

Five states achieve medical liability reform wins

ALASKA, GEORGIA, ILLINOIS, MISSOURI, AND SOUTH CAROLINA earned key medical liability reform victories during their legislative sessions this year. All five states passed laws that lowered or instituted caps on noneconomic damages in medical liability cases.

“Perseverance was one of the keys to success in these five states. All five wins this year were after two to three years of defeat,” said Kathryn Moore, ACOG’s director of state legislative and regulatory affairs. “Medical liability reform doesn’t happen overnight, and it’s important for physicians not to give up and to keep the momentum going.”

Persistence pays off

MO Missouri is a prime example of the importance of perseverance. The state passed perhaps the strongest bill of the five states, strengthening a \$350,000 cap that had increased to \$579,000 because of annual inflation adjustments. Now, the \$350,000 cap will apply regardless of the number of defendants in a case and cannot be increased for inflation.

Similar legislation had passed the previous two years but was vetoed each time by then-Missouri Governor Bob Holden, a Democrat and trial lawyer. But this year, newly elected Republican Governor Matt Blunt signed the bill into law.

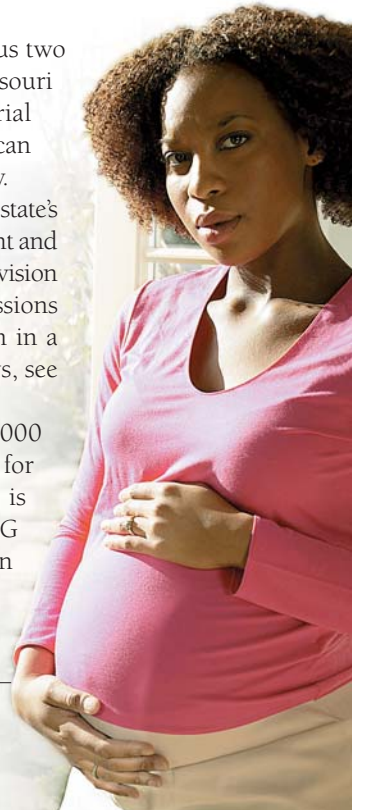
Missouri’s tort reform also strengthened the state’s statute of limitations for minors, eliminated joint and several liability, and enacted an “I’m Sorry” provision that protects physicians’ apologies or expressions of sympathy from being used against them in a liability claim. (For more on “I’m sorry” laws, see page 12.)



In Illinois, legislators approved a \$500,000 cap for physicians and a \$1 million cap for hospitals. Although the physician cap is higher than the \$250,000 cap that ACOG supports, the fact that any cap passed in Illinois is a strong victory.

□ PAGE 12

Who will deliver my baby?



▲ US ob-gyn residents at Kyoto’s Gold Pavilion: Drs. Sam Siddighi, Rajiv B. Gala, Sindhu Srinivas, Jessica C. Souther, Manda Ghahremani, and Deborah A. Bartz. Not pictured: Drs. Meghan E. Ogden, George Kontopoulos, Shira M. Varon, and Alysia D. Turner Townsend.

Exchange program unites US and Japan residents

TEN JUNIOR FELLOWS EMBRACED A UNIQUE OPPORTUNITY in April during a trip to Japan, learning about the differences in ob-gyn practice in the US and Japan, interacting with Japan residents, and spending time with some of ACOG’s top leaders.

Each ACOG district selected one resident to attend the 57th annual scientific meeting of the Japan Society of Obstetrics and Gynecology in Kyoto, Japan. In turn, 10 Japanese residents attended ACOG’s Annual Clinical Meeting in May.

“This experience was one of the very best of my life,” said Jessica C. Souther, MD, who was selected to attend the JSOG meeting by the Armed Forces District. “It was definitely the most memorable week of my ob-gyn life so far!” □ PAGE 5



Volume 49, Issue 7

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American College of
Obstetricians and Gynecologists,
409 12th Street SW
Washington, DC 20024-2188

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

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EXECUTIVE DESK

ACOG leaders help guide the AMA

ACOG continues to have strong representa-
tion in the American Medical Association,
as another ACOG Fellow joins the AMA
board of trustees.

At the AMA annual meeting in June, the House
of Delegates elected ACOG Fellow Robert M. Wah,
MD, Capt, MC, USN, to the AMA board. Dr. Wah has
served as a delegate or alternate delegate for ACOG
and the American Society for Reproductive Medicine
for many years. He is an active member in the AMA,
most recently serving as chair of the AMA Council on
Long-Range Planning and Development. Congratula-
tions to Robert! (For more information, see page 3.)

Dr. Wah joins two more ACOG Fellows on the
AMA board: Joseph M. Heyman, MD, of Amesbury,
MA, and John C. Nelson, MD, of Salt Lake City, the
immediate past president of the AMA.

This year's AMA meeting was extremely important.
The top issue, apart from the professional liability crisis,
was the impending implementation of the pay-for-
performance program. The concept is still unproven
and confusing. However, the major payors—health in-
surers and employers who are concerned about rising
health care costs—seem enthralled with the concept
and will begin implementation despite questions and
concerns about the development and mechanics.
The AMA has developed a strong set of principles
and guidelines that I believe will give physicians the
ability to have significant input over any program.

However, to be effective, the AMA must show that it
represents American physicians. The only way to ac-
complish this is by having a robust membership. This
fact is just one of several reasons that ACOG urges
its members to join the AMA. If you are not a member,
please join, and if you are already a member, please
remain a member.

In this age of increasing expenses and declining
revenues, I recognize that you may be cautious before
paying dues to be an AMA member. However, increas-
ing expenses and declining revenues is exactly the
reason that we need a strong AMA fighting for us in
regard to medical liability reform, pay-for-performance
mandates, and belt-tightening regulations.

“Together we are stronger” is the new AMA ap-
proach, and it is true. When you join, please designate
ACOG to represent you in the House of Delegates.
Led by the able leadership of ACOG delegate
Kathleen Fitzgerald, MD, Providence, RI, your dele-
gates and alternates fight hard to protect your prac-
tice and improve your practice. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

- Michael D. Coffey, MD**
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Chesterfield, MO • 6/05
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Obstetrics & Gynecology
HIGHLIGHTS



The following
ACOG documents
are included in the
August issue of
the Green Journal:

**Management of Endometrial
Cancer** (Practice Bulletin #65, new)
See article on page 9.

**Health Care for Homeless
Women** (Committee Opinion #312,
new) See article on page 9.

Hysteroscopy
(Technology Assessment #4, new)



ACOG Today recognized for excellence

ACOG TODAY was honored with two awards recently. For the second year in a row, the newsletter received an APEX Award of Publication Excellence from Communications Concepts Inc. for one- to two-person-produced newsletters. The newsletter also received a bronze EXCEL award from the Society of National Association Publications for “Week calls attention to plight of uninsured,” a cover article in the May/June 2004 issue. The article announced Cover the Uninsured Week and called for ob-gyns to become proactive in the fight for universal health care. ♀

Green Journal series now offers CMEs



ACOG MEMBERS can now earn continuing medical education credits through the Green Journal’s Clinical Expert Series. After reading an article in the series, Fellows answer approximately five questions online at www.greenjournal.org, emailing their answers to the ACOG Cognates Department.

Per test, members can earn a maximum of two category 1 credits toward the American Medical Association’s Physician’s Recognition Award or a maximum of two category 1 ACOG cognate credits. ACOG is accredited by the Accreditation Council for Continuing Medical Education to provide CME programs for physicians.

The program debuts in the August issue of *Obstetrics & Gynecology*. Tests will be available online for three years after publication of each Clinical Expert Series article.

“We have offered CME credit to reviewers and authors, but this is the first time we’ve offered it to readers,” said *Obstetrics & Gynecology* Editor James R. Scott, MD. “We selected the Clinical Expert articles to focus on because we publish one almost every month and they are clinically important, up-to-date articles written from a best-evidence approach by respected authorities.” ♀

info

www.greenjournal.org



New Clinical Update on balance disorders

AT SOME point in their life, many women experience trouble with their balance. This is especially true for pregnant women and elderly women.

A new monograph from ACOG can help ob-gyns identify and manage balance disorders in their patients. *Balance Disorders* (CU016), the latest issue in the ACOG series *Clinical Updates in Women’s Health Care*, was written by experts in the field of balance and fall prevention. ♀

info

www.clinicalupdates.org | 800-762-2264, ext 192

Fellow Dr. Wah elected to AMA board

ACOG IS PLEASED to announce that Fellow Robert M. Wah, MD, Capt, MC, USN, was elected to the American Medical Association board of trustees at the AMA Annual Meeting in June.



Dr. Wah served as a delegate for ACOG in the AMA’s House of Delegates. He was nominated by ACOG and endorsed by the Medical Society of Virginia, the American Society for Reproductive Medicine, and the Association of Military Surgeons of the US.

Dr. Wah chaired the AMA Council on Long-Range Planning and Development and served on the AMA’s Pay-for-Performance Task Force prior to his election. Dr. Wah has served on ACOG’s Executive Board and Health Care Commission and currently serves as associate chief information officer of the Military Health System. His practice of reproductive endocrinology is with the fellowship program at the National Institutes of Health and Walter Reed and Bethesda naval hospitals. ♀

Call for papers, posters, films for 2006 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 2006 Annual Clinical Meeting, to be held May 6–10 in Washington, DC. All abstracts must be submitted online.

The committee also welcomes online submission of abstracts of films for the 2006 Film Festival on topics of interest to practicing ob-gyns.

Submission details and the online application are on the ACOG website, www.acog.org. ♀

Deadlines for online submission

Paper/poster abstracts:
September 16

Film Festival abstracts:
November 18



ACOG helps improve residency programs in Central America

WHEN ACOG APPROVED the creation of a Central America Section in 2001, the new section's leaders had some lofty goals in mind. They wanted to create a single residency accreditation process in Central America and develop an ob-gyn certification exam. Now, their efforts are coming to fruition.

Honduras, Nicaragua, El Salvador, Costa Rica, Guatemala, and Panama, all a part of the Central American Federation of Associations and Societies of Obstetrics and Gynecology, or FECASOG. To develop an accreditation program, the section and FECASOG created the Committee of Accreditation FECASOG-ACOG, or CAFA, which has two representatives from each of the region's six national ob-gyn societies and one member from ACOG.

"It has been a very successful collaboration," said Central America Section Chair Jorge R. Escobedo, MD. "The section has provided money to CAFA and is working to recruit residents to become Junior Fellows of ACOG. In addition, the section has a special interest in organizing scientific events, as a support to the National Conferences of Central American Societies, with the participation of ACOG professors."

CAFA developed objectives modeled after the CREOG education objectives for ob-gyn residents in the US. Then, CAFA developed a set of requirements for ob-gyn residency programs.

CAFA has visited nearly all of the 21 residency programs in Central America.

"By ACOG helping FECASOG accredit its residency programs and administer exams, the College is helping to improve the quality of residency training," said Luis (Ben) Curet, MD, ACOG's CAFA member. "Better education for the residents translates into the ultimate objective, which is better care for women in Central American countries."

Developing relations

ACOG's involvement in Latin America began in 1998 when the College became involved with the Save the Mothers program initiated by the International Federation of Gynecology and Obstetrics, or FIGO. At that time, ACOG was paired up with four Central American countries, Honduras, Nicaragua, El Salvador, and Guatemala, to work together to reduce maternal mortality in those countries. The College is currently preparing its final report of the Save the Mothers project.

During the collaboration, representatives from the countries expressed a desire to expand their relationship with ACOG in the form of a Central America Section.

The successful creation of an accreditation and certification process in Central America has piqued the interest of other Latin American countries. ACOG will be working with the Dominican Republic during the next year to develop a similar program at the request of ob-gyns in that country.

The word has spread about the Central American program partly through ACOG's active participation in its equivalent organizations in the region. ACOG presents programs at the congresses of both FECASOG and the Latin American Federation of Ob-Gyn Societies, or FLASOG.

ACOG Fellows attended the FLASOG Congress in May in Punta Cana, Dominican Republic, where Dr. Curet gave a presentation on the Central American program.

◀ **ACOG Fellows were presenters at the FLASOG meeting in May: Left to right, Eduardo Cordova, MD, of El Salvador; Paulino E. Vigil de Gracia, MD, of Panama; and Luis (Ben) Curet, MD, and Jack Ludmir, MD, both of the US.**



▲ **Ana Celia Diaz-Caceres, MD, a CAFA representative from El Salvador, gives a presentation at a CAFA meeting.**

In addition, Fellows Jack Ludmir, MD, professor and chair of ob-gyn, Pennsylvania Hospital, and Paulino E. Vigil de Gracia, MD, professor of ob-gyn in Panama, presented a two-day course on gestational hypertension.

Dr. Curet encourages other Fellows who are fluent in Spanish to get involved in the College's Latin American outreach programs.

"It's important to increase the visibility of ACOG and encourage ob-gyns in Latin America to take advantage of ACOG's multiple educational opportunities," Dr. Curet said. "Both partners in this endeavor will ultimately be rewarded by the knowledge that all our efforts culminate in the betterment of health care for Latin American women." ♀



¿Habla español? ACOG wants you!

ACOG IS LOOKING FOR Fellows interested in helping to evaluate residency programs in Central America and help with other Latin America projects. Fellows must be fluent in Spanish and have extensive experience working with residency programs. ♀

info

□ Janet Chapin, RN, MPH, ACOG's director of women's health: jchapin@acog.org; 800-673-8444, ext 2579



□PAGE 1 As part of the JSOG meeting, the ACOG residents joined Japanese residents, as well as residents from Sweden, Canada, and Germany, for an international symposium.

“The JSOG president’s vision was to bring an international cohort of young physicians to Japan to talk about the experiences they’ve had at the early stages of their careers so everyone could realize how similar we are in some areas but also how different we are in others,” said Rajiv B. Gala, MD, who was selected by District VII to attend the JSOG meeting.

During the one-day symposium, residents were divided into small groups to debate certain topics, including prenatal testing and diagnosis, oral contraceptive use by teenagers, and whether the fields of obstetrics and gynecology should remain together or be separated.

“A number of the discussions revolved around prenatal tests and whether they’re becoming tests that only the upper class can afford,” Dr. Gala said. “We also discussed the idea that it’s the patient’s choice to have whatever test she wants.”

One of the more heated debates in Dr. Gala’s group was on oral contraceptive use among teenagers. Dr. Gala learned that oral contraceptives are not used much in Japan; people tend to use barrier methods instead.

“They weren’t in favor of using oral contraceptives in younger populations because of rising rates of chlamydia,” he said. “Also, they felt that because the teen pregnancy rate is already low, condoms must be working. . . . It was really just a cultural difference in that they felt that barrier methods were better.”

The residents eagerly attended several scientific sessions.

“There were several interesting scientific sessions from the subspecialists of ob-gyn from different countries,” Shira M. Varon, MD, of District IV, explained. “Headsets were provided to translate Japanese into English for the lectures given in Japanese.”

