringer Ingelheim Pharmaceuticals, Inc
Pfizer Inc

**PLATINUM LEVEL**

Eli Lilly and Company
Merck and Company, Inc

**GOLD LEVEL**

Ferring Pharmaceuticals
Solvay Pharmaceuticals

**SILVER LEVEL**

BD Diagnostics
Ethicon Endo-Surgery, Inc
ETHICON Women’s Health & Urology
Forest Laboratories, Inc
Greenway Medical Technologies
Halt Medical, Inc
K-Y® Brand
Xanodyne Pharmaceuticals, Inc

**BRONZE LEVEL**

C-Panty: The After Cesarean Underwear Conceptus
Novo Nordisk
Olympus
Skyscape, Inc
Upsher-Smith Laboratories, Inc
Watson Pharma, Inc
**DURING HIS YEAR** as ACOG president, Dr. Gerald F. Joseph, Jr, led ACOG on several fronts to advance perinatal and postpartum depression screening and treatment, while ACOG released new findings on the topic. ACOG also received wide media coverage on the issue, and involved scores of Fellows in expanding awareness of the condition and screening options. Dr. Joseph set out to call national attention to a very common problem that may not be on the radar screen for many ob-gyns. ACOG’s efforts paid off as more resources are available for ob-gyns, and patients and the public are hearing more about the dangers of what has been a silent struggle for many with dangerous consequences.

“We’re talking about a huge number of women with postpartum depression—between 200,000 to more than one million each year. Screening is important so that we can start gathering the data for future evidence-based guidelines,” he said. “It’s also important during pregnancy so we find it early and prevent a worsening condition after delivery.”

**Ob-gyns encouraged to consider screening**
Clinical depression is common among reproductive-age women and is the leading cause of disability in women in the US each year. Between 14% and 23% of pregnant women will experience depression and 5%-25% of women will have postpartum depression. In February, a new Committee Opinion was released (Committee Opinion #453), *Screening for Depression During and After Pregnancy*, stating that screening for depression during pregnancy and afterward benefits women, infants, and families. Because pregnancy and the postpartum period are pivotal times to identify women suffering from depression, the College encourages ob-gyns to strongly consider screening for it. Studies have shown that untreated maternal depression negatively affects an infant’s cognitive, neurologic, and motor skill development, and can also negatively impact older children’s mental health and behavior. During pregnancy, depression can lead to preeclampsia, preterm delivery, and low birth weight, according to the Committee Opinion. Women diagnosed with depression during pregnancy or postpartum should be referred for treatment and follow-up evaluation, it states.

**Joint report covers treatment options**
Also during the past year, the College and the American Psychiatric Association (APA) released a joint report to help doctors and patients weigh the risks and benefits of various treatment options during pregnancy. The report, “The Management of Depression During Pregnancy: A Report from the American Psychiatric Association and The American College of Obstetricians and Gynecologists,” is based on an extensive review of existing research, and was published in *Obstetrics &*
The Silent Struggle

"According to Katherine L. Wisner, MD, society, it continues to be associated with stigma in our of disability for women throughout the world, first year after giving birth. any time during pregnancy or throughout the sion, which refers to depression that occurs at in women. in the field of mood disorders and depression in Iowa City, is a widely recognized authority professor of psychology at the University of Iowa discussed "Perinatal Depression: Diagnosis, and Treatment." Dr. Wisner is a professor of psychiatry, obstetrics-gynecology and reproductive sciences. "We hope this will be a resource to clinicians who care for pregnant women who have or are at risk of developing major depressive disorder."

According to the report, some patients with mild-to-moderate depression can be treated with psychotherapy (individual or group) alone or in combination with medication. Additionally, the report discusses the need for ongoing consultation between a patient's ob-gyn and psychiatrist during pregnancy and presents algorithms for treating patients in common scenarios, including women thinking about getting pregnant, pregnant and on medication, and pregnant and not on medication.

