THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

AUGUST 2008

ACOG recommends routine HIV testing for women ages 19–64

ALL WOMEN AGES 19 TO 64 SHOULD BE TESTED FOR HIV. For some ob-gyn practices, this may be a dramatic shift in screening procedures. Currently, practices may be testing only their pregnant patients or testing patients according to their risk factors or only testing upon patient request.

"ACOG now recommends routine HIV screening for all women ages 19 to 64, regardless if they're pregnant or what their risk factors might be," said Denise J. Jamieson, MD, MPH, chair of the Committee on Gynecologic Practice. "Furthermore, ACOG recommends targeted screening be used for women outside that age range who have risk factors. For example, sexually active teenagers should be tested, as should women older than 64 who have had multiple partners in recent years."

ACOG has recommended since December 2006 that HIV testing be a part of routine care for women. This month, a new Committee Opinion, *Routine Human Immunodeficiency Virus Screening* (#411, August 2008), empha-

➤PAGE 12

Feds to revamp Rx labels for pregnancy

THE US FOOD AND DRUG Administration has proposed an overhaul of how pregnancy and breastfeeding information is included on physician labeling for prescription drugs. Comments can be submitted on the proposed revisions until August 27 (see "info" on page 13). ACOG's Committee on Obstetric Practice has reviewed the proposed rules, which were published in the May 29 issue of the *Federal Register*, and the College will be submitting its comments.

The new labeling would eliminate the current lettering system, which can be misleading and does not require labeling updates as new information becomes available.

"The most important problem with the current system, which uses the A, B, C, D, X system, is that it uses two different criteria for classifying the drugs. The first criterion is how risky the drug is, and the other is the quality or quantity of evidence about the risk," said ACOG Fellow Michael Furman Greene, MD, director of obstetrics at Massachusetts General Hospital in Boston. Dr. Greene was the first chair of the FDA subcommittee convened in 1999 to revise the pregnancy labeling.

According to Dr. Greene, people assume

➤PAGE 13

acog TODAY

Volume 52, Issue 7

Executive Vice President
Ralph W. Hale, MD, FACOG

Director of Communications
Penelope Murphy, MS

Editor
Melanie Padgett Powers

Contributors
Jeanne Mahoney
Savonne Montue, MBA, RHIT, ACS-OB
Nonda Wilson
Marian Wiseman, MA

Design and Production
Marcotte Wagner Communications

Advertising
Greg Phillips
202-863-2529
gphillips@acog.org

Letters to the Editor
Melanie Padgett Powers
Editor
ACOG Today
PO Box 96920
Washington DC
20090-6920

Fax: 202-863-5473
Email: mpowers@acog.org
Letters may be edited for length.

Permission to Photocopy or Reprint
Melanie Padgett Powers
Editor
Email: mpowers@acog.org

Main Phone
800-673-8444 or
202-638-5577

Resource Center
202-863-2518
toll free for members only
800-410-ACOG (2264)

Address Changes
800-673-8444, ext 2427,
or 202-863-2427
Fax: 202-479-0054
Email: membership@acog.org

Order Publications
Online at sales.acog.org
or call 800-762-2264 or
770-280-4184

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

EXECUTIVE DESK

Managing pregnant patients with thyroid disease

THYROID DISEASE IS THE SECOND most common endocrine disease affecting women of reproductive age, and appropriate management of the pregnant patient with thyroid disease is important.

Fetal thyroid begins to concentrate iodine at 10 to 12 weeks' gestation. By 20 weeks' gestation the fetal thyroid is under pituitary TSH control. The maternal plasma iodide level decreases during pregnancy due to fetal utilization and increased maternal renal clearance of iodide. Up to 15% of women may actually see an increase in thyroid gland size during gestation.

Inadequately treated hyperthyroidism is associated with an increase in low-birth-weight infants, medically indicated preterm delivery, and possibly increased fetal loss. Regular evaluation for patients on antithyroid drugs is essential to ensure continuation of the maternal euthyroid state.

Women with inadequately treated hypothyroidism are reported to have a higher incidence of low-birth-weight infants and preeclampsia. Women who have iodine-deficient hypothyroidism—the most common type—are at significant risk of having babies with congenital cretinism. Ensuring appropriate iodine replacement for iodine-deficient populations in the first and second trimester significantly reduces the incidence of the neurologic abnormalities of cretinism.

Some helpful pearls for ob-gyns are:

- Pregnant women should take 220 mcg of iodine-containing multivitamins daily, while breastfeeding women should take 290 mcg daily. Other women of childbearing age should take 150 mcg daily of iodine-containing multivitamins
- Women should avoid taking levothyroxine and multivitamin and iron supplementation at the same time of the day. These supplements interfere with the absorption of levothyroxine
- A majority of women with preexisting hypothyroidism will need to increase their dose of levothyroxine and have the dose monitored during pregnancy. Postpartum, they can return to their prepregnant dose
- Pregnant women on antithyroid drugs for the treatment of hyperthyroidism should receive frequent monitoring to ensure appropriate treatment

ACOG has clinical guidelines that address these issues (see "info" below). As women's health care physicians, it is important that we recognize that thyroid dysfunction can have a significant impact on a woman's health. Age-related screening and symptom-related screening are important components of ongoing women's health care. We should be aware that patients with one autoimmune disease are at risk of developing others.

The National Institute of Child Health and Human Development's Maternal-Fetal Medicine Network has an ongoing trial on this issue. Because uncontrolled hypothyroidism is associated with numerous adverse outcomes, including an increased risk of preeclampsia and mental deficits in the offspring, the trial aims to clarify whether treatment of women with subclinical hypothyroidism during pregnancy is associated with intellectual improvement in the offspring (see *ACOG Today*, May/June 2008). ♀

Hal C. Lawrence, MD

Hal C. Lawrence III, MD, FACOG
Vice President for Practice Activities

info

- ACOG Practice Bulletin *Thyroid Disease in Pregnancy* (#37, August 2002): www.acog.org/publications/educational_bulletins/pb037.cfm
- ACOG Committee Opinion *Subclinical Hypothyroidism in Pregnancy* (#381, October 2007): www.acog.org/publications/committee_opinions/co381.cfm

IN MEMORIAM

William James Burgess, MD
Brampton, ON • 4/08

Donald Patrick Carlson, MD
Reidsville, NC • 1/08

Albert Marvin Ellman, MD
Loudonville, NY

Samuel M. Goodrich, MD
Milledgeville, GA • 5/08

Robert T. Hoover, MD
Apopka, FL

Marissa Christine Keene, MD
Laredo, TX

Nicholas F. Khoury, MD
Fresno, CA

Jack Kushner, MD
New Orleans

Alfred E. Lauden, MD
Houston

Robert W. Leibold, MD
San Antonio

ACOG SEEKS AWARD NOMINATIONS

Deadline: October 1

Outstanding District Service Award

It's time to honor Fellows for their unwavering service to their districts. ACOG is seeking nominations from each district for the Outstanding District Service Award.

Forward your nomination to one of your section or district officers before your Annual District Meeting this fall. All nominations must be voted on and accepted by the District Advisory Council. Accepted nominations are due to ACOG by October 1 (see "info" below).

Nominees must:

- Be a Fellow who has made a significant contribution within the district, in government, research, teaching, or patient care
- Have provided service to the district sufficient to receive national ACOG recognition

Deadline: November 30

Wyeth Pharmaceuticals Section Award

Section chairs are asked to consider exceptional section projects for nomination for the 2008 Wyeth Pharmaceuticals Section Award. Section chairs may select one outstanding activity conducted within the section during 2008 and submit an activity report to their district chair. All reports are due to the chair before the fall District Advisory Council meeting. Individual District Advisory Councils will discuss nominations at the fall district meetings, and district chairs will submit nominations with a letter of recommendation to ACOG. Nominations are due two weeks post-ADM or by November 30 (see "info" below).