Soaking up knowledge

The Japan trip gave the US residents the opportunity, early in their careers, to spend time with top ACOG leaders, including ACOG President Michael T. Mennuti, MD; Immediate Past President Vivian M. Dickerson, MD; Past President John M. Gibbons Jr, MD; and ACOG Executive Vice President Ralph W. Hale, MD.

“It was a neat experience for all of us [resi-

dents] to have the opportunity to interact with Drs. Mennuti, Dickerson, Gibbons, and Hale,” Dr. Gala said. “They just seem so untouchable because they’ve done so much in their life, but we were able to spend time with them and hear some of the things they’ve done and lessons they imparted on us.”

In turn, ACOG’s top leaders witnessed how rewarding the program was for the younger physicians.

“The young people at the meeting bonded extraordinarily quickly, and within a few days lasting friendships were established,” Dr. Mennuti said. “I had the opportunity to see some of the people from the Kyoto meeting at a Canadian meeting, and they embraced like long-lost friends and continued the exchange of ideas.”

Experiencing a US ob-gyn meeting

At ACOG’s ACM in May, the Japanese residents were impressed with the warm welcome, the meeting format, and the quality of the sessions.

“We were permitted to join the meeting, and we also had the chance to join receptions and the President’s Dinner Dance,” said Seiji Sumigama, MD. “Participation in receptions provided me many opportunities to speak English with native speakers.”

The US and Japan residents frequently discussed the differences in training and practice.

“We talked about what we were doing—working in a general hospital, in a university hospital, doing scientific experiments in a lab, etc—our subspecialty, our interests, the differences of the residency system between the US and Japan, and so on,” said Yuka Horiuchi, MD, one of the Japanese residents who attended the ACM. “Among some female doctors, we also talked about how to manage the balance between work and family.”

The US-Japan exchange was so successful that the two organizations have decided to continue the program.

“From this trip, I have learned that many of the same challenges that we encounter in our specialty in the United States are present in other countries worldwide,” Dr. Varon said. “If we approach these hurdles united with physicians from an international alliance, our impact will be much greater. The perspective I have gained since this experience has motivated me to be more involved with women’s health policy.” ♀



ACOG Ambassadors

EACH DISTRICT selected a Junior Fellow in residency to attend the JSOG meeting in Kyoto.

DISTRICT I: Meghan E. Ogden, MD

DISTRICT II: George Kontopoulos, MD

DISTRICT III: Sindhu Srinivas, MD

DISTRICT IV: Shira M. Varon, MD

DISTRICT V: Deborah A. Bartz, MD

DISTRICT VI: Alysia D. Turner Townsend, MD

DISTRICT VII: Rajiv B. Gala, MD

DISTRICT VIII: Manda Ghahremani, MD

DISTRICT IX: Sam Siddighi, MD

ARMED FORCES

DISTRICT: Jessica C. Souther, MD



Dr. Hale becomes honorary fellow of Japan ob-gyn society

ACOG EXECUTIVE Vice President Ralph W. Hale, MD, was recognized with honorary fellowship in JSOG during the organization’s 57th annual scientific meeting in April in Kyoto, Japan.

District IX addresses language barriers in health care

THE FEMALE PATIENT SPOKE only Spanish, and the clinician giving the patient her mammogram spoke only English. Therefore, there was little communication between the two, and the patient had no idea what to expect from her first mammogram.

When the mammogram began to hurt, the patient started yelling and said, in Spanish, that she wanted the machine to stop, that she didn't want to feel such awful pressure anymore. Because of the language barrier, the patient was unsure if she was feeling normal pain associated with mammograms or if the test was being done incorrectly.

This real-life experience was described by a woman in a District IX focus group of limited-English-speaking patients.

A second focus group participant sympathized with the woman: "If I don't speak English, and I go have a mammogram for the first time, and it hurts, I'm not going to go back."

Language barriers can be frustrating for both patients and physicians and can compromise care. With a grant from the California Endowment, District IX is examining patient and physician experiences caused by language barriers and developing tools to improve communication. The district has held two patient focus groups and two physician focus groups, is developing a physician survey, and plans to create a physician toolkit.

Developing ob-gyn resources

The project is modeled after one developed by the California Academy of Family Physicians, which developed a toolkit for family physicians about language-access issues. But District IX Fellows wanted to do more than simply adopt the family physicians' toolkit.

"Because ob-gyn addresses unique, sensitive issues such as sexual history, pregnancy history, or domestic violence, we thought it'd be helpful to start at the previous step and hold focus groups to find out what ob-gyns know about limited-English-speaking patients," said ACOG Fellow Elizabeth Gutrecht Lyster, MD, MPH, the project's physician consultant and an ob-gyn in private practice.

In the focus groups, women talked about their experiences with physicians and their staffs who didn't speak their language, how the women felt about the experiences, and how the experiences affected their care and their outlook toward the health care system.

"They discussed how negative experiences due to language problems stay with them," Dr. Lyster said. "If they had a bad experience, they were less likely to access health care in the future."

Even if a physician spoke their language or provided a translator, the women may have had trouble. Sometimes, women were unable to make an appointment with staff over the phone or had difficulty filling out forms.



In the physician focus groups, the ob-gyns shared their experience with limited-English-speaking patients and expressed their concerns about confidentiality when using translators and obtaining accurate information about their patients through translators or from the patients themselves.

"Everyone was concerned about making sure their patients understood their recommendations and instructions and that the patients were comfortable in the office, on labor and delivery, and in the OR," said ACOG Fellow Christopher D. Bencomo, MD, MPP, a member of the project's advisory committee and an ob-gyn at Sequoia Community Health Foundation, Fresno.

To communicate with their patients, physicians in the focus group have used hospital translators, family and friends of the patient, office staff, and telephone translation services.

"Everyone in the focus group had encountered the challenges of working with a population that they could not directly communicate with and the less-than-perfect results of the various interpretation choices available," Dr. Bencomo said.

Translation difficulties

While the physicians recognized the potential pitfalls with using office staff or family members as translators, sometimes there's no alternative, particularly for less-common languages.

Family members and office staff untrained in medical translation may not understand the medical terms or be able to accurately explain a diagnosis or treatment.

In addition, ob-gyn care deals with sensitive issues that the patient may not want to discuss in front of a family member, such as the English-speaking son who drove his mother to her doctor's appointment, Dr. Lyster said.

District IX distributed a survey to all ob-gyns in its district this summer and expects to have results in October. ♀

Experiences of limited-English-speaking patients

"[When you have good communication with your doctor], you feel like you are a person and you deserve to be heard."

"I think [what] makes a bad doctor is when they don't have the patience to try to communicate and understand, and that really hurts. You can't tell them more—you wish you could—but they don't give you time."

"If you don't have insurance and you go to places where you say 'I don't have insurance,' right away, the secretary looks at you in a different point of view."

"When people don't speak English, [clinicians] don't speak to them—because I've been interpreting, and [the clinician] would look at me. Tell them this or that; they don't look at [the patient]."

**Comments taken from District IX patient focus group*

Routine episiotomy offers no maternal benefits

Routine use of episiotomy does not offer any benefits to patients, a recent review of scientific evidence found. However, it is estimated that 30% to 35% of vaginal births in the US still include episiotomies, according to the review, published in the May 4 issue of the *Journal of the American Medical Association*.

ACOG requested the review from the Agency for Healthcare Research and Quality.

ACOG's *Guidelines for Perinatal Care* (fifth edition) cautions against routine episiotomy use: "Episiotomy may be used to aid in the management of delivery in some situations. The routine use of episiotomy is not necessary and may lead to an increase in the risk of third- and fourth-degree perineal lacerations and add to a delay in the patient's resumption of sexual activity."

The use of episiotomy had been believed to prevent pelvic floor disorders and tearing of the perineum and was a common practice in the US during much of the 20th century. After researchers in the 1980s and '90s began studying episiotomy outcomes, rates declined. However, episiotomy use varies widely among practices, suggesting that use is "heavily driven by local professional norms, experiences in training, and individual practitioner preference rather than variation in the needs of individual women at the time of vaginal birth," according to the *JAMA* review.

Episiotomy doesn't prevent pelvic floor disorders

In the review, researchers found that episiotomy doesn't prevent urinary or fecal incontinence, pelvic organ prolapse, or difficulties

with sexual function in the three months to five years after delivery.

In fact, women in the routine episiotomy groups were almost twice as likely to have persistent incontinence of stool or flatus. No research studied the long-term effects of episiotomy.

When providers restricted episiotomy use, patients were less likely to have perineal damage and need suturing and more likely to resume intercourse earlier.

The findings show that immediate outcomes after routine use of episiotomy are no better than outcomes after restrictive use, according to the researchers.

Researchers concluded that routine use is actually harmful because some women who would have had a lesser injury had an episiotomy instead. ♀

Develop referral resources for your patients

DURING A PRECONCEPTION office visit your 32-year-old patient admits that she uses cocaine and is worried she won't be able to stop when she becomes pregnant. Do you know of substance abuse services in her part of town? What if she doesn't have insurance to cover their program?

Or, a 16-year-old patient asks for help in finding a weight-loss program. Is the hospital-based nutritionist to whom you referred your 43-year-old patient the best resource for this teen?

As primary care physicians to many patients, ob-gyns are called upon to help patients with a wide array of health and social issues that go beyond obstetrics and gynecology. Is your practice adequately prepared to refer patients to programs and services they need?

Match referral resources to your patient population

Fellow Maureen G. Phipps, MD, MPH, urges ob-gyns to compile a list of community resources for patient needs before a need arises.

"A robust, helpful list of such resources takes time to put together, but it pays off when you need it," said Dr. Phipps, a member of ACOG's Committee on Health Care for Underserved Women and director of the National Center of Excellence in Women's Health at Brown University/Women & Infants Hospital, Providence, RI.



Tap hospitals for their lists

Local hospitals and emergency departments are likely to have a head start on compiling information about community resources. Check with the hospital social services director or outreach department, or talk to the emergency department director.

Dr. Phipps is adapting a list first developed by Women & Infants Hospital. The resources are organized alphabetically by topic, from adoption and asthma to walk-in clinics and weight loss.

Many of the Medicaid organizations and safety-net service consortiums also have very helpful patient support services that ob-gyns should be aware of, according to Deborah M. Smith, MD, MPH, another member of the Committee on Health Care for Underserved Women.

Dr. Smith suggested checking websites of nonprofit organizations such as the American Cancer Society and the Lupus Foundation for information about their local affiliates.

Follow up after referral

After you refer a patient, be sure to ask her about the referral resource.

"The physician or staff person should obtain feedback from patients on the referral service to be aware of changes and to find out how well the service met her needs," Dr. Smith said. ♀

Shoulder dystocia: a rare but frightening OB complication

Shoulder dystocia occurs in only about 1% of vaginal deliveries, but when it happens, there's little warning and a normal delivery suddenly becomes an emergency situation. Shoulder dystocia occurs when the anterior fetal shoulder gets stuck behind the mother's pubic symphysis or when the posterior fetal shoulder gets stuck on the sacral promontory, halting the delivery.

When this happens, the ob-gyn alerts the nursing and OB team, and everyone coordinates their efforts to promptly free the baby without injury to the child or the mother. If they are unable to relieve the shoulder dystocia quickly enough, the baby is at risk of losing oxygen. But acting too quickly could lead to the improper performance of the maneuvers to free the impacted shoulder.

ACOG Fellow Robert B. Gherman, MD, explains why the thought of shoulder dystocia can make any doctor anxious: "It's an unpredictable emergency, and you have a relatively short period of time to alleviate it, and there's a risk of neonatal injury."

Shoulder dystocia cannot be predicted

Some physicians believe that shoulder dystocia can be predicted by attempting to estimate the birth weight or by recognizing that a pregnant woman has diabetes, according to Dr. Gherman, who has researched shoulder dystocia and is the department chair at Washington Adventist Hospital, Takoma Park, MD.

Physicians who believe they can predict shoulder dystocia may try to avoid its occurrence by inducing labor or doing a prophylactic cesarean delivery. However, the ACOG Practice Bulletin *Shoulder Dystocia* (#40, November 2002) does not recommend inducing labor or performing a cesarean delivery for the sole indication of suspected macrosomia.

"We're trying these things because we think we can predict shoulder dystocia, but we can't," Dr. Gherman said.

While fetal macrosomia and maternal diabetes increase the risk of shoulder dystocia,

many cases occur among women without diabetes and among infants weighing less than 4,000 grams at birth, according to the Practice Bulletin. The document cites a study that found that both diabetes and macrosomia predicted 55% of the cases of shoulder dystocia but also points out several other studies that could not find any combination of risk factors that accurately predicts its occurrence.



"It's an unpredictable emergency, and you have a relatively short period of time to alleviate it, and there's a risk of neonatal injury."

The McRoberts and other maneuvers

When shoulder dystocia does occur, there are several maneuvers ob-gyns can attempt. According to the Practice Bulletin, the McRoberts maneuver is a reasonable initial maneuver. However, there's little data to show which maneuver is more effective at alleviating shoulder dystocia without injury.

"If the McRoberts maneuver doesn't work by itself, the perfect sequence after that isn't known," said Sean C. Blackwell, MD, assistant professor of ob-gyn, Wayne State University, Detroit, and co-author of the *Shoulder Dystocia* Practice Bulletin. "There are several options; however, it's not as important which maneuver the physician chooses to use next—

for example, suprapubic pressure versus rotation of fetal shoulders—but that the maneuvers are performed, if possible, in an organized and coordinated manner."

Shoulder dystocia as a medical liability risk

Obstetrics is one of the hardest-hit specialties in today's medical liability climate, with an average of 2.6 claims filed against ob-gyns during their career. Although studies show that shoulder dystocia is unpredictable and that most cases of brachial plexus injuries do not lead to permanent disability, ob-gyns may still be blamed and sued.

"Lawsuits are not uncommon when there is severe neonatal injury," Dr. Blackwell said. "Families are not expecting it since its occurrence is so unpredictable, and these children do often suffer with long-term physical therapy requirements, potentially multiple surgeries, and lifelong handicaps. Often the response to this crisis is to sue the obstetrician, regardless of the circumstances."

To prepare for shoulder dystocia, Dr. Blackwell recommends that physicians and their OB teams practice maneuvers and discuss procedures through shoulder dystocia drills. ACOG offers a videotape on such drills through the ACOG bookstore. The video provides recommendations for how to conduct drills and shows live deliveries, computer animations, and vintage film excerpts. The video uses a coordinated team approach to demonstrate primary and secondary maneuvers. Primary maneuvers shown include the McRoberts, episiotomy, and rotation of the baby using suprapubic or intravaginal pressure. ♀

info

- ACOG Practice Bulletin *Shoulder Dystocia* (#40, November 2002): Published in ACOG's 2005 *Compendium* or find by doing an "advanced search" on the ACOG members-access website, www.acog.org
- ACOG *Shoulder Dystocia Drill* video: Order at <http://sales.acog.org>; 800-762-2264, ext 192



New Committee Opinion focuses on care of homeless women

NEARLY ONE-THIRD of the homeless in the US are women, and women are one of the fastest growing subgroups among the homeless. It's no surprise that homeless women are less likely to be able to get appropriate health care, but a new ACOG Committee Opinion offers recommendations on how ob-gyns can help.

