THE ADOLESCENT PATIENT:
Beginning a lifetime of care
Many teenage girls do not obtain an annual preventive health care visit and less than half of those who do talk about STIs, HIV, or pregnancy prevention during those visits.

Our country has the highest rate of teen pregnancy among all industrialized nations, so while teen births have decreased by 33% since 1991, the numbers remain far too high. In 2008, nearly 42 out of every 1,000 teens gave birth to a child. Roughly three in 10 girls in the US are pregnant before age 20 and more than 400,000 births to teen mothers occur each year.

Prevention is the key. As an obstetrician, each of us is in a position to have a lifelong impact on a young patient who otherwise might not have access to information she needs to take charge of her own health. Reproductive health care visits before the onset of sexual activity give teens opportunities to discuss their personal questions and concerns safely. We should take extra care to make young patients feel at ease as we care for them.

An adolescent’s initial visit to an obstetrician opens the door for a neutral dialogue about sexuality and pregnancy, sex and contraceptive options, STIs, the challenges of being a mother, and the importance of avoiding too-early pregnancy and parenthood. By giving accurate trusted information, we allow teens to better determine their futures.

The recently updated Committee Opinion, The Initial Reproductive Health Visit, was developed by the Committee on Adolescent Health Care, and is highlighted on page six. This document is an example of the critical work done by Fellows who serve on the College’s and Congress’ committees. It is through their dedication and hard work that we all are able to better serve our patients.

I cannot stress enough how critical this initial visit is for us to help alleviate any fears and dispel myths, and for us to start off on the right foot in creating a healthy doctor-patient relationship with an adolescent. This visit is the beginning of a lifetime of care.
ACOG continually strives to develop new benefits and resources for members. Staff and ACOG committees are often the impetus for these new ideas, but they are not the only source. We frequently receive suggestions from you—our members—often based on needs you experience in your practices. For example, the development of ACOG (the Congress) as a companion organization to the College was a direct result of members wanting us to address their socio-economic and business needs in today’s shifting climate of medicine. We encourage you to continue to send your ideas to us.

One significant College benefit that continues to grow is the College-endorsed insurance programs from AON’s Affinity Insurance Services, the world’s second largest insurance services provider. This member benefit is another example of a College program developed from your suggestions. What was once a simple term life program is now a compilation of diverse insurance offerings to meet our members’ needs, including:
- 10- or 20-year level term life
- Disability income
- Professional overhead expense
- Accidental death and dismemberment
- Medicare supplemental
- Umbrella liability

The College also provides US members free identity theft insurance with a $10,000 policy limit and no deductible. In addition, the College now covers all third- and fourth-year US residents with term life and disability insurance to protect them in their most vulnerable years. Visit www.acog.org, pull down the Membership menu, and click on Member Benefits to learn more.

Take advantage of ACOG’s outstanding member benefits, and rest assured we will continue to strive to meet your needs. Please send me suggestions on how we can continue to improve our member benefits. Email rhale@acog.org. I look forward to hearing from you.

Ralph W. Hale, MD, Executive Vice President

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FOR YOUR PATIENTS, THE NEW ISSUE OF pause

AT HTTP://PAUSE.ACOG.ORG

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THE LATEST WORD

Take advantage

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Call to register for ACOG’s Annual District Meetings

SEPTEMBER
15 District V, Junior Fellows, Carmel, IN 202-863-2552
15 District III, Junior Fellows, Minneapolis, MN 202-863-2588

OCTOBER
1–3 District IV, Savannah, GA 202-863-2488
8–10 District I, Bar Harbor, ME 202-863-2531
8–10 Districts III and VI, Key Biscayne, FL 202-863-2574
14–16 Districts VII, VIII, IX, and XI, Maui, HI 202-863-2530
15 District III, Junior Fellows, Philadelphia, PA 888-872-7813
17–20 Armed Forces District, San Antonio, TX 202-863-2571
20–23 District V, Cancun, Mexico 202-863-2574
29–31 District II, New York, NY 518-436-3461