Obstetrics & Gynecology HIGHLIGHTS

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

Routine Human Immunodeficiency Virus Screening
(Gynecologic Committee Opinion #411, new)
For more information, see page 1.

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome and Women of Color
(Underserved Women Committee Opinion #414, new)
For more information, see page 1.

Aromatase Inhibitors in Gynecologic Practice
(Gynecologic Committee Opinion #412, new)

Age-Related Fertility Decline
(Gynecologic and ASRM Committee Opinion #413, new)

Alternatives to Hysterectomy in the Management of Leiomyomas
(Gynecologic Practice Bulletin #96, revised)

Each issue of the Green Journal now lists the latest ACOG documents (and their website address) that have been reaffirmed by their respective committees. Documents are reviewed by ACOG on a regular basis and are either revised, withdrawn, or reaffirmed as is.

Then-ACOG President Kenneth L. Noller, MD, MS (on the right), presents ACOG President Elect Gerald F. Joseph Jr, MD, with the District VII Outstanding District Award at the 2008 Annual Clinical Meeting.

Deadline: Feb 1, 2009

Distinguished Service Award and Honorary Fellowship

ACOG is seeking nominations for the College's Distinguished Service Awards and Honorary Fellowships to be presented in 2010.

Send two recommendation letters and the nominee's CV to Terrie Gibson in ACOG's Office of the Executive Vice President by Feb 1, 2009. Nominations will be considered by the ACOG Committee on Honors and Recognitions at its May 2009 meeting.

Criteria for the Distinguished Service Award

- Must be an outstanding individual in ob-gyn who has made important contributions within the College or in government, research, training, or direct patient care
- May be an individual in maternal and child health
- Should be an individual living within the geographic confines of the College
- May be any person who has made an outstanding contribution to the College and/or the discipline of ob-gyn

Criteria for Honorary Fellowship

- Must have made an outstanding achievement in ob-gyn or an allied discipline in any country
- Must have obtained national and international recognition (achieved distinction and recognized for a leadership position by being elected president or a senior officer of a national or international ob-gyn society or organization)
- May be an editor of a major international ob-gyn journal
- May be involved in international public service (may have achieved major leadership in international organizations that relate to ob-gyn)
- May be a non-ob-gyn who has distinguished himself or herself internationally in an area that affects women's health and the specialty
- Should have a relationship with US activities involving women's health care ♀

info

➜ **District and Wyeth awards:** On the ACOG website, www.acog.org, under "Membership," click on "District and Section Activities" or contact LaShawn Jordan: 800-673-8444, ext 2332; ljordan@acog.org

➜ **Distinguished Service Award and Honorary Fellowship:** Terrie Gibson: 800-673-8444, ext 2515; tgibson@acog.org

Members to see reductions in insurance premiums

IMPORTANT AND VALUABLE changes have been made to one of the member benefits the College offers you. Because of the financial health of the insurance programs the College offers its members, Fellows received a 10% to 20% credit on their annual premium for several of these insurance plans. The new premiums took effect July 1.

The ACOG Term Life Insurance provided a 20% credit—this pertains only to the five-year plan, not the 10- or 20-year term life plan. In addition, the Disability Income plan provided a 15% credit, and the Professional Overhead Expense plan and the Medicare Supplemental Health insurance plan each provided a 10% credit.

"The College wanted to pass on the rewards to its members through these reductions."

"Offering these plans is a valuable service to ACOG members, and with the plans doing well in the past year, the College wanted to pass on the rewards to its members through these reductions," said Executive Vice President Ralph W. Hale, MD, FACOG.

ACOG is also announcing a carrier change for two of its affinity insurance plans. The Disability Income plan and the Professional Overhead Expense plan will now be underwritten by the United States Life Insurance Company in the City of New York, which already provides the ACOG Term Life Insurance plan.

"Fellows can rest assured that we believe these changes are beneficial to our members," Dr. Hale said. ♀

Take ACOG practice management survey

ALL PRACTICING OB-GYNS of ACOG are urged to complete the 2008 Socioeconomic Survey, which will assess the impact of the economic environment on ob-gyn practice and track important trends in practice structure, workload, and finances.

ACOG will use the survey findings to provide reports to the membership about the economics of ob-gyn practice, as well as to guide advocacy and educational efforts. Documenting the impact of rising practice costs and declining reimbursement will help immeasurably with the College's efforts to effect positive change for ACOG Fellows and their patients.

This year's survey includes new questions about electronic medical records and health information technology. Reports will be made available to all ACOG members on topics such as ob-gyn practice arrangements, workload, and productivity. ♀

info

- Access the survey on the ACOG website, www.acog.org. Under "Practice Management," click on "Practice Management and Managed Care" and then click on "Members Encouraged to Participate in 2008 ACOG Socioeconomic Survey"
- Questions: James Scroggs, 800-673-8444, ext 2447

Call for participation for 2009 ACM

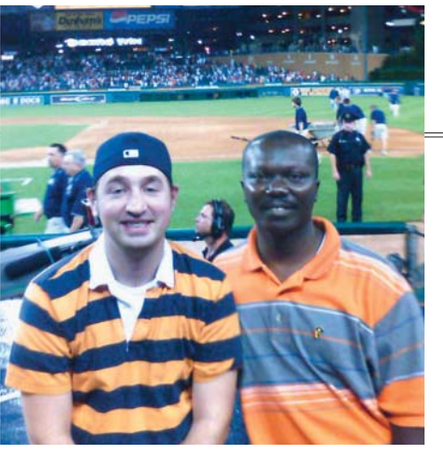
THE ACOG COMMITTEE ON SCIENTIFIC PROGRAM is inviting submissions of abstracts of paper or poster presentations on any topic related to ob-gyn for the 2009 Annual Clinical Meeting, to be held May 2–6 in Chicago. All abstracts must be submitted online.

The committee also welcomes online submission of abstracts of films for the 2009 Film Festival on topics of interest to practicing ob-gyns. For submission details and the online application, visit www.acog.org/acm.

Deadlines for online submission

- Paper/poster abstracts: September 12
- Film Festival abstracts: November 5 ♀

Exchange program continues collaboration with Ghana



Dr. Kwame Anim-Boamah (on the right) takes time to enjoy his first American baseball game with Clark Johnson, a fourth-year Wayne State University medical student who plans to pursue an ob-gyn residency after his September rotation at the maternity hospital in Korle Bu, Ghana.

ALANA ZAKS, MD, HAD SEEN too many cases of late-stage cervical cancer, and she wanted desperately to begin conducting routine Pap tests, but it wasn't as simple as it sounded.

Dr. Zaks was seeing patients at Korle Bu Teaching Hospital in Accra, Ghana, as part of an elective exchange through her ob-gyn residency program at the University of Michigan. "In one month I saw too many cases of stage 4 cervical cancer. Annual Pap smears are not routine in Ghana," said Dr. Zaks, who is now in her third year of residency.

For Ghanaian women, obtaining annual cervical cancer screening is a difficult process, she explained. "The patients have to first go to the pathology department and pay for the Pap supplies and pay the pathologist to ensure the slide will be read. The woman then returns to the doctor for her exam, pays for a speculum, waits, and then comes back for a third appointment to discuss the results."

Beyond that, most patients do not have $30 to pay for the test kit or the speculum. "I wanted to do a Pap test on a patient, but the [local] doctor asked me to consider 'Is this in the patient's best interest if she needs to feed her children, pay her bills?'"

Dr. Zaks's exchange is part of a larger collaborative program between the University of Michigan and the Ghana Postgraduate Training Program, which, for more than 20 years, has offered ob-gyn training in Ghana. The program was developed in 1986 by ACOG and the Royal College of Obstetricians and Gynaecologists in the United Kingdom. The premise was that those who train in Ghana will stay in Ghana. The program worked, stopping the flow of physicians who left their home country seeking medical training and never returned to Ghana to practice, and ultimately improving rates of maternal morbidity and mortality in Ghana.

More than 60 ob-gyns have been trained through the program and passed their specialty board exams, with 99% of the ob-gyns remaining in Ghana, and maternal mortality has decreased since the program began, according to Timothy R.B. Johnson, MD, chair of the ob-gyn department at the University of Michigan, who has been involved with the program since its inception.

Medical students and residents in Michigan can elect to spend one-month rotations at hospitals in Ghana, part of a long-standing partnership between US and Ghanaian ob-gyn programs.

Learning from each other

While Michigan ob-gyn residents can spend a month in Ghana as an elective, Ghanaian ob-gyn residents are required to spend time in the US or the UK. Ghanaian ob-gyn Dr. Kwame Anim-Boamah is spending 11 weeks in Michigan this summer.

"I hope to learn more about advanced technologies that are not available in my country and also about information management systems," Dr. Anim-Boamah told *ACOG Today*. "Everything is computerized and updated at Michigan. [In Ghana] we use paperwork for all our documentation, and our record systems are all manual, which makes research somewhat difficult. ... Everything in the specialty you read about and have not had the opportunity to see—when you come to the US, you see the technology. It turns the theoretical into practical."

Dr. Zaks and Dr. Anim-Boamah both commented on the difference between the physician-patient relationship in Ghana and the US. "There, the patient looks to the physician to make all the decisions," Dr. Zaks said.

When asked about this, Dr. Anim-Boamah said, "Communication with patients is certainly better here. In Ghana, especially among the uneducated patients, when you explain to them their disease condition and the treatment options available and ask 'what do you prefer?' they turn it back to you and say 'well, you know what to do; you go ahead and do what you think is best.' Sometimes it can be a little discouraging. You want patients to partake in the discussion."

When Dr. Anim-Boamah returns to Ghana at the end of August, he will become the sole ob-gyn at the Eastern Regional Hospital in Koforidua. "I'm really interested in public health. I hope to practice for some years before starting a fellowship in reproductive health and family planning and/or maternal and fetal medicine," he said.

"Medical students, residents, and faculty are eager for international experiences, and these can be, as in my case, life changing," Dr. Johnson said. "It is my observation that all who participate feel they get much more out of it than they ever imagined. I predict many other institutions will be encouraged and stimulated by their students to replicate similar partnerships and programs." ♀

Vote in elections online

VOTE ONLINE IN THE JUNIOR Fellow district elections, August 1–31. You can first review candidates' names and CVs online.

To cast your vote, have your ACOG ID number handy—it can be found on all ACOG mailings, as well as in 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

➜ Questions: Christine Himes, 800-673-8444, ext 2561; chimes@acog.org

Submit essays for contest

JUNIOR FELLOWS ARE ENcouraged to share their thoughts on "Ob-Gyn … The Day I Made a Difference" for this year's Junior Fellow essay contest. Essays are due November 30.

Submissions should provide reflection on a day that you felt you made a difference. The experience could have been a clinical, political, social, public, or international event that affected your outlook on medicine and ob-gyn as a career.

Essay participants must be Junior Fellows. Essays should be between 500 and 750 words. No specific names of patients should be mentioned.

One winner will be selected from each district to receive $500. A national winner will receive an additional $500 and an expenses-paid trip to the 2009 Annual Clinical Meeting in Chicago. ♀

info

➜ On the ACOG website, www.acog.org, click on "Junior Fellows" in the "Quick Links" box

District VI pairs interim meeting with legislative conference

AFTER DISTRICT VI JUNIOR Fellow officers were given the go-ahead to begin holding an interim meeting, they mulled over the possible venues and formats. What would be attractive to Junior Fellows and maximize their involvement?

Three of the District VI Fellow officers are former McCain fellows, who worked at ACOG on legislative issues alongside government relations staff. These Fellows—Chair Thomas M. Gellhaus, MD; Vice Chair Thomas F. Arnold, MD; and Junior Fellow Advisor Paul G. Tomich, MD—feel strongly about ob-gyns' getting involved in legislative advocacy, and each year the district supports numerous Junior Fellows to attend the ACOG Congressional Leadership Conference. Therefore, the answer seemed natural: pair the Junior Fellow interim meeting with the Congressional Leadership Conference, held in late winter in Washington, DC, home of ACOG headquarters.

Iowa Junior Fellow officers and Fellows meet with Rep. Bruce Braley (D-IA) during the ACOG Congressional Leadership Conference. Left to right, Iowa Junior Fellow Vice Chair Debra J. Piehl, MD; Iowa Junior Fellow Chair Alison C. Agner, MD; Fellow Deborah LaBeau, MD; Rep. Braley; and Fellows Michael J. McCoy, MD; Marygrace Elson, MD; District VI Chair Thomas M. Gellhaus, MD; and Thaddeus L. Anderson, MD.

The trial run in 2007 was a huge success for the District VI Junior Fellow district officers and Junior Fellow section chairs who attended, and in 2008, the District Advisory Council increased funding so that the Junior Fellow section vice chairs could also attend.

The benefits of pairing the Junior Fellow interim meeting with the CLC are many. Junior Fellows held their interim meeting the day before the conference began, and then they learned about ACOG's top legislative issues, the legislative process, and how to increase their legislative advocacy. They had the opportunity to learn more about ACOG, meet College staff, network with Fellows, and meet with their congressional representatives and their staff on Capitol Hill.

"Section leaders don't often get to go to these national meetings, so it was a whole new world," said District VI Junior Fellow Chair Heather B. Kerrick, DO. "It's important, no matter what office you hold in ACOG, that you have a maximum understanding of what ACOG is and what it stands for and how much of what we do can really support our patients.

"The congressional visits were a good way for Junior Fellows to mingle with the Fellows in their district," Dr. Kerrick continued. "Many of us didn't realize that members went to the congressional offices and actually spoke to representatives themselves."

Junior Fellow College Advisory Council Chair Eric J. Hodgson, MD, supports the idea of pairing Junior Fellow interim district meetings with the CLC and encourages other districts to consider the same approach.

"The CLC provides a great venue for Fellows and Junior Fellows to come together and work to improve women's health," Dr. Hodgson said. "It allows the Junior Fellows a chance to see the big picture of ACOG and meet potential mentors and colleagues, and it can motivate the Junior Fellows to get more involved in the College." ♀

JFCAC teaches residents how to cope with adverse events

A BOWEL IS PERFORATED AND a patient becomes septic. A patient is given the wrong dose of medication and dies. A fetal heart rate tracing is misinterpreted and the newborn is taken to the NICU.

When residents are involved in—or even just witness—an adverse event, they may feel guilty, ashamed, and scared and may question their ability to practice medicine. In the culture of medicine, physicians aren't encouraged to talk about their feelings when something goes wrong—a fact that the ACOG Junior Fellow College Advisory Council and the Committee on Patient Safety and Quality Improvement are trying to change.

"Not dealing with the emotional impact of an adverse event may lead to early physician burnout, changing professions, and ultimately more medical mistakes," said JFCAC Vice Chair Taraneh Shirazian, MD. "Residents, medical students, and all involved staff may carry the weight of an adverse event with them throughout their professional careers."

The JFCAC began to raise awareness of the issue at this year's Annual Clinical Meeting, when Fellow Patrice M. Weiss, MD, of the ACOG patient safety committee, gave a presentation to residents at the Junior Fellow Business Meeting about how to cope with adverse events.

