MEDICAL LIABILITY REFORM:
A look at the landscape
Our medical liability system is seriously flawed, and we all know it. It rewards abuse and is unfair. Our patients experience unnecessary medical interventions, while our society as a whole suffers. In the 2009 ACOG Survey on Professional Liability, almost 63% of ob-gyns reported making changes to their practices due to the risk or fear of liability claims or litigation, and nearly 60% made changes because liability insurance was unavailable or unaffordable.

Let me illustrate one way our litigation system imposes enormous harm on our patients and on our specialty: The vast majority of instances of neonatal encephalopathy and cerebral palsy are attributable to events occurring before labor begins. We know that less than 10% of cases of neurologic impairment in newborns result from events in labor and, of these, the majority are not preventable. Not only are ob-gyns held responsible, but we are also subjected to enormous judgments when a legal case results in an award.

In September we convened our multi-specialty Task Force on Neonatal Encephalopathy and Cerebral Palsy, chaired by Mary E. D’Alton, MD. This international group of experts is updating our classic authoritative booklet on this topic. This document—endorsed and supported by key federal agencies and organizations—has been used in the courtroom to level the playing field, and we must keep it current so it will continue to be a respected source.

ACOG is continually active in pursuing medical liability reform, including advocacy at the federal and state levels. On page six, read about the current medical liability reform landscape in the US. Our vibrant Committee on Professional Liability provides medical liability resources for ob-gyns. Our expert Committee on Patient Safety and Quality Improvement develops recommendations and resources to improve patient safety. These materials can help us stay out of the courtroom.

Liability is a part of our daily lives, and even though our current system is broken and unjust, it is important for us to recognize it as part of our profession. Each of us must stay focused on the big picture and on the remarkable things we do for so many. We need to keep ourselves emotionally healthy and strong for the good of our patients, our families, and our futures.

Through our work, we have the capacity to save lives and keep families intact for generations as we deliver new babies, while protecting and caring for their mothers. I have witnessed miracles on the obstetric floor and after 30 years of caring for women, I am constantly reminded that our patients depend on ob-gyns to provide a safe environment for their most vulnerable moments and conversations. When people ask why I am an ob-gyn in the face of so many challenges, my answer is simple: “We ob-gyns make all the difference in the lives of our patients.”

Richard N. Waldman, MD
President
Clinical Updates emphasize total care of women

The Clinical Updates in Women’s Health Care series was first launched by The College nearly 10 years ago. This series of educational monographs was designed to help our members recognize, diagnose, and treat common disorders of women that are not usually related to the female reproductive system, but are frequently encountered by ob-gyns in their practices. The content is developed and overseen by an editorial board. The monographs emphasize the total care of women, are written by experts in their respective fields, and are peer-reviewed. Self-assessment questions are included with each monograph, which enables subscribers to test their clinical skills and earn five continuing medical education credits.

As the practice of obstetrics and gynecology evolves, ob-gyns increasingly serve as patients’ medical homes, and the information provided in the Clinical Updates in Women’s Health Care series also is evolving and becoming more and more essential. Recent topics include Anorectal Disorders, Continuing Care for Women With Breast Cancer, and Occupational Diseases and Injuries. Upcoming topics include Perioperative Considerations for Co-existing Medical Conditions, Multiple Sclerosis, and Renal Disease. Hypertension and Diabetes Mellitus are also part of the series. The College frequently revises these topics to keep physicians apprised of new guidelines and therapies. Occasionally, we feature a complex reproductive condition, such as vulvar disease, or a compelling subject such as elder abuse, to inform and educate our readers.

A subscription to Clinical Updates in Women’s Health Care provides four quarterly issues and a fifth bonus issue. College residents receive complimentary copies of the quarterly issues to help them prepare for ambulatory practice. The subscription also provides online access to all monographs in the series at www.clinicalupdates.org.

Abstracts and tables of contents of current issues are available online for both subscribers and non-subscribers. If you are a non-subscriber, please visit www.clinicalupdates.org and review them. New features for subscribers include periodic updates, links to tables of contents of each issue, direct links to references, and links to PubMed, Obstetrics & Gynecology, and The College’s patient education materials. All of these enhancements are designed to speed your access to information and strengthen your practice.