NOVEMBER
19–20 District VI, Junior Fellows, Minneapolis, MN 202-863-2588

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Cristian Lazzari/StockPhoto
James T. Breeden, MD
Carson City, NV
Professional Position
President, Carson Medical Group
Education
MD: Marquette School of Medicine, Milwaukee
Residency: Mercy Hospital, San Diego
ACOG Activities
National: vice president; treasurer; member, Executive Boards; chair, Council of District Chairs; vice chair, Grievance Committee; member, Ob-Gyn PAC Governing Committee; member, Appeals Panel Committee; member, task forces on Establishing a 501(c) (6) Organization, Strategic Planning; member, Audit Committee; member, committees on Finance, Credentials, Coding and Nomenclature, Nominations, Compensation; participant, Leadership Institute
District VIII: chair; vice chair; treasurer; member, Advisory Council; Outstanding District Service Award; Junior Fellow “Top Fellow” Award; Nevada Section chair; vice chair; Gazette editor

John C. Jennings, MD
Odessa, TX
Professional Position
Regional Dean, School of Medicine, Ted Roden Endowed Chair, professor of ob-gyn, Texas Tech University Health Sciences Center
Education
MD: University of Tennessee, College of Medicine
Residency: University of Tennessee, City of Memphis Hospitals; University of Texas Health Sciences Center, Houston
ACOG Activities
National: member, Executive Boards; member, Council of District Chairs; chair, Working Group on Midwifery; member, Committee on Government Affairs, State Legislative Subcommittee, Task Force on Strategic Planning; participant, Chantilly II Conference on “Future of Residency Training”; representative, AMA State Legislative Conference; formal discussant, National Maternal Mortality Committee; ACM prize paper

Owen C. Montgomery, MD
Philadelphia, PA
Professional Position
Chair, department of ob-gyn, Drexel University College of Medicine, Philadelphia; chief of service, Hahnemann University Hospital, Philadelphia
Education
MD: Hahnemann University, Philadelphia
Residency: Jefferson Medical College
ACOG Activities
National: member, Executive Boards; chair, Council of District Chairs; Executive Board Junior Fellow Advisor; member, task forces on Governance, Strategic Planning, District and Section Activities; vice chair, Committee on Patient Education; member, committees on Ambulatory Practice Operations, Finance, Adolescent Health Care, Electronic Medical Records; member, Advisory Committee, Sexual Assault Prevention

District III: chair; vice chair; secretary; assistant secretary; member, Advisory Council; Annual District Meeting scientific co-chair; Pennsylvania Section chair, vice chair, secretary; National Junior Fellow Resident Representative RRC; Junior Fellow chair; vice chair, secretary

J. Craig Strafford, MD, MPH
Gallipolis, OH
Professional Position
Staff physician, Holzer Medical Center
Education
MD: The Ohio State University
Residency: Indiana University Medical Center
ACOG Activities
National: vice president; member, Executive Boards; member, Council of District Chairs; chair, vice chair, Grievance Committee; chair, vice chair, Committee on Practice Management; member, committees on Coding and Nomenclature, Gynecologic Practice, Government Relations and Outreach, Nominations, Credentials, Health Care for Underserved Women, Electronic Medical Records; delegate and alternate delegate to AMA; McCain Fellow
District V: chair; vice chair; treasurer; member, Advisory Council; general arrangements chair, Annual District Meeting; Ohio Section chair, vice chair, secretary-treasurer, key contact
ACOG encourages Fellows to participate in the national officer elections by discussing candidates with Committee on Nominations members, and at fall district meetings. In November, the Committee on Nominations will meet to select the slate to be voted on at the annual meeting in Washington, DC, May 2, 2011. Information on how to vote by proxy will be provided in March. You may vote by proxy, or vote in person at the annual meeting.