ACM speakers highlight prevalence

The President's Program at the ACM featured two of the country's leading experts on women's mental health. Michael W. O'Hara, PhD, discussed "Perinatal Depression: Screening, Diagnosis, and Treatment." Dr. O'Hara, a professor of psychology at the University of Iowa in Iowa City, is a widely recognized authority in the field of mood disorders and depression in women. He specializes in perinatal depression, which refers to depression that occurs at any time during pregnancy or throughout the first year after giving birth.

"Although depression is the leading cause of disability for women throughout the world, it continues to be associated with stigma in our society," according to Katherine L. Wisner, MD, MS, who also spoke at the opening session. "Stigma contributes to the perception that antidepressant drug therapy is less justifiable for pregnant women with depression than, for example, antibiotics or drugs used to treat gastric ailments." Dr. Wisner is a professor of psychiatry, obstetrics-gynecology and reproductive sciences, epidemiology and women's studies at the University of Pittsburgh School of Medicine, and director of the Women's Behavioral HealthCARE program at the Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center.

"Depression in pregnant women often goes unrecognized and untreated in part because of concerns about the safety of treating women during pregnancy."

"Ob-gyns, as primary care providers for women and especially in the context of pregnancy care, are in a perfect position to identify women who are depressed and to provide or facilitate access to treatments," said Dr. O'Hara. "What matters is that ob-gyns initiate the discussion of depression with their pregnant patients and new mothers and this can be accomplished by asking good, sensitive questions. This step is critical—you can't tell by looking at a woman whether or not she is depressed.

"One big misconception is that there is little risk to not treating," noted Dr. O'Hara. "We know very clearly that women who are depressed are more likely to smoke and take drugs. In addition, the presence of major depression during pregnancy is associated with preeclampsia, preterm birth, and low birth weight."

ACM audience hears personal story of postpartum depression

IN A COMPELLING AND MOVING ACCOUNT of her personal experiences with postpartum depression, the former First Lady of New Jersey, Mary Jo Codey, spoke during the President's Program at the ACM. Her lecture, "Recognizing Postpartum Depression: Speak Up When You're Down," was named after the statewide education campaign put in place during Governor Richard Codey's term. Codey, who suffered postpartum depression with both of her two pregnancies, resolved to speak out so that other struggling mothers would know they are not alone and need not feel ashamed. She recounted in intimate detail the intrusive thoughts she had about harming her baby and killing herself, treatments that were unsuccessful, including antidepressants and psychotherapy, and the anger she felt when she was given shock therapy in a psychiatric hospital. Monoamine Oxidase Inhibitor (MAOI) treatment finally helped bring her depression under control. "Nothing that has happened in my life was worse, not even breast cancer and a double mastectomy. They can't even compare," she said. "I recognized that there ought to be a law, a national law," she explained. "I wanted to make sure that no other woman would have to endure what I went through."

When her husband became governor of New Jersey 20 years later, she helped drive the Speak Up When You're Down initiative and legislation in New Jersey that became the foundation of the Melanie Blocker-Stokes MOTHERS Act, which increases funding for research, education, and awareness of postpartum mood disorders. The provisions were included in the final federal health care reform legislation.
Stopping deadly clots

ACOG FELLOW ANDRA H. JAMES, MD, still remembers an obstetric patient she saw many years ago. “She was perfectly healthy, although considerably overweight. After she failed to progress in labor, the baby was delivered by cesarean section, and everything seemed fine. Two days after she went home, she died from a massive pulmonary embolism,” said Dr. James, associate professor of obstetrics and gynecology at Duke University and a co-director of Duke’s Comprehensive Thrombosis and Hemostasis Center.

Thromboembolic events are the leading cause of maternal death associated with childbirth in the US and a leading cause of disability and death in all postoperative, hospitalized patients. During pregnancy, the risk of a thromboembolic event is increased between four- and five-fold, and the risk skyrockets to 100-fold during the first week postpartum before slowly going back to baseline by about eight weeks after delivery, according to Dr. James.

Pulmonary embolisms kill patients fast—usually within about 30 minutes.

“We get blindsided with blood clots, and we’re helpless,” Dr. James said. “We can manage hemorrhage very well, but we can’t always get inside blood vessels and stop clots from taking the lives of our patients.”

Risk factors
To prevent deaths from pulmonary embolism it’s essential to prevent the DVT that causes the embolism in the first place. Risk factors include previous venous thromboembolism, inherited thrombophilia, and surgery.

“Among ACOG members, urogynecologists and gynecologic oncologists doing surgery on an older patient would be most likely to encounter cases of DVT, but it can occur in younger patients as well,” said Daniel Clarke-Pearson, MD, chair of the ob-gyn department and the Robert A. Ross Distinguished Professor at the University of North Carolina School of Medicine. “While not everybody needs prophylaxis, the current consensus is that everyone who has major surgery, no matter what their age, is at high enough risk to benefit from having some sort of VTE prevention.”

In pregnant patients, Dr. James notes that the most significant risk factor for clotting problems is a history of thrombosis; between 15% and 25% of clotting events in pregnancy are recurrent events. The next most significant culprit is thrombophilia. A number of genetic factors predisposing patients to thrombophilia have been identified in recent years, the most common being Factor V Leiden, which occurs in about 5% of the general population but is found in about 20% of thrombosis patients, according to the College’s Practice Bulletin Prevention of Deep Vein Thrombosis and Pulmonary Embolism (#84, August 2007).

But Dr. James is even more concerned about the “insidious risk factors” that affect many more pregnant women, such as obesity and cesarean delivery.

“As our childbearing women put on quite a few pounds, and more of them have cesarean deliveries, these risk factors don’t become additive, they become multipliers, and doctors may not realize the overall increased risk,” she said.

How to prevent DVT
DVT can be prevented using both medical and mechanical approaches.

Graduated compression stockings are generally recommended as first line. Dr. Clarke-Pearson notes that they must be fitted properly. They can act as a tourniquet and actually increase the risk of clots, according to Dr. Clarke-Pearson, if they are not a correct fit.

Medical DVT prophylaxis involves either low-dose unfractionated heparin or low molecular weight heparin. Both are effective at reducing DVT, and both are safe in pregnancy because neither crosses the placenta, but Dr. James noted that low molecular weight heparin is associated with fewer side effects than unfractionated heparin.

Deciding the best approach for your patient
How do you determine the most effective DVT prevention strategy for your patient?

The Practice Bulletin recommends classifying preoperative patients into one of four categories: low, medium, high, and highest risk, on the basis of their accumulated risk factors. Low-risk patients—those younger than 40 with no additional risk factors who are undergoing a surgery lasting less than 30 minutes—need no specific prophylaxis other than early mobilization.

Older patients, those undergoing more prolonged surgery, and those with additional risk factors are stratified into the moderate-to-higher risk categories, with recommendations that they receive heparin or mechanical prophylaxis, or a combination of the two, depending on their specific risk category.

Always be aware of the warning signs of DVT, Dr. Clarke-Pearson said. They include pain in the legs, edema, and redness.

“Odds are it’s not a clot, but you don’t want to delay diagnosis,” he said. “One never knows when a clot will break loose and go to the lungs.”
Delivering in Haiti

Five weeks after the January 12th earthquake in Haiti, Junior Fellow Isabelle Guichard, MD, took a leave from her work in Washington, DC, to travel to Port-au-Prince to care for disaster victims.

Born and raised in Port-au-Prince, she felt she could not stay away. Through the Haitian Embassy she was able to get in touch with a group in Miami arranging for physicians to assist with medical relief.

“When I saw the collapsed Eglise Sacre-Coeur, the church I attended with my grandmother, and learned that people I knew were under the rubble of the supermarket where my mother shops, I felt attached to the effort. Most of all, in the midst of all the chaos, seeing the resilience of the people in Haiti compelled me to get out of my comfort zone,” she said.

“My most treasured experience was when I delivered a healthy full-term baby boy,” she said. “Amidst the chaos of amputees, suffering kids and orphans, an 18-year-old pregnant woman showed up at 5 am one morning,” she said. The girl delivered naturally three hours later. “Another unforgettable experience was watching an eight-year-old girl’s determination when showing her mother she could walk on crutches after a below-the-knee amputation,” said Dr. Guichard.

“During my five days at the medical camp in Haiti, there were only two ob-gyns, including myself. I was the only one who slept at the camp, so for my stay the team relied on me to see any patients needing ob-gyn care, mainly in triage. I think the patients appreciated having a female ob-gyn who spoke Creole.