We continually strive to produce valuable educational materials and opportunities for our members. The Clinical Updates in Women’s Health Care series is a particularly important part of our offerings. If you are a subscriber, you are aware of the value. If not, I urge you to visit www.clinicalupdates.org and review the abstracts, or call 800-762-2264 to learn more. I believe you will become convinced of the value of this resource.

Ralph W. Hale, MD, Executive Vice President

ACOG recognizes best mentors . . . . . 4
Family risk of breast cancer . . . . . . 5
Medical liability reform . . . . . . . . . 6
ACOG’s liability resources . . . . . . . 9
Preventing surgical errors . . . . . . . 10
Issue of the year: collaborative practice . . 11

ACOG’s 2011 Congressional Leadership Conference
Washington, DC
February 27–March 1, 2011

Attend ACOG’s 29th Congressional Leadership Conference, February 27–March 1, 2011, in Washington, DC. Following two days of CME-accredited advocacy training, ACOG President Richard N. Waldman, MD, will lead participants to Capitol Hill meetings. Contact your district or section chair to register or request sponsorship, or contact Stacie Monroe at 800-673-8444, ext 2505, or smonroe@acog.org.

At the 2010 CLC, US Senator Charles Grassley (R-IA) (center), ranking member of the Senate Finance Committee, met with ACOG members (from left) District VI chair Thomas M. Gellhaus, MD, Thaddeus L. Anderson, MD, Michael P. Woods, MD, Debra Piehl, MD, Susan E. Wing, MD, and Michael J. McCoy, MD.

DECISION 2011

**It’s a great time to be a Junior Fellow**

**New incoming Junior Fellow district chairs**

Junior Fellow district chairs offer guidance, leadership, and inspiration. Contact your new chair, listed below, to learn more about ACOG’s resources and opportunities to get involved.

<table>
<thead>
<tr>
<th>District</th>
<th>Name</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Jeannine Marie Miranne, MD</td>
<td>Providence, RI</td>
</tr>
<tr>
<td>II</td>
<td>Jessica M. Atio, MD</td>
<td>New York, NY</td>
</tr>
<tr>
<td>III</td>
<td>Aasta D. Mehta, MD</td>
<td>Philadelphia, PA</td>
</tr>
<tr>
<td>IV</td>
<td>Hilary A. Roeder, MD</td>
<td>Durham, NC</td>
</tr>
<tr>
<td>V</td>
<td>Jessica A. Shepherd, MD</td>
<td>Louisville, KY</td>
</tr>
<tr>
<td>VI</td>
<td>Diane Horvath-Cosper, MD</td>
<td>Eagan, MN</td>
</tr>
<tr>
<td>VII</td>
<td>Winston McCain Ashurst, MD</td>
<td>Montgomery, AL</td>
</tr>
<tr>
<td>VIII</td>
<td>Jeanelle Sabourin, MD</td>
<td>Edmonton, AB, Canada</td>
</tr>
<tr>
<td>IX</td>
<td>David L. Finke, MD</td>
<td>Los Angeles, CA</td>
</tr>
<tr>
<td>Armed Forces</td>
<td>Jason C. Massengill, MD</td>
<td>Gaithersburg, MD</td>
</tr>
<tr>
<td>XI</td>
<td>Luke A. Newton, MD</td>
<td>San Antonio, TX</td>
</tr>
</tbody>
</table>

**Recognize your excellent mentors**

ACOG ENCOURAGES YOUNG PHYSICIANS and Junior Fellows to nominate their ob-gyn mentors for the 2011 ACOG Mentor Award.

“Mentors play important roles as counselors and advisors to new physicians. This award is a great way to acknowledge ob-gyns who have been excellent mentors to younger doctors as they begin practice,” said Cynthia A. Brincat, MD, PhD, chair of the Junior Fellow Congress Advisory Council (JFCAC). “Any Young Physician or Junior Fellow may nominate a mentor, so go for it!” The deadline for nominations is February 1, 2011. All nominations must be submitted online at www.acog.org. Winners will receive lapel pins and be recognized in ACOG Today, online, and in district newsletters.