COMMITTEE ON NOMINATIONS
Kenneth L. Noller, MD, MS, chair
John B. Makin, MD, District I
Eva Chalas, MD, District II
Joseph Apuzzio, MD, District III
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Frank R. Gamberdella, MD, District IX
Paul R. Ziaya, MD, Armed Forces District
Charles E. Lee Brown, MD, District XI
Patrick S. Ramsey, MD, MSPH, at-large member
Dane M. Shipp, MD, at-large member
Douglas H. Kirkpatrick, MD, past president
Douglas W. Laube, MD, MEd, past president
The College recommends that teenage girls see an ob-gyn for the first time between ages 13 and 15. Though this age may seem young, the early visit is an important opportunity for physicians to inform and guide patients, alleviate their fears, and develop trust. The College has updated Committee Opinion #460, *The Initial Reproductive Health Visit*, published in the July issue of the Green Journal and available online at www.acog.org under Publications.

“The adolescent years are a critical time in a young woman’s psychosocial, emotional, and sexual development,” said Diane F. Merritt, MD, Committee on Adolescent Health Care chair. “This update was written to raise awareness in the medical community about new guidelines in reproductive care for teens and emphasize the critical concepts that should be addressed during the initial visit.”

Two annual ‘well-child’ visits
During adolescence, teen girls often transition from a pediatric to a gynecologic care setting. Depending on training and experience, ob-gyns, pediatricians, family medicine physicians, and adolescent medicine specialists may or may not provide both reproductive care and general preventive care to teens. If they do, it may be difficult to provide the full range of both general and reproductive care in one office visit. “In these instances, a team approach is needed in which one physician offers general preventive care and an ob-gyn provides the necessary reproductive preventive health care,” said Dr. Merritt. “And both annual visits ought to be covered by insurance to ensure teens are getting comprehensive preventive care.”

Pelvic exam not needed
During the first consultation with patients and parents, the College recommends initially informing both there won’t be an internal pelvic examination, unless problems are discovered in a patient’s medical history, and the first Pap test should occur at age 21. “It is often the mistaken belief of patients and parents that any visit to the gynecologist includes a speculum exam and Pap smear,” said Dr. Merritt. “This myth needs to be dispelled. Young patients and their parents are quite relieved to hear that a Pap smear is not needed and are more willing to seek care and participate in the initial visit.”

Important screenings
Many parents have no idea when their teenager should first see an ob-gyn, so encourage your adult patients to bring their teen daughters in for a visit. Screening for sexually transmitted diseases, such as HIV, gonorrhea, and chlamydia, is important if a teen is sexually active. Routine screening for chlamydia is recommended annually for all sexually active women age 25 or younger, and routine screening for HIV and gonorrhea is recommended for all sexually active adolescents. Chlamydia and gonorrhea screening can be obtained through urine testing using nucleic acid amplification techniques, thereby alleviating the need for a speculum exam to collect samples.

Reimbursement
The Committee Opinion addresses reimbursement and coding for the initial reproductive health visit. In some cases, the visit will only be covered if it’s the patient’s sole preventive care visit of the year. The College recommends insurance coverage for both a general preventive visit and a dedicated reproductive health visit as both are critical to adolescent health. (If initial visit coverage presents a problem, contact ACOG to request a template of a letter to insurers. Email adollhealth@acog.org.)

ACOG supports comprehensive medically-accurate age-appropriate sexuality education from kindergarten through 12th grade in schools and communities. Sexuality education should encourage young people to delay becoming sexually active and, if sexually active, to use contraception and barrier protection to avoid unintended pregnancy and STIs. ACOG members are urged to participate in, and actively support, sexuality education.
Rachel J. Miller, MD, is medical director of pediatric and adolescent gynecology at Children’s Hospitals and Clinics of Minnesota. “My favorite part of my job is initiating reproductive health care in girls and teens in a positive light, and providing guidance to young patients and families,” she said. “A patient’s first visit to an ob-gyn is important because it sets the tone for her future visits and shapes her perceptions of ob-gyns overall.

