

## Emergency contraception hot topic in state legislatures

**A**T LEAST SIX STATES EXPANDED ACCESS TO emergency contraception this year. However, more than a dozen states tried to enact laws that would allow pharmacists to refuse to fill prescriptions for emergency contraception and other drugs that they say are against their personal beliefs—so-called “conscience clause” or “refusal” legislation.

While the Food and Drug Administration continues to delay its decision on over-the-counter status of EC, states throughout the US are addressing the issue. In at least seven states legislation was defeated that would have required hospital emergency rooms to provide EC information, services, and/or referrals to sexual assault victims. Legislators in Colorado passed this type of hospital access legislation, only for it to be vetoed by Republican Gov. Bill Owens.

“EC is a hot topic at the state level—from state legislatures that believe pharmacists should have the right to refuse to dispense EC to those who are striving to expand women’s access to EC,” said Kathryn Moore, ACOG’s director of state legislative

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### FDA delays EC decision

*Your help is needed!*

*Fellows are urged to send letters to the FDA by November 1 deadline.*

▶ SEE PAGE 8 FOR DETAILS

## e-health the first in an ongoing series

### Paperless practices: Reality or fantasy?

**A**PATIENT WHO SUFFERS from acute cystitis comes to your office for the first time. She just moved into the area, changing states, jobs, and health insurance. But you already know her medical history because you accessed her electronic health record in your office. Before you write her a prescription for Cipro, the electronic system will alert you to any contraindications. Seeing none, you send the Rx electronically to your patient’s nearest pharmacy, where it will be waiting for her by the time she leaves your office and returns to her neighborhood.

Will this scenario become everyday reality in the US in a few years or is it as far off base as the 1950s’ image of 2005: flying cars, robotic servants, and vacations to the moon? The federal government is striving to make such a universal health network a reality. Last year, President

Bush announced his vision of having all hospitals and physician practices go paperless by 2014. He created the Office of the National Coordinator for Health Information Technology and appointed David J. Brailer, MD, PhD, to carry out his vision.

According to ACOG Fellow Edward M. Zabrek, MD, paperless offices will indeed become a reality in the near future. Dr. Zabrek, a practicing ob-gyn in Houston and medical editor of *Pocket PC* magazine, believes the government and private payers will begin to offer incentives for clinicians to adopt an electronic health system.

“Around 2007, things will happen to start encouraging paperless offices,” Dr. Zabrek said. “Professional liability companies may begin to charge more for practices that aren’t paperless, while the government may offer low-interest loans to physicians to install electronic health record systems.”

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EXECUTIVE DESK

*Mandated program to begin in 2007*

ACOG, ABOG developing modules  
for maintenance of certification

THE AMERICAN BOARD OF MEDICAL  
Specialties is requiring all specialty boards to  
establish a mechanism to determine ongo-  
ing competency of their diplomates. ACOG has been  
working with the American Board of Obstetrics and  
Gynecology to develop such a program.

This concept is part of maintenance of certifica-  
tion, and for those who have a time-limited certificate  
it will be required to remain board-certified. There  
are four parts to the program:

- ▶ Evidence of professionalism
- ▶ Evidence of commitment to lifelong learning
- ▶ Evidence of cognitive expertise
- ▶ Evidence of evaluation of practice performance

ABOG is responsible for evaluating professional-  
ism, lifelong learning, and cognitive expertise, while  
ACOG and ABOG together are developing a program  
to evaluate practice performance. This program is  
known as the "Road to Maintaining Excellence."

A presentation about this program was given to the  
College Advisory Council at the 2004 Annual Clinical  
Meeting, and I have written about this program  
previously. Now, I want to give you an update.

After volunteers completed trial modules on group  
B streptococcal infection and deep-vein thrombosis,  
we enlarged the working group and began to prepare  
more self-assessment modules, which are currently

undergoing development by working groups of  
Fellows. The modules will be in the areas of obstet-  
rics, gynecology, and ambulatory care. Each will  
contain required and optional references.

Once a physician selects an evaluation, he or she  
will pull the case files for the 10 most recent patients  
with that diagnosis and complete a self-assessment  
of the management of each of the 10. Physicians will  
need to complete 10 different modules every six  
years and answer a follow-up questionnaire for  
each module. It is anticipated that two modules will  
be completed each year. Completion of each module  
will earn designated CME credit.

During the 2006 ACM, we will announce plans  
about the start of the program. In the fall of 2006,  
further details and enrollment instructions will be  
available. The program will officially debut in  
January 2007. Although the start date is more than  
a year away, ACOG believes it is essential to begin  
early notification because the importance of this new  
ABMS requirement is so great. Stay tuned to *ACOG  
Today* for future announcements. ♀

*Ralph W. Hale MD*

Ralph W. Hale, MD, FACOG  
Executive Vice President

IN MEMORIAM

**Cornell I. McFadden, MD**  
Chapel Hill, NC • 6/05

**James L. Rorie, MD**  
Oakland, CA • 5/05

**George Rubino, MD**  
Brooklyn, NY

**Joseph P. Salerno, MD**  
Houston

**Marc A. Simon, MD**  
Ambler, PA

**Herman G. Sturman, MD**  
Calabasas, CA

**A. Frank White, MD**  
Paris, TX

Obstetrics & Gynecology  
HIGHLIGHTS



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

- Smoking Cessation During Pregnancy*  
(Committee Opinion #316, revised)
- Racial and Ethnic Disparities in Women's Health*  
(Committee Opinion #317, new)
- Screening for Tay-Sachs Disease*  
(Committee Opinion #318, revised)

*The Role of the Obstetrician-Gynecologist in the Assessment  
and Management of Obesity*  
(Committee Opinion #319, new) See page 12 for more information  
*Medical Management of Abortion*  
(Practice Bulletin #67, revised)



## ACOG responds to hurricanes

**A**COG IS REACHING OUT TO its members and their patients affected by Hurricanes Katrina and Rita. The College has established a special section on the ACOG website about how to help ob-gyns, patients, medical students, and others displaced by the hurricanes. Visit [www.acog.org](http://www.acog.org) and click on "Katrina Information."

ACOG has also agreed to waive the 2006 national dues for all members located in areas devastated by Katrina and has worked with the College's Career Connection partner,

HEALTHeCAREERS Network, to create a website to help ob-gyns find permanent or temporary jobs. The site also provides information for ob-gyns in other parts of the country who wish to volunteer in the relief efforts. Visit [www.healthcareers.com/katrina](http://www.healthcareers.com/katrina).

Look for a full package of articles in the November/December issue of *ACOG Today* about how the hurricanes affected ACOG members and their patients and how other members are reaching out. ACOG will continue to update members through the ACOG homepage at [www.acog.org](http://www.acog.org). ♀

## LETTERS TO THE EDITOR

**REGARDING THE ARTICLE** "Shoulder dystocia: a rare but frightening OB complication" [*ACOG Today*, