COPING WITH THE STRESS
OF LIABILITY LITIGATION

NOT IF, BUT WHEN
Medical liability and its effects on our specialty are the most important issues facing ob-gyns. Medical liability lawsuits against ob-gyns are far too common. The current threat is causing ob-gyns to retire early, cease to provide obstetric care, or engage in defensive medicine.

Our new Committee Opinion #497, Coping with the Stress of Medical Professional Liability Litigation, discusses how to manage the isolation, anxiety, and emotional turmoil ob-gyns experience during litigation. See the article inside for more information.

Being sued is often a matter of “when” and not “if” for ob-gyns, a reality that raises the question of what is being done to address the crisis. ACOG is continually working on many fronts to achieve national and state-level professional liability reforms.

For decades, The College has provided evidence-based information to help us understand, diagnose, and manage many conditions we encounter during the care of our patients, thereby defining the best ways to practice. Reducing unnecessary variation in health care has been shown to promote safer care, improve patient outcomes, and potentially decrease professional liability exposure. When a system of care is well defined and practiced, a particular outcome that does not meet expectations would not indicate any wrongdoing if the evidence-based plan was followed.

Increasingly, The College has received requests from our members to help clarify and provide evidence-based clinical support. Toward this end, The College has developed patient safety checklists and order sets to help practitioners practice safely and correctly. Checklists identify items that should be confirmed before or during the scheduling or the performance of a procedure, or facilitate documentation of what was accomplished or used during the procedure. Protocols provide the physician with clear paths in patient management that are problem-specific. Order sets direct physicians toward therapeutic options for particular clinical situations and medications. In November 2011, the first in the series of The College’s Patient Safety Checklists will be published in the Green Journal and will also be available online.

All of these tools, in addition to existing College guidelines, intended for optimizing patient safety and quality, will be developed through our practice committees, with the approval of the Executive Board. I believe that this effort can be very beneficial for both patients and providers.

Exxcellence in Clinical Research Now Open to Ob-Gyn Fellows and Junior Faculty

The Foundation for Exxcellence in Women’s Health Care is pleased to announce that starting October 26 applications are being accepted for the April Exxcellence in Clinical Research course.

The Exxcellence Foundation continues to seek funding to support the courses. In addition to corporate and foundation funding, and to insure the growth and sustainability of the program, tuition of $5,000 per attendee is being charged.

Current Fellows in ABOG-approved fellowships or ob-gyn junior faculty are eligible. For more details, please visit our website at www.exxcellence.org.
ACOG announces “Reentry into Practice” as the subject of our 2012 Issue of the Year Award. An increasing number of practicing ob-gyns are choosing to take extended time away from their practices, primarily for family reasons. Historically, physicians limiting their practices tended to be nearing retirement when a loss of obstetrical or surgical privileges was less problematic.

Maintenance of Certification and Joint Commission requirements that hospital credentialing committees prove ongoing physician competency create significant return-to-practice hurdles for younger physicians. Another group of physicians—those who choose early in their careers to stop obstetrics but later decide to restart the practice—also encounter credentialing difficulties.

Retraining, evaluating, and documenting competency for reentry is a formidable process. Institutions choosing to offer reentry training face liability concerns, as well as challenges ensuring they have appropriate faculty. Physicians wishing to go through reentry may find it difficult to obtain liability coverage and handle expenses.

For several years, ACOG has reviewed these issues from a practice, liability, and educational perspective. Our Patient Safety and Quality Improvement Committee surveyed retraining programs and found most are point-in-time assessments and not true educational and clinical experience programs.

The Residency Review Committee for Obstetrics and Gynecology has clearly stated that retraining of physicians, if done in an institution with an ob-gyn residency, must not detract from the educational experience of the residents, and that ob-gyns in a retraining situation could not be utilized as faculty to supervise residents.

The Issue of the Year program invites institutions and emerging reentry programs to submit papers using publication criteria from the Green Journal. Papers should describe how a reentry program was developed and how it addresses the issues outlined above, including success achieved, barriers encountered, and solutions that enabled success. The winning paper will receive a cash award and be published in the Green Journal. The author will be invited to present to the Executive Board in February 2012. Submissions are due December 1 by email to csacks@acog.org. We hope many emerging reentry programs will share their stories and become a resource to benefit all ob-gyns.