“Children and adolescents are a somewhat lost population when it comes to gynecologic care. Until recently, no one was really focusing on medical and surgical aspects of pediatric gynecology,” Dr. Miller said.

Growing up in Fargo, ND, she was the daughter of a pediatrician and nurse. “We lived in a relatively small community which made the gap between pediatric and gynecologic care more obvious; there were no adolescent medicine or gynecology providers.” As teens, it was clear to her and her peers that they were perplexing to pediatricians and adult gynecologists alike.

As a medical student at the University of North Dakota School of Medicine, Grand Forks, she realized she most enjoyed working with reproductive-aged women. Her initial exposure to ob-gyn was through busy generalist ob-gyns. She appreciated the multi-tasking they undertook each day, juggling the OR, labor, and delivery, but after medical school, and elective rotations in high-risk ob-gyn, her interests were confirmed. Following her residency at the Oregon Health Sciences University School of Medicine, she went on to a fellowship in pediatric and adolescent gynecology at the Cincinnati Children’s Hospital Medical Center.

“I’m passionate about educating the regional medical community on reproductive concerns that present in childhood and may have long-term complications, such as adolescent amenorrhea and prepubertal vulvitis. As the only fellowship-trained pediatric and adolescent gynecologist in Minnesota, I try to be a resource for pediatricians and their patients.”

The College’s Tool Kit for Teen Care offers resources for practices interested in seeing more teen patients. It includes tools to make your office more adolescent friendly, as well as display cards, and letters to give parents on when and why teens should first visit an ob-gyn. Order hard copies at sales.acog.org or call 800-762-2264. View it online at www.acog.org/goto/teens. Click on Tool Kit for Teen Care at upper left.

DO YOU KNOW A REMARKABLE OB-GYN WHO IS MAKING A DIFFERENCE? SEND YOUR NOMINATION AND BRIEF DESCRIPTION TO LHUMPHREY@ACOG.ORG. WE WILL TRY TO FEATURE HIM OR HER IN A FUTURE ISSUE.

Sexual initiation does not vary much by family income. However, higher-income girls are more likely than their lower-income counterparts to use contraception at first coitus.
MANAGEMENT OF PREGNANT PATIENTS
with inherited thrombophilias can present a real clinical challenge for obstetrical providers, particularly given the abundance of small, often contradictory case control studies which can be subject to selection and ascertainment biases, according to Charles J. Lockwood, MD, chair of the department of ob-gyn and reproductive sciences at Yale University School of Medicine, and chief of ob-gyn at Yale New Haven Hospital. Inherited thrombophilias are associated with increased risk of dangerous venous thromboembolism, and have been linked to adverse pregnancy outcomes.

The College’s new Practice Bulletin, Inherited Thrombophilias in Pregnancy, “reviews the best evidence available to generate practical management advice for Fellows,” Dr. Lockwood said. Bulletin #113, published in the July Green Journal, is online at www.acog.org under Publications. “The key information in the bulletin includes: clarification of which women need prophylaxis to prevent pregnancy associated venous thromboembolism, and which patients need workups for inherited thrombophilias; plus a candid assessment of the lack of convincing data linking inherited thrombophilias to adverse pregnancy events.

“This latter observation suggests that workups for inherited thrombophilias should not be part of standard evaluations for fetal loss, severe preeclampsia, and fetal growth restriction, but rather should only be conducted in this setting as part of an IRB-approved study. The bulletin should lead to a reduction in unnecessary and very expensive evaluations for inherited thrombophilias in reproductive age women,” said Dr. Lockwood.

Dr. Lockwood noted this is an area of dynamic investigation, and recommendations are subject to frequent revision as data from large prospective trials are obtained. “So keep vigilant,” he added.

