Babies Were Born to be Breastfed.” Breastfeeding advocates are hoping that that message becomes as familiar to Americans as “Only You Can Prevent Forest Fires” and “Take a Bite Out of Crime,” thanks to a new public service campaign from the Ad Council and the US Department of Health and Human Services’ Office on Women’s Health.

The campaign, which was launched in June, encourages mothers to breastfeed their newborns for at least the first six months of their lives and explains why breastfeeding is healthier for their babies. ACOG Fellows and staff critiqued the ads during the development stage and worked to ensure the ads were based on scientific evidence.

“New parents are often discouraged from breastfeeding because of confusion about duration and doubts about their ability,” says Cristina Beato, MD, HHS acting assistant secretary of health. “These new public service announcements speak to parents clearly about the consequences of not breastfeeding, which may help encourage more mothers to initiate and continue to breastfeed exclusively for six months.”

The television ads use humor to get the message across. One ad shows two actresses posing as pregnant women struggling to keep their balance while competing in a log rolling competition—one woman eventually falls off the log. Another ad shows a “pregnant” woman whooping it up on a mechanical bull before being thrown off.

A message on the screen follows each ad: “You wouldn’t take risks before your baby’s born. Why start after?” A voiceover then offers some of the health benefits to breastfeeding: “Studies show babies who are breastfed are less likely to develop ear infections, respiratory illnesses, and diarrhea. Babies were born to be breastfed.” During the voiceover, a message on the screen states “Breastfeed exclusively for 6 months.”

The campaign includes television, radio, newspaper, magazine, and outdoor public service announcements. All of the PSAs conclude by repeating the message “Babies Were Born to be Breastfed,” and

Obesity & Ob-Gyn

A crisis hitting America’s waistline

We’re an overweight nation. As we rush from work to home to our children’s school events, we grab dinner from fast food take-out windows. We relax in front of the television and don’t exercise as much as we should. We are served enormous portion sizes in restaurants and consume ounces and ounces of soft drinks instead of water.

Many of us know we should exercise and change our eating behaviors, but often we’re overwhelmed, ashamed, or don’t know how to begin.

And all the while, we’re inundated with stories in the media about the overweight and obesity crisis and the latest diet crazes.

What role do ob-gyns play in Americans’ fight against overweight and obesity? How do overweight and obesity affect your patients’ obstetrical and gynecological health? How can you speak to your patients about these issues comfortably— without patients feeling guilty or shame? How can you help your patients lose weight and lead healthier lives? Is that even the role of ob-gyns?
ACOG Fellow selected to lead AMA

ACOG Fellow John C. Nelson, MD, MPH, was installed as president of the American Medical Association in June. Dr. Nelson, an ob-gyn in private practice in Salt Lake City, has been active in the AMA for many years and has been a valuable liaison for ACOG with the AMA hierarchy.

Dr. Nelson’s theme for his inaugural address, “The Federation of Medicine is a Team Effort,” was highlighted by the many medical society presidents, state society presidents, and others who sat behind him on the stage.

We at ACOG are proud of John and his achievements. He has always been a strong supporter of our specialty, and he will continue to do so in the future. For the next year, John is in a unique position to bring forth key issues facing our specialty. We are all aware of the devastating impact liability and liability premiums have had on ob-gyn. John will continue to emphasize this issue as the AMA’s No. 1 priority—just as it is ACOG’s No. 1 priority. John also plans to address the issue of disparities in health care, an increasing problem for our Fellows and their uninsured patients.

A united approach to reform

To accomplish his goals in one year will be difficult, but by encouraging a united approach, all of medicine can continue the uphill battle that must succeed if we are to preserve the best of all health care systems.

ACOG is justly proud that one of its members has attained such a high position in the structure of medicine. We will work diligently with John as he works toward his goals, and I hope each of you will do likewise.

One big step will be to continue your AMA membership. If you’re not a member, I encourage you to join. AMA is still viewed by most of our citizens and Congress as the voice of medicine. This voice is vital in our quest for professional liability reform, health care reform, and reasonable reimbursement. With your membership and John’s leadership, we will maintain our influence in AMA activities.

Ralph W. Hale, MD, FACOG
Executive Vice President

Call for papers, posters, films for 2005 ACM

The ACOG Committee on Scientific Program is inviting submissions of abstracts of paper or poster presentations on any topic related to ob-gyn for the 2005 Annual Clinical Meeting, to be held May 7–11 in San Francisco. All abstracts must be submitted online.

The committee also welcomes online submission of abstracts of videotape, CD-ROM, or DVD presentations for the 2005 Film Festival on topics of interest to practicing ob-gyns.

Submission details and the online application are on the ACOG website.

Deadlines for online submission:
- Paper or poster abstracts: September 17
- Film Festival abstracts: November 19

Join ACOG webcast on embezzlement protection

Learn how to protect your practice with the September webcast from ACOG. *Internal Financial Controls to Protect Your Practice* will teach physicians and practice managers how to implement internal controls to protect their practice’s financial assets from embezzlement. The webcast will be held September 7 from 1 to 2:30 pm Eastern time.

To participate, you will need to have a telephone and a computer with Internet access. Speakerphones are helpful, especially if more than one person will be participating in the webcast at your site. (The cost for each webcast is per site, allowing several physicians and/or staff personnel to take part at the same site for one price.)

Education just a phone call away

The webcast is part of a new series of webcasts this year to help with liability, coding, and practice management issues. The webcasts began in July and will be presented on the first Tuesday of each month through December. All presentations will be from 1 to 2:30 pm Eastern time.

Upcoming webcasts
- October 5: Financial Statement Analysis for a Medical Practice
- November 2: Breast Care Management & Medical Liability Risk Reduction
- December 7: Physician-Patient Communications: Reducing Medical Liability Risks

District II clarifies meeting date

District II members: please note that your Annual District Meeting will be held Oct. 29–31. The dates have been published incorrectly in various materials.

info

- 202-863-2498
- Register for each webcast by visiting the “Postgraduate Courses” section under “Meetings” on the left side of the ACOG homepage, www.acog.org
History library given forceps replica

ACOG’s history library recently received an exciting addition to its collection. Ralph W. Hale, MD, ACOG Executive Vice President, presented the J. Bay Jacobs, MD, Library for the History of Obstetrics and Gynecology in America with a reproduction of the third pair of the original Chamberlen forceps.