"We need to recognize that when there are medical errors, there is an emotional impact and perhaps a long-term impact and consequences on the development of the physician, whether in training or out of training, in their response to that error," Dr. Weiss said. "They need emotional and collegial support just as the patient does."

Dr. Weiss calls the traditional way that medicine handles adverse errors the "name blame shame game," rather than a system of support and encouragement.

"We single people out; we find an individual and then blame them," she said. "The culture of medicine now is looking at systems-based contributions to medical errors and what in the system helped contribute to the untoward event."

Fellow Patrice M. Weiss, MD, discusses the emotional impact adverse events can have on physicians during the Junior Fellow Business Meeting at the Annual Clinical Meeting in May.

The patient safety committee and the JFCAC are now looking at how they can further educate residents and other ob-gyns about this issue.

"Awareness is the first step," Dr. Shirazian said. "We want people to know that adverse events happen to everyone. Everyone is in the same boat. Residents need to process adverse events when they happen and have support mechanisms in place to discuss these events. With awareness and recognition, they can start to cope and heal." ♀

info

- Dr. Patrice M. Weiss: pmweiss@carilion.com
- Dr. Taraneh Shirazian: taraneh.shirazian@mssm.edu

JAPAN EXCHANGE CONNECTS RESIDENTS

AN OB-GYN RESIDENT SELECTED FROM EACH ACOG DISTRICT ATTENDED the annual meeting of the Japan Society of Obstetrics and Gynecology in April as part of the annual JSOG/ACOG Exchange Program.

Front row: Junior Fellows Heather B. Kerrick, DO; Gillian Mackay, MD; Cynthia A. Brincat, MD, PhD; and Monique S. Ruberu, MD. Residents and fellows from China, Japan, and the Phillipines are in the back row.

Junior Fellows Monique S. Ruberu, MD, and Heather B. Kerrick, DO, see the sites.

Congress halts Medicare physician payment cuts in dramatic fashion

CONGRESS STOPPED THE 10.6% Medicare physician payment cut and provided a 1.1% increase through 2009 by a veto-proof margin. In a surprise return to Capitol Hill on July 9, Sen. Edward M. Kennedy (D-MA), who has been undergoing chemotherapy in Boston for a brain tumor, showed up to give the bill the one more vote it needed to pass.

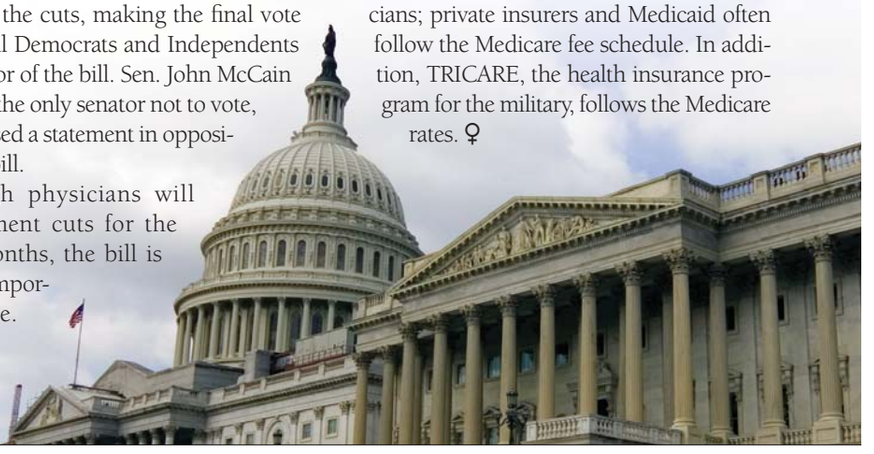
The US House of Representatives had voted 355 to 59 in June to halt the cuts, but the Senate had fallen one vote shy of the 60 votes needed to prevent a filibuster. President Bush made good on his promise to veto the bill, but Congress easily overrode his veto with more than the two-thirds majority needed.

Disagreement was primarily over how to finance payments to physicians. The final bill makes cuts to Medicare Advantage, the program that allows the elderly to choose private insurance programs. Republicans generally favor the program, while Democrats say private insurers are being overpaid.

After Sen. Kennedy voted for the bill and it was sure to pass, nine more Republicans switched their earlier vote, joining nine other Republicans who had already voted in favor of stopping the cuts, making the final vote 69 to 30. All Democrats and Independents voted in favor of the bill. Sen. John McCain (R-AZ) was the only senator not to vote, but he released a statement in opposition to the bill.

Although physicians will avoid payment cuts for the next 18 months, the bill is merely a temporary bandage. Every year Congress is faced with halting cuts to physician payments, which are based on a flawed "sustainable growth rate" formula. ACOG has long advocated fixing the flawed formula, but Congress cannot agree on a solution.

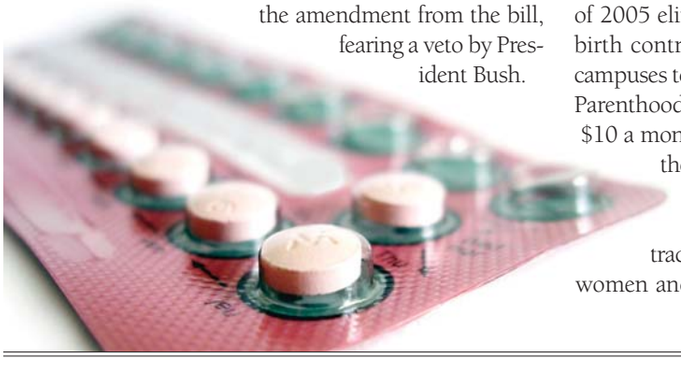
Medicare physician payment cuts affect not only Medicare patients and their physicians; private insurers and Medicaid often follow the Medicare fee schedule. In addition, TRICARE, the health insurance program for the military, follows the Medicare rates. ♀



Bill signed without price-fixing amendment

Birth control prices remain high on college campuses

PRESIDENT BUSH SIGNED A war spending bill in June without an amendment that would have fixed a birth control pricing problem that Congress inadvertently created that affects college campuses and certain family planning clinics. The US Senate had approved the amendment, but the House stripped the amendment from the bill, fearing a veto by President Bush.



Traditionally, Congress has made low-priced drugs available to family planning clinics and college health facilities to assist vulnerable populations. Many of these facilities depended on the discounts to be able to provide deeply discounted birth control to college students and underserved women. However, a technical error in the Deficit Reduction Act of 2005 eliminated these discounts, causing birth control prices at these clinics and on campuses to skyrocket. According to Planned Parenthood, women who were paying $5 to $10 a month are now paying $40 to $50 for the same prescription.

"It's ridiculous that a technical error is hindering access to contraception for millions of underserved women and college students," said Alan G. Waxman, MD, MPH, chair of ACOG's Committee on Health Care for Underserved Women. "Confronted with the higher costs, many of these women have chosen to go without birth control pills, increasing their risk for unintended pregnancy, and some college clinics have stopped carrying birth control altogether."

The amendment was modeled after a bill introduced by Sen. Barack Obama (D-IL), Sen. Claire McCaskill (D-MO), and Rep. Joseph Crowley (D-NY) called "Prevention Through Affordable Access Act" (S2347/H4054).

ACOG members can support that bill by letting their congressional representatives know that they should restore affordable contraception to millions of women. Call Congress at 202-224-3121. ♀

New codes allow payment for tobacco, alcohol abuse screening

ALCOHOL AND/OR SUBSTANCE ABUSE CODES

99408: Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes

99409: Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intevention (SBI) services; greater than 30 minutes

G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and brief intervention; 15 to 30 minutes

G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and intervention greater than 30 minutes

SMOKING AND TOBACCO USE COUNSELING CODES

99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes, up to 10 minutes

99407: Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

"MY DAUGHTER TOLD ME she's concerned about how much I drink, but when I saw my doctor last week, she never even asked about drinking. I guess there's nothing to worry about."