THE RISING NUMBER OF ob-gyn obstetricians in the US holds promise for benefiting both patients and physicians while also maintaining safe and effective care, according to the College’s new Committee Opinion, The Obstetric-Gynecologic Hospitalist.

Although there are potential limitations to ob-gyn hospitalists, there are many benefits to patients, hospitals, ob-gyns in practice, and the hospitalists themselves.

Some of the patient benefits include having an immediately available, well-rested physician. This can enhance patient safety and improve outcomes. A successful hospital laborist program also may be a first step in helping communities that have a shortage of obstetricians, according to the Committee Opinion. One potential downside to a patient is that the physician who delivers her baby may be a laborist and not her ob-gyn with whom she has developed a trusting relationship, so patients should be informed in the prenatal period that laborists may be part of the health care team.

Ob-gyn hospitalists, and laborists who practice solely in the hospital setting, stand to benefit from more predictable schedules, assistance with medical liability insurance premiums, avoidance of work-related fatigue, and freedom from day-to-day practice worries such as overhead costs, billing, and collections. One of the advantages to general practice ob-gyns is that hospitalists can assume on-call obligations, which, for the busy ob-gyn practice, can extend beyond 24 hours.

“Hospitalists and laborists represent a new and growing field,” said Rob Olson, MD, a hospitalist in Bellingham, WA. “The Committee Opinion tells how hospitals can use OB hospitalists to improve the safety of women in labor, and also improve the lives of physicians and nurses caring for patients in labor,” he said. “I enjoy working as an OB hospitalist because it allows me to focus on patients without the outside pressure of the office, gynecologic surgery, and lack of sleep. It recreates some of the joy of helping a woman in labor that I first experienced as a medical student. It is my dream job,” said Dr. Olson.

“Physicians in private practice, especially those in small groups or solo practices, may want to approach their hospitals about employing hospitalists,” said Jennifer Kasirsky, MD. “We are on the verge of something revolutionary in our field. This career option has the potential to increase the number of medical students going into ob-gyn by virtue of providing a fantastic lifestyle in OB, something that has been missing in our field.” Dr. Kasirsky is an ob-gyn hospitalist at Prince William Hospital, Manassas, VA, and regional medical director at Delphi Healthcare Partners.

Committee Opinion #459 is published in the July 2010 Green Journal and is online at www.acog.org under Publications.
ACOG urges strict enforcement of tobacco regulations

MORE THAN 3 MILLION US adolescents are cigarette smokers and more than 2,000 young people under the age of 18 start smoking each day. If the present tobacco use patterns persist, an expected 6.4 million children will die prematurely from a smoking-related illness.

One year after President Obama signed into law the Family Smoking Prevention and Tobacco Control Act, ACOG and national health groups together urged the Food and Drug Administration (FDA) to vigorously enforce the law’s major rule. The rule took effect June 22, and seeks to curtail access to and the appeal of cigarettes and smokeless tobacco products to children and adolescents in the US.

“ACOG deplores the advertising and marketing practices of tobacco companies that target women, especially adolescent girls, those at risk for pregnancy, and women who are educationally disadvantaged,” said ACOG President Richard N. Waldman, MD. “The consequences of smoking disproportionately affect the health of women, in terms of lung cancer deaths, increased rates of preterm births, low birth weight infants, and infant deaths from Sudden Infant Death Syndrome.”

The new rule allows the FDA to regulate tobacco products by:

- Restricting advertising and promotions, especially to children
- Preventing illegal sales to children
- Banning candy-flavored cigarettes
- Requiring changes, such as the removal of harmful ingredients
- Prohibiting health claims about so-called “reduced risk” products
- Requiring tobacco companies to disclose the contents of tobacco products, changes to the products, and research about their health effects
- Requiring larger, more informative health warnings on products
- Prohibiting terms such as ‘light,’ ‘mild,’ and ‘low-tar,’ which mislead consumers into wrongly believing certain cigarettes are safer than others

Joining ACOG to voice support for the rule were the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Medical Association (AMA).