Congratulations to the 2010 recipients of the ACOG Mentor Award:

- Rudi Ansbacher, MD
- Jeffrey R. Cragun, MD
- Thomas S. Gatewood, Jr, MD
- Richard Cullen Hopkins, MD
- Reza Shah-Hosseini, MD
- Kailash R. Makhija, MD
- Richard C. Mooney, MD
- Vicki L. Seltzer, MD
- Donald S. Wiersma, MD
- Mary R. Wren, MD
- Darrell E. Zeller, MD

**Information:** Visit [www.acog.org](http://www.acog.org) and click on “Junior Fellows.”
Although 90% of breast cancers are sporadic, approximately 10% are due to inherited genetic susceptibility syndrome. For women with a hereditary risk of cancer, early identification and referral to a specialist could greatly improve their chances of preventing or surviving a cancer if it occurs. During National Breast Cancer Awareness Month (www.nbcam.org) in October, The College reminds ob-gyns of the critical importance of taking a thorough family history to recognize women at increased risk. High-risk women may include those with multiple family members who’ve had breast or ovarian cancer, dual primary cancers, or premenopausal breast cancer.

“It’s exciting that we may be able to treat patients better and alter their risk if we know of a hereditary link,” said Eva Chalas, MD, professor and vice chair of the Department of OB-GYN and director of Clinical Cancer Services at Winthrop University Hospital in Mineola, NY. “We ob-gyns still are not doing a good job of taking family history and identifying women who might need to be genetically tested. It’s our obligation to recognize these women and steer them in the right direction.”

A referral to a gynecologic oncologist or genetic specialist or counselor is a natural next step once a hereditary link has been established. “When women have a family history of cancer, there are a lot of things that we do differently,” said Susan C. Modesitt, MD, associate professor and director of the Gynecologic Oncology Division and The High-Risk Breast and Ovarian Cancer Clinic of the University of Virginia Health System in Charlottesville.

A risk assessment model is typically run to better understand a woman’s risk of carrying a deleterious BRCA mutation and of developing breast cancer. “If the calculated lifetime risk is higher than 20% or if there is a known genetic predisposition, we would recommend MRIs of the breasts in addition to annual mammography. We might also add a pelvic ultrasound or CA-125 if the patient is at risk for ovarian cancer,” Dr. Modesitt noted. Additional risk-reduction strategies may also be needed, such as therapy with tamoxifen and/or raloxifene or oral contraceptives, or prophylactic mastectomy or oophorectomy.

An awareness message for all women
“High-risk or not, women know they have a one-in-eight chance of developing breast cancer in their lifetime. Women are very scared of breast cancer and they come in worried,” Dr. Modesitt said, adding that many of her patients are often confused about whether or not they should take soy or hormones or if they should drink alcohol.

The College recommends that women in their 40s continue mammography screening every one to two years, and women age 50 or older continue annual mammography screening. Additionally, ob-gyns can underscore lifestyle interventions such as eating a healthy diet, exercising, and maintaining a normal body weight, which can lower their risk of cancer and other health problems such as heart disease, the number-one killer of women.

Information:
Currently, on the national level, a serious disconnect exists between what is happening in health care reform and not happening in medical liability reform. On one hand, the new health care reform law is designed to lower health care costs and introduce tens of millions more patients into the system. On the other, the current medical liability environment—where essentially no reform is occurring on the federal level—is making it harder and, some would argue, nearly impossible for ob-gyns to confidently deliver the experienced care patients need and deserve.

The greatest potential for change now appears to be with alternative strategies for reform, and some activity on the state level is beginning to show promise. For instance, $25 million in grants, recently offered through the Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) (see sidebar on page eight), has been awarded to address the issue. The federal health reform bill, the Patient Protection and Affordable Care Act (PPACA), contains a small provision to authorize grants for state demonstration programs to evaluate alternatives to current medical tort litigation, but it has not yet been funded and includes restrictions. Additionally, some progress has been made in certain states, although steps backwards have been taken in others.

ACOG continues to make medical liability reform a top priority.

**ACOG survey reveals majority of ob-gyns make changes to their practices**

ACOG released survey results on medical liability last fall, which provide detailed insights into how medical liability is affecting ob-gyns. Overall, the survey revealed that nearly 63% of ob-gyns made changes to their practices due to the risk or fear of liability claims or litigation, and nearly 60% have made changes to their practice because liability insurance is either unavailable or unaffordable.

