ACOG task force releases hormone therapy guide

A comprehensive guide on how to effectively address hormone therapy with your patients is now available from ACOG. Fellows will receive the Task Force Report on Hormone Therapy as a supplement to their October issue of Obstetrics & Gynecology. The report, developed by the ACOG Task Force on Hormone Therapy, is a thorough, evidence-based evaluation of the risks and benefits of HT.

While hormone therapy has been examined in Committee Opinions and other College documents before, this is the first ACOG publication that encompasses the numerous health issues related to HT, said ACOG Fellow Isaac Schiff, MD, task force chair.

“To develop this report, ACOG selected experts who have an enormous insight into the wide range of HT issues,” Dr. Schiff said. “The report provides clinicians with the information they need to advise patients on this complex issue.”

WHI findings question HT use
In the 1980s and 1990s, physicians were providing HT not just for relief from menopausal symptoms but for other health conditions. WHI findings have raised questions about the benefits and risks of HT.

Mammograms saving lives, but disparities still exist

Women’s knowledge about the importance of mammography screening has improved dramatically in recent years: In 2002, 70% of women 40 and older had received a mammogram in the past two years—compared with just 29% in 1987, according to the National Center for Health Statistics.

“It is very gratifying to see women taking care of themselves in such a positive way,” said ACOG President Vivian M. Dickerson, MD. “No one loves the process of getting a mammogram, but it is very clear that early detection of any possible abnormality is of paramount importance to a woman’s health.”

Screening and detection have come a long way since National Breast Cancer Awareness Month was created 20 years ago. Since then, every October is dedicated to increasing the public’s awareness of the importance of early detection. Mammography centers across the US will offer reduced-cost and free screenings on October 15, National Mammography Day, and throughout the month of October.
In the ongoing fight for tort reform, a common argument we hear from trial attorneys is that a cap on noneconomic damages would have no effect on the rising costs of medical liability insurance premiums. This is not true. We all know about the positive impact MICRA had in California, but more recently, Texas has also experienced a turnaround thanks to tort reform.

The passage of a constitutional amendment allowing the Texas legislature to cap noneconomic damages led the state’s largest insurance carrier, Texas Medical Liability Trust, to lower its rates on Jan 1, 2004, by 12%.

In addition, Continental Casualty Company cut its rates by 11.5%, and other companies plan to expand in Texas, with as many as 10 new carriers applying to enter the Texas market.

The positive news in Texas has led ACOG to change the state’s Red Alert status from “in crisis” to “crisis pending outcome of recent laws.” ACOG recently deemed three more states Red Alert states. With the addition of Wyoming, Arizona, and Maryland, 23 states now face a medical liability crisis that threatens the availability of physicians to deliver babies.

Texas’ success will give us good information and support as we take our fight to other states. Congratulations to our members in Texas. This is a well-earned result.

Ralph W. Hale, MD, FACOG
Executive Vice President
ACOG revises grievance procedures

ACOG’s Executive Board has revised the College’s grievance process, the mechanism to consider complaints against Fellows about behavior that may violate the College’s Code of Professional Ethics.

Each year, all voting Fellows are notified by confidential letter of the disciplinary actions imposed on Fellows during the previous year.

The notification for all future complaints will include the names of the Fellows disciplined—except for those issued warnings—and a brief summary of the reason for the disciplinary action. The letter will also include a summary of warnings given to Fellows but will not include the names of those Fellows.

Previously, ACOG only included the names of Fellows who were expelled from the College. Now, names of Fellows who have been censured or suspended will be included in the letter as well. In the future, voting Fellows will be able to access this information on the ACOG website also.

The change to the grievance process takes effect with the complaints submitted to the Grievance Committee at its meeting this month. The change is not retroactive—Fellows who have been censured or suspended in the past will not be named in letters or on the website.

However, the College will continue to respond to written requests about an individual Fellow’s standing, informing the requesting party of any disciplinary action taken by the College.

For questions or copies of grievance procedures or the College’s Code of Professional Ethics, contact grievance@acog.org or 800-673-8444, ext 2584

College secures grant to fight obesity

ACOG will develop educational materials about obesity thanks to a grant recently awarded to the College from the Centers for Disease Control and Prevention.

The project will have three phases:

1. ACOG will survey Fellows and Junior Fellows on their clinical management of obesity from teens to the elderly and will include a focus on pregnant women

2. The survey results will be used, along with medical literature, to develop educational materials for physicians that provide guidance on assessment and prevention of obesity

3. A follow-up survey will ascertain whether Fellows and Junior Fellows are aware of the educational materials and whether they are using them in their practice

The College began surveying a random sample of Fellows and Junior Fellows in September. The educational materials are expected to be distributed next fall to Fellows and Junior Fellows in practice. The follow-up survey is scheduled for February 2006.

“This project allows us to examine the clinical practice patterns of Fellows to see how they address overweight and obesity issues with their patients,” said Stanley Zinberg, MD, MS, ACOG’s vice president of practice activities. “The prevalence of obesity in the US is reaching epic proportions, and ob-gyns can play a critical role in preventing and managing overweight and obesity.”
Congressional action on ob-gyn issues

Protecting in-office imaging

There’s a move in Congress to prohibit ob-gyns from performing ultrasound and other radiology services on their patients in their own offices. The American College of Radiology is advocating expansion of the Stark prohibition against physician self-referral to cover these services on the grounds that specialists are driving up the use of imaging procedures and Medicare costs of radiology. Legislation could also be introduced.

At the June American Medical Association House of Delegates meeting in Chicago, ACOG joined with several physician specialty organizations to oppose legislation that would expose in-office radiology and imaging services—vastly important in areas like obstetrical and fertility care—to the physician self-referral laws.