New, Expanded, and Revised ICD-9-CM Codes

New, expanded, and revised ICD-9-CM codes became effective October 1, 2011. Changes of interest to ob-gyns include:

- New codes for complications of vaginal mesh and other prosthetic materials
- Code 646.7 now includes biliary (liver and biliary tract disorders in pregnancy)
- New code for personal history of gestational diabetes (V12.21)
- Category V23 includes new codes for history of ectopic pregnancy and inconclusive fetal viability
- New code 651.0 added to report what is referred to imprecisely as false positive pregnancy
- New code 649.3 added to report planned cesarean delivery after 37 weeks, but before 39 completed weeks of gestation, resulting from (spontaneous) onset of labor

For complete details, please refer to full article under Coding on the ACOG website (www.acog.org).
Venous thromboembolism is a leading cause of maternal morbidity and mortality in the US. Pregnant women have a four- to five-fold increased risk of venous thromboembolism compared with nonpregnant women. The risk is present from the first trimester and is even higher postpartum.

The College’s new Practice Bulletin #123, Thromboembolism in Pregnancy (which replaces Practice Bulletin #19, published in August 2000), reflects a greater emphasis on preexisting medical conditions, acquired risk factors, and pregnancy complications, such as cesarean delivery, according to Andra H. James, MD, MPH, associate professor of ob-gyn and medicine at Duke University Medical Center in Durham, NC, who helped develop the new Practice Bulletin.

The College now supports thromboprophylaxis at the time of cesarean delivery. “Cesarean delivery approximately doubles the risk of venous thromboembolism,” said Dr. James. The College is recommending that women not already receiving thromboprophylaxis have pneumatic compression devices placed at the time of cesarean delivery. “Fitting inflatable compression devices on a woman’s legs before cesarean delivery is a safe, potentially cost-effective preventive intervention,” said Dr. James.

“A personal history of thromboembolism and inherited or acquired thrombophilias are the major risk factors for venous thromboembolism in pregnancy,” said Dr. James. “The first step in planning a strategy for an individual patient is to obtain a thorough history, and then continually reevaluate her throughout pregnancy and postpartum for acquired risk factors.

“We must be assertive in our queries regarding a history of thrombosis and risk factors for thromboembolic events,” she added. “For instance, patients may not volunteer information that they do not think is relevant to their pregnancy, such as information about a clot that occurred years earlier.”

Inherited thrombophilias include the common thrombophilic mutations or deficiencies of the natural anticoagulants. (See related Practice Bulletin #124, Inherited Thrombophilias in Pregnancy.) Acquired thrombophilia in pregnancy is predominantly the antiphospholipid syndrome.

The bulletin provides detailed information on risk factors, diagnosis, management, and prevention of thromboembolism, particularly venous thromboembolism in pregnancy, and presents various clinical scenarios and strategies for antepartum management and postpartum management.

Women with a history of thrombosis should be evaluated to determine whether anticoagulation medication is appropriate during pregnancy, according to the bulletin. “In most cases it is,” said Dr. James. “Most women who take anticoagulation medications before pregnancy will need to continue during pregnancy and postpartum, and heparin compounds are the anticoagulants of choice in pregnancy,” she said. “Neither unfractionated heparin nor low molecular weight heparin crosses the placenta, and both are considered safe.”

Saudi Arabia Ob-Gyn Conference

ACOG Fellows are invited to participate in the Saudi Arabia Ob-Gyn Conference, January 8–11, 2012, a joint academic meeting of the National Guard Health Affairs and ACOG. Attendees can expect an outstanding international faculty from ACOG, Europe, the Gulf, and Saudi Arabia to present the latest scientific, clinical, and technological advancements in ob-gyn and provide valuable information you can take home to your practice.

The conference will be held at the Makarim Convention Center of the Marriott Hotel in Riyadh, the capital of Saudi Arabia, a city rich in historic and cultural sites. To learn more about the meeting and to register, visit www.saogc.net. The deadline for early registration is December 7.
Women are affected disproportionately by sexually transmitted infections (STIs), and adolescent girls and young women ages 15–24 in the US consistently have the highest number of cases of gonorrhea and chlamydia. One of the contributing factors is reinfection from untreated sexual partners. Expedited partner therapy (EPT) involves treating partners of patients with STIs by providing prescriptions or medications to patients to take to their partners who are unlikely or unable to otherwise receive in-person evaluations and treatments. EPT is not intended, however, for cases of suspected child abuse, sexual assault or abuse, or in situations where there is a question of the patient’s safety.