“This survey shows that the medical liability situation for ob-gyns remains a chronic crisis and continues to deprive women of all ages—especially pregnant women—of experienced ob-gyns,” said Albert L. Strunk, JD, MD, ACOG deputy executive vice president. “Women’s health care suffers as ob-gyns further decrease obstetric services, reduce gynecologic procedures, and are forced to practice defensive medicine.”
Of the survey respondents who reported making changes to their practices as a result of the risk or fear of professional liability claims or litigation, the survey revealed how it affects the decisions they make:

**Obstetric practices**
- 30% decreased the number of high-risk obstetric patients they accepted
- 29% reported performing more cesarean deliveries
- 25.9% stopped offering and performing vaginal births after cesarean (VBACs)
- 13.9% decreased the number of total deliveries
- 8% reported stopping practicing obstetrics altogether

**Gynecologic practices**
- 15% decreased gynecologic surgical procedures
- Just over 5% stopped performing major gynecologic surgery
- 2% stopped performing all surgery

**Claims reported**
- Regarding claims, nearly 91% of ob-gyns indicated they had experienced at least one liability claim filed against them, for an average of 2.69 claims per physician
- 62% of the total reported claims were for obstetric care
- 38% were for gynecologic care
- Of those who reported claims, nearly 43% reported at least one claim filed against them was a result of care rendered during their residency training

**AMA survey confirms negative impact of liability challenges**
On August 3, the AMA released results from its Physician Practice Information survey, revealing new information about medical liability challenges physicians face, and confirming ACOG’s findings regarding the negative impact of liability on ob-gyns and their patients. According to the AMA:
- Six out of 10 physicians ages 55 and older have been sued
- Based on career-to-date measures of physicians surveyed, 95 liability claims were filed per 100 physicians
- Before they reach the age of 40, more than 50% of ob-gyns have already been sued
- The number of claims per 100 physicians was more than five times greater for ob-gyns and general surgeons than it was for pediatricians and psychiatrists

**Texas holds steady**
Despite national survey findings, some progress has been made at the state level. For instance, Texas passed legislation in 2003, and ultimately a constitutional amendment, limiting non-economic damages in medical liability cases to $250,000, which continues to be upheld today. The result has been decreased insurance premiums, increased numbers of physicians practicing in the state, improved access for patients, and significantly more carriers offering liability insurance.

“The bottom line is that non-economic caps work,” said William L. Rayburn, MD, who serves as chair of ACOG’s Committee on Professional Liability. “Texas was fortunate because legislation was passed, the governor signed the bill, and state voters passed a constitutional amendment to approve the content of the legislation. Texas created a coalition of businesses, hospitals, health care systems, chambers of commerce, insurance companies, physicians, and health care workers who supported the legislation—that was the key.”

**Florida fund working better than ever**
Florida’s Birth-Related Neurological Injury Compensation Association (NICA), a physician-, certified-nurse-midwife-, and hospital-funded program that offers no-fault compensation for certain catastrophic birth-related medical injuries, has been in place since 1988. According to Robert W. Yelverton, MD, chief medical officer of Women’s Care Florida and chair of the NICA Medical Advisory Committee, not only does the program continue to work well, it is working even better than before.

“There are fewer challenges to the system now and people understand and respect it—it is well administered and applied,” he said. “The number of physicians who participate has approximately doubled since the program began.” Part of the reason why the model works so well, he explained, is the way it is funded and the fact that it does not attempt to cover everything.
Medical liability reform and patient safety grant recipients begin work, focusing on better communication

In June, the Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) announced nearly $25 million in grants to support efforts to implement and evaluate patient safety approaches and medical liability reforms.

A team lead by Thomas Gallagher, MD, associate professor of medicine at the University of Washington in Seattle, was awarded a $2.9 million grant through the program, and began its work on July 1. Dr. Gallagher explained that his team believes communication is the missing link when it comes to improving patient safety and reducing medical liability risk.

“Communication breakdowns happen among health care workers, but also between health care workers and patients,” Dr. Gallagher said.

“Communication among health care workers is critical to preventing adverse events and errors from happening, and includes sharing information with one another and resolving conflicts. These same skills are equally important when health care workers respond to a patient after an adverse event, talking with the patient about what happened and supporting his or her emotions. These skills should be taught as an integrated package.”