The original pair is held at the Royal College of Obstetricians and Gynaecologists headquarters in London. RCOG produced 250 replicas to commemorate its 75th anniversary celebration and to raise money for a London education center.

The reproduction was cast from bronze and is tied together with a silk braid copied from the original one used to bind the two blades together. The forceps came with a certificate of authenticity and a short history of the Chamberlen family.

History library receives special gift at ACM

ACOG’s history library now houses a set of anatomical tables from the “Master of British Midwifery,” thanks to a generous donation during the Annual Clinical Meeting in May.

During the 8th Annual History Special Interest Group Breakfast, B. Victor Lewis, MD, an ob-gyn from London, England, presented a copy of the 2nd edition of William Smellie’s Set of Anatomical Tables to ACOG Executive Vice President Ralph W. Hale, MD, and the J. Bay Jacobs, MD, Library for the History of Obstetrics and Gynecology in America.

William Smellie (1697–1763) was the first to teach obstetrics and midwifery on a scientific basis, establish safe rules for the use of forceps, and separate obstetrics from surgery.

His famed treatise on midwifery appeared in 1752, followed two years later by his set of plates.

This folio volume contains 39 anatomical plates with accompanying texts designed to illustrate the obstetrical principles laid down in Smellie’s treatise.

The life-size plates are distinguished for their accuracy and are only to be compared with those of Smellie’s pupil, William Hunter, whose Anatomica Uteri Humani Gravidi was one of the highest points in anatomical atlases. In fact, most of the illustrations in Smellie’s plates were made by Jan van Rymsdyck, the foremost medical illustrator of the 18th century, who later prepared the illustrations for Hunter. Among other notable items, Smellie’s atlas included the first anatomical drawing of a rachitic female pelvis (Plate XI).
Junior Fellow Elections take place in August

Go online to cast your vote

For the first-time ever, ACOG is introducing online voting for Junior Fellow District Officer Elections. To cast your vote, follow these simple rules:

> Know your ACOG ID number. This 7-digit member number is listed on all ACOG mailings
> Review candidate bios and election information.
> Log on to https://eballot.votenet.com/acog
> Vote August 1–31 at the above website

The new officers will be announced on the Junior Fellow website the first week of September. Officer terms begin at the conclusion of the fall district meetings.

“Junior Fellow elections are an integral part of involvement in ACOG activities,” says Mary Behneman, ACOG director of district and section activities. “The move to online elections ensures Junior Fellows timely and convenient access to help decide who will represent them at the district level. The response has been overwhelmingly positive, and we are excited to see how this new process turns out.”

ACOG ID: Membership Department at 800-673-8444; membership@acog.org

Election updates and other information: visit the Junior Fellows section under Member Services on the ACOG members-access website

Questions: Mary Behneman: 800-673-8444, ext. 2533; mbehneman@acog.org

Find the perfect job through ACOG

Remember to take advantage of the new ACOG Career Connection, which allows you to search online for ob-gyn positions.

The service, which is free to ACOG Fellows and Junior Fellows, offers ob-gyns more features and greater functionality than other job banks offer. Search results will show job positions, locations, and company names. Candidates can post their resumes and quickly and easily reply to jobs online.

Other features include the ability to send a cover letter, accurately track current and past activity, receive email notification of new listings, and access personal assistance, five days a week at no charge.

“Since ACOG began working with a new job bank service earlier this year, both job seekers and employers have benefited greatly,” says Robert Shalett, ACOG director of marketing. “College Fellows and Junior Fellows now have a more robust and effective placement experience with the new Career Connection. The response at the recent ACM was extremely positive from everyone.”

Launched in January, Career Connection is a part of the HealtheCareers Network. To access, click on the ACOG Career Connection logo on the left side of the ACOG homepage, www.acog.org.

Share your experience with essay contest

Why did you select ob-gyn?

What keeps you committed to providing health care for women?

By answering these questions and putting your thoughts into words, you could earn a cash prize plus a free trip to next year’s Annual Clinical Meeting.

Who: All Junior Fellows in residency, practice, and fellowship


When: The deadline for submitting an essay is November 15. Entries must be limited to 500–750 words. Only online submissions will be accepted; visit www.acog.org

An essay will be selected from each district, and an overall winner will be chosen from the district winners. District essay winners will receive $500, and the overall winner will receive an additional $500 plus an all-expenses paid trip (including registration fee, coach airfare, and a per diem for room and board for 2–3 days) to attend the 2005 ACM in San Francisco. The winning selections will be made by January 2005.

Visit the Junior Fellows section under Member Services on the ACOG members-access website. Click on “Junior Fellow Essay Contest.”

Mary Behneman: 800-673-8444, ext. 2533; mbehneman@acog.org
Greetings Junior Fellows!

My name is Erica Marsh, and I am honored to serve as the new resident representative for the Obstetrics and Gynecology Residency Review Committee. I am currently a chief resident at the Brigham and Women’s Hospital and Massachusetts General Hospital Integrated Residency Program in Boston. I formally began my term with the RRC in May.

What the RRC and ACGME represent

The RRCs serve as the “functional units” of the Accreditation Council for Graduate Medical Education. There are RRCs for each medical specialty and most medical subspecialties. The ACGME is the body that monitors resident and some Fellow education and training. Its major responsibilities are to monitor residency programs individually, by specialty, and in aggregate to maintain the high quality and standard of postgraduate medical training that we have in the US.

The ACGME as a whole, as well as the individual RRCs, continually assesses the programs that it accredits, facing the challenge of being responsive to the constant changes that medicine and physicians have to negotiate. For example, the Ob-Gyn RRC is in the process of reviewing the role of vaginal breech deliveries as a training requirement in the current culture and climate of ob-gyn.