In September, The College’s Committees on Adolescent Health Care and on Gynecologic Practice published a joint Committee Opinion, #506, Expedited Partner Therapy in the Management of Gonorrhea and Chlamydia by Obstetrician-Gynecologists, expressing The College’s support for implementation of EPT where permitted by law and as outlined in Centers for Disease Control and Prevention (CDC) recommendations. The CDC guidelines, and endorsements from professional organizations such as the AMA, Society for Adolescent Health and Medicine, American Bar Association, and the American Academy of Pediatrics, are important elements in establishing a standard of care for EPT.

“Evidence indicates that EPT can decrease reinfection rates compared to standard partner referrals for examination and treatment,” said Diane F. Merritt, MD, chair of the Committee on Adolescent Health Care. Studies of adolescent and young adult women have demonstrated rates of reinfection of 14–26% within 12 months of an initial infection with chlamydia. Increased risk for reinfection was associated with a younger age at the time of infection and an untreated partner.

“Ideally, the partners of patients diagnosed with gonorrhea and/or chlamydia should receive a complete in-person clinical evaluation before antibiotics are prescribed for treatment of those infections,” said Dmitry Kissin, MD, CDC Division of Reproductive Health liaison to the Committee on Adolescent Health Care, “but that just does not always happen.” If EPT is provided, Dr. Kissin said the partner should be encouraged to seek medical evaluation as soon as possible, and be screened for other STIs and HIV.

**Barriers to routine use of EPT**

Despite the effectiveness of EPT, legal, medical, practical, and administrative barriers hinder the routine use of EPT by ob-gyns. EPT is permitted in 27 states and one city, and potentially permitted in 15 other states. In some states, regulations by medical or pharmacy boards prohibit doctors from prescribing and pharmacists from dispensing medicine to patients that the clinician has not evaluated. In other states, medical licensing laws may be a barrier. Ob-gyns should rely on state or local legal counsel to determine whether they are allowed to practice EPT in their locale.

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**Frequently Asked Questions (FAQs) for Patients**

**New format for online patient education resources**

The educational resources available to patients on The College website have undergone a makeover. Each patient education pamphlet is now available to patients in a “Frequently Asked Questions” or “FAQ” format. The FAQs offer the same high-quality information as the pamphlets, but in a web-optimized, easy-to-read format. The FAQs are also cross-linked to other pertinent FAQs so that readers can explore issues in greater depth. Visit [www.acog.org/publications/faq](http://www.acog.org/publications/faq).
A COG’s most recent survey on professional liability revealed that 90.5% of A COG Fellows have been sued; 42.8% of this group has experienced at least one claim resulting from care provided during residency.

When an ob-gyn is sued, it can be, and often is, devastating on multiple levels. On a personal level, the related stress can have an impact on every area of a physician’s life, from emotional upheaval to somatic problems to interpersonal relationship challenges, and beyond. It can also play out negatively in practice, with a physician either consciously or unconsciously adopting a defensive approach to care, becoming distracted, or developing a sense of doubt in his or her abilities—all of which could lead to medical errors and more litigation.

“We are losing bright, full-scope practicing ob-gyns who are leaving practice early or limiting their practice because of this stress,” said Stella Dantas, MD, an ob-gyn practicing at Northwest Permanente/Kaiser in Portland, OR, who also serves as vice chair of ACOG’s Committee on Professional Liability. In addition to being damaging on an individual level, this stress can also adversely affect the specialty as a whole.

“The fear of future litigation and the resulting stress, as well as the specialty’s reputation for having high liability insurance premiums, can also make it challenging to attract the best and brightest to our specialty,” said Dr. Dantas. “This ultimately will result in decreasing available obstetric and gynecologic resources to patients everywhere.”

Break the silence, reduce stress, and strengthen the specialty
Psychiatrist Ronald Hofeldt, MD, medical director/consultant for the Wellness Development Group, has spent the past 30 years treating physicians. He and his son, Timothy Hofeldt, MD, also a psychiatrist, focus on providing services that support physician wellness, particularly when a physician or medical group is affected by litigation.

Dr. Ronald Hofeldt said the first and best step toward reducing the stress associated with medical liability litigation—and strengthening the specialty as a whole—is to bring the topic to the forefront.

“Physicians are good at keeping silent when it comes to medical liability litigation, but it needs to be discussed,” he said. “The way we interpret a suit also needs to be reframed—more than 90% of ob-gyns will be sued. Therefore, it is not a matter of if it will happen, it’s when. Approaching the topic from this vantage point helps normalize and destigmatize the process.”

ACOG is taking an active role in promoting more dialogue by publishing a new Committee Opinion focused on the topic. Committee Opinion #497, Coping with the Stress of Medical Professional Liability Litigation, released in August, offers an overview of the issues involved and provides resources physicians can turn to for help.

Normal coping mechanisms don’t work
Even though a physician faced with litigation is no doubt aware that he or she is under stress, what that individual may not understand is that the normal coping mechanisms he or she employs will likely fail in this unique situation.

“Most every aspect of litigation is counterintuitive to a physician,” he explained. “One normal stress reaction, for instance, is to talk about what is causing the stress—yet with litigation, you can’t share the details. Also, doctors enter medicine because they excel—but a lawsuit is staggering because it is claiming the opposite, failure.”

Dr. Timothy Hofeldt said one seemingly logical place to seek help—through mentorship from a senior physician who has been through litigation—is not necessarily a good approach.

“Oftentimes, a mentor can try to be helpful, but ends up passing along biases, fears, or information that is no longer relevant,” he said. “Fortunately, there are better options and resources available.”
“Changed the way she practiced medicine forever”

Jennifer M. Keller, MD, MPH, associate director, residency program, and assistant professor, department of obstetrics and gynecology, at The George Washington University School of Medicine in Washington, DC, described a litigation situation, that although unique in its details, may sound familiar to many ob-gyns.

“A colleague was sued basically the first time she was on call after residency. The suit was not unexpected, and the patient’s husband seemed adversarial from the initial encounter they had in labor and delivery,” she explained. “After the suit, my colleague spent many hours worrying and became nervous performing forceps deliveries, which was what the suit involved, and instead performed more cesareans. In addition, she spent many hours with her attorney and away from her family. Her practice began to express concern about the financial consequences of the suit as well.”

Then, Dr. Keller said, just days prior to her court date, the suit was dropped: The physician’s documentation in the medical record had made the plaintiff reconsider the charges against her.

“The hardest part of the process—which took four years to resolve—was the emotional toll it took on my colleague,” said Dr. Keller. “Even though the case never went to court, this event has probably changed the way she practices medicine forever.”

Steps to reduce stress for those facing litigation

In addition to the need to discuss medical liability litigation on a broader level, there are also strategies physicians today can take to reduce stress facing medical liability litigation. Drs. Ronald and Timothy Hofeldt believe a physician can regain a sense of control and reduce his or her stress by adopting this approach:

1. Remind yourself that you are not alone and that litigation is part of being an ob-gyn
2. Acknowledge what is happening. Although you cannot discuss the details of your case, you can and should discuss your emotional responses and reactions
3. Understand the litigation process and stay informed
4. Trust and invest time and energy in your defense team. Maintain communication with your attorney and claim representative
5. Take a step back and make sure your patients continue to receive your usual level of competent and compassionate care
6. Do not try to cope in isolation. Draw on your support systems
7. Remember that doctors need doctors, too. Visit your primary care physician, and if needed, get a referral to a psychiatrist
8. Get help sooner rather than later. Physicians as a whole tend to wait too long to ask for help

Finally, Dr. Ronald Hofeldt said physicians should stay open to the possibility that litigation can in fact bring unexpected rewards.

“Know that you can not only survive it, but it may bring certain things to light, and you can become an even better physician because of it,” he said. “You deserve to have enjoyment and excitement in practicing medicine. Trust that you are a good doctor and trust that your team will help you through it.”

Prepare now for future litigation

Resources are available to help ob-gyns prepare for and manage the stress of litigation. Visit www.acog.org and search “litigation stress.”

ACOG State-by-State Litigation Stress Resource Directory
Compiled by ACOG staff, this free directory (at www.acog.org) contains information about resources available through state medical societies, professional liability insurance companies, and specially designed websites.