“I learned about human suffering, resilience after such a tragedy, and the ability of a patient to still smile in adverse circumstances,” she said, “and I was able to provide ob-gyn care while learning about wound care, amputees, and pediatrics. My life has become richer as a result.”

Emotions and cancer: an edge in the battle

R. LEWIS S. RATHBUN, MD, is an innovator in improving quality of life for cancer survivors. He founded Life after Cancer in Asheville, NC, in 1977, a program that trains patients to use mind-body connections and positive emotions to battle the disease. Since then, an estimated 10,000 participants have been helped by its programs, which focus on the premise that mind and body are one, and must be treated as one for successful results.

“In addition to being an outstanding physician, Dr. Rathbun is visionary in recognizing the therapeutic benefit of emotional support for patients fighting cancer,” said Hal C. Lawrence, III, MD, ACOG’s vice president of Practice Activities. “Asheville’s Life After Cancer program is a result of his vision and dedication.

“Ob-gyns can learn from Dr. Rathbun that understanding our patients’ hopes, dreams, and fears is important. It does not take much more time for us to listen and provide understanding. In fact, in our practices we find that when our patients feel supported, physician time can be more productive,” said Dr. Lawrence.

At age 96, Dr. Rathbun continues to meet with cancer patients in group sessions, and to speak to civic, social, and religious groups about the healing power of emotional support. Asheville’s hospital hospitality house, the Rathbun Center, was named for him by local philanthropist and breast cancer survivor Adelaide Key. It provides “a home away from home” for families of patients receiving care in the region.

Educated at Harvard Medical School, Dr. Rathbun entered ob-gyn before antibiotics, and served in World War II. During his long career, he saw changes in every aspect of ob-gyn, including patient-doctor communication, technology, and the proliferation of subspecialists. One thing that has never changed in his practice is the importance of treating the mind and body together.
Making the Rounds

New Resources

Assess your knowledge of the most recent scientific advances in obstetrics with the popular series PROLOG. The sixth edition of Reproductive Endocrinology and Infertility (AA172) is now available. Each unit of PROLOG covers a different major aspect of obstetrics, presenting clinical evidence case scenarios, and features a multiple-choice test and critique book that thoroughly discusses each answer. The College awards CME credit for each unit of PROLOG for its initial three years.

Also new is the fourth edition of Precis: Obstetrics (AA276), which includes new sections with the latest information on obesity, substance abuse, and chronic pain and headache management in pregnancy.

To order these publications, go to sales.acog.org or call 800-762-2264.

Practice Updates

The following committee opinions have been released in 2010. To read them online, visit www.acog.org, view the Publications menu, and click on Committee Opinions.

- **458** Use of Hysterosalpingography After Tubal Sterilization (June 2010)
- **457** Preparing for Disasters: Perspectives on Women (June 2010)
- **456** Forming a Just Health Care System (March 2010)
- **455** Magnesium Sulfate Before Anticipated Preterm Birth for Neuroprotection (March 2010)
- **454** Health Care for Homeless Women (February 2010) (Replaces No. 312, August 2005)
- **453** Screening for Depression During and After Pregnancy (February 2010)

Also released this year are the following practice bulletins. To see them online, visit www.acog.org, view the Publications menu, and click on Practice Bulletins.

- **112** Emergency Contraception (May 2010), (Replaces Practice Bulletin Number 69, December 2005)
- **110** Noncontraceptive Uses of Hormonal Contraceptives (January 2010), (Replaces Committee Opinion Number 337, June 2006)

Register online at www.acog.org/postgrad/index.cfm. To learn more, call 202-863-2498 or email coding@acog.org.

2010 ACOG Coding Workshops

- June 25-27, Portland, OR
- July 9-11, New York, NY
- July 23-25, Las Vegas, NV
- August 6-8, Sante Fe, NM
- August 27-29, Charlotte, NC
- September 24-26, Nashville, TN
- October 15-17, San Antonio, TX
- November 19-21, Chicago, IL
- December 3-5, Atlanta, GA