Specifically, Dr. Gallagher and his team will focus on four key areas:

- Creating a multi-stakeholder collaborative, including health care associations, trial lawyers, consumer groups, and others in the state to study ways to enhance communication to prevent and respond to medical injuries
- Implementing intensive communication training to prevent and respond to medical injuries at 10 partner health care institutions
- Developing and evaluating a collaborative approach to adverse event analysis, disclosure, and compensation between five of 10 partner health care institutions and Physicians Insurance, the primary insurer in the state of Washington
- Extending the communication training statewide via interactive e-learning modules and assessing its impact on patient safety and medical liability

“We’re fortunate that Washington State provides a unique environment for improving health care communication,” Dr. Gallagher said. “This includes a statewide infrastructure for quality of care data sharing in a protected setting that feeds a peer-led approach to system change. Our governor and US senators have endorsed the project as well, and Physicians Insurance, which insures over half the state’s physicians, is a key project partner.”

(State Review continued)

“Physicians, certified nurse midwives, and hospitals are willing to fund it themselves—if it had been presented as a taxpayer responsibility, it likely would not have been adopted by the Florida legislature or been effective if passed,” Dr. Yelverton said. “Also, it is limited in what it can cover—for instance, it does not cover cerebral palsy without mental injury.”

Attempts to reach consensus failing in New York State

New York obstetricians pay some of the highest medical liability premiums in the nation, and New York leads the country in the number of medical liability claims filed. After four decades of failed attempts to reach consensus on medical liability tort reform in the state, little hope of legislative success remains. A number of hospitals in New York have closed their OB departments or reduced their numbers of OB beds.

In June, however, New York was one of seven states to be awarded a Health and Human Services Medical Liability Reform and Patient Safety Demonstration Grant (see sidebar above) to study medical liability. The $2.9 million project has three components. The first will work directly with clinicians to measure the culture of safety, improve it, and measure it again. The second is based on work at the University of Michigan, whereby cases, in which the standards of care are clearly not met, are brought to the patient with an apology and offer of a settlement. Third, for cases that end up in the court system, New York will expand its judge-negotiated settlement program currently operating in the Bronx court system.

“In order to position the judges who will be involved in the negotiated settlements, ACOG Fellows have been asked to assist with the provision of ‘judicial medical training,’” said Donna Montalto, MPP, executive director of ACOG’s District II. “Judges will be learning what the standard of care means and why it matters; how to read a medical chart; brief anatomy and physiology; and what diagnostic testing is, and why is it used,” she explained.

Caps invalidated in Illinois

In February, a long-awaited ruling from Illinois’ high court invalidated the state’s cap on non-economic damages of $500,000 for physicians and $1 million for hospitals. The Illinois Trial Lawyers Association made a public announcement, indicating it would rely on this lawsuit to challenge the constitutionality of the 2005 tort reform law in its entirety. (It is noteworthy that after the cap was passed in 2005, medical liability lawsuits in Cook County, IL, dropped 25% the following year.)

This was the third ruling against caps. Once in 1976, and again in 1997, the Illinois Supreme Court ruled against them. The 2005 law had been crafted with careful attention to these past rulings, and included a findings section emphasizing the public policy value of caps in preserving patient access, as well as a severability clause tying the cap to increased state oversight of physicians and liability insurers.
ACOG’s medical liability resources

ACOG’s Committee on Professional Liability has developed materials and resources to educate and empower the Fellowship. William L. Rayburn, MD, committee chair, recommends that ACOG members familiarize themselves with the following materials, available from the ACOG Bookstore (sales.acog.org or 800-762-2264):

**Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists, 2nd Edition**

This book recognizes the need for physicians to both reduce medical errors and be prepared for the reality of civil litigation. It covers a wide array of professional liability and risk management issues, concepts, and practical strategies presented in an easily accessible format, from the basic elements of professional liability to surviving the insult of being faced with a lawsuit. The guide is an important primer for the new ob-gyn, but also a valuable refresher or discussion catalyst for experienced physicians and practice management staff.

A complimentary teaching guide and quiz series to supplement the book is available on the Professional Liability web page of the ACOG website. The teaching guide consists of seven PowerPoint modules and scripts, each well suited for a 20- to 30-minute presentation and discussion between ob-gyn program instructors and residents in training.