“The FDA needs to assert its regulatory power to aggressively prevent tobacco use, especially among teens and youth,” said Sharon T. Phelan MD, professor of ob-gyn at the University of New Mexico School of Medicine. “This power should also extend to new ‘smokeless’ tobacco products on the market. As health care providers for women, ACOG members must help patients quit smoking by using educational materials and resources such as 1-800-QUIT-NOW. We need to educate adolescents and their mothers on tobacco risks, and encourage candid discussions at home.” Dr. Phelan trains providers on delivering smoking cessation messages to patients.

Are you passionate about prevention of women’s cancers?

Join the Society of Gynecologic Oncologists (SGO).
Enjoy collaborating with others committed to early detection.
Receive discounted CME courses, a journal subscription, breaking cancer news, and more. Applications are requested by July 31 for current cycle.
To apply, visit www.sgo.org, contact membership@sgo.org or call SGO headquarters at 312-235-4060.
IN AN UPDATED PRACTICE BULLETIN, Management of Endometriosis, the College recommends conservative, nonsurgical treatment for women with endometriosis associated pain, followed by more invasive procedures if pain persists. The new bulletin, #114, published in the July issue of the Green Journal, includes the latest recommendations on diagnosis and treatment.

“We recommend starting with conservative approaches,” said Tommaso Falcone, MD, who led the document update. “For instance, continuous oral contraceptives and nonsteroidal anti-inflammatory drugs are effective. If these fail, then gonadotropin-releasing hormone agonists or progestins can help by suppressing the disease.” Medical therapy, however, will not improve fertility for women trying to get pregnant since most of these medications suppress ovulation. Recurrence of pain is common if drugs are discontinued. Surgery to remove endometriosis tissue helps improve pregnancy rates among infertile women, but it is difficult to predict by how much, Dr. Falcone said.

According to the College, vaginal ultrasound is the best way to investigate the presence of endometriosis. Laparoscopy also can remove visible endometriosis lesions, but it is not 100% effective in helping pain. As with medical therapy, there is a high recurrence of symptoms in patients after laparoscopic surgery. Both laparoscopic surgery and long-term hormone suppression will likely be needed to control pain. The treatment of last resort to consider for women with severe endometriosis is hysterectomy, Dr. Falcone noted.

THE US CENTERS for Disease Control and Prevention (CDC) has issued its first set of evidence-based recommendations on contraceptive safety for health care professionals in the US. The US Medical Eligibility Criteria for Contraceptive Use, 2010 offers guidance to physicians and health care professionals when providing family planning services to women, especially to those with specific medical conditions.

“These new CDC contraception guidelines will help providers and patients choose safe, effective methods of contraception, given each individual’s unique health circumstances,” said ACOG President Richard N. Waldman, MD. The guidelines, released May 28, give safety ratings from numbers one to four to approximately 1,800 combinations of contraceptive methods and medical conditions. A rating of one indicates no restrictions, and a four rating represents a condition that has an unacceptable health risk with the use of a specified contraceptive. The CDC notes that availability, acceptability, and personal preference should be considered when deciding a contraceptive.

The CDC recommendations were adapted from the guidance previously developed by the World Health Organization and will be regularly updated to reflect the latest published evidence. The US version adapts some of the guidance for better alignment with recommendations from ACOG and to better fit the US health care system.

“About half of all pregnancies in the US are unplanned,” said Dr. Waldman. “These new recommendations should encourage more widespread use of effective contraception. The bottom line is that most women, including those with chronic disease, can safely use most types of contraception.”