Who sets the standards

The Ob-Gyn RRC comprises 13 members, including a resident member. In addition to the regular members, there are three ex officio members as well as guests. Members are appointed by either ACOG, ABOG, or the Council on Medical Education of the AMA. The committee meets three times a year to review residency programs and to establish requirements that define the standard to which ob-gyn residency programs are held. At the May meeting, 53 programs were reviewed.

Ob-gyn residency challenges addressed

The RRC also discussed the resident clinic experience and the challenges that residencies are facing to maintain continuity of care given the increased role of the “night float.”

Many training programs established a night-float system to enable them to adhere to the new ACGME standards for work-hour limits that took effect in July 2003. In most cases, working overnight and then having to go to the continuity clinic does not allow for the 10 hours off between shifts that the ACGME requires. The situation is particularly difficult for smaller programs.

The committee acknowledges the problem and is in the process of thinking of creative solutions to this challenge that would preserve the unique role of the continuity clinics in residency education and facilitate easier adherence to the ACGME work-week restrictions.

As the Ob-Gyn RRC resident representative, I also sit on the Residents Council of the ACGME, which comprises the resident representatives from each of the RRCs. The primary issues discussed in February were the update on the ACGME Residency Questionnaire, work/duty hours compliance, and the development of an excellence model for residency programs in the US, i.e., if one could build a perfect residency from the ground up, what would it look like and how close are we to that model today?

Keeping you informed and voicing your concerns

I look forward to keeping you abreast of the educational strides our specialty is making and will continue to make over the two years of my term. If you have any questions or concerns, don’t hesitate to contact me. ☏

info

› Dr. Marsh: emarsh@partners.org
› ACGME: www.acgme.org
› RRC: www.acgme.org/RRC/committee.asp

HELP for residents and Fellows in training Fall deadline is October 1

Financial assistance is available to residents and Fellows in training through the ACOG Higher Educational Loan Program. To qualify for a low-interest HELP loan from ACOG, applicants must have completed their first year of ob-gyn residency or be enrolled in an approved fellowship program.

The maximum loan amount is $10,000, available at 4.5% interest. Loan payments do not begin until one year after completion of training.

Applications are reviewed twice a year. The fall application deadline is October 1, with notification by November 1. ☏

info

› Tonya Smith: 800-673-8444, ext. 2595; tsmith@acog.org
Before beginning their terms as section officers, 33 ACOG Fellows attended Officer Orientation at ACOG national offices in Washington, DC, in June. The two-day event included sessions on the organization of the College, the function of the districts and sections, membership benefits, committee service, media interaction and training, and the ACOG website. The officers also received an overview of each of the College’s divisions and went on a tour of ACOG headquarters.

Dave W. Kittrell, MD, Texas Section chair, and Charlene A. Lyndon, MD, Alberta Section vice chair

Maryanne McDonnell, MD, Connecticut Section chair

Bruce W. Honsinger, MD, Idaho Section vice chair, and Kelly A. McCue, MD, vice chair, Section 1, District IX

Andrew E. Good, MD, Minnesota Section chair

Estelle H. Whitney, MD, Delaware Section vice chair and Thomas H. Burwinkel, MD, Ohio Section vice chair
The reality of how a bill becomes a law differs from what one learns in high school government class, discovered Thomas F. Arnold, MD, through his experience as a McCain Fellow.

After spending four weeks this past spring working with the ACOG Office of Government Relations and Outreach in Washington, DC, Dr. Arnold said he realized that getting legislation passed by Congress requires a lot of behind-the-scenes work conducted by lawmakers, legislative staff, and advocates. Coalitions are developed, compromises are worked out, and strange bedfellows are often made.

“I was impressed with the knowledge of issues and process and the familiarity with congressional members that was demonstrated by the staff at ACOG,” Dr. Arnold says.

Focusing on professional liability

Although taking time away from his practice was challenging, Dr. Arnold found his experience as a McCain Fellow exhilarating and rewarding.

Dr. Arnold, of District VI, practices ob-gyn at the MedCenter One/Dickinson Clinic in Dickinson, ND. During his DC stint, much of the focus was on the professional liability crisis, as the Senate prepared for its third vote on tort reform. Dr. Arnold participated in meetings with congressional staff, and attended strategy sessions of the Alliance of Specialty Medicine, a coalition of medical specialties working for professional liability reform and Medicare reimbursement.

“Medical liability issues affect both rural areas such as North Dakota and metropolitan areas, but in subtly different ways,” he says.

Though the Senate vote fell short of victory, Dr. Arnold remains optimistic.

“I came away feeling that there is an awful lot of support for medical liability reform, and I think with time, the public will come to appreciate this,” he says. “We need to continue our efforts as I do think they are starting to make an impact.”

Speaking out on women’s health

Dr. Arnold also worked on Medicare reimbursement and other women’s health issues, meeting with legislative staff and other medical organizations, and attending hearings on Capitol Hill. He plans to continue to be an advocate for women’s health, speaking out on professional liability reform and other issues.

“It is very necessary for our Fellowship to become involved because what goes on in Washington affects our patients and our day-to-day medical practices,” Dr. Arnold says.

ACOG continues the push for tort reform

ACOG leaders continue to fight for professional liability reform, meeting with US senators and representatives both for and against the cause.

ACOG President Vivian M. Dickerson, MD; Immediate Past President John M. Gibbons Jr, MD; and Past President Charles B. Hammond, MD, joined advocates from across the country recently to stress the need for professional liability reform at the Alliance of Specialty Medicine’s Legislative Fly-In in Washington, DC. ACOG is an active participant in the Alliance, a coalition of medical specialties working for professional liability reform and Medicare reimbursement.

At the event, Senate Majority Leader Bill Frist, MD (R-TN), vowed to continue the fight for medical liability reform. Sen. Frist outlined his five top health priorities: medical liability reform, Medicare reimbursement reform, patient safety, health technology, and Medicare prescription drug access for seniors.

Sen. Frist was joined by Sens. John McCain (R-AZ) and Jim Bunning (R-KY), as well as House Energy and Commerce Chair Joe Barton (R-TX) and Rep. Bart Gordon (D-TN). The congressional leaders spoke about the importance of ending the culture of medical lawsuit abuse in the US by enacting medical liability reform and about the importance of restoration of Medicare physician payments.

Representing a wide spectrum of congressional views, legislative staff from the offices of Sens. Judd Gregg (R-NH), Michael Enzi (R-WY), and Dick Durbin (D-IL) debated the merits of current professional liability reform legislation and commented on prospects for passage.

During this Congress, legislation modeled after California’s MICRA reform and introduced by Sen. Gregg has been voted on three times. A supporter of MICRA, Sen. Enzi has introduced legislation that would replace the current tort system with an entirely new system based on recommendations from the Institute of Medicine, including state demonstration projects to test the concepts of early offer, medical courts, and a no-fault model.

Sen. Durbin, along with Sen. Lindsey Graham (R-SC), is considering the introduction of legislation that focuses more on insurance reforms and the creation of a federal preemption panel.

The Alliance of Specialty Medicine also launched its own website during the Fly-In, offering another valuable resource for Fellows to learn more about key legislative issues. Visit the website at www.specialtydocs.org.
National Depression Screening Day kits offer more materials this year to help physicians screen their patients for mood and anxiety disorders. National Depression Screening Day, cosponsored by ACOG, will be held October 7.

The toolkits have been expanded to include more materials geared toward both physicians and patients on anxiety disorders, more information on how to recognize the physical symptoms of depression, and an expanded clinician’s guide.

The kit also includes the NDSD screening tool, a one-page questionnaire that screens for depression, bipolar and generalized anxiety disorders, and post-traumatic stress disorder. The form is brief, allowing it to be filled out by patients in reception areas, scored by personnel, and added to patient charts by the time they meet with their doctors.

Also new this year, NDSD is highlighting the effect depression has on the body. Studies have shown that patients with physical illnesses have better outcomes if their mental health disorders are treated at the same time as their physical ones, according to NDSD.

See below for how to receive free NDSD kits and/or to register an NDSD event. Clinicians who conduct an NDSD event are eligible to receive CME credits for completing a brief self-education component.

Teach patients about organ donation with new materials

Ob-gyns can educate their patients about organ donation with the help of free materials from the US Department of Health and Human Services. Materials include brochures in several languages, pull-out informational cards, organ donor cards, and lapel pins supporting organ donation. Also available are health passports in English and Spanish in which patients keep track of their health information—including previous surgeries, immunizations, medications, and health screenings—all in one place. Materials can be handed out to patients or displayed in reception areas.

More than 85,000 people are on an organ transplant waiting list, with a disproportionate number of minorities waiting for compatible organs. In response, HHS created a special version of the health passport aimed at blacks. Patients’ systems may be less likely to reject organs if they are donated by someone from the same ethnic and racial group, according to HHS.

Cards, brochures, and the Donate Life logo can be downloaded through an HHS website, while other materials can be ordered at no cost through the Ask HRSA telephone number.

Call for abstracts for fibroids meeting

The 2nd NIH International Congress on Advances in Uterine Leiomyoma, Research and Clinical Implications, is now seeking abstracts for the Feb 24–25, 2005, meeting in Bethesda, MD. Abstracts are being sought from basic, clinical, or translational research relating to uterine leiomyoma, including research in related fields such as smooth muscle biology or pathobiology. The submission deadline is October 15.

For submission requirements and more information, contact Susan F. Meikle, MD: smeikle@ahrq.gov; 301-427-1515
ACOG issues position on first-trimester screening methods

First-trimester screening for genetic defects is now an option for pregnant women, but only if certain criteria are met, according to a new ACOG Committee Opinion. New technologies, such as measuring nuchal translucency, have allowed for earlier, noninvasive screening for chromosomal abnormalities and, when combined with serum screening in the first trimester, have comparable detection rates as standard second-trimester screening.

The new Committee Opinion, First-Trimester Screening for Aneuploidy, was published in the July issue of Obstetrics & Gynecology and developed by the Committee on Genetics and the Committee on Obstetrics. The new document replaces Committee Opinion #225, First-Trimester Screening for Fetal Anomalies with Nuchal Translucency.

First-trimester screening offers some advantages
First-trimester screening offers several potential advantages over second-trimester screening, the Committee Opinion states. When test results are negative, it may help reduce maternal anxiety earlier. If results are positive, it allows women to take advantage of first-trimester prenatal diagnosis by chorionic villus sampling at 10–12 weeks or second-trimester amniocentesis. Detecting problems earlier in the pregnancy may allow women to prepare for a child with health problems. It also affords women greater privacy and less health risk if they elect to terminate the pregnancy.

In the past decade, research has shown an association between fetuses with certain chromosomal abnormalities and ultrasonographic findings of an abnormally increased NT (an area at the back of the fetal neck) between 10 and 14 weeks gestation. The newer first-trimester screening method includes measurement of NT, free beta subunit of human chorionic gonadotropin (hCG), and pregnancy-associated plasma protein-A (PAPP-A). It has a comparable detection rate for Down syndrome as the more commonly used second-trimester screening using four serum markers (alpha-fetoprotein, hCG, unconjugated estriol, inhibin-A).

“Researchers developed this new method of testing because women want to know earlier in their pregnancies if there are any problems,” says Deborah A. Driscoll, MD, immediate past chair of ACOG’s Committee on Genetics. “Many women also want to avoid having an invasive diagnostic procedure such as CVS, which carries a small risk of miscarriage. However, it is important for women to recognize that a negative screen indicates that their risk of having a child with Down syndrome is reduced. This is not a diagnostic test.”

First-trimester screening can also help detect other chromosomal abnormalities such as trisomy 18. In addition, measurement of NT may help detect pregnancies at risk for major heart defects in the fetus.

Certain criteria essential if first-trimester screening used
According to the new ACOG Committee Opinion, sonographer training and ongoing quality assurance are essential if NT is used as a screening method. Because small differences in NT measurements can have a large impact on the risk prediction of Down syndrome, sonographers need to be monitored closely.