**From Exam Room to Courtroom: Navigating Litigation and Coping with Stress**

Hosted by physician mentors, this CD-ROM empowers physicians to effectively navigate the legal system, recognize and cope with symptoms of litigation stress, and emerge intact from such painful experiences. Content areas include: Handling an Adverse Event; Dealing With the Lawsuit; Understanding Pre-Trial Discovery; Deciding Whether to Settle; Getting Through the Trial; Life After the Trial; and Stress Relievers and Tools.

Physicians can earn up to 12 CME for completing the program.

**Professional liability and risk management webcasts**

Each year, ACOG selects three webcast topics focusing on clinical areas commonly associated with liability claims. The next webcast, “Cord Blood Gases: From Delivery room to Courtroom,” will be offered on November 9. Visit www.acog.org/postgrad/pgpage.cfm?recno=536

**Other ACOG resources**

- Committee Opinion #406 Coping with the Stress of Medical Professional Liability Litigation (May 2008)
- Professional Liability webpage: www.acog.org/departments/dept_web.cfm?recno=4

---

**Snapshot of a practice: Jackson Healthcare for Women**

For some practices, the medical liability environment affects them on several levels. Earl Stubblefield, MD, current member of ACOG’s Committee on Professional Liability, is an ob-gyn practicing at Jackson Healthcare for Women in Jackson, MS. As part of a team of 15 obstetricians and gynecologists, he describes the conditions under which they operate.

“We practice in a tri-county area, which includes one county that is a bad venue from a defense perspective for liability claims,” he says. “Many physicians have shifted their practices outside of this county, including us. We still do some work there, but prefer to avoid it.”

On a day-to-day level, there is a constant awareness at Jackson Healthcare for Women of the risk of medical liability.

“When it comes to obstetrics, concerns about liability claims significantly increase the amount of testing we do,” he says. “These concerns also can have a tendency to increase our cesarean rates and affect our relationships with our patients because they are aware of this. They know we do some of these things in order to place ourselves in a better defensive position.”

**Broad reform needed, and ACOG Fellows must be proactive**

There is no question that liability reform must move to the forefront of the national health care agenda if patients are to continue to receive the quality care they need. At the same time, Dr. William L. Rayburn, chair of ACOG’s Professional Liability Committee, stresses there is much Fellows can do to minimize their risk of liability, including following protocols and reviewing *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists*, and other ACOG resources (see sidebar at right).

“The adoption of specific practice protocols (such as the standardization of oxytocin administration) and the use of standardized documentation for events such as shoulder dystocia and postpartum hemorrhage can significantly reduce risk,” he said. “Additionally, implementing systems to monitor and track lab and imaging results, service recovery, and effectively communicate with unhappy patients are important components of an in-office risk management program.”

“Judges will be learning what the standard of care means and... how to read a medical chart.”
Prevention of Surgical Errors begins long before a patient enters the operating room and requires instituting some fairly simple routines, such as using checklists, eliminating distractions, and designating the actual surgical site on the patient with a marker, according to new recommendations issued by The College in September. Actively involving the patient before surgery also is an essential element in avoiding errors during surgery.

According to The Joint Commission, there were 116 wrong-site surgical errors in the US in 2008. Wrong-site surgeries are operations on the wrong-side of a patient, the wrong organ, or the wrong patient. Some common circumstances that increase the risk for surgical errors include having multiple surgeons involved, multiple procedures being performed on the patient at the same time, patients with unusual physical characteristics (such as morbid obesity or a physical deformity), and time pressures to start or complete the surgery.

“It’s fair to say that communication failures between surgeons and the rest of the health care team is a frequent theme in why many, if not most, surgical errors occur,” said Patrice M. Weiss, MD, chair of The College’s Committee on Patient Safety and Quality Improvement. “We’re highlighting the common situations that raise the risk of surgical errors and offering concrete steps to prevent them. We hope that physicians will utilize these preventive measures to protect their patients.”

The Joint Commission’s three-part universal protocol to prevent surgical errors is one useful tool for health care teams, according to The College. The first component entails having the health care team ensure that all of the patient’s relevant documents and all of the surgical equipment is available, correctly identified, and reviewed before surgery. The second element entails marking the incision or insertion site of the surgery. Calling a “time out” before the surgery begins for the health care team to confirm the identity of the patient, the surgical site, and the indicated surgery is the third protocol component.