Health Care for Homeless Women (Committee Opinion #312) was written by the ACOG Committee on Health Care for Underserved Women and published in the August issue of *Obstetrics & Gynecology*.

Contributing factors to homelessness include job loss, personal or family crisis, an increase in rent, reduction in public health benefits, and early motherhood.

The majority of homeless people seek care in hospital emergency departments, with only 27% having an established am-

bulatory care provider, according to the Committee Opinion. Barriers to obtaining needed care include lack of health insurance, transportation to care, and availability of shelters and treatment facilities, and competing needs for survival (food, clothing, shelter).

Violence is common among homeless people, and a disproportionate number of homeless women suffer from posttraumatic stress disorders, major depression, and substance abuse. Homeless women are unlikely to use condoms regularly, despite their high risk for STDs and HIV infection, and are likely to have low rates of breast exams, mammograms, and Pap tests. Unintended pregnancy rates are high in the homeless population, and adverse birth outcomes are substantially higher in homeless women than in the general population. ♀

How ob-gyns can help

The new Committee Opinion offers several recommendations for ob-gyns, including:

- ▶ Caring for the homeless in individual practices without bias
- ▶ Seeking donations of medications from pharmaceutical companies for use in homeless clinics and shelters
- ▶ Working with medical schools and residency programs to encourage modification of the educational curriculum to increase awareness of the problems associated with homelessness and to involve medical students and residents in care for the homeless as part of their training

New Practice Bulletin informs the generalist about endometrial cancer

MORE THAN 40,000 WOMEN will be diagnosed with endometrial cancer this year in the US. Because it's the most common female genital tract malignancy, nearly all ob-gyns will encounter the disease sometime in their career.

A new ACOG Practice Bulletin provides information on the epidemiology, pathophysiology, and management of endometrial cancer, which will allow ob-gyns to identify women at increased risk, contribute toward risk reduction,

help diagnose cases early, and assist in treatment decisions.

Management of Endometrial Cancer (Practice Bulletin #65) was written in partnership with the Society of Gynecologic Oncologists

and published in the August issue of *Obstetrics & Gynecology*.

"This important collaboration between ACOG and SGO provides a distillation of important scientific data relevant to all practitioners," said James W. Orr Jr, MD, immediate past president of SGO. "The comprehensive guidance offered for the management of endometrial cancer should contribute to improving patient outcome; in particular, the recognition and understanding that the histologic findings obtained during systematic surgical staging can direct future management, lessening the necessity, risks, and expense of over- or under-treatment."

Treatment of endometrial cancer

The Practice Bulletin recommends that most women with endometrial cancer should undergo complete systematic surgical staging, including pelvic washings, bilateral pelvic and paraaortic lymphadenectomy, and complete resection of all disease. Women with atypical

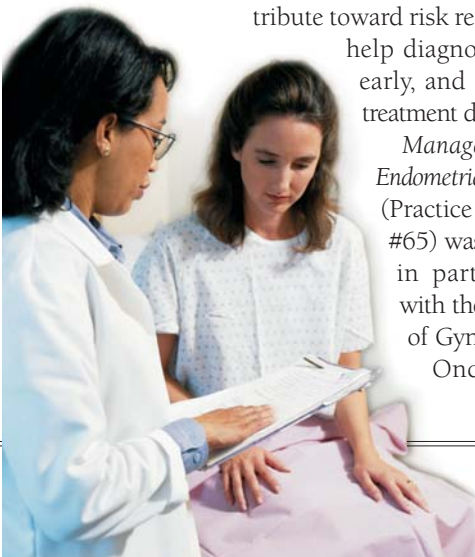
endometrial hyperplasia and endometrial cancer who want to maintain their fertility may be treated with progestin therapy.

To detect any recurrent disease, patients who have not received radiation therapy should undergo pelvic exams every three to four months for two to three years, then twice a year, after surgical treatment of the cancer.

The Practice Bulletin answers several questions regarding clinical considerations and recommendations, such as:

- ▶ What elements of preoperative evaluation are useful for women with endometrial cancer?
- ▶ What constitutes appropriate staging for women with endometrial cancer?
- ▶ How are patients with intraperitoneal disease or cervical involvement managed?
- ▶ What are the recommendations for women found to have endometrial cancer after a hysterectomy?

The document also outlines instances in which patients may benefit from referral to a gynecologic oncologist. ♀



Online Junior Fellow elections held in August

TAKE A FEW MINUTES THIS MONTH to cast your vote in the Junior Fellow district elections. Junior Fellow elections will be held online August 1–31. Junior Fellows can review candidates' names and CVs online before voting.

To cast your vote, follow these simple rules:

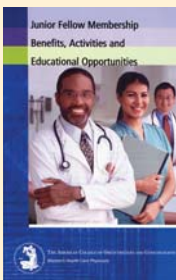
- ▶ Know your ACOG ID number. This seven-digit member number is listed on all ACOG mailings, as well as the election email reminders that were sent in July
- ▶ Log on to <https://eballot3.votenet.com/acog> to review candidate bios and election information
- ▶ Vote August 1–31 at the above website

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. ♀

info

- Vote: <https://eballot3.votenet.com/acog>
- ACOG ID: Membership Department at 800-673-8444; membership@acog.org
- Election updates: visit the Junior Fellow section under "Membership" on the ACOG website, www.acog.org
- Questions: Christine Himes, 800-673-8444, ext 2561, or chimes@acog.org

New brochure details Junior Fellow membership benefits



A NEW ACOG BROCHURE offers an all-encompassing look at the numerous membership benefits for Junior Fellows. The brochure, which was developed by the Junior Fellow College Advisory Council, will be mailed to all new Junior Fellows with their new member packets and can also be used by residency program coordinators to encourage residents to join ACOG.

"The brochure was developed because there are so many levels and capacities at which Junior Fellows can get involved with ACOG, but many are unaware of these opportunities," said JFCAC Chair May Hsieh Blanchard, MD. "This brochure provides a comprehensive listing of what ACOG offers to Junior Fellows and also outlines how Junior Fellows can contribute to our specialty through ACOG activities. The educational and professional rewards of ACOG involvement are tremendous."

The brochure provides information on:

- ▶ Officer positions and committee appointments open to Junior Fellows
- ▶ Educational opportunities, including several research awards
- ▶ Publications available through ACOG
- ▶ National, district, and section activities
- ▶ The Stump the Professors session at the Annual Clinical Meeting
- ▶ The ACOG Future Leaders Conference ♀

info

- For copies of the brochure: 800-673-8444, ext 2344; akhalaf@acog.org



Essay about mentor due by November 15

Successful essay contest returns

BECAUSE LAST YEAR'S contest was so successful, the Junior Fellow College Advisory Council is sponsoring another essay contest this year to promote enthusiasm within the specialty.

The contest, which is open to all Junior Fellows, will focus on the theme "How My Ob-Gyn Mentor Influenced Me." The essays should be between 500 and 750 words and should not mention the specific names of any mentors. All essays must be submitted online by November 15.