The full recommendations are available at www.cdc.gov/mmwr

Updates and supporting information for clinicians are available at www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm

New CONTRACEPTIVE SAFETY RECOMMENDATIONS

Best Approach for Endometriosis Pain

Look out for LARC

Watch your mailbox. ACOG sent a folder to members in early July filled with Long Acting Reversible Contraceptive (LARC) resources, including the latest Committee Opinion on LARC, a poster for your practice office, coding guide, coding resource publications, and patient education tear-off pads for the IUD and implant, with an order form. Learn more about LARC at www.acog.org under Women’s Issues.

http://www.acog.org/departments/dept_web.cfm?recno=50
In the Northeast African country of Eritrea, a woman’s likelihood of dying from pregnancy-related causes is more than 40 times higher than in the US. The country of 4.9 million people has only about 125 physicians and just 10 of them are ob-gyns.

To address the country’s physician shortage, the Eritrean Ministry of Health, the George Washington University Medical Center (GWUMC) in Washington, DC, and non-profit Physicians for Peace partnered in 2006 to develop the country’s first postgraduate educational programs. Since then, the Partnership for Eritrea implemented three residency programs in pediatrics, surgery, and ob-gyn.

The perception of health care in Eritrea has changed dramatically since the start of these programs, according to Huda Ayas, EdD, executive director of international medicine programs at GWUMC and one of the Partnership’s founders. “Eritreans say they used to go to the hospital to die. Now they have more confidence in their country’s health care,” she said. The curricula for each residency program were collaboratively designed by the Partnership’s Eritrean and American physicians. “The programs brought a culture of learning to Eritrea that didn’t exist before,” Dr. Ayas said.

The country’s first ob-gyn residency program began in August 2009 with five residents. Fellow Susan Marzolf, MD, program director, said that increasing the number of ob-gyns in Eritrea is the key to laying a strong foundation from which Eritreans can improve health care for women and families.

Enabling Eritreans to sustain the postgraduate programs was a crucial Partnership goal. “While external, humanitarian medical assistance helps bridge gaps of medical care throughout the world, it’s important to develop sustainable health care systems that do not rely on outside help,” said Fellow Charles J. Macri, MD, director, division of maternal-fetal medicine at GWUMC, and previous co-director of the ob-gyn residency program in Eritrea, with Fellow Laurie C. Zephyrin, MD, assistant professor of clinical ob-gyn at Columbia University Medical Center. “Our programs train Eritreans to be future leaders of their own health care system.”

The US medical staff recently transitioned the management of medical education programs to the Eritrean Ministry of Health. The Partnership helped establish solid ground for Eritrea’s local capacity, and laid the foundation to allow local physicians to continue the teaching. Dr. Marzolf continues as ob-gyn residency director, and visiting faculty from abroad assist in filling gaps that local specialists are unable to cover. “During the coming year, one of the goals will be to work with local ob-gyn specialists to teach them to take more ownership and be future program directors,” Dr. Marzolf said. “Though the management has changed, the continued commitment to the program has not.”

Learn more at www.physiciansforpeace.org and www.partnershipforeritrea.org.
Your First Gynecologic Visit—Especially for Teens (May 2010) AP150 Patient Education Pamphlet
This pamphlet tells your adolescent patient what to expect during her first gynecologic visit, exams that may be done, special concerns that may be discussed, and more about taking charge of her own health. Order at sales.acog.org or call 800-762-2264.

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These documents appear in the July issue of the Green Journal, and are online under Publications at www.acog.org

New Resources

Making the Rounds

Continuing Medical Education Webcasts
■ August 10, Coding the Global Obstetric Package
■ September 21, Physician Recovery from Medical Error
■ October 12, Diagnosis Coding for Obstetric Care Complications
■ November 9, Cord Blood Gases: From Delivery Room to Courtroom
■ December 14, Preview of New Codes for 2011

To learn more or register, visit www.acog.org/postgrad/index.cfm, call 202-863-2498, or email coding@acog.org. The College is accredited by the Accreditation Council for Continuing Medical Education (ACCME).

Mark Your Calendar
April 30–May 4
Annual Clinical Meeting 2011
WASHINGTON, DC