“Using standard checklists, systems, and routines may sound to some like cookbook medicine, but they have been proven to greatly reduce surgery errors,” said Richard N. Waldman, MD, president of The College. “Airplane pilots routinely use checklists to reduce risks and improve safety—why shouldn’t physicians?”

Another useful tool to enhance patient safety is a checklist published by The World Health Organization (WHO), said Dr. Weiss. The checklist allows surgical teams to review routine items and procedures before they administer anesthesia, before they make the first incision, and again before the patient is wheeled out of the operating room. The WHO maintains that errors can be reduced when the entire surgical team verifies the incision site and that any team member should be encouraged to point out a possible error without fear of being reprimanded or ridiculed.

All pregnant women should be given antibiotics before having a cesarean delivery to help prevent infections, according to new recommendations issued by The College. Antibiotics should be given within one hour of the start of surgery for maximum effectiveness.

Infection is the most common complication of cesarean delivery and can occur in 10% to 40% of women who have a cesarean compared with 1% to 3% of women who deliver vaginally. “Based on the latest data, prophylactic antibiotics given to pregnant women before a cesarean significantly reduce maternal infection and do not appear to harm newborns,” said William H. Barth, Jr, MD, chair of The College’s Committee on Obstetric Practice. “We’re recommending that all women who undergo cesarean get a preventative course of antibiotics before the surgery starts.”

An exception to this, Dr. Barth noted, are pregnant women who are already taking appropriate antibiotics for another problem, such as chorioamnionitis (infection of the membranes surrounding the fetus).

Encourage your patients to participate in gynecologic cancer clinical trials

FOR THE ESTIMATED 83,000 women who will be diagnosed with a gynecologic cancer in 2010, participation in clinical trials offers an opportunity both to ensure that future patients benefit from the most up-to-date treatments and increased survival rates and to potentially improve the health of current patients. The College encourages ob-gyns to raise awareness about gynecologic cancers and participation in clinical trials—a main focus of this year’s Gynecologic Cancer Awareness Month (GCAM) in September.

“Raising awareness of gynecologic cancers is extremely important because every woman is at risk,” said Richard N. Waldman, MD, president of The College. “As ob-gyns, we have a responsibility to educate our patients about the very real threat of these cancers, which will kill approximately 28,000 women in the US this year alone.” Gynecologic cancers originate in the female reproductive organs, including the cervix, ovaries, uterus, fallopian tubes, vagina, and vulva.

Women who participate in clinical trials make an extremely valuable contribution to scientific knowledge. They also may gain access to new research treatments before they are widely available and can benefit from having their health closely monitored on an ongoing basis. They often have easy access to the clinical trial team, obtain expert medical care at leading health care facilities, and are able to raise questions and concerns during treatment. Some women who participate in a clinical trial report feeling empowered because they are taking an active role in decisions regarding their health.

Despite the importance of participating in clinical trials, only 3% of adults do so. That rate is even lower among low-income women and minorities, groups that have disproportionately higher rates of cancer-related deaths.

The Gynecologic Cancer Foundation (GCF), which sponsors GCAM, urges women diagnosed with a gynecologic cancer to learn more about clinical trials. The GCF’s Women’s Cancer Network website (www.wcn.org) is a comprehensive and educational resource. Your patients can find out about clinical trials that are currently enrolling, take a free 15-minute online risk assessment to learn about their personal risk of developing cancer, and more.

More information about common cancers affecting women, prevention, symptoms, and treatment options can be found at www.protectanddetect.org.

2011 Issue of the Year:
Successful Models of Collaborative Practice in Maternity Care
Invitation to submit papers

THE COLLEGE IS CALLING for papers describing successful collaborative practice involving ob-gyns and certified nurse-midwives/certified midwives. The submission deadline is February 1, 2011. Papers should include discussions of how physician and midwife collaborative practice models have affected maternity and women’s health care in both community and academic settings. Papers may be selected for publication in Obstetrics & Gynecology. Top papers will receive monetary awards, and authors will present at the 2011 ACM and the American College of Nurse-Midwives 2011 Annual Meeting.