ACOG CD-ROM From Exam Room to Courtroom: Navigating Litigation and Coping with Stress*
Primary 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; Stress Relievers and Tools. (Earn up to 12 CME.)

A Physician’s Guide: Adverse Events, Stress, and Litigation* by ACOG consultants Sara C. Charles, MD, and Paul R. Frisch, JD.

ACOG-recommended online resource: www.physicianlitigationstress.com

* Available from the ACOG Bookstore. Visit http://sales.acog.org or call 800-762-2264.
An abuse of power: Sexual misconduct

“Sexual misconduct on the part of the ob-gyn is an abuse of professional power and a violation of patient trust. Sexual contact or a romantic relationship between a physician and a current patient is always unethical.” – Code of Professional Ethics of The College

The relationship between an ob-gyn and a patient includes interaction at times of intense emotion and vulnerability for the patient. It involves both sensitive physical exams and procedures and discussions of a woman’s most personal issues. This relationship demands the highest level of trust and professional responsibility. Preserving that trust is essential to providing quality health care. Sexual misconduct is a concern for ob-gyns in today’s environment of shifting roles for women and men, and greater sexual freedom. J. Craig Strafford, MD, MPH, past chair of ACOG’s Grievance Committee, former ACOG vice president, and a member of the Ohio State Medical Board, said, “There are no typical or known predispositions to sexual misconduct.” He advises Fellows to remember that if you possess power or authority over the other person in any way, then it is her perception of your actions that determines if you committed sexual misconduct. “Think about how someone else could view your activity and whether it could be interpreted by a patient or colleague to border on or be sexual misconduct,” he said.

“Most instances of sexual misconduct involve male physicians and female patients,” he said. An ob-gyn can prevent many potential misunderstandings, according to Dr. Strafford, by increasing one’s sensitivity to the fears and concerns of each patient, avoiding remarks that might be mistakenly interpreted by the patient as sexually provocative, and explaining appropriately and adequately all examination procedures.

ACOG routinely monitors state medical board disciplinary actions taken against ACOG Fellows. Under ACOG policy, ACOG may expel a Fellow or take any other disciplinary action for any adverse action taken against a Fellow’s medical license in any jurisdiction based on sexual misconduct. Since 2005, of the state medical board action complaints that ACOG identified and sent to ACOG’s Grievance Committee, 56% have involved sexual misconduct (see the examples at right). ACOG has taken numerous disciplinary actions against Fellows as a result of these state medical board actions.

“Trust is the mainstay of the physician-patient relationship. Earn that trust and preserve what you have earned,” said Dr. Strafford. “Never compromise on what you know is the right thing to do.”

For more information, visit www.acog.org to review The College’s Code of Professional Ethics; read Committee Opinion #373, Sexual Misconduct, under Publications; visit www.acog.org/goto/grievance; or contact the Office of the General Counsel at 202-863-2584 or grievance@acog.org.

Guidance for ACOG Fellows

• Sexual contact or a romantic relationship between a physician and a current patient is always unethical, and may also be unethical between a physician and a former patient
• Don’t throw away your career, for a sexually-motivated action
• If you think you might be getting into trouble due to a possible sexual misconduct issue seek help from a trusted friend, colleague, or mentor. Ask for advice and be honest with yourself
• If you see a colleague, friend, or co-worker involved in what appears to be sexual misconduct, approach him or her with your concerns and follow up with referrals
• All ob-gyns should strongly consider having a chaperone present whenever they are performing any physical examination on a patient
• Physicians who abuse power and violate the physician-patient trust by committing sexual misconduct could face permanent revocation of their licenses to practice, be reported to the National Practitioner Data Bank, and be subjected to discipline by ACOG

Examples of the types of state medical board actions that ACOG would forward to the ACOG Grievance Committee for review:

Example 1) Dr. A has a thriving ob-gyn practice. Dr. A sexually molestes three patients by touching them inappropriately during pelvic exams. Patients X, Y, and Z file complaints with the state medical board and the police. The state medical board finds the evidence against Dr. A to be compelling and indefinitely suspends Dr. A’s medical license.