This actual conversation from one woman to another begs the question: Why didn't the doctor ask about alcohol use? Studies have shown that most patients who use alcohol or other substances at risk levels will change their behavior with the advice and assistance of a health professional.

One reason the physician may not have brought up the subject is the lack of compensation for screening and intervention. But that barrier has now been lifted. This year, new Current Procedural Terminology, or CPT, coding has been added for health professionals to provide "screening and brief intervention," or SBI, for the hazardous use of alcohol, tobacco, and other drugs.

The new codes state that the screening must include a standardized questionnaire and focus on the frequency and quantity of substance use over a particular timeframe. Brief intervention, which happens immediately after a patient screens positive, consists of a discussion with the patient to help her understand the impact of her substance use and to offer motivational strategies for change. Patients who demonstrate symptoms of dependence or complications from their use should be referred to specialty treatment.

Medicare, as well as the insurance plan for federal employees and Medicaid in at least 10 states now reimburse physicians using these new CPT codes, according to the Office of National Drug Control Policy. Many private insurers are climbing on board also, but physicians should check with private payors for their specific policies.

Alcohol and/or substance abuse coding

Effective January 2008, both CPT and HCPCS (Healthcare Common Procedure Coding System) created two codes to report for structured screening and brief intervention services for alcohol and/or substance abuse (see box at right). Use CPT codes 99408 and 99409 for nonMedicare patients but HCPCS codes G0396 and G0397 for Medicare. These codes are reportable only for structured screening and brief intervention. They are not reportable when physicians ask patients about their alcohol or drug use as part of a comprehensive medical history. The services under these new codes may be provided as part of a periodic, scheduled, preventive care office visit or in an acute care setting.

Smoking and tobacco use counseling coding

As of January 2008, the HCPCS temporary smoking cessation counseling codes G0375 and G0376 were deleted. CPT created two new codes as replacements (see box at right).

Under Medicare, two cessation attempts are covered per year. The counseling must be either intermediate or intensive. An intermediate counseling E/M service is described as two to three sessions of three to 10 minutes each and is reported using CPT code 99406. An intensive counseling E/M service is described as four sessions of more than 10 minutes each and is reported using CPT code 99407. If the counseling occurs during a separately identifiable E/M service, append the modifier 25 (significant, separately identifiable E/M service) to the applicable E/M code (eg, 99201–99215).

Counseling involving only one session of less than three minutes is included in current E/M payment and not covered separately. Each attempt may include a maximum of four intermediate or intensive counseling sessions. The total annual benefit is for eight sessions in a 12-month period. Again, check with private payors for their specific policies.

The Centers for Medicare and Medicaid Services allows these services to be provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist, or clinical social worker. CMS does not have specific training requirements but may in the future. The counseling must be provided face to face with the patient. Use a diagnosis code indicating the patient's condition or treatment that is being adversely affected by her tobacco use. ♀

info

- For more information on conducting screening and brief intervention: www.niaaa.nih.gov/Publications/EducationTrainingMaterials
- ACOG's *Special Issues in Women's Health*, chapter "Substance Use: Obstetric and Gynecologic Implications": www.acog.org/publications/specialissuesinwomenshealth
- Coding: On the ACOG website, www.acog.org, click on "CPT Coding" in the "Quick Links" box on the left side of the home page

ACOG reviews differ from hospital perspective

FOR 22 YEARS ACOG HAS BEEN reviewing ob-gyn care delivered in US hospitals. Through ACOG's peer review program—Voluntary Review of Quality of Care—hospitals can request an objective review of their ob-gyn clinical care and related administrative systems. Following a four-day site visit by a team of three physicians and a nurse selected from a panel of trained reviewers, ACOG gives the hospital a confidential report of the team's findings and recommendations for improvement.

Fellow Abraham Lichtmacher, MD, a team leader in the VRQC program, recently analyzed these reports from 136 hospital reviews conducted from 1997 to 2007 in an article published in the March issue of *Obstetrics and Gynecology Clinics of North America*. He found that the reasons that hospitals gave for requesting a review often differed from the problems ultimately discovered by the ACOG review team.

"The hospitals lack outside perspective in being able to recognize their own problems," he told *ACOG Today*.

To develop a clear picture of the hospital's problems and challenges, the VRQC team conducts confidential interviews with both clinical and administrative staff.

"We are in a much better position to get the true skinny about what is going on, versus someone going in from a regulatory standpoint," he said.

Behavioral problems

As an example of a discrepancy between the teams' findings and the hospitals' self-perception of problems, Dr. Lichtmacher offers the problem of disruptive physician behavior. Recommendations regarding behavioral problems were made in reports of 29% of the hospitals reviewed, while only 7.6% of hospitals requesting VRQC review stated this as a reason for review.

The VRQC incidence rate of disruptive physician behavior also exceeds the estimate of 3% to 5% reported in the medical literature. Because the literature contains self-reported surveys, the true incidence of disruptive behavior may be much higher, Dr. Lichtmacher said.

The most common type of behavioral problem is a lack of professionalism among professional providers, he said.

"Being a bully is an example, such as when a physician berates a nurse in front of a patient. In addition, the notion of the surgeon as 'captain of the ship' is sometimes taken too far, resulting in discourteous treatment of neonatal and anesthesia colleagues."

The most frequently found problem, found in about two-thirds of the 136 hospitals, is a lack of an effective quality assessment program, including effective peer review.

"In most facilities, people responsible for specific quality assessment tasks can explain what their individual role is in the peer review process, but they don't see the overall picture—how what they do fits into the big scheme of things," Dr. Lichtmacher said.

"In most facilities, people responsible for specific quality assessment tasks can explain what their individual role is in the peer review process, but they don't see the overall picture."

Another problem often identified in a hospital's peer review process was that there was "continual gathering of information, but to no end," Dr. Lichtmacher said.

"No threshold was set for when to stop monitoring and actually do something to initiate change—to close that loop and avoid the same problems in the future. What's the point of it if you are not going to initiate some change?"

Labor induction problems

Poor management of induction of labor was the clinical problem most frequently identified by VRQC teams.

"A common reason was that elective induction of labor would be initiated without establishing fetal lung maturity when gestation was less than 39 weeks," Dr. Lichtmacher said.

Another finding related to induced labor was that the clinician did not differentiate between the latent and active stages of labor. Induction was often abandoned too early, and the patient never got into labor but went to operative delivery.

A third problem with inductions was that elective inductions were performed when the cervix was unripe.

"Patient expectations about delivering at a certain gestational age seem to vary regionally," Dr. Lichtmacher said. "In certain parts of the country, when patients reach 40 weeks, they feel they should be delivered [induced], while in other areas they are content to wait until labor begins spontaneously."

Dr. Lichtmacher acknowledges that the self-selection of the hospitals requesting VRQC review may lead to selection bias, but he believes that the growing pool of data from VRQC surveys may be useful in identifying areas for improvement. ♀

info

➜ Full article: Obstet Gynecol Clin North Am. 2008 Mar;35(1):147–62.

➜ VRQC overview: www.acog.org/goto/vrqc; msaraco@acog.org; (800) 266-8043

OB Team Stat improves emergency response

WHEN AN EMERGENCY such as cord prolapse or profound fetal bradycardia calls for a cesarean delivery at Sharp Mary Birch Hospital for Women in San Diego, the mean time between the emergency team activation and the delivery is 14 minutes ± 5.35.

That's a significant change from back in the day—before the hospital launched a new rapid response protocol called "OB Team Stat" in late 2005. Although the time from "decision to incision" had almost always been within 30 minutes before then, it was seldom within 15 minutes of bradycardia onset.

Maternal-fetal medicine specialist Fellow Val A. Catanzarite, MD, PhD, led a core group of clinical and administrative staff in developing the new emergency response protocol, which features simultaneous activation of all the team members via an overhead page and beeper page.

Team assignments are key

When the emergency page is made, everyone goes into action to meet in the OR. The average time to get the patient from her room to the OR has been reduced from 12.5 minutes to 3.3 minutes, according to Sue Faron, RNC, MN, a perinatal clinical nurse specialist at Birch.

OB Team Stat also reduces the time spent waiting for the entire team to arrive in the OR, reports Philip J. Diamond, MD, who practices at Birch and chairs ACOG's Committee on Professional Liability.

"It doesn't help to get the patient to the OR quickly if there is no anesthesiologist, for example," he said.

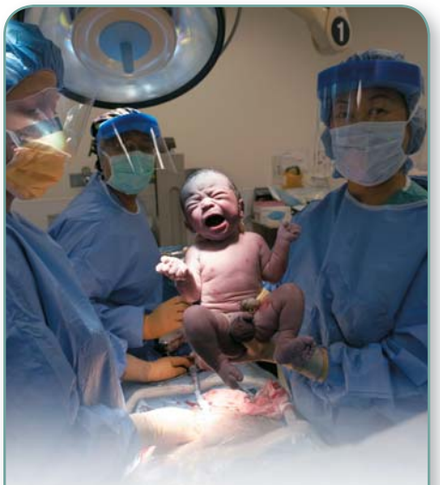
Defined role assignments are one of the best results of the new process, according to Dr. Diamond.

"There were times previously when many people responded to an emergency, but their actions were often inefficient and lacked coordination," he said.

The emergency response system has also promoted a team culture.

"Every member of the team shares in the success of delivering a healthy baby," Dr. Diamond said.

The current team spirit differs markedly from the milieu of the past, he notes, when emergency situations were often marked by a physician yelling at everyone and criticizing the response later.



"Every member of the team shares in the success of delivering a healthy baby."

Nurses call the code

A hallmark of OB Team Stat is that any team member can activate the emergency code. In practice, this person is almost always the labor and delivery nurse. Having nurses take this initiative requires them to act outside their traditional comfort zone and represented a major change in the physician-nurse practice culture. Ms. Faron credits Dr. Catanzarite and his practice group with promoting a culture of empowerment. Nurses were told, "I trust you to pull the trigger."

Dr. Diamond believes that empowering nurses to make critical decisions in these situations has benefits beyond that of reducing the emergency response time.

"If they feel comfortable making this type of decision, they may be more willing to voice their opinions when they see something else going on that adversely affects patient safety," he said.

Regarding the loss of physician autonomy in making the decision about a cesarean delivery, Dr. Diamond said, "Everyone saw the wisdom of doing this, so the initial push-back was not that strong. Ultimately, the existence of a program like this reassures physicians that even in their absence their patients who have an emergency will be well cared for in a timely manner."

'No harm, no foul'

A concern before launching the protocol was that it could result in a number of false alarms. Team members might become demotivated if they respond to the OR but, for example, the fetal bradycardia subsequently resolves and no surgery is needed. The developers decided that the potential benefits outweighed the risks, however, and if the patient returns to her room, the response could rightly be considered a drill and not a waste of time for the team members.

"The initial misgiving that OB Team Stat would be activated too often has not really been the case," Dr. Diamond said, adding that "a few too many is better than one too few." In 2007, the code was activated in 78 obstetric cases; of those, 29 patients recovered and did not result in an emergency delivery.

Could this work at a small hospital?

With 8,000 deliveries a year, Mary Birch hospital has in-house obstetric and surgical availability around the clock. Could this approach be used in smaller facilities?

"I believe this could be modified for use by all hospitals," Dr. Diamond said. "Even if there is no in-house physician, the patient still needs to be moved to an OR in anticipation of a cesarean delivery, and the rest of the team must be activated in a timely fashion."

He stresses that having everyone know his or her role is what really works to improve patient safety. ♀

info

➜ For more details about OB Team Stat: Sue Faron at sue.faron@sharp.com

ACOG recommends routine HIV testing for women ages 19–64

➤PAGE 1

sizes this recommendation and provides more information about rapid testing and opt-out vs. opt-in testing. A second Committee Opinion, *Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome and Women of Color* (#414, August 2008), calls attention to the disproportionate effect that HIV/AIDS has on minority women, particularly blacks and Hispanics.

It is estimated that one-quarter of US residents with HIV are unaware of their status. Women continue to represent a growing proportion of HIV and AIDS cases, and it's critical that they know their status. This knowledge can improve their chances of survival, reduce morbidity, help them take steps to avoid unintended pregnancy, protect their sexual partners, and reduce the likelihood of mother-to-child transmission should pregnancy occur, according to the Committee Opinion on routine testing.

"Women represent the fastest growing population of persons infected with HIV in this country, and heterosexual transmission has become a much bigger factor," Dr. Jamieson said. "There are two messages for patients: Every woman should know her HIV status, and it's a simple test."

Use opt-out testing if possible

ACOG recommends opt-out HIV testing, in which the patient is notified that HIV testing will be performed as a routine part of gynecologic and obstetric care unless the patient declines testing. Neither specific signed consent nor prevention counseling is required. However, many state and local laws are not consistent with opt-out testing and may require informed consent or counseling. Ob-gyns need to be aware of and comply with the laws in their areas (see "info" below).

Rapid HIV testing is becoming more available across the US, and while it can provide test results more quickly to the patients, a positive result must be confirmed with additional testing.

As ob-gyns prepare to test patients—whether through rapid or conventional testing—they will need to be ready to discuss positive results, Dr. Jamieson said.

> **"WOMEN** *represent the fastest growing population of persons infected with HIV in this country, and heterosexual transmission has become a much bigger factor."*
>
> —Denise J. Jamieson, MD, MPH

"One of the barriers to routine HIV testing is physician discomfort, especially in practices that don't do obstetrics and haven't been testing at all," Dr. Jamieson said. "Practices will need to have a plan in place for how to deliver the results to a patient and how the practice is going to link patients who test positive to HIV care and resources."

Effects on women of color

While all women should be screened for HIV, it's important for physicians and their patients to be aware that women of color are disproportionately affected by the disease.

"Rates of infection among African Americans—and also among Hispanics—are much, much higher than among white women," said ACOG Fellow D. Heather Watts, MD, who helped develop the women of color Committee Opinion as a liaison member on the ACOG Committee on Health Care for Underserved Women. "Sixty-four percent of women with HIV are black, whereas blacks only make up about 13% of the US population."

According to the new Committee Opinion, a combination of testing, education, and brief behavioral interventions can help reduce the rate of HIV infection among women of color.

"Education plays an important role. Because HIV is more prevalent in their communities, women of color should know they are more likely to be exposed to HIV," Dr. Watts said. "Women should be aware of ways to protect themselves, such as limiting their number of partners and using condoms consistently."

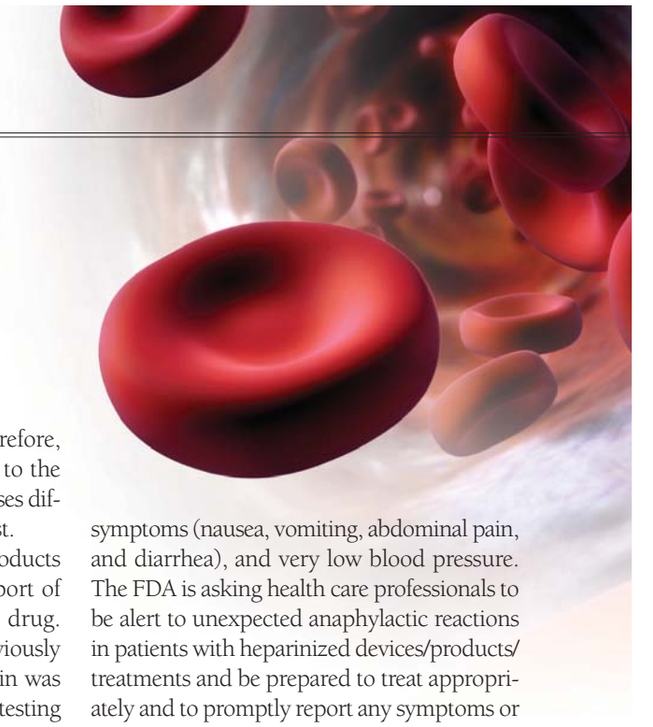
Studies show that behavioral interventions can increase rates of condom use, reduce risk-taking behaviors, and decrease rates of acquisition of sexually transmitted infections.

According to Dr. Watts, ob-gyns can start with the question "Have you ever been tested for HIV?"

"They can explain to their patient that it's recommended for all adults now and that there are numerous benefits to being tested," Dr. Watts said. "We are trying to destigmatize this and make it a part of routine care." ♀

info

- *Routine Human Immunodeficiency Virus Screening* Committee Opinion (#411, August 2008): www.acog.org/publications/committee_opinions/co411.cfm
- *Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome and Women of Color* Committee Opinion (#414, August 2008): www.acog.org/publications/committee_opinions/co414.cfm
- State HIV laws: www.nccc.ucsf.edu/statelaws
- National HIV/AIDS Clinicians' Consultation Center: www.nccc.ucsf.edu; 800-933-3413
- *Human Immunodeficiency Virus* Committee Opinion (#389, December 2007): www.acog.org/from_home/publications/ethics/co389.pdf
- Patient Education Pamphlets *HIV and Women* (see page 16) and *HIV and Pregnancy*: http://sales.acog.org;



Heparin recall brings up new safety concerns

PHYSICIANS AND HEALTH CARE facilities should no longer be using multi-dose and single-dose injections of heparin sodium or heparin flush solutions manufactured by Baxter International, following a recall earlier this year.

According to the Institute for Safe Medication Practices, some affected heparin products may still be found in some clinical locations. The institute encourages health care professionals to review and examine all drug/device storage areas, including emergency kits, dialysis units, and automated dispensing cabinets to ensure all the recalled heparin products have been removed.

Other manufacturers have worked to fill the demand for heparin, which has averted a major heparin shortage, according to the US Food and Drug Administration. However, hospitals are now receiving heparin in quantities, strengths, and packaging that are unfamiliar to staff, and some are concerned about potential dosing errors, according to ISMP. Therefore, physicians should pay close attention to the heparin packaging, which may be in doses different from the heparin used in the past.

Baxter began recalling its heparin products in January after an increase in the report of adverse reactions associated with the drug. An FDA investigation uncovered a previously unknown contaminant, and the heparin was traced to suppliers in China. New FDA testing requirements should prevent any more contaminated heparin from hitting the market.

The FDA is also concerned about the safety and effectiveness of medical devices that may be affected by contaminated heparin. Physicians and other health care providers are advised to avoid use, whenever possible, of products containing, coated with, or affected by heparin found to be contaminated with oversulfated chondroitin sulfate.

Contaminated heparin could be associated with severe allergic reactions, gastrointestinal symptoms (nausea, vomiting, abdominal pain, and diarrhea), and very low blood pressure. The FDA is asking health care professionals to be alert to unexpected anaphylactic reactions in patients with heparinized devices/products/treatments and be prepared to treat appropriately and to promptly report any symptoms or adverse events that might be due to heparin to the FDA's MedWatch Adverse Event Reporting program (see "info" below). ♀

info

- www.fda.gov/cder/drug/infopage/heparin
- *Prevention of Deep Vein Thrombosis and Pulmonary Embolism* (Practice Bulletin #84, August 2007): www.acog.org/publications/educational_bulletins/pb084.cfm
- FDA's MedWatch Adverse Event Reporting program: www.fda.gov/MedWatch/report.htm; 800-FDA-1088

Feds to revamp Rx labels for pregnancy

➤PAGE 1

that the lettering system means there is a gradient of risk as the letters decrease. However, the majority of the drugs labeled for pregnancy are labeled "C" because there isn't any strong data about the potential risks, according to Dr. Greene.

"You can be misled if you assume that an 'A' is safer than a 'C' when what it really means is the 'A' has been studied and the 'C' hasn't," he said.

The new system would eliminate the lettering and provide brief bulleted information on the potential benefits and risks for the mother and the fetus and how these risks may change during the course of pregnancy. Another important change is that the new system would require drug labels to be updated as new data emerge.

"Previously there was no requirement and, furthermore, no incentive for companies to update their labels," Dr. Greene said.

Proposed new format

The newly designed format for the pregnancy section would have three sections:

- The first section, called the "Fetal Risk Summary," would briefly describe what is known about the effects of the drug on the fetus, and if there is a risk, whether the risk is based on information from animals or humans. The section would include a risk conclusion based on the available data and provide examples depending on the quality and quantity of those data
- Another section, called "Clinical Considerations," would include information about drug effects for inadvertent exposures before a woman knows she's pregnant, as well as prescribing information during pregnancy and labor and delivery. This section would also feature discussions about the risks of the disease to the mother and the fetus, dosing information, and how to address complications
- The third section, under the heading "Data," would describe in more detail the available data regarding use of the drug in humans and from animal studies that were used to develop the Fetal Risk Summary

The breastfeeding section would use the same format as the pregnancy section. ♀

info

- To view and comment on the rules, visit www.fda.gov/cder/regulatory/pregnancy_labeling. In the article, click on the first hyperlink, "Proposed Rule"

YOU ASKED, WE ANSWERED

Terminating the physician-patient relationship

Q CAN I TERMINATE THE RELATIONSHIP with a patient who fails to follow a recommended treatment plan or who chronically fails to pay for the services I provide?

A YOU HAVE AN ETHICAL AND legal obligation to continue providing care to a patient with whom you have established a physician-patient relationship. This obligation, however, does not continue indefinitely. Under some circumstances you might find it necessary to terminate the physician-patient relationship. These circumstances could include:

- You are closing your practice because of relocation or retirement
- A patient is noncompliant, disruptive, or abusive
- A patient has not paid outstanding bills, in spite of your repeated attempts to address the nonpayment
- You feel that you cannot meet a patient's unrealistic expectations for her care
- You are changing the scope of your practice—for example, dropping obstetrics

Although you do have the right to stop providing care to a patient in a number of situations, you must terminate the relationship properly. If you do not follow appropriate procedures for terminating a physician-patient relationship and a patient suffers harm, you could be vulnerable to charges of patient abandonment. A successful claim of patient abandonment must demonstrate the following:

1. You terminated the physician-patient relationship unilaterally
2. You failed to provide the patient with enough notice so that she could find another qualified physician
3. Your inappropriate termination of the relationship caused the patient's injury

To terminate the physician-patient relationship properly, focus on ensuring continuity of care for the patient. A key element is that you make reasonable attempts to provide both adequate notice of the termination and assistance in finding another source of care. And you should be sure to document those efforts by doing the following:

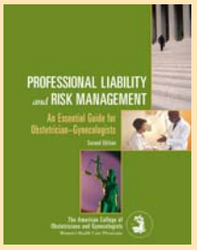
- Provide advance written notice of termination. The appropriate time period can vary. In some circumstances, 30 days is adequate notice, but some patients may need more time
- Include in the written notice your reasons for withdrawing from the patient's care. Be sure you state the reasons objectively and have documentation that supports those reasons
- Note the patient's current medical condition and her needs for ongoing care
- Provide information to help her find another physician. You could include a list of other ob-gyns in the community or the telephone number of a medical society or hospital physician referral service
- Offer to provide copies of medical records to the patient's new physician. You may want to enclose an authorization form for transferring records for the patient to complete when she finds a new physician
- Retain a copy of the letter, and document that the patient received the letter. Registered mail with a return receipt is a good procedure although it's not required
- Pregnant patients might need more time to find another obstetrician. A patient in her third trimester may be unable to find another physician to care for her, so terminating the relationship might not be feasible or appropriate

If you are closing your practice or discontinuing obstetric services, plan to continue providing care until delivery for patients who are already in the third trimester. Assist first- and second-trimester patients in finding another obstetrician.

There are some circumstances in which you cannot terminate a physician-patient relationship:

- Dismissing a patient on the basis of race, religion, disability, ethnic origin, age, or, in some locations, sexual orientation can violate federal, state, or local laws and professional ethical standards
- Your agreements with health plans might restrict your ability to end a physician-patient relationship with a plan member. Check your contracts carefully
- Terminating the physician-patient relationship when the patient is unstable or in advanced pregnancy could leave you open to charges of patient abandonment ♀

Professional liability, risk management guide



THE NEWEST EDITION OF ACOG'S POPULAR GUIDE *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists* can be a helpful tool for Fellows and Junior Fellows.

This newly updated edition covers a wide array of professional liability and risk management issues, concepts, and strategies in an easily accessible format. Chapters are devoted to such topics as emerging legal theories, the role of the expert witness, consent issues, risk management, liability insurance, high-risk areas for ob-gyns, special liability issues for residents, and litigation stress. ♀

info

➜ http://sales.acog.org; 800-762-2264

2008 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

AUGUST

8–9
ACOG Future Leaders in Ob-Gyn Conference
Washington, DC
202-863-2515

12
ACOG WEBCAST:
Interrupted Pregnancy Coding
1–2:30 pm ET
800-673-8444, ext 2498

14–16
Infectious Diseases Society for Obstetrics and Gynecology 35th Annual Scientific Meeting
Seattle
www.idsog.org/AnnMtg.cfm
202-863-2570

15–16
36th Annual Seminar for Physicians on Breastfeeding
Providence, RI
www.llli.org/ed/PhysSem.html

21–23
ACOG District III, VI, and IX Annual Meeting
Banff, AB
202-863-2530

24–28
18th World Congress on Ultrasound in Obstetrics and Gynecology
Chicago
www.isuog2008.com
info@isuog.org
+44(0) 20-7471-9955

SEPTEMBER

4–6
American Urogynecologic Society 29th Annual Scientific Meeting
Chicago
www.augs.org
202-367-1167

5–7
ACOG District I Annual Meeting
Brewster, MA
202-863-2531

5–7
ACOG District IV Annual Meeting
Orlando, FL
202-863-2441

9
ACOG WEBCAST:
E/M Coding and Medical Necessity
1–2:30 pm ET
800-673-8444, ext 2498

11–13
American Gynecological and Obstetrical Society
Carlsbad, CA
www.agosonline.org
202-863-2648

17–20
Royal College of Obstetricians and Gynaecologists 7th International Scientific Meeting
In conjunction with ACOG and the Society of Obstetricians and Gynaecologists of Canada
Montreal, QC
www.rcog2008.com

17–20
Association of Reproductive Health Professionals Annual Meeting
Washington, DC
www.arhp.org
202-466-3825

17–20
Society of Laparoendoscopic Surgeons 17th Annual Meeting & Endo Expo
Chicago
www.laparoscopy.org
305-665-9959

17–21
American Academy of Family Physicians Scientific Assembly
San Diego
www.aafp.org
800-274-8043

21–25
Annual World Congress for the International Society for the Study of Hypertension in Pregnancy
Washington, DC
www.isshp2008-washington.org
202-877-8141

24–27
North American Menopause Society 19th Annual Meeting
Orlando, FL
www.menopause.org
440-442-7657

25–28
ACOG District VII, VIII, and XI Annual Meeting
Los Cabos, Mexico
202-863-2542

OCTOBER

11–14
American Academy of Pediatrics National Conference & Exhibition
Boston
www.aap.org
847-434-4000

12–15
ACOG Armed Forces District Annual Meeting
Norfolk, VA
202-863-2571

12–16
American College of Surgeons 94th Annual Clinical Congress
San Francisco
www.facs.org/clincon2008
312-202-5000

14
ACOG WEBCAST:
Physician Employment Contracts
1–2:30 pm ET
800-673-8444, ext 2498

15–19
Pacific Coast Obstetrical and Gynecological Society
Victoria, BC
www.pcogs.org
650-723-8156

17–19
ACOG District V Annual Meeting
Cincinnati
202-863-2574

22–25
Central Association of Obstetricians and Gynecologists
New Orleans
www.caog.org
701-838-8323

24–26
ACOG District II Annual Meeting
New York City
518-436-3461

23–26
Academy of Breastfeeding Medicine 13th Annual International Meeting
Dearborn, MI
www.bfmed.org

28–Nov 1
The 37th Global Congress of Minimally Invasive Gynecology—American Association of Gynecologic Laparoscopists Annual Meeting
Las Vegas
www.aagl.org
714-503-6200

31–Nov 5
Association of American Medical Colleges Annual Meeting
San Antonio
www.aamc.org
202-828-0553

ACOG COURSES

1. For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
2. For Coding Workshops, visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Telephone registration is not accepted for Coding Workshops.

Registration must be received one week before the course. On-site registration subject to availability.

AUGUST

15–17
ICD-9-CM and CPT Coding Workshop
Richmond, VA

21–23
Practical Obstetrics and Gynecology (in conjunction with the ACOG District III, VI, and IX Annual Meeting)
Banff, AB

SEPTEMBER

12–14
ICD-9-CM and CPT Coding Workshop
Chicago

18–20
Update on Cervical Diseases
Charleston, SC

26–28
ICD-9-CM and CPT Coding Workshop
Dallas

NOVEMBER

6–8
Practical Obstetric and Gynecologic Ultrasonography: Spotlight on Chronic Pelvic Pain
Naples, FL

14–16
ICD-9-CM and CPT Coding Workshop
Atlanta

20–22
New Surgical Approaches to Incontinence and Prolapse
Chicago

DECEMBER

4–6
The Art of Clinical Obstetrics
New York City

5–7
ICD-9-CM and CPT Coding Workshop
Las Vegas

RESOURCES

Audio recordings of 2008 ACM courses available

AUDIO RECORDINGS FROM THE 2008 ANNUAL Clinical Meeting, held in New Orleans, May 3–7, are now available as MP3 CD-ROMs and audio CDs. Recordings of ACM courses can be extremely useful for Fellows who attended the ACM as well as those who were unable to be there. Recordings are available of postgraduate courses, clinical seminars, interactive sessions, scientific sessions, current issues updates, and the presidential inauguration and convocation. ♀

info

➜ For a list of available products and to order: http://store.avmg.com/acog; 800-283-2864; 9 am to 5 pm Central Time; refer to code 1908SC

NIH global health exhibit debuts

THE NATIONAL LIBRARY OF Medicine is showcasing a new interactive exhibition, "Against the Odds: Making a Difference in Global Health," which focuses on how individuals and communities, in collaboration with scientists, advocates, governments, and international organizations, have made a difference in the health of people around the globe. The exhibit can be viewed online or visited in person at the National Institutes of Health in Bethesda, MD. ♀

info

➜ The exhibit is open to the public and free of charge. The interactive website can be accessed at http://apps.nlm.nih.gov/againsttheodds

The American College of Obstetricians and Gynecologists
PO Box 96920
Washington, DC 20090-6920

Nonprofit Org.
US Postage
PAID
Merrifield, VA
Permit No. 6418