One winner will be selected from each district to receive \$500. A grand-prize winner will be selected from the district winners and receive an additional \$500 plus an all-expenses-paid trip to the 2006 Annual Clinical Meeting in Washington, DC. (The prize includes ACM registration fee, coach airfare, and two to three days per diem for room and board.) ♀

info

- Visit the Junior Fellow section under "Membership" on the ACOG website, www.acog.org
- Christine Himes, 800-673-8444, ext 2561, or chimes@acog.org

Residents happy with new work-hour restrictions

NEARLY THREE-FOURTHS of residents surveyed by ACOG approve of the effects of the new work-hour restrictions implemented in 2003 by the Accreditation Council for Graduate Medical Education.

Questioned as part of a CREOG survey, 72% of residents said the restrictions have had a positive impact on their education, while 13.8% said there was a negative impact and 13.4% said there was no impact. Furthermore, 81.8% of residents said the restrictions had a positive impact on their personal lives, while 3% said they had a negative impact, and 14.1% said they had no impact.

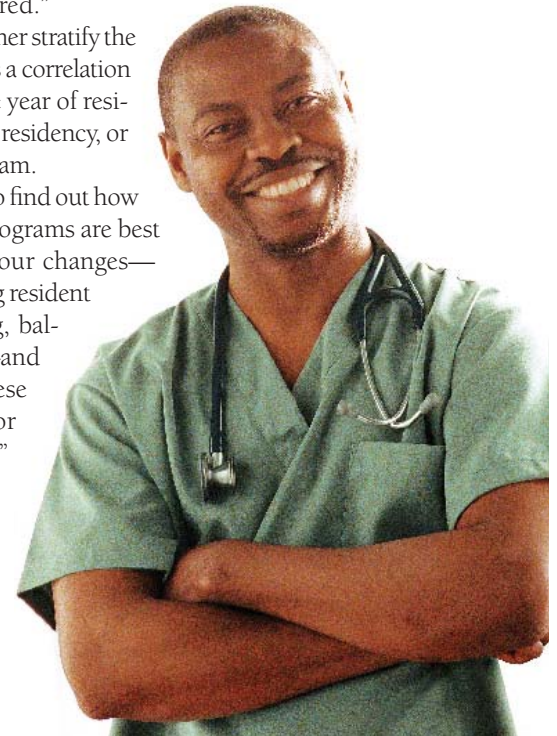
For more than a year, the Junior Fellow College Advisory Council has been examining the effects of the restrictions, which limit residents to an 80-hour work week on average, require a 10-hour rest between duty periods, set a 24-hour limit on continuous duty, and limit in-house on-call duty to no more than once every three nights.

The JFCAC is now analyzing the results of the survey to determine if further study on the effects of the restrictions is needed. While the survey shows that the majority of residents approve of the effect on their education, some Fellows and Junior Fellows have expressed concern about a shift-work mentality, a lack of continuity of care, and decreased time in surgical training.

“The initial results of the CREOG survey were somewhat surprising in the positive impressions reported on the part of the responding residents,” said JFCAC Chair May Hsieh Blanchard, MD. “We’re happy to see that the changes have not had the onerous impact we had originally feared.”

The JFCAC plans to further stratify the survey data to see if there is a correlation between responses and the year of residency, location and size of residency, or size of the residency program.

“Ultimately, our goal is to find out how residents and residency programs are best implementing the duty-hour changes—with the goal of maximizing resident education and well-being, balanced with patient care—and hopefully disseminate these best practices to all Junior Fellows and their programs,” Dr. Blanchard said. ♀



info

□ Share your experiences and/or concerns about the work-hour restrictions. Email letters to the editor to mpadgett@acog.org or fax letters to 202-863-5473. Include your full name and city and state.

Looking for a great job?

POST RESUMES and search for the perfect women's health job through the ACOG Career Connection. The service is free to job seekers, offering ob-gyns more features and greater functionality than other job banks.

The search function allows job seekers to search by job positions, locations, and keywords. Employers can search through online responses to job postings and can quickly search the candidate's profile, review his or her CV, and contact the candidate online.

Career Connection is a part of the *HEALTHeCAREERS* Network.

Candidates can also:

- ▶ Send a CV and cover letter online
- ▶ Receive email notifications of new listings
- ▶ Track current and past activity
- ▶ Access personal assistance toll-free five days a week ♀

info

- Click on the ACOG Career Connection logo on the ACOG home page, www.acog.org
- 888-884-8242; info@healthcareers.com

Application deadline: October 1

HELP for residents in training

FINANCIAL ASSISTANCE IS available to residents 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, or tsmith@acog.org

States achieve medical liability reform wins

PAGE 1 At press time, the bill was awaiting signature by the governor. Illinois physicians embarked on a three-year campaign for medical liability reform in a state where the Supreme Court has twice rejected caps on medical liability awards and where a Democratic governor and an entrenched Democratic legislative majority oppose caps.

AK The Alaska Legislature lowered the state's cap on noneconomic damages from \$400,000 to \$250,000 except in wrongful death cases or cases of severe permanent physical impairment in which the person is more than 70% disabled. In those cases, noneconomic damages were lowered from \$1 million to \$400,000.

It takes a multipronged effort

ACOG members were very active lobbying for medical liability reform in Georgia and South Carolina.

SC South Carolina's new law includes a \$350,000 cap on noneconomic damages that applies to each health care professional and institution, which means that when multiple health care professionals or health care institutions are

involved, a plaintiff can receive up to a total of \$1.05 million in noneconomic damages with a single defendant not liable for more than \$350,000. The cap will be adjusted annually based on the Consumer Price Index.

Both the Georgia and South Carolina laws include important liability protections for ob-gyns handling emergency "drop-in" deliveries. In such cases, if the obstetrician has not previously treated the pregnant woman during her pregnancy, the ob-gyn is not liable for claims unless there is gross negligence.

GA Georgia also instituted a \$350,000 stacked cap modeled on the Texas law passed two years ago.

"It takes a multipronged effort," said ACOG Fellow Gregory C. Cook, MD, president of the Georgia Obstetrical and Gynecological Society. "First of all, the health care community in Georgia was united and focused together on the issue. We surveyed the state and were able to document by physician name and city that about 15% of the ob-gyn work force was leaving or retiring. The ob-gyn society hired a full-time lobbyist in addition to our regular lobbyist, and I went to the Capitol once a week during the session to meet with legislators." ♀

- ARIZONA
- CONNECTICUT
- GEORGIA
- ILLINOIS
- LOUISIANA
- MAINE
- MISSOURI
- MONTANA
- NEW HAMPSHIRE
- SOUTH DAKOTA
- VIRGINIA
- WEST VIRGINIA

Apology laws catch on

TWELVE STATES THIS YEAR passed "I'm Sorry" laws, which protect physicians' apologies or expressions of sympathy from being used against them in a liability claim. These laws have only recently caught the attention of legislatures.

Illinois went a step further than most and approved the "Sorry Works!" pilot program, which will be implemented in one hospital the first year and a second hospital in year two. Under the program, "participating hospitals and physicians shall promptly acknowledge and apologize for mistakes in patient care and promptly offer fair settlements," according to the legislation. The state will collect data to compare the hospital's liability claims costs before and during the program to determine the effectiveness of Sorry Works!

At press time, the Illinois and Connecticut laws were awaiting governor signatures. ♀



Bill would fund investigation of tort litigation alternatives

LEGISLATION INTRODUCED in the US Senate would allow for state grants to develop, implement, and evaluate alternatives to current medical tort litigation. The "Fair and Reliable Medical Justice Act," or S. 1337, was introduced at the end of June by Sens. Michael Enzi (R-WY) and Max Baucus (D-MT).