The Committee Opinion states that first-trimester screening should only be offered if the following criteria are met:
- Appropriate ultrasound training and ongoing quality monitoring programs are in place
- There are sufficient resources and information to provide comprehensive counseling to women regarding the different screening options and limitations of these tests
- Access to an appropriate diagnostic test is available when screening tests are positive

“Women need to be aware of all the different screening options that are available, including their detection rates and limitations, so that they can choose the test that’s best for them,” Dr. Driscoll says.

More health plans cover contraceptives
Women have more contraceptive choice than they had a decade ago now that more health insurance plans are paying for prescription contraceptives.


ACOG helped call attention to inequality in health coverage. At the 1998 ACM, the College received widespread publicity after denouncing gender bias in health plans that don’t cover contraception for women but cover prescription drugs geared toward men for conditions such as erectile dysfunction.

The report found that the percentage of plans covering no contraceptive method dropped dramatically, from 26% in 1993 to 2% in 2002. The largest increases in coverage were for the intrauterine device, from 32% of plans to 94%, and the diaphragm, from 33% to 83%.

The study also found that in the 20 states with laws requiring contraception coverage for plans that cover prescription drugs the coverage was more extensive. However, 30 states do not have a law requiring contraception coverage, and self-insured plans are not covered by state mandates.

Paying for contraception out of her own pocket may cause a woman to not use it at all, skip doses, or choose a cheaper method based more on her budget than on her personal choice, the report says. Enabling a woman to choose the method that best fits her lifestyle and health means she is more likely to use the contraception consistently and correctly, thereby reducing the number of unintended pregnancies, according to the report.

info
- www.guttmacher.org
Obesity continued from page 1

During the coming months, ACOG Today will look at these and other issues surrounding the overweight and obesity crisis in the US in the ongoing series Obesity & Ob-Gyn.

Majority of Americans face weight problems
ACOG President Vivian M. Dickerson, MD, says ob-gyns must be on the forefront of the “battle of the bulge.”

“We are often the first, and even the only, physician that most women see,” Dr. Dickerson says. “Since women represent a very large proportion of the truly obese, it is incumbent on ob-gyns to talk about weight issues and to help patients find ways of losing weight.”

An estimated 129.6 million Americans—or 64%—are overweight or obese. A study from the CDC earlier this year showed that overweight and obesity may soon surpass tobacco as the leading cause of death in the US. Deaths from overweight and obesity increased 33% in the 1990s, and in 2000, 400,000 people in the US died from poor diet and lack of exercise, according to the CDC.

Institutions throughout the US—and the world—are beginning to examine the crisis more closely. Member states of the World Health Organization recently endorsed a global strategy to fight overweight and obesity, recognizing that noncommunicable diseases, including cardiovascular disease, and type 2 diabetes, account for approximately 60% of global deaths. The Harvard Medical School focused a symposium in June on obesity medicine as a new discipline, and the Duke University School of Medicine has announced the development of a course for fourth-year medical students that will cover the underlying causes of obesity and its treatment options.

The ob-gyn’s role in the epidemic
Being overweight has become the norm in the US, says ACOG Fellow M. Natalie Achong, MD, assistant professor at the University of Connecticut and a national speaker and researcher on the topic.

“For many women, particularly in their 20s, 30s, and 40s, ob-gyns serve as their primary care physicians. Therefore, we have a responsibility to our patients to educate, if not counsel, on general principles of maintaining healthy weight, fitness, and exercise,” Dr. Achong says. “These issues are on the minds of obese and non-obese women; often they are hoping for us to take the lead by starting the dialogue.”

Because ob-gyns weigh patients as a routine part of care, it is a logical starting point for a conversation about weight, according to Dr. Achong. She first asks her patients if they know how much they weigh and if they’re comfortable with it. She tracks their weight from year to year and speaks with them if they continue to gain weight each year. Oftentimes, she says, patients don’t monitor their weight weekly or monthly and don’t realize they are gradually gaining weight.

“We need to at least scratch the surface and approach the topic,” she says.

However the ob-gyn decides to tackle the overweight and obesity crisis, it’s clearly a problem that affects patients. The issue is of such importance that Dr. Dickerson has chosen obesity as the medical issue of the year to focus on during her presidency.

“There are numerous gynecologic and obstetrical implications of obesity, including fetal macrosomia, gestational diabetes, endometrial hyperplasia, and abnormal uterine bleeding,” Dr. Dickerson says. “We also know that obesity can lead to hypertension, diabetes, hyperlipidemia, and ultimately, cardiovascular disease—the No. 1 killer of women. We cannot afford the luxury of avoiding these issues.”

Next: In the September issue of ACOG Today, learn how to communicate with your patients about overweight and obesity.

Find drug assistance programs easier online

A new website tool from the Pharmaceutical Research and Manufacturers of America allows physicians and their patients to find a prescription drug assistance program faster and easier.

The new feature, “Fast Access,” is part of the www.helpingpatients.org website. Physicians and patients enter the patient’s data into the online tool, which feeds the information to various pharmaceutical company-sponsored drug assistance programs for low-income people.

Fast Access will determine which programs may be a match for the patient and will display the appropriate application forms to be printed. Physicians must approve the applications before a patient submits them.

The website maintains a database of 40 patient assistance programs that offer a total of more than 400 medications—some free and some discounted.
Researchers look to improve breast cancer screening

Mammography specialists in short supply

A shortage in breast-imaging specialists and the closure of many mammography facilities are putting women’s health at risk.

Early detection of breast cancer through mammography continues to be the most effective strategy in the fight against breast cancer, according to a report released in June from the Institute of Medicine and the National Research Council of the National Academies.

However, access to mammography screening is endangered as fewer radiologists go into breast imaging because of lawsuits fears, heavy regulation, and low reimbursement. At the same time, the number of mammography centers is decreasing, from 9,400 facilities in 2000 to 8,600 in 2003, according to the report Saving Women’s Lives: Strategies for Improving the Early Detection and Diagnosis of Breast Cancer.