Papers must be coauthored by at least one ACOG Fellow and one certified nurse-midwife/certified midwife who is a member of the American College of Nurse-Midwives. Suggested topics include the practice model and how patient care decisions are made; state, regulatory, and credentialing issues; practice outcomes (using data if possible) related to women, providers, and the health care setting; challenges and solutions; and interdisciplinary education and training; among others. Manuscripts may be prepared according to the author guidelines for Obstetrics & Gynecology for “Current Commentary” (www.editorialmanager.com/ong/) and be 10 to 30 pages. Submit applications via email to csacks@acog.org, or by postal mail, to: Ms. Catherine Sacks, Practice Activities, ACOG, 409 12th Street SW, Washington, DC 20024

Information:
Learn about judging criteria and what to include at www.acog.org/from_home/misc/issueoftheyear.cfm. Contact Catherine Sacks at 202-863-2501 or csacks@acog.org; or Tina Johnson, CNM, MS, at 240-485-1840 or tjohnson@acnm.org.

PLAN TO ATTEND
March 20–23, 2011
1st World Congress of Obstetrics, Gynaecology and Andrology: Psychosomatic and Biological Perspectives on Clinical Controversies, London • www.bspoga.org
MAKING the Rounds

New Resources

Ob-Gyn Buyer’s Guide
A new online Ob-Gyn Buyer’s Guide is now available for ACOG members. Find the newest products quickly and easily through streamlined searches. “ACOG is constantly looking for ways to help our members in their practices,” said Ralph W. Hale, MD, ACOG’s executive vice president. “Our new Buyer’s Guide is one of the ways you can benefit from ACOG.” Visit obgynbuyersguide.com or go to www.acog.org and click on “Ob-Gyn Buyer’s Guide.”

Pelvic Floor Disorders DVD
An outstanding teaching tool, and also a resource to explain the anatomy of pelvic floor disorders to patients, this DVD-ROM features a dynamic 3D atlas that complements an extensive clinical section covering commonly presenting conditions including prolapse, incontinence, voiding dysfunction, and postpartum dysfunction. Technical Specifications: PC—Windows 98 and above including Vista. Mac—OS X and above. Item: MM011. Order at sales.acog.org or call 800-762-2264.

Practice Updates

Committee Opinions
- **467 Human Papillomavirus Vaccination** (Replaces #344, September 2006)
- **466 Ethical Considerations for Performing Gynecologic Surgery in Low-Resource Settings Abroad**
- **465 Antimicrobial Prophylaxis for Cesarean Delivery: Timing of Administration**
- **464 Patient Safety in the Surgical Environment**

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

ACOG COURSES AND CODING WORKSHOPS
- **OCTOBER 7-9.** Quality and Safety for Leaders in Women’s Health Care, Atlanta, GA
- **OCTOBER 8-10.** Reawakening the Excitement of Obstetrics and Gynecology, In conjunction with the District I Annual Meeting, Bar Harbor, ME
- **OCTOBER 8-10.** Update on Cervical Diseases, In conjunction with District III and District VI Annual Meeting, Key Biscayne, FL
- **OCTOBER 12.** ACOG Webcast: Diagnosis Coding for Obstetric Care Complications
- **OCTOBER 14-16.** Reawakening the Excitement of Obstetrics and Gynecology, In conjunction with Districts VII, VIII, IX, and XI Annual Meeting, Maui, HI
- **OCTOBER 15-17.** Coding Workshop, San Antonio, TX
- **NOVEMBER 4-6.** Update on Cervical Diseases, Las Vegas, NV
- **NOVEMBER 9.** ACOG Webcast: Cord Blood Gases: From Delivery Room to Courtroom
- **NOVEMBER 19-21.** Coding Workshop, Chicago, IL
- **DECEMBER 2-4.** Practical Obstetrics and Gynecology, Chicago, IL
- **DECEMBER 2-4.** Twenty-First Century Obstetrics and Gynecology, New York, NY
- **DECEMBER 3-5.** Coding Workshop, Atlanta, GA
- **DECEMBER 14.** ACOG Webcast: Preview of New Codes for 2011

REGISTER ONLINE at www.acog.org/postgrad/index.cfm.

To learn about freestanding postgraduate courses, email PGCourses@acog.org. To learn about coding courses and webcasts, call 202-863-2498 or email coding@acog.org.