ACOG is working actively with several physician specialties and the AMA to educate members of Congress about the need for patients to have easy access to important diagnostic tests and to keep this important exception in place.

Promoting patient safety

Landmark patient-safety legislation passed both the US House of Representatives and Senate in July, and President Bush is expected to sign it into law.

ACOG has long supported patient-safety legislation that would allow physicians to report and share information without fear of discovery in a lawsuit. The legislation creates patient-safety organizations to collect and analyze data from physicians on the incidence of medical errors, adverse events, and near misses. Physicians would be legally protected, and attorneys could not access information submitted to the patient-safety organizations.

These federal disclosure protections—key to our support—are imperative to develop information collection and sharing systems that encourage reporting, improve patient safety, and guarantee physicians that information they report cannot be accessed by attorneys who might use it against them.

More Americans are uninsured

The number of people without health insurance and the number of people living in poverty increased slightly in 2003, according to new data released in August by the US Census Bureau.

While the number of people with health insurance last year grew by 1 million, the number of people without health coverage increased by 1.4 million. In 2003, 45 million people, or 15.6% of the population, did not have health insurance, up from 15.2% in 2002.

The number of people below the official poverty threshold increased as well, to 35.9 million in 2003. The increase of 1.3 million people living in poverty set the poverty rate at 12.5%, up from 2002.

EPA database pinpoints waterways with mercury-contaminated fish

Thirty-five percent of total US lake acres and 24% of river miles are now under fish advisories, mainly due to mercury contamination, according to the annual fish advisory report from the US Environmental Protection Agency.

The report, released in August, is based on data provided by the states on the number of fish advisories that states issued in 2003. The advisories pertain to noncommercial fish and shellfish caught by individuals in lakes and rivers and along the US coastline. The report includes an online database that allows individuals to search for advisories by state or body of water.

High levels of mercury can damage fetuses’ central nervous systems, and pregnant women, nursing mothers, and women of childbearing age are cautioned to cut back on such fish. Each advisory varies on how much fish these women can safely consume.

The number of fish advisories continues to increase: last year, lake acres under an advisory increased by 2%; river miles, by 9%; and coastline, by 4%. However, EPA says a large part of the lake and river increases are because Montana and Washington issued statewide advisories for all of their lakes and rivers and Hawaii issued a statewide advisory for its entire coastline.
New name and look for Physicians for Women’s Health

Join OB-GYNs for Women’s Health
By John M. Gibbons, MD, president, OB-GYNs for Women’s Health and ACOG past president

Physicians for Women’s Health, ACOG’s advocacy arm in Congress, was created almost four years ago. Since then, thousands of ACOG Fellows have joined, and we’ve seen great strides in our ability to work with Congress on ob-gyn issues.

It’s time for our next big step forward. Physicians for Women’s Health now has a new face and name: OB-GYNs for Women’s Health. See the box in the center of the page for our new logo. I hope that with this new name even more Fellows will recognize the close connection between ACOG and OB-GYNs for Women’s Health. And, I hope that lawmakers will more readily recognize that this organization represents ob-gyns and your concerns.

Having an impact on Capitol Hill
Serving as president of ACOG last year gave me a wonderful perspective on how our specialty fits into the world around us—internationally and here at home. ACOG is unparalleled in its dedication and ability to advance the interests of patients and ob-gyns in research, clinical guidelines, education, and legislative advocacy.

As I traveled across the US, I heard from Fellows everywhere I went that we must—not should or ought to, but must—win the critical legislative battles that face our specialty. And one important part of my answer to all of you is this: Join OB-GYNs for Women’s Health on ACOG’s 2005 dues statement.

ACOG has led the way in representing women’s health interests on Capitol Hill for years. It has spoken to the issues that uniquely affect our specialty as no other national organization can. However, ACOG’s particular federal tax-exempt status limits how much it can spend in this area and prohibits the College from participating in political activities.

OB-GYNs for Women’s Health is a different type of nonprofit tax-exempt organization, with fewer legal restrictions on its lobbying activities. For example, OB-GYNs for Women’s Health can have a federal political action committee and help elect individuals to the US Senate and House of Representatives who will support issues affecting our specialty. This fall, in your ACOG dues renewal mailing, you’ll have the opportunity to join or renew your membership in OB-GYNs for Women’s Health. Membership is just $25 a year.

I hope you’ll agree that the time for hoping is over. We need to act now. Start by joining the thousands of Fellows who have already added their names to this powerful organization. It’s time ob-gyns become fully engaged in the important challenges and opportunities facing us in Congress. We can’t leave it to others. We can’t just hope all goes well. We have to take charge of our future. Join OB-GYNs for Women’s Health.

Addressing infant mortality

Two participants in the Fifth National Conference of the National Fetal and Infant Mortality Review Program chat before the keynote address. NFIMR is a partnership between ACOG and the federal Maternal and Child Health Bureau. The conference was held in Washington, DC, in August.
as well. Many believed estrogen helped prevent numerous chronic conditions such as heart disease. Then along came the Women's Health Initiative study, a double-blind, randomized, controlled study of the effect of HT on chronic conditions such as heart disease and Alzheimer’s disease.

In 2002, the combined estrogen and progestin arm of WHI was halted early because of increased rates of heart disease and breast cancer. Two years later, the estrogen-only arm of the study was halted because of increased risk of stroke. The estrogen-only arm showed no breast cancer risks.

“There is an enormous amount of data having significant clinical impact has been available recently, and more will be forthcoming. Clinicians are advised to process new data as they are published and to consider their impact on their personal practice patterns.”

Hormone Therapy continued from page 1

**When to use HT—and for how long**

The task force report concludes that HT remains an effective therapy for vasomotor symptoms and vaginal atrophy as well as osteoporosis. However, the current data do not support the use of HT for prevention of chronic conditions such as heart disease. Future data may further define risk groups to show which women may derive benefit from HT and which women should avoid it, the report says.

The WHI findings also raised the question of how many years women should be on HT. Previously, short-term therapy was defined as at least five years—and five years of therapy was thought to have no risks.

However, the combined arm of WHI showed otherwise, with a breast cancer risk after two years, coronary risk in the first year, and stroke risk during the second year. The estrogen-only arm showed small early increases of venous thromboembolism and stroke but no breast cancer risks.

According to the task force report, the WHI findings show that it is now unclear what is the safe interval for HT. The task force recommends that physicians discuss the benefits and risks in detail with patients before they begin therapy and review the benefits and risks at least annually so that women can make the best decisions for their health.

The report finds that it is inappropriate to withhold HT from persistently symptomatic menopausal women who prefer to continue taking it or who do not experience relief from HT alternatives. This includes women who feel better with HT or who feel it improves sexuality, the report says.

“One of the major achievements of the WHI has been its ability to provide improved estimates of risks associated with HT,” the report states. “An enormous amount of data having significant clinical impact has been available recently, and more will be forthcoming. Clinicians are advised to process new data as they are published and to consider their impact on their personal practice patterns.”

**Task force responds to HT controversy**

The 20-member task force of HT experts was convened in 2002 by then-President Charles B. Hammond, MD, so that the College could examine HT in light of rising controversy over its benefits and risks.

The task force was created just a few months before the first phase of WHI was halted and responded quickly to the WHI findings, issuing statements to both physicians and patients to help alleviate the confusion and concern among women and their ob-gyns.

The WHI announcement made the task force’s assignment even more pertinent, Dr. Hammond said.

“The task force has done a great job,” Dr. Hammond said. “This excellent report sets the stage for a better understanding of hormone therapy and clinical risk-benefit understanding.”

New Managing Menopause includes latest HT findings

The fall/winter issue of Managing Menopause and the Years Beyond has been thoroughly updated to reflect the latest hormone therapy data and guidelines.

The award-winning Managing Menopause continues to be the magazine that women turn to for practical advice about what to expect in menopause and how to prepare for it.

This fall, clinicians can refer to the comprehensive, evidence-based HT guidance in ACOG’s new Task Force Report on Hormone Therapy (see cover article), while distributing Managing Menopause to their patients as a consumer companion piece. Offering the magazine to your patients is one of the best ways to provide them the latest HT information.

The magazine’s scientific advisory board, at its recent meeting, extensively reviewed and discussed the findings from ACOG’s Task Force Report on Hormone Therapy and updated the magazine to reflect its recommendations.

Managing Menopause is distributed free to ACOG Fellows. If your office received the spring/summer 2004 issue, you will automatically receive the fall/winter 2004 issue, arriving in November. If not, contact the ACOG Office of Communications (see below) for your subscription.
Despite the limitations of breast cancer detection methods, many women expect their ob-gyns to be able to establish whether they have breast cancer and to uncover the disease early. "Patients have expectations for 100% accuracy of making an early diagnosis for their breast cancer, and that’s an unrealistic expectation," said Douglas H. Kirkpatrick, MD, ACOG vice president.

Dr. Kirkpatrick will lead an ACOG webcast in November that will teach Fellows how to lessen their medical liability risk in breast cancer cases. The webcast, Breast Care Management & Medical Liability Risk Reduction, will be held on November 2 from 1 to 2:30 pm Eastern time.

Seventy percent of breast cancer liability claims are filed by patients who have found their own lesions but had an "unremarkable" physician exam combined with a negative mammogram and were told to return prn or "as needed," according to Dr. Kirkpatrick. “It is a very convenient way to stay up-to-date on selected subjects,” said Green Journal Editor James R. Scott, MD. “It saves a tremendous amount of time for busy physicians because repeated searches do not have to be done—and it is free.”

How the alert system works
The service offers three different types of email notification:
- Keyword alerts will notify you when new content is published containing keywords specified by you
- Author alerts will notify you when key authors of interest to you publish a new paper
- Citation alerts will notify you when a paper of interest to you is referenced by another paper

“I would encourage all Fellows to sign up for the email alerts,” Dr. Pellegrini said. “Type in your favorite topic that you want to concentrate on to get good, in-depth knowledge of a specific topic. Then, maybe after a few months, change the topic and concentrate on another health issue.”

To sign up, visit www.greenjournal.org; click on “Email alerts” on the left side of the page, then click on “Sign up now!” under “About CiteTrack”
Young Fellows honed their leadership skills and learned how to become active members in ACOG during the Future Leaders in Obstetrics and Gynecology Conference in August.

“I want to get involved.” That was the reason given time and time again when participants were asked why they decided to attend the conference. Often, they linked their desire to become involved to ACOG’s top legislative priority and a leading concern for ob-gyns: medical liability reform.

“I became involved mainly from a legislative perspective and because I want to ensure that we do all we can to bring about tort reform,” said Junior Fellow Ricardo S. Mastrolia, MD, a third-year resident at Saint Luke’s Hospital in Bethlehem, PA. “I think that’s central to why most of us are involved in lobbying efforts.”

Junior Fellow Elizabeth A. Buys, MD, who is in her second year of practice in Asheville, NC, agreed: “Any information we can use on the medical liability issue is important. We have to work together on this issue, and ACOG is working hard at the core of the effort.”

Leaders of tomorrow
ACOG Executive Vice President Ralph W. Hale, MD, initiated the Future Leaders conference eight years ago at the request of the Council of District Chairs. Each ACOG district is invited to send up to three participants who are Junior Fellows or Fellows in practice for less than five years.

“These young Fellows are the future of our College, and it’s important that we show them how they can become active members,” said Dr. Hale, who oversaw the conference and led several sessions. “Their passion and motivation are inspiring, and their involvement is paramount to the continued success of ACOG.”

Knowledgeable about ACOG
Participants were given an overview of tort reform lobbying efforts and learned how they could educate the public about legislative and medical issues through the media. ACOG’s Office of Communications presented a two-hour session on communication skills development, giving tips on how to prepare for interviews, answer tough questions, and reference personal ob-gyn experience to show expertise on an issue.

The future leaders also learned about ACOG’s internal and external structure, legal obligations and restrictions as a 501(c)(3) nonprofit organization, and ACOG’s grievance process. In addition, they gained valuable leadership skills in sessions on decision-making, meeting effectiveness, and project planning.

Such skills are crucial both in ACOG leadership roles and as the head of a practice or ob-gyn department, said Leah A. Kaufman, MD, chair of the Junior Fellow College Advisory Council and a Future Leaders’ participant two years ago.

“It’s important for the Junior Fellows of the College to understand that we really can change the future of women’s health care, as well as make practice better for our colleagues, by being involved,” Dr. Kaufman said. “Future Leaders was an incredible experience.”

Conference nurtures ACOG’s future leaders
JFCAC task force evaluates new duty-hour rules

New duty-hour requirements limit residents to an 80-hour work week on average in an effort to improve patient safety, mitigate residents’ sleep deprivation, and improve resident education.

Are the new rules working as intended? Are residents getting more sleep? Has there been an improvement in patient safety? Or has there developed a lack of continuity of care and a shift-work mentality?

The Junior Fellow College Advisory Council, led by Chair Leah A. Kaufman, MD, is evaluating the effects of the duty-hour requirements, which were instituted in June 2003 by the Accreditation Council for Graduate Medical Education.

Dr. Kaufman has taken on the project as her chair’s initiative for the year and has established the Resident Work Hours Task Force to look at the issue in-depth.

“The task force has been charged with creating surveys to enable us to receive feedback in several areas—all of which address the goals ACGME established when instituting the changes,” Dr. Kaufman said. “The task force will look at the impact on quality of patient care, quality of resident life, and quality of education, with specific attention to the assessment of professionalism.”

Challenges and changes

In addition to instituting an average 80-hour work week, the rules also require a 10-hour rest between duty periods, a 24-hour limit on continuous duty, and an in-house call limit of no more than once every three nights.

One consequence of the new rules is the development of a shift-work mentality, according to Junior Fellow Rajiv B. Gala, MD.

“You don’t see the loyalty to excellence in patient care as much as you used to,” said Dr. Gala, who completed his ob-gyn residency in June at the University of Alabama at Birmingham. “There’s this idea of ‘do what you can and when I come on, I’ll take over,’ but practitioners in rural America don’t have that luxury without sacrifice to their patients.”

To address scheduling challenges, Dr. Gala’s residency program—which already had a night-float system in place—made lighter rotations more call heavy and harder rotations as call free as possible. The department also had nurse practitioners help with routine postpartum rounding to allow residents more time for complicated cases, Dr. Gala said.

Junior Fellow Amanda B. Flicker, MD, who completed her residency in June at Pennsylvania Hospital in Philadelphia, saw positive effects on continuity of care.

“I feel it was better overall because we had a day team and a night team for each service who knew patients better than a different team every night could,” she said.

Developing list of best practices

Chaired by JFCAC Vice Chair May Hsieh Blanchard, MD, the Resident Work Hours Task Force has drawn up a comprehensive list of the issues, dividing them into four areas:

1. Logistics, including regular scheduling as well as coverage when residents attend medical meetings or go on vacation
2. Educational, including issues related to teaching, research, and clinical care
3. Professionalism, including the perception of a shift-work mentality and lack of professionalism
4. Other, including effects on personal well-being as well as interactions with support staff, attendings, and other residents

The task force will soon survey residents, faculty, and program directors and coordinators to gather their insights on the new rules and to collect ideas on how to adhere to the rules while maintaining a strong residency experience.

“Once completed, the survey data should allow us to address physician perception of the impact that the duty hours have had on patient safety and continuity of care,” Dr. Kaufman said. “In addition, the data will allow us to create a resource of the best practice models for solutions to optimally educate dedicated, experienced, professional ob-gyns within the 80-hour work week.”

Wanted: difficult case diagnoses for Stump the Professors

Have you ever come across a case that baffled you and your colleagues? When was the last time you uttered, “Wow, this is interesting!” when confronted with a case that was challenging and exciting to manage?

The quest is on for intriguing, mind-boggling, and arduous medical cases for the next Stump the Professors program at the 2005 ACM. The cases should require thought, global perspective, and attention to potential change in practice and should represent the depth and breadth of ob-gyn.

December 3 deadline

Four cases will be selected to be presented to a panel of professors at the ACM in San Francisco on Tuesday, May 10.

The event will be held at 9:30 am, following the Junior Fellow breakfast business meeting. Each case presenter will receive free registration to attend the ACM and travel and hotel expenses for two days.

Cases will be accepted by online submission only. The deadline is December 3. Submissions should include a one-page case summary of 700 words or less, including final diagnosis.

On the members-access website at www.acog.org, click on Junior Fellows

Chris Himes: 800-673-8444, ext 2561; chimes@acog.org
New Committee Opinions focus on adolescent health concerns

ACOG has developed three new Committee Opinions that address the unique health issues of teenage girls. “Caring for teens takes special consideration and a recognition that health behaviors, sexual history, diagnosis, and treatment are different in a lot of ways from what we experience with adult patients,” said Marc R. Laufer, MD, chair of ACOG’s Committee on Adolescent Health Care, which developed the Committee Opinions.

The following documents were published in the October issue of Obstetrics & Gynecology:

- Cervical Cancer Screening in Adolescents (Committee Opinion #300)
- Sexually Transmitted Diseases in Adolescents (Committee Opinion #301)
- Guidelines for Adolescent Health Research (Committee Opinion #302)

Taking a sexual history critical

The Committee Opinion Cervical Cancer Screening in Adolescents is intended to provide additional guidance on the cervical cancer screening guidelines issued by the American Cancer Society in late 2002 and supported by ACOG. These updated guidelines recommend that teen patients should have their first Pap test approximately three years after first intercourse or by age 21.

However, the Committee Opinion points out that there may be instances in which a Pap test may be performed earlier and that decisions about cervical cancer screening should be based on the clinician’s assessment of risks.

“We don’t want physicians to feel that they can never perform a Pap test on a teenager until exactly three years after the teen had sex for the first time,” said S. Paige Hertweck, MD, the committee’s immediate past chair. “There are certain circumstances in which a Pap test may be appropriate. For example, ob-gyns may have a reluctant patient who they believe won’t come back for regular care.”

The Committee Opinion also stresses the need to take a complete and accurate sexual history of teenagers, including the need to ask age at first intercourse to assist in determining the timing of initial Pap testing. The Committee Opinion provides information on how to conduct such a history.

The document points out that teens and their parents may be confused by the new guidelines and may not understand the difference between a Pap test and a pelvic exam. They may construe the guidelines to mean that teen girls should not see a gynecologist until they are 21.

Therefore, it’s crucial that ob-gyns stress the need for preventive care prior to sexual activity. ACOG recommends that a teen’s first visit to the gynecologist occur between ages 13 and 15. This visit does not need to include a pelvic exam unless there is a problem.

Screening teens for STDs

The Committee Opinion Sexually Transmitted Diseases in Adolescents addresses the fact that teens are at greater risk for STDs compared with adults and need to be managed a little differently.

“The Committee Opinion focuses on more than diagnosis and treatment of STDs. It addresses the differences between adolescents and adults in terms of cognitive differences, behavioral differences, and risk factors,” said Fellow Melisa M. Holmes, MD, associate professor of ob-gyn and pediatrics at the Medical University of South Carolina. “It is especially important to use on-site single-dose antibiotics whenever possible, use presumptive treatment if it will be difficult to get the adolescent to return for treatment, and facilitate prevention by providing condoms to female adolescents.”

Conducting research

The Committee Opinion Guidelines for Adolescent Health Research attempts to clarify the misconception that parental consent is always needed before including a teen in a study.

“There are instances where it may be possible to waive parental consent, and we wanted to make that clear,” Dr. Hertweck said. “This document may assist researchers who may need to have clarification for their Institutional Review Board.”

For example, parental consent is not required when the research involves the provision of health care for which adolescents do not legally need parental consent. Consent laws differ from state to state, and researchers should become familiar with the laws in their own state.

Curriculum aims to fill gaps in reproductive health training

A new curriculum on reproductive health is available at no charge from the Reproductive Health Initiative, a project of the American Medical Women’s Association.

The second edition of the RHI Model Curriculum is a comprehensive resource designed to assist medical students, faculty, and health care providers with improving reproductive health medical education and services.

The content can help medical schools fill education and training gaps and address underrecognized or ignored areas of reproductive health education. In addition, the curriculum can be used in clinical settings as a tool for staff training or as a reference for providers to help strengthen their practice.

The curriculum is available for free on the American Medical Women’s Association website.

info

- www.amwa-doc.org/rhi/curriculum
- Jen Hurlburt, MPH, project manager: 703-838-0500, ext 3315; jhurlburt@amwa-doc.org
Pregnant women may be “eating for two,” but that doesn’t mean they should eat twice as much food. But is that message getting across to patients?

Some pregnant women may be gaining more weight than necessary—weight they may have trouble losing after their baby is born. And the cycle could continue with each consecutive child, leading women to become overweight or obese.

“Pregnancy is not a license to eat everything you want to eat,” said Fellow Ann L. Honebrink, MD, medical director of Penn Health for Women in Radnor, PA. “If you take it as a license to not eat properly, it’s not going to work out well as far as weight gain.”

Focusing on healthy eating

It’s important, however, that patients understand the necessity of weight gain in pregnancy in order to provide the proper nutrients to their baby.

Fellow Raul Artal, MD, chair of the Department of Ob-Gyn and Women’s Health at St. Louis University, is concerned that the recommended weight gain of 25–35 pounds for a woman of normal weight is too much for some women. (See box at right for ACOG recommendations.) Dr. Artal said he believes that obstetricians should focus more on a woman’s eating habits and caloric intake than on a weight goal.

“I don’t know if there’s a magic number because it will differ from one person to another,” he said.

Fellow Laura E. Riley, MD, chair of the ACOG Committee on Obstetric Practice, said she uses the guidelines not to encourage women to strive for a particular weight but to show them what is a reasonable weight gain.

What’s essential, Fellows agreed, is that women eat well.

“They’re just that, they’re guidelines,” Dr. Honebrink said. “What’s probably more important is that women are eating healthy and they’re not eating extra calories all in junk food.”