“Breast imagers are becoming an endangered species,” says Martin D. Abeloff, MD, director of the Johns Hopkins’ Sidney Kimmel Comprehensive Cancer Center and a member of the committee that developed the report.

The lack of access means women in some areas of the US are waiting up to five months for mammograms, the report says. Compounding the problem are the aging US population and the increase in the proportion of women older than 40 who are seeking mammograms. ACOG recommends that women age 40–49 have a mammogram every one to two years, while women 50 and older have a mammogram every year.

Evaluating new technologies

Although it’s seen as the best weapon against breast cancer, early screening by mammography is not perfect. Up to 17% of breast cancer tumors go undetected through mammography screening, and the rate of false positives is 1 in 10. The report encourages the development of new technologies but recognizes that any “breakthroughs” would more likely be improvements in existing technology that could be used alongside mammography.

New methods currently being assessed include digital mammography, computer-assisted detection, ultrasound, and magnetic resonance imaging. Promising research and discovery phases of new technology are also being conducted, the report says.

New technologies may offer improved accuracy over mammography interpretations and better identification of high-risk women, but questions remain as to whether these technologies will improve health outcomes and can be used effectively in routine clinical practice.

The report recommends more support for research on how to evaluate and apply new screening technologies and more research on genetic risk factors. If risk factors were better identified, screening could be tailored so that women at highest risk were screened more often and women at lowest risk, less often.

The Gail Model, which is used to determine risk based on five risk factors, accurately predicts the number of women in various age and risk groups who will develop cancer within the next five years but is not as accurate at predicting the actual individuals who will develop the disease, the report says.

Communicating risks to patients

More than 200,000 new cases of breast cancer will be diagnosed this year, and more than 40,000 women will die from the disease. While more women die of lung cancer every year, more women will be diagnosed with breast cancer each year than any other cancer, causing women to fear breast cancer more than other diseases.

“Because breast cancer is so common and because there are so many breast cancer survivors, including young women, most women are quite aware of the very high incidence of the disease,” says Vicki L. Seltzer, MD, an ACOG past president and vice president for women’s health services of the North Shore-Long Island Jewish Health System. “One of the things that makes so many women feel vulnerable is the large number of women they know who have had the disease.”

According to the Saving Women’s Lives report, however, too many women misperceive their individual risk of getting breast cancer.

“Younger women and those with a family history of breast cancer overestimate their risk,” Dr. Abeloff says. “In contrast, older women underestimates their risk.”

While age, along with gender, is the most significant risk factor, few women know this, according to the report. In a survey cited in the report, women overestimated family history as a risk factor, with more than 75% listing it as a risk factor, while fewer than 1 in 8 correctly identified old age as a risk factor. The probability of a 40-year-old woman developing breast cancer in the next 10 years is 1.45%, compared with 4.31% for a 70-year-old woman, according to the American Cancer Society.

While women may not know their risks as well as the experts, Dr. Seltzer says they are becoming more knowledgeable and their concern about breast cancer is appropriate. Since the 1980s, women have also become better informed about mammograms, according to Dr. Seltzer.

“I think there’s been an evolution in large part because ob-gyns have done a good job of explaining the importance of mammograms … and the media have done a good job of calling attention to this issue as well.”

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-> Saving Women’s Lives report: http://books.nap.edu/catalog/11016.html
-> Poster: Breast Self Exam (AA364) Order online at http://sales.acog.org or call 800-762-2264, ext. 192
-> Patient Education Pamphlets: Mammography (AP076); Detecting and Treating Breast Problems (AP026); Breast Self Exam (AP145) Order online at http://sales.acog.org or call 800-762-2264, ext. 192
-> Practice Bulletin: Breast Cancer Screening, April 2003 (#42) Published in ACOG’s 2004 Compendium, or find by doing an “advanced search” on the members-access section of the ACOG website, www.acog.org
The answer will depend largely upon your state law. Check with your hospital’s risk managers or legal staff or with your personal attorney to be certain about legal requirements.

A number of religions have doctrines that restrict or prohibit certain medical practices. For example, followers of the Jehovah’s Witness denomination refuse to accept blood and certain blood products as part of medical treatment.

In general, many states have laws protecting a patient’s right to refuse medical treatment, either on the basis of the patient’s religious beliefs or under case law principles of “self-determination,” meaning that patients have a right to make their own decisions on medical care.

ACOG’s Ethics Committee also urges physicians to respect the ethical principle of patient autonomy, noting that obstetricians should refrain from performing procedures that are unwanted by a pregnant woman. (See Ethics in Obstetrics and Gynecology, second edition.) However, the right to refuse treatment, including blood transfusions, is not absolute. States have become involved in cases in which the state’s interest in preserving the health, safety, or welfare of citizens can be demonstrated—particularly when the welfare of children is involved.

**Courts are mixed on pregnant women’s right of refusal**

The Ethics Committee agrees that court-ordered intervention against the wishes of a pregnant woman is rarely, if ever, acceptable and that the use of courts to resolve conflicts is warranted only in extraordinary circumstances.

Courts, however, are mixed. An Illinois Appellate Court has held that the state cannot, to save the life of the fetus, override a pregnant woman’s competent decision to refuse recommended blood transfusions during surgery.

Other courts (NY, GA, NJ) have held that protecting the life of an unborn child overrides the mother’s right to refuse care based on religious belief. Courts appear more likely to order treatment when the fetus is viable, the risks of permanent injury or death for the fetus are high, and chances of survival are good if the recommended treatment is administered.

When it comes to the health of the mother alone, other states have declined to require medical care refused by the patient because of religious belief. Thus, a Connecticut court concluded that a mother’s right to refuse a transfusion after her baby was born was a “common law right of bodily self-determination.”

**Steps in caring for women with religious restrictions**

In non-emergency situations, patients may make it known there will be religious-based restrictions on care. If those restrictions are clearly inconsistent with good medical practice and the physician chooses to do so, he or she can usually refuse to establish or continue a physician-patient relationship.

If a physician chooses to accept the care of the woman or is confronted on an emergency basis with such refusals, he or she can take certain steps to limit liability.

Depending on the setting, contact the hospital’s risk manager or a personal attorney for guidance. Recognize that the patient could be classified as “high risk” and that medical care may need to be adjusted in order to provide her with the safest environment possible.

When a high-risk patient is in labor, the physician may need to come to the hospital earlier than usual and stay longer after delivery. Post-operative patients may need closer monitoring and for longer periods than other patients. Have in mind an alternative plan of treatment should an emergency arise that would normally indicate the treatment being refused. Discuss these plans with the patient and, as appropriate, the family.

**Document informed consent**

As with any case that involves refusal of medical care, inform the patient of the risks associated with refusing the recommended treatment. If the patient continues to refuse, document clearly that the patient was informed of the consequences. If possible, obtain a signed informed refusal form and place it with the permanent medical record. Document the patient’s level of capacity (e.g., alert and oriented x 3) at the time of the discussion. Indicate the patient was provided with the option of changing her mind later. ☒

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liability@acog.org

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

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COG has updated its VBAC guidelines after reviewing the risks and benefits associated with vaginal births after cesareans.

The new Practice Bulletin, Vaginal Birth After Previous Cesarean, was published in the July issue of Obstetrics & Gynecology and replaces the 1999 Practice Bulletin of the same name.

Because of higher risk of uterine rupture, ACOG now recommends that women with two or more prior cesarean deliveries and no vaginal deliveries not attempt VBACs. Previously, women who had two previous low-transverse cesarean deliveries were considered candidates for VBACs.

The Practice Bulletin cites a study that controlled for other potential confounding variables and found that the risk of uterine rupture was nearly five times greater for women with two previous cesarean deliveries when compared with that for women with one prior cesarean. However, women with a vaginal delivery followed by a cesarean delivery were only about one-fourth as likely to have a uterine rupture during a trial of labor, according to the Practice Bulletin.

ACOG continues to recommend that for women to attempt a VBAC there should be a physician immediately available throughout active labor who is capable of monitoring labor and performing an emergency cesarean delivery. The College also recommends that anesthesia and personnel be available for an emergency cesarean delivery.

“The operational definition of ‘immediately available’ remains the purview of the local institutions, based on their geographic location and available resources,” says Stanley Zinberg, MD, MS, vice president of practice activities. “It would be difficult for ACOG, as a national organization, to provide a more precise definition that would cover all Fellows in all clinical settings. It’s also important that physicians and hospital staff reach consensus on this issue based on the resources available to them.”

Risks of VBACs and cesarean births

While successful VBACs are associated with shorter hospital stays, less blood loss and fewer transfusions, less infectious morbidity, and fewer thromboembolic events, a failed trial of labor can lead to major complications, such as uterine rupture, hysterectomy, operative injury, increased maternal infectious morbidity, and increased need for transfusion. The risk of infant mortality is greater also.

On the other hand, multiple cesarean deliveries lead to an increased risk of placenta previa and accreta. Because risks exist for both VBACs and cesarean births, one model analysis cited in the Practice Bulletin suggests that a trial of labor is reasonable if the chance of success is 50% or more and the desire for future pregnancy after cesarean delivery is at least 10% to 20%.

“ACOG continues to evaluate the latest findings on VBACs and to make recommendations that aim for the safest and most optimal outcome for women and their children,” Dr. Zinberg says.

Breastfeeding resources and materials

- Poster: Breastfeeding Your Baby (AA462)
  Order online at http://sales.acog.org or call 800-762-2264, ext 192
- Patient Education Pamphlet: Breastfeeding Your Baby (AP029)
  Order online at http://sales.acog.org or call 800-762-2264, ext 192
  Published in ACOG’s 2004 Compendium; or find by doing an “advanced search” on the members-access section of the ACOG website, www.acog.org
Associate Fellow James T. Bradbury dies at age 97

A COG Associate Fellow James T. Bradbury, ScD, died February 25 in Bozeman, MT, at the age of 97.

Dr. Bradbury, an expert researcher in endocrinology, was a professor of obstetrics and gynecology for more than 40 years and was the first basic scientist to hold a full-time appointment in a clinical department. He received his doctorate in zoology at the University of Michigan, writing his doctoral thesis on endocrine factors influencing mammary development and secretion.

He began his academic career at the University of Michigan, moving on to the University of Iowa in 1944, where he spent the next 30 years except for a three-year period at the University of Louisville. After retiring from the University of Iowa, he taught at Montana State University.

During his career, in collaboration with clinical colleagues, he was among the first to identify the high LH levels characteristic of polycystic ovary syndrome, and he demonstrated ovulation inhibition with cyclic estrogen. He also collaborated on the development of various means of fetal assessment in high-risk pregnancies.

He became an Associate Fellow of ACOG in 1953 and received the College’s Distinguished Service Award in 1977.

Former ACOG education director dies

Richard W. Stander, MD, ACOG Life Fellow and former ACOG director of education, died January 21 at the age of 81.

Dr. Stander attended Michigan State College from 1940–42 before serving in World War II from 1942–46. After the war, he finished his bachelor’s degree at the University of Colorado. He received his medical degree and completed his residency at the University of Michigan in 1951, where he then taught for one year. Later, he was a faculty member at Indiana University and the University of Cincinnati.

He left teaching in 1975 to join the staff of ACOG—which was then headquartered in Chicago. A Fellow since 1958, he served as the College’s director of education from 1975–79. He later became an ob-gyn professor at the University of New Mexico.

Dr. Stander was also an ABOG examiner, chair of ACOG’s District V, and on the editorial board of Obstetrics & Gynecology.

Mother of OB anesthesia dies

Gertie F. Marx, MD, of Southbury, CT, known as the “Mother of OB Anesthesia,” died January 25, at the age of 91.

Dr. Marx, a Life Fellow of ACOG, was known for her pioneering contributions to obstetric anesthesia, helping the field become recognized as its own specialty. The Gertie Marx Spinal Needle, used to administer epidural anesthesia, was named in honor of her.