"ACOG applauds the leadership of Sens. Enzi and Baucus for their willingness to identify innovative and effective solutions for resolving medical liability litigation in this country," said ACOG President Michael T. Mennuti, MD. "The liability crisis is worsening every day and is affecting every aspect of our nation's ability to deliver health care services. Reform measures to help curb this escalating crisis are desperately needed and are needed now."

While ACOG advocates national reform to end the medical liability crisis, including a reasonable cap on noneconomic damages, the College recognizes that a comprehensive, multifaceted approach is needed. The state demonstration projects would provide an opportunity to explore strategies that complement a national solution.

The bill would authorize the US secretary of health and human services to award demonstration grants for such alternatives as special health care courts, which would help guarantee that injured patients are fairly, quickly, and fully compensated for their economic and noneconomic damages.

Special courts would also take injury claims out of the adversarial tort system, where facts are often poorly understood, and put them into the hands of experts whose goals are fairness and patient safety. ♀

YOU ASKED, WE ANSWERED

Coping with a crisis in your professional liability coverage

Q HOW DO I COPE with an unaffordable hike in my professional liability insurance premium, or worse yet, deal with an unexpected policy cancellation?

A TALES OF OB-GYNS suddenly learning that their professional liability insurance premium will double next year or being notified that their policy will not be renewed are becoming all too familiar. A few strategies may help you overcome these situations.

Try to salvage the situation

- ▶ File an appeal with the insurer. Become familiar with your carrier's process for appealing unreasonable premium increases or nonrenewal decisions before you are faced with a crisis.
- ▶ Enlist the help of your state insurance commissioner. The National Association of Insurance Commissioners' website, www.naic.org, can help you locate contact information. The insurance department may be able to mandate an emergency extension of your coverage if the policy has been cancelled. Use the extra time to explore other options for coverage.

Reduce coverage limits

- ▶ Determine whether state law mandates coverage limits. If not, lower your per-claim and aggregate limits to lower your premium.
- ▶ Be sure to determine whether hospital staff bylaws and managed care contracts will permit you to carry lower coverage amounts.
- ▶ Find out whether your carrier or another carrier will offer a lower premium if you have a deductible, which would require you to pay all damages up to the amount of the deductible.
- ▶ Make sure your personal asset protection plan is strong if you lower your coverage limits. You assume more risk in the event of a successful claim against you.

Explore other sources of coverage

- ▶ If you have been labeled a poor insurance risk, or have a negative claims history and are otherwise unable to obtain coverage, as an ACOG Fellow or Junior Fellow you have access to the services of an insurance broker who can help you find insurers writing coverage in your state. Contact Mark Giamalva at JLT Services Corporation, 800-214-8122.
- ▶ As a last resort, if you cannot find insurance from conventional sources, look into secondary market insurers, also known as "surplus lines." Be aware, though, that coverage in the secondary market will probably be significantly more expensive.

Change your employment situation

- ▶ Your hospital may be able to provide coverage. You may have to become an employee or contractor of the hospital to avoid trouble with laws banning kick-backs and self-referrals. Consult an attorney before launching an arrangement with the hospital.
- ▶ Think about affiliating with a larger group. Some very large groups may have established their own captive plans; others may be able to negotiate for lower premiums. If you do end up deciding to relocate or close your practice, you will need to obtain tail coverage unless you had an occurrence policy. In addition, you will need to provide patients with adequate notice to avoid charges of patient abandonment. ♀

info

liability@acog.org



Handling the emotional toll of a lawsuit

A YOUNG OB-GYN was dealing with a complex case in which the patient was at risk for a bleed from a placental abnormality. Despite planning for back-up and holding and recording a detailed informed consent session, the ob-gyn was later sued.

An obstetric emergency left the patient recovering slowly in the intensive care unit, where she later died from cardiac arrest after a fatty emulsion feeding was administered through the patient's intravenous line instead of her stomach tube.

Although the ob-gyn had done everything right during the OB emergency, she was devastated by the death and was certain she would be sued. She began to doubt herself and have trouble closing abdomens, obsessed that each patient would bleed to death.

This real-life tale is described in the

new book *Adverse Events, Stress, and Litigation: A Physician's Guide*, written by Sara C. Charles, MD, a psychiatrist who has worked with ACOG on medical liability issues for nearly 20 years, and Paul R. Frisch, JD.

While most ob-gyns who are sued end up winning their medical liability case, the lawsuits still take a toll, and this new book shows physicians how to deal with the stress through every step of a lawsuit.

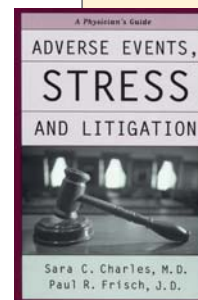
The book goes hand-in-hand with a new website, www.physicianlitigationstress.org, recently developed by Dr. Charles and four colleagues, including Larry L. Veltman, MD, chair of the ACOG Committee on Professional Liability.

The book uses true tales from physicians to illustrate how lawsuits affect physicians.

The book also educates physicians about the legal steps they can expect and covers the controversial topic of disclosure. ♀

info

- ▢ The new litigation stress website also has information on how to order the book *Adverse Events, Stress, and Litigation: A Physician's Guide*: www.physicianlitigationstress.org



Medem unveils online patient health record

MEDEM HAS DEVELOPED a system that allows patients to create their own online health records. Launched in May, the Interactive Health Record, or iHealthRecord, is a free service to patients in which they can store information about their medical conditions, history, and medications, which can then be viewed by physicians of their choosing.



ACOG members can access the records at no charge through their Medem websites or at www.ihealthrecord.org. Patients can also print out their records to give to physicians and create wallet cards listing allergies and emergency contact information.

The iHealthRecord includes:

- ▶ Automated education programs specific to a patient's conditions and medications
- ▶ Patient-physician secure email and online consultation as an optional service

The iHealthRecord access and content is controlled by the patient.

Medem is working to integrate the iHealthRecord with e-prescribing and electronic medical records and other applications. ♀

info

- ▶ www.ihealthrecord.org
- ▶ Questions: info@medem.com; 877-926-3336

Postgraduate course focuses on latest practice management issues

LIKE MANY OB-GYNs, are you working faster and harder? Is your practice considering electronic medical records? Do you understand the new consumer-driven health plans and how they affect your bottom line? Will pay-for-performance programs help or hurt you and your patients?

The ACOG postgraduate course *Practice Management Update for the Ob-Gyn* is designed to help you find answers to these and other questions. The three-day course will be held November 11–13 at the Hotel Del Coronado in Coronado, CA. Each day focuses on different management skills, issues, and topics for both physicians and practice managers.

"This seminar will bring together, as faculty, proven experts who will focus on contemporary practice management issues such as the pay-for-performance movement and the office-imaging controversy," said course director Robert W. Yelverton, MD, CEO and medical director of Tampa Bay Women's Care in Florida. "They will also provide an update on proven methods to enhance quality and

office efficiency while increasing revenue through the use of new electronic technology, improved contracting, practice consolidation, development of ancillary services, and utilization of advanced nurse practitioners."

Dr. Yelverton will discuss practice consolidation and profitability, office-based surgeries, and benefiting from ancillary services.

Arnold Cohen, MD, Albert Einstein Medical Center in Philadelphia, will discuss strategies for implementing electronic medical records in a medical practice. He will also discuss negotiations for physicians and the current controversy surrounding office ultrasounds.

Thomas R. Kay, MD, Garden State Ob-Gyn, Voorhees, NJ, will focus on building and maintaining physician networks and extending your practice with mid-level practitioners.