Helping patients make smart food choices

ACOG recommends that women consume 300 more calories a day when they’re pregnant. Dr. Honebrink cautions her patients not to abandon all good eating habits in pregnancy. Pregnant women will feel hungrier, but they can make healthy choices, eating extra fruit instead of candy or chips, she said. If they’re suffering from insatiable cravings, they can try to eat less of the food they’re craving—just half of the candy bar or a smaller bowl of ice cream.

Ob-gyns can help their patients through these food choices, Dr. Honebrink said. She also suggests that patients keep a food diary, which usually leads people to eat better than they normally do.

ACOG’s Patient Education Pamphlet Nutrition During Pregnancy stresses to patients the importance of eating healthy snacks, planning meals, and eating a mixture of proteins, carbohydrates, vitamins, fats, and minerals.

Ob-gyns can also encourage women with normal pregnancies to exercise, although they should not diet. ACOG guidelines recommend 30 minutes or more of moderate exercise most, if not all, days of the week for pregnant women. However, pregnant women should avoid sports and exercise with a high risk of falls or abdominal trauma and should avoid supine positions as much as possible.

Pregnancy is an ideal time to introduce healthy behavior, Dr. Artal said.

“I think there has to be more recognition among physicians in general that obesity is a chronic disease and pregnancy can be a trigger for this disease,” Dr. Artal said. “If women gain too much weight while pregnant, they’ll have trouble losing it, leading them to become overweight and possibly obese. This will affect them their entire lives.”

ACOG recommends the following weight gains for pregnant women:

- Normal weight: 25–35 pounds
- Underweight: 28–40 pounds
- Overweight: 15–25 pounds
- Obese: 15 pounds
- Carrying twins: 35–45 pounds

Historical Perspective

Recommendations concerning weight gain in pregnancy have steadily increased in the last 100 years, from a low of 15–20 pounds in the early 1900s to the current 25–35 pounds.

Pregnant women were once encouraged not to gain much weight because it was thought more weight meant bigger babies and thus, harder deliveries, according to the Institute of Medicine’s Nutrition During Pregnancy, published in 1990.

The first edition of Expectant Motherhood by Nicholson J. Eastman, MD, published in 1940, stated that weight gains of 20–25 pounds were considered natural and healthy. The book recommended that weight gains of 30 pounds or more were undesirable and that “you will feel much better if you keep your weight gain under 25 pounds.”

These recommendations continued into the 1970s when discussion turned to allowing women to eat as much as they wanted and evaluating pregnancy weight gain differently for underweight, normal, and overweight women.

The current IOM guidelines, which ACOG follows, first appeared in 1990.
Recognizing disparities in screening

Increased rates of mammography screenings and improvement in cancer drugs have clearly helped save women’s lives. Breast cancer deaths decreased 2.3% each year from 1990 to 2000, with larger decreases in women younger than 50, according to the American Cancer Society.

However, the cancer society estimates that almost 216,000 women will discover they have breast cancer in 2004 and that more than 40,000 women will die of breast cancer this year. In addition, vast disparities exist among racial and ethnic minorities, uninsured women, and immigrants.

Blacks, Hispanics, Asian Americans, and American Indians and Alaska Natives all have lower mammography rates than do whites. The lowest percentages are among uninsured women, with only 40% receiving a mammogram in the previous two years, and women living in the US less than 10 years, with only 41% receiving a mammogram in the previous two years.

Tailoring education to the patient

To ensure patients are getting the message that mammograms are important, ob-gyns need to follow screening guidelines set forth by ACOG and the American Cancer Society as well as educate themselves on patients’ belief systems and cultural differences, said ACOG Fellow Jandel Allen-Davis, MD, an ob-gyn with the Colorado Permanente Medical Group in Denver.

“Physicians need to understand the role of culture in decision-making,” Dr. Allen-Davis said. “Be aware of how your biases may be affecting how you may be giving care.”

Some patients may believe that mammograms can cause breast cancer, while others may be terrified of the pain of mammograms.

“It’s important to educate patients about the realities and treatment of breast cancer,” said ACOG Fellow Eve Espey, MD, professor at the University of New Mexico.

In addition, some women may not want to undergo a procedure that may tell them they have cancer when they feel healthy and have no symptoms, Dr. Espey said.

“Different cultures see preventive care differently,” she said.

Ensuring care for the underserved

Ob-gyns with patients who cannot afford mammograms may be able to offer help through state and federal programs. The National Breast and Cervical Cancer Early Detection Program through the Centers for Disease Control and Prevention helps low-income, uninsured, and underserved women receive breast and cervical cancer screening.

Ob-gyns can also reach out to underserved populations by encouraging their hospitals and clinics to provide mobile services or by participating in grass roots efforts and connecting with community organizations. In Denver, Dr. Allen-Davis takes part in Kaiser Permanente’s annual health fair, Neighbors in Health, which offers the community free health education and preventive care, including Pap tests, pelvic exams, and clinical breast exams.

Ob-gyns can also become active on the legislative front by calling attention to the uninsured crisis and advocating universal health care coverage.

Dr. Dickerson is a strong believer in advocating for patients outside of a practice.

“I believe that we have tremendous clout in the formulation of legislation and regulations that affect women’s health,” Dr. Dickerson said. “We are the ones who can truly explain what it means to be without health insurance and without access to care. We understand firsthand the adverse effects on health care access that result from lack of medical liability reform and excessive insurance regulation. We must speak out for women who cannot speak out for themselves.”

Percent of women 40 and older who received a mammogram in the past two years:

* American Cancer Society
Global health

Witnessing health epidemics up close

It’s one thing to read about it or see it on television. It’s quite another to see it with your own eyes: adults dying of AIDS with no hope of recovery, children dying from diseases unheard of in more-developed countries.

Twelve pre-med students from Iowa visited Tanzania earlier this year, witnessing firsthand the individual crises that make up global health epidemics. ACOG Fellow Rebecca D. Shaw, MD, was with the students, serving as a mentor.

“They were so discouraged that they couldn’t do more immediately,” said Dr. Shaw, who is in private practice in West Des Moines, IA. “I encouraged them that over a period of time one person can make a difference and not to be discouraged, not to be overwhelmed by the tremendous needs.”

Dr. Shaw and her husband, a neonatalogist, tagged along with the student group from Luther College, Dr. Shaw’s alma mater in Decorah, IA, as the students learned about global health and observed numerous health care settings in Tanzania.

“We saw care being provided to AIDS hospice patients in their homes, children with cutaneous anthrax, and an entire village affected by fluorosis, resulting in bone deformities of its children,” Dr. Shaw said. “We also visited a hospital with an entire wing of women recovering from surgical repair of vesicovaginal fistulae, resulting mainly from unattended births.”

In addition, the group had the opportunity to speak to traditional birth attendants, who provide most of the prenatal and postpartum care for Tanzanian women.

“The trip became an avenue for me to expand my horizons beyond my usual professional work in the United States,” Dr. Shaw said. “I was inspired by the doctors, nurses, and other health care personnel we met, and I continue to explore future opportunities for global health service.”

info

บัติ657

info

Developing a medical school system in Iraqi Kurdistan

An ob-gyn professor from Tennessee traveled halfway around the world to help strengthen medical education. ACOG Fellow Martin E. Olsen, MD, Tennessee Section chair, spent three weeks in May in Iraqi Kurdistan to help develop a medical school system in the region. The trip was part of a project at East Tennessee State University in Johnson City, TN, where Dr. Olsen is chair of the ob-gyn department.

The university has been working with Kurdish medical schools for several years as part of a US State Department grant. In 2001, an Iraqi Kurdish delegation visited Johnson City, and this year, it was the Americans’ turn.

Dr. Olsen, along with pediatrician Wayne Meyers, MD, and health care administrator Bruce Behringer, toured cities and rural towns that have been sealed off from the rest of the world. Iraqi Kurdistan has been separate from the Iraqi government since 1992 after a Kurd uprising was crushed by Saddam Hussein’s army, leading the United Nations to declare the area a safe haven for the Kurds and establish a no-fly zone.

Dr. Olsen toured the city of Halabja, which was decimated in 1988 by a poison gas attack from Hussein’s regime. Five thousand died, 20,000 were injured, and the population continues to face devastating conditions with a high rate of miscarriages and birth defects, according to Dr. Olsen.

In Iraqi Kurdistan as a whole, there is a high maternal mortality rate as well, thought to be as high as 1%. Hospitals deliver as many as 50 babies a day but still can’t keep up with demand. Many births are overseen by traditional birth attendants, Dr. Olsen said. Some birth attendants have little or no medical training, but the medical schools have begun to develop training and monitoring programs for these caregivers.

With no access to Iraqi medical schools after 1992, the Iraqi Kurds converted old military bases—once used by Hussein’s army—into medical schools. The three schools, located in Erbil, Sulaimani, and Dohuk, have been sending graduates to underserved rural areas since the late 1990s.

During their visit, Dr. Olsen and his colleagues taught lessons on how to educate medical students.

“We spent a lot of time simply teaching them how to teach,” Dr. Olsen said. “We found the medical community to be eager for new ideas and able to make significant progress with only limited financial investment.”

The medical students—nearly half of them women—were bright, eloquent and blunt about their need for US support.

“They are dedicated and talented physicians,” Dr. Olsen said. “It’s truly impressive what they’ve accomplished.”

info

olesn@mail.etsu.edu
I read the recent issue of *ACOG Today* [August 2004] and its lead article about the obesity crisis in ob-gyn. The points highlighted in the first article of the series were well made, but so far, I don’t see any self-introspection.

I reflect to my residency training and recall continuously lecturing my patients about their prenatal weight gain. This posture continued when I entered private practice in 1962. In my mind, I could never account for more than 17 pounds of weight gain necessary to complete a healthy pregnancy. Throughout my practice, I insisted on a weight gain of no more than 20–25 pounds.

Then came the politically correct researchers who alleged that if a patient didn’t gain 35–40 pounds, serious consequences such as SGA, prematurity, and mental retardation, etc., would surely ensue. This news was promulgated by consumer magazines, media, and most practitioners and happily received. Some patients even left my practice because of my insistence on a reasonable weight gain. Well, you know what happened. In fear of damaging their unborn, women gained weight with reckless abandon. So they gained 45 pounds, lost 15, did it three times, resulting in a patient who checked in with her first gestation at 120 pounds, and is now and forever 210 pounds.

We can’t blame it all on fast food!

Charles R. Thomas, MD, FACOG, Greenwood, IN

Upon reading the most recent copy of *ACOG Today*, I was struck by the article by Dr. Hale regarding a complaint from an ACOG Fellow [Executive Desk, July 2004]. This complaint was with regard to the cost of the ABC examination.

The ABC exam is the best deal in the United States. For a minimal cost, a physician can obtain 25 CME credits, learn the up-to-date knowledge that the American College of Obstetricians and Gynecologists would like us to know, and maintain your updated board certifications.

I defy anyone in the United States to find a less expensive and more educational opportunity.

Sincerely yours,

William E. Houck, MD, FACOG, Chesterfield, MO

---

**Ob-gyn’s legacy lives on with hall of fame induction**

The late Sandra L. Welner, MD, a dedicated ob-gyn and tireless advocate for the disabled, will be inducted into the National Hall of Fame for Persons with Disabilities in November.