Dr. Marx was born in Germany, where she began medical school. However, she and her family soon fled as they saw Adolph Hitler rise to power, and she completed her medical degree at the University of Bern, Switzerland, in 1937. She immigrated to the US and completed her residency at Beth Israel Hospital in New York and was an attending anesthesiologist at the hospital for 11 years.

She left Beth Israel to join the staff at the Albert Einstein College of Medicine of Yeshiva University in the Bronx, NY, where she worked for 45 years. She was very active in the Society for Obstetric Anesthesiologists and Perinatology from its inception and was a founder of the Obstetric Anesthesia Digest.

Dr. Marx was one of only two women to receive the Distinguished Service Award from the American Society of Anesthesiologists, and in 1993, Britain’s Queen Elizabeth II presented her with the College Medal from the Royal College of Anaesthetists for her lifetime achievement.
2004 calendar

Please contact individual organizations for additional information.

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<th>August</th>
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<td><strong>11th Scientific Meeting on Chronic Pelvic Pain</strong>&lt;br&gt;5–7 Chicago Sponsored by The International Pelvic Pain Society <a href="http://www.pelvicpain.org">www.pelvicpain.org</a></td>
<td><strong>ACOG District I</strong>&lt;br&gt;30–Oct 3&lt;br&gt;Kennebunkport, ME 207-622-3374</td>
<td><strong>ACOG District II</strong>&lt;br&gt;29–31&lt;br&gt;New York City 518-786-1529</td>
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<td><strong>ACOG District VI Fellows</strong>&lt;br&gt;17–19 Salt Lake City, UT 202-863-2540</td>
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<td><strong>ACOG District VIII</strong>&lt;br&gt;17–19 Salt Lake City, UT 202-863-2540</td>
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<td><strong>October</strong>&lt;br&gt;<strong>ACOG District IX</strong>&lt;br&gt;17–19&lt;br&gt;Salt Lake City, UT 202-863-2540</td>
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<td><strong>CPT and ICD-9-CM Coding Workshop</strong>&lt;br&gt;6–8 • Minneapolis</td>
<td><strong>Best Practices in Gynecology</strong>&lt;br&gt;26–28 • Teton Village, WY</td>
<td><strong>Practice Management Update for the Ob-Gyn</strong>&lt;br&gt;5–7 Washington, DC 202-863-2540</td>
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<td><strong>September</strong>&lt;br&gt;<strong>Controversies in Obstetrics</strong>&lt;br&gt;9–11 • Tucson, AZ</td>
<td><strong>October</strong>&lt;br&gt;<strong>CPT and ICD-9-CM Coding Workshop</strong>&lt;br&gt;10–12 • New Orleans</td>
<td><strong>The Mature Woman: From Perimenopause to the Elderly Years</strong>&lt;br&gt;11–13 Boca Raton, FL</td>
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<td><strong>November</strong>&lt;br&gt;<strong>Medical Liability Litigation: Gaining Perspective and Control</strong>&lt;br&gt;10–12 • Washington, DC</td>
<td><strong>November</strong>&lt;br&gt;<strong>CPT and ICD-9-CM Coding Workshop</strong>&lt;br&gt;1–3 • Atlanta</td>
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**ACOG Postgraduate Courses**

Two ways to register:
1 Call 800-673-8444, ext 2540/2541, or 202-863-2540/2541, weekdays 9 am–4:45 pm ET
2 Go to www.acog.org and click on “Postgraduate Courses” under “Meetings and Events”

Registration must be received one week before the course. Onsite registration subject to availability.

**August**

CPT and ICD-9-CM Coding Workshop<br>6–8 • Minneapolis

CPT and ICD-9-CM Coding Workshop<br>13–15 • Cleveland

Practical Obstetrics and Gynecology<br>19–21 • Charleston, SC

**Best Practices in Gynecology**<br>26–28 • Teton Village, WY

**September**

Controversies in Obstetrics<br>9–11 • Tucson, AZ

Advanced Quality Improvement and Management Skills for Leaders in Women’s Health Care<br>9–11 • Chicago

Medical Liability Litigation: Gaining Perspective and Control<br>10–12 • Washington, DC

CPT and ICD-9-CM Coding Workshop<br>10–12 • New Orleans

**October**

CPT and ICD-9-CM Coding Workshop<br>1–3 • Atlanta

**November**

Practice Management Update for the Ob-Gyn<br>5–7 • Washington, DC

**December**

The Mature Woman: From Perimenopause to the Elderly Years<br>11–13 Boca Raton, FL

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Teaching ob-gyn care for American Indians

Through the Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care, ACOG Fellows play an integral role each year in the education of health care providers who serve American Indians and Alaska Natives.

About half of the faculty members of the course are ACOG Fellows. The annual course, which was held in Denver in June, was developed by ACOG for the US Indian Health Service and is geared toward IHS, tribal, and urban primary care providers and nurses.

Physicians, clinical nurses, nurse practitioners, certified nurse midwives, and physician assistants spend four days attending lectures and participating in interactive workshops, learning important concepts in ob-gyn and neonatal care management. This year, a Neonatal Resuscitation Program course was offered before the conference.

New Patient Education Pamphlets available in Spanish

More Patient Education Pamphlets are now available for your Spanish-speaking patients:
- Domestic Violence (SP083) is available in Spanish for the first time
- The recently revised Mammography pamphlet (SP076) is now in Spanish
- Eleven more pamphlets, which can be ordered individually or as a set, are also available in Spanish:
  - Nutrition During Pregnancy (SP001)
  - How to Tell When Labor Begins (SP004)
  - Birth Control (SP005)
  - Cesarean Birth (SP006)
  - Understanding Hysterectomy (SP008)
  - How to Prevent Sexually Transmitted Disease (SP009)
  - The Menopause Years (SP047)
  - Osteoporosis (SP048)
  - Vaginal Birth After Cesarean Delivery (SP070)
  - Maternal Serum Screening for Birth Defects (SP089)
  - HIV Testing and Pregnancy (SP113)
  - Complete set of Spanish pamphlets (SP000)

Order online at http://sales.acog.org or call 800-762-2264, ext 192