L. Michael Fleischman, FAAHC, Gates Moore and Company in Atlanta, will discuss goal setting in the medical practice, pay-for-performance, patient safety, and the new consumer-driven health plans. ♀

info

- ▶ To register, go to www.acog.org; click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Or call, 800-673-8444, ext 2540 or 2541
- ▶ Questions about the course? Call 800-673-8444, ext 2444



Young Fellow discussion group launched

ACOG YOUNG FELLOWS can brainstorm and swap ideas with peers year-round thanks to a new online discussion group available through the young Fellows' section of the ACOG website, www.acog.org.

Young Fellows are defined as Fellows who are younger than 40 or who are within their first five years of fellowship. (The Executive Board voted in February to change the definition to "eight years of fellowship," but the College bylaws must be amended in 2006 before the change can take effect.)

"This new forum is an exciting opportunity for young Fellows to exchange ideas with their peers and for ACOG to identify issues of importance to young Fellows," said Erin E. Tracy, MD, MPH, one of two young Fellow representatives on the Executive Board. Dr. Tracy and Laura A. Dean, MD, serve on the Executive Board as Fellows-at-Large. ♀

info

- ▶ Log on to the young Fellows discussion group at www.acog.org. Click on "young Fellows" under "Membership"

2005 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

AUGUST

2

ACOG WEBCAST: Medicare Rules for Documenting Evaluation and Management Services

1-2:30 pm ET
800-673-8444, ext 2498

SEPTEMBER

6

ACOG WEBCAST: How to Survive an Audit

1-2:30 pm ET
800-673-8444, ext 2498

14-18

ACOG District I Annual Meeting

Quebec City, QC
800-673-8444, ext 2531

22-25

ACOG District VII Annual Meeting

San Antonio
800-673-8444, ext 2540

22-25

ACOG District VIII Annual Meeting

San Antonio
800-673-8444, ext 2540

25-29

15th World Congress on Ultrasound in Obstetrics & Gynecology

Vancouver, BC
www.isuog2005.com

27-30

Royal College of Obstetricians and Gynaecologists 6th International Scientific Meeting

Cairo, Egypt
pioneerevents@yahoo.com
www.rcog2005.com

28-Oct 1

NAMS: North American Menopause Society

San Diego
www.menopause.org
440-442-7550

29-Oct 1

The American Gynecological and Obstetrical Society and the American Association of Obstetricians and Gynecologists Foundation

Victoria, BC
www.agosonline.org
800-673-8444, ext 1648

30-Oct 2

ACOG District V Annual Meeting

Toronto, ON
800-673-8444, ext 2540

30-Oct 2

ACOG District VI Annual Meeting—Fellows

St. Thomas, Virgin Islands
800-673-8444, ext 2540

OCTOBER

4

ACOG WEBCAST: Managing Adverse Outcomes

1-2:30 pm ET
800-673-8444, ext 2498

15-19

61st Annual Meeting of the American Society for Reproductive Medicine (in conjunction with the 51st Annual Meeting of the Canadian Fertility and Andrology Society)

Montreal, QC
www.asrm.org
205-978-5000

20-24

Academy of Breastfeeding Medicine Annual Meeting

Denver
www.bfmed.org/meeting.html

28-30

ACOG District II Annual Meeting

New York City
518-786-1529

28-30

ACOG District III Annual Meeting

Los Cabos, Mexico
916-442-8865

28-30

ACOG District IV Annual Meeting

Los Cabos, Mexico
916-442-8865

28-30

ACOG District IX Annual Meeting

Los Cabos, Mexico
916-442-8865

30-Nov 2

ACOG Armed Forces District Annual Meeting

Seattle
800-673-8444, ext 2540

NOVEMBER

1

ACOG WEBCAST: Complications of Laparoscopic Surgery

1-2:30 pm ET
800-673-8444, ext 2498

4-8

American Medical Association Interim Meeting

Dallas
www.ama-assn.org
800-673-8444, ext 2515

9-12

Global Congress of Minimally Invasive Gynecology—34th Annual Meeting of the American Association of Gynecologic Laparoscopists

Chicago
www.aagl.org
800-554-2245 or
714-503-6200

DECEMBER

2-4

ACOG District VI Annual Meeting—Junior Fellows

Minneapolis
800-673-8444, ext 2540

6

ACOG WEBCAST: Preview of New Codes for 2006

1-2:30 pm ET
800-673-8444, ext 2498

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 and CPT Coding Workshops" under "Meetings"
- Registration must be received one week before the course. Onsite registration subject to availability.

AUGUST

5-7

CPT and ICD-9-CM Coding Workshop

Dearborn, MI

SEPTEMBER

6-8

Special Problems for the Advanced Gynecologic Surgeon

Laguna Niguel, CA

9-11

Screening in Ob-Gyn

Laguna Niguel, CA

16-18

CPT and ICD-9-CM Coding Workshop

Atlanta

23-25

CPT and ICD-9-CM Coding Workshop

Memphis, TN

OCTOBER

7-9

CPT and ICD-9-CM Coding Workshop

Las Vegas

NOVEMBER

11-13

Practice Management Update for the Obstetrician- Gynecologist

Coronado, CA

12-13

No Frills—Operative Hysterectomy

Chicago

18-20

CPT and ICD-9-CM Coding Workshop

Washington, DC

DECEMBER

1-3

Complications in Obstetrics

New York City

2-4

CPT and ICD-9-CM Coding Workshop

Sante Fe, NM

8-10

Pearls from Ob-Gyn

Chicago



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Debuting in January 2006 will be the fifth edition of *Gynecologic Oncology and Critical Care* (formerly titled *Gynecologic Oncology and Surgery*). ♀

info

- PROLOG registrar: 800-673-8444, ext 2569
- Order PROLOG units at <http://sales.acog.org>; 800-762-2264, ext 192

Unit	Edition	Credit Through
<i>Reproductive Endocrinology and Infertility</i> (2000)	4th	2005
<i>Gynecologic Oncology and Surgery</i> (2001)	4th	2006
<i>Gynecology and Surgery</i> (2004)	5th	2006
<i>Patient Management in the Office</i> (2002)	4th	2007
<i>Reproductive Endocrinology and Infertility</i> (2005)	5th	2007
<i>Obstetrics</i> (2003)	5th	2008

Get answers to your coding questions

DO YOU HAVE A CODING QUESTION? Facing a coding conundrum? Help is available. Fellows or their staff can submit specific questions to ACOG's coding staff.

Submit questions by email to Terry Tropin at ttropin@acog.org or Savonne Alford at salford@acog.org or by fax to 202-484-7480. Please do not include any identifiable Protected Health Information in your email or fax. Questions are answered in approximately three to four weeks. ♀



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APGO creates competencies on women's health

THE APGO Women's Healthcare Education Office has developed new competencies to teach medical students about sex and gender differences in health and disease. The resource, titled *Women's Health Care Competencies for Medical Students: Taking Steps to Include Sex and Gender Differences in the Curriculum*, is available online at no charge.

The competencies link learning objectives to suggested evaluation methods, residency-level competencies, and references in current literature. They also distinguish sex and gender differences in a variety of topics, including cardiovascular health, pharmacology, reproductive health, domestic violence, and health care access.

Grants available

Thanks to a grant from the Ford Foundation, WHEO has funds available to support five curriculum development projects to integrate sex and gender differences in health and disease into the medical school curriculum, using the new women's health care competencies.

A total of \$30,000 is available over two years for each grant-winning institution. Applications must be submitted online by October 3. ♀

info

- www.apgo.org/wheocomp
- Questions? Contact WHEO Director Roberta Rusch, MPH, at rrusch@apgo.org or 703-815-3111