Each year, the hall of fame honors an outstanding individual for exceptional achievements and contributions to humanity. Dr. Welner was a passionate and visionary pioneer in the field of gynecologic care for women with disabilities until her death from injuries suffered in an apartment fire in 2001 at age 42.

A few years after she began practicing ob-gyn, Dr. Welner became physically disabled after a cardiac arrest during a medical procedure. She fought to regain her independence and return to medicine—an experience that inspired her to refocus her skills to address the unique gynecologic needs of women with disabilities and chronic medical conditions.

Recognizing that women with disabilities may skip important medical follow-up because mobility problems can make doctors’ appointments an ordeal, Dr. Welner designed the first universally accessible examination table for women with disabilities.

As a member of ACOG’s Committee on Health Care for Underserved Women, Dr. Welner contributed to the 1998 Committee Opinion *Access to Health Care for Women with Disabilities*. She also authored a section on women with disabilities in ACOG’s *Guidelines for Women’s Health Care*, second edition.

A graduate of the Medical College of Pennsylvania in Philadelphia, Dr. Welner began her ob-gyn residency training at St. Louis University Hospital and completed training at Danbury Hospital/Yale-New Haven Hospital in Danbury, CT. She was an assistant professor of ob-gyn at Georgetown University Hospital in Washington, DC, when she died.

---

**Letters to the editor**

- Dr. Welner

---

**in memoriam**

- Panayotis Apostolidis, MD • Athens, Greece • 4/04
- Raymond Cutts Jr, MD • Washington, DC • 3/04
- Peter J. McFarlane, MD • Godfrey, IL • 5/04
- Amo J. Mundt, MD • Tucson, AZ • 6/04
- Irving Schreiber, MD • Cliffside Park, NJ • 8/04

---

**October is Domestic Violence Awareness Month.**

*Visit http://dvam.vawnet.org for materials and local event information.*
ACOG Postgraduate Courses

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

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

October
CPT and ICD-9-CM Coding Workshop
1–3 • Atlanta

November
Practice Management Update for the Ob-Gyn
5–7 • Washington, DC
The Mature Woman: From Perimenopause to the Elderly Years
11–13 • Boca Raton, FL
Obstetrics Update: Emergencies
18–20 • Las Vegas
CPT and ICD-9-CM Coding Workshop
19–21 • San Francisco
No Frills—Advances in Urogynecology
20–21 • Chicago

December
Gynecology Update
1–4 • New York City
Controversies in Gynecology
2–4 • Chicago

2005
February
Practical Obstetrics and Gynecology
3–5 • Keystone, CO
Patient Safety in Obstetrics: New Approaches to Improving Patient Safety and Reducing Practice Liability
14–16 • St. Thomas, Virgin Islands
Your patients are likely seeking out complementary and alternative medicine and treatments, but you may not know it.

Studies have shown that the number of visits for such treatment is close to the number of visits to primary care providers and that most patients don’t tell their physicians about their use of alternative approaches.

Learn more about complementary and alternative medicine and treatments with *Complementary and Alternative Medicine* (CU013), the latest issue in the ACOG series *Clinical Updates in Women’s Health Care*.

*Complementary and Alternative Medicine* will help physicians understand what different alternative approaches are and how they work.

The monograph will allow ob-gyns to:
- Identify complementary and alternative practices
- Identify practitioners of alternative practices and their training and licensing requirements
- Understand the efficacy and dangers of such treatments
- Understand the interaction of alternative treatments with standard medical treatments
- Understand why patients use alternative therapies and be able to advise them on how to integrate such therapies safely into their total treatment regimen

*Complementary and Alternative Medicine* may be purchased individually through the ACOG website, or Fellows can subscribe to *Clinical Updates*.

Upcoming titles of the quarterly monograph series include *Hypertension* and *Continuing Care for Women with Breast Cancer*.

**Free breastfeeding posters available**

Free posters that encourage breastfeeding are available to physicians from the US Department of Health and Human Services’ Office on Women’s Health, which developed the campaign “Babies Were Born to be Breastfed” with the Ad Council.

The campaign, launched in June, encourages mothers to breastfeed for at least the first six months of their babies’ lives. (See cover article, *ACOG Today*, August 2004.)

The posters are available in sets of five: three color posters in English, one color poster in Spanish, and one black-and-white poster in English.

**FIGO seeking mentors for fistula repair**

The International Federation of Gynecology and Obstetrics is interested in obtaining the names of ob-gyns who would be willing to mentor and train physicians on fistula repair in less-developed countries.

Interested physicians should send a letter of interest with a brief curriculum vitae to gsatterfield@acog.org or Ralph W. Hale, ACOG, PO Box 96920, Washington, DC 20090-6920.

**ACOG Fellow oversees AMA long-range planning**

ACOG Fellow Robert Wah, MD, was elected chair of the American Medical Association Council on Long-Range Planning and Development in June.

Dr. Wah and the council are principal advisers to the AMA Board of Trustees and the AMA for strategic planning. Dr. Wah has been a member of the AMA House of Delegates since 1990 and an ACOG delegate since 2000.

Dr. Wah is a captain in the US Navy and is currently director of information management for the Military Health System, where he leads the Department of Defense Health Information Systems. He also works with residents and fellows, seeing patients at National Naval Medical Center, Bethesda, MD, and Walter Reed Army Medical Center, Washington, DC, as a board-certified reproductive endocrinologist.

A poster featuring two dandelions explains that breastfeeding may reduce a child’s risk of respiratory illnesses.