Example 2) Dr. B has a busy ob-gyn practice. Dr. B treats Patient J, but Dr. B and Patient J decide to date. Dr. B believes he terminated the physician-patient relationship before dating Patient J. However, Dr. B subsequently writes Patient J a prescription for an antibiotic while they are dating. After Dr. B and Patient J break up, Patient J files a complaint with the state medical board. The state medical board determines that Dr. B was still Patient J’s physician and therefore in violation of the sexual misconduct rules. Dr. B’s license is placed on probation for two years.
Pilot program underway for Women’s Health Safety Certification for Outpatient Practice Excellence (SCOPE)

A COG’s new program to address quality and safety of outpatient care—titled Women’s Health Safety Certification for Outpatient Practice Excellence (SCOPE)—has begun its initial pilot phase.

Joanna M. Cain, MD, special consultant to ACOG for women’s health, patient safety, and quality improvement, has involved ACOG Fellows in developing SCOPE’s criteria to be used in certifying patient safety in the office setting. “Office practice certification will likely be part of our specialty’s future, and this is our opportunity to really take hold of it and define what the elements of safety and quality for women’s health will be in that setting,” she added.

Patient safety is of particular concern when considering office-based surgery, according to ACOG. Recent advances in minimally-invasive gynecologic surgery techniques have made procedures once only available in a hospital setting—such as tubal sterilization, endometrial ablation for heavy periods, and loop electrosurgical excision procedure (LEEP) for precancerous cervical conditions—a feasible and popular offering at the ob-gyn office. Today, roughly 30% of gynecologic surgeries are in-office.

According to James T. Breeden, MD, president-elect of ACOG, adverse events are 10 times more likely to occur in an office setting than in the hospital. “In many ways, the area of office-based surgery is young, and the checks and balances that have existed for years in hospitals have not been as well-established for the office setting. The SCOPE program is ACOG’s effort to improve in-office patient safety procedures.”

SCOPE is a voluntary comprehensive review program—available to all ob-gyn and other medical practices devoted to women’s health—that looks at practices through a patient safety lens. In order to participate, practices will request a SCOPE survey that collects information on characteristics of the practice, providers, and specific safety measures and processes within the practice. The survey will be reviewed and followed with a site visit. Participants will also receive a report from ACOG that will include suggestions for additional opportunities to improve office patient safety. Visit www.acog.org and search “SCOPE” to learn more.

Executive Board final actions
Three Fellows were expelled from The Congress and The College. Additionally, The Congress suspended one Fellow from The Congress and The College. As required, The Congress reported the expulsions and the suspension to the National Practitioner Data Bank. The Congress also issued three censures and three warnings to Fellows.

Grievance Committee activities
The Grievance Committee has reviewed 14 complaints and conducted four hearings so far this year.

For further information about the grievance process or the Code of Professional Ethics, visit www.acog.org/goto/grievance or contact the Office of the General Counsel at 202-863-2584 or grievance@acog.org.
WANTED: Intriguing and challenging cases for the 2012 Stump the Professors session

Have you ever come across a case that stumped you and your colleagues? Have you managed a case that was extremely unique, challenging, and unforgettable? The quest is on for ob-gyn cases that are intriguing and mind-boggling for the Gerald and Barbara Holzman Stump the Professors session to be held at the 2012 ACM, May 5–9 in San Diego, CA.

Submitting cases
You must be a Junior Fellow In-Training to submit a case. Cases should require deliberation, be in the field of ob-gyn, and be considerate of potential change in practice. Cases must be submitted online and include a one-page summary of 700 words or less. They should also include a final diagnosis. The deadline for submissions is November 28, 2011.

Four Junior Fellows will be selected to present their cases at the ACM. The Stump the Professors session will be held from 9:30–11 am on May 8. Each selected presenter will receive free Junior Fellow ACM registration, coach airfare, and travel and hotel expenses for three days. The presenters will be notified in early January 2012.

To submit your case, visit www.acog.org and click on Junior Fellows under Quick Links. Contact Erica Bukevicz with questions at ebukevicz@acog.org.

ACOG Legislative Leaders Convene in Washington for State Advocacy Roundtable

ACOG’s District and Section Legislative Chairs and government affairs experts from 35 states gathered in Washington, DC, this fall to share insights into priority issues affecting ob-gyns. ACOG’s State Legislative Roundtable was an energetic, two-day meeting that left ACOG’s state leaders motivated to bolster their legislative efforts at home.

The Roundtable provided the opportunity for Legislative Chairs from across the country to network with state lobbyists in order to gain insight and information on legislative “best practices.”

The conference featured a lively discussion of strategies for advocacy in state capitols on key issues, including scope of practice, liability, reproductive health and access, and federal health care reform implementation. The Roundtable also served as a vehicle for states’ advocates to share information on new and emerging legislative issues, including state legislation impacting informed consent and physician reimbursement.

Information
For updates on state issues, and to download tool kits and resources, visit State Legislative Activities under Advocacy at www.acog.org.
A new College Committee Opinion serves as a guide for ob-gyns to understand and use the *US Medical Eligibility Criteria for Contraceptive Use, 2010* (MEC) issued by the US Centers for Disease Control and Prevention (CDC). The MEC, released in May 2010, and updated in July 2011, provides comprehensive evidence-based recommendations for health care professionals on contraceptive safety, and offers guidance to clinicians providing family planning services to women, especially women with medical conditions.

“ACOG has officially endorsed the MEC and hopes this Committee Opinion will lead to increased use of contraception by more women,” said ACOG President James N. Martin, Jr, MD. “Half of all pregnancies in the US are unintended, often resulting in suboptimal health outcomes for women, infants, and families,” he said. “Women with certain medical conditions are at a higher risk for adverse outcomes with an unintended pregnancy, and the MEC can assist clinicians in helping patients choose the most appropriate contraceptive method.”

Committee Opinion #505, *Understanding and Using the US Medical Eligibility Criteria for Contraceptive Use, 2010*, explains MEC’s four-category classification of contraceptive methods based on their safety when used by women with certain characteristics or medical conditions. Ob-gyns can use the categories to assess what contraceptives are appropriate for individual patients, taking into account a woman’s personal preference, the severity of her condition, and the effectiveness, acceptability, and availability of alternative methods.

In July, the CDC added updated information on the use of combined hormonal contraception by postpartum women.

“This Committee Opinion emphasizes that ACOG endorses the MEC,” said Eve Espey, MD, chair of The College’s Long-Acting Reversible Contraception Working Group, which co-authored the document with the Committee on Gynecologic Practice. “It also serves as a quick reference guide to the CDC’s evidence-based recommendations in a format that’s easily accessible for our Fellows.”

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**Immunize your patients against the flu**

With the peak of flu season on its way, ACOG reminds ob-gyns that all pregnant women, regardless of trimester, should receive the influenza vaccine. Though vaccination rates are improving for pregnant women, they are still too low. The immunization rate for pregnant women was 49% during the 2010–11 flu season, according to the Centers for Disease Control and Prevention.

Preventing the flu during pregnancy is an essential element of prenatal care. It is imperative that physicians, health care organizations, and public health officials improve their efforts to increase immunization rates among pregnant women.

Clinicians should start vaccinating patients in September or as soon as vaccines become available. Flu season can begin in the fall and continue through mid-May, with activity usually peaking in January or February.

For more information, visit ACOG’s Immunization for Women website at [www.immunizationforwomen.org](http://www.immunizationforwomen.org). Also, see The College’s Committee Opinion #468, *Influenza Vaccination during Pregnancy* (October 2010), at [www.acog.org/publications/committee_opinions/co468.cfm](http://www.acog.org/publications/committee_opinions/co468.cfm).
Things to see and do in San Diego

San Diego Zoo
The famous San Diego Zoo has over 800 species of exotic animals including the giant pandas.

Come enjoy the perfect weather and see old colleagues and meet new ones!

ACOG Courses and Coding Workshops

| October 21–23 | ACOG Coding Workshop, Seattle, WA |
| November 8   | ACOG Webcast: Thrombophilias in Pregnancy |
| November 10–12 | Quality and Safety for Leaders in Women’s Health Care, New Orleans, LA |
| November 17–19 | Twenty-First Century Obstetrics and Gynecology, Las Vegas NV |
| November 18–20 | ACOG Coding Workshop, Chicago, IL |
| December 1–3  | Update on Cervical Diseases, New York, NY |
| December 2–4  | ACOG Coding Workshop, Atlanta, GA |
| December 2–4  | Practical Obstetrics and Gynecology, Chicago, IL |
| December 13   | ACOG Webcast: Preview of New Codes for 2012 |

Get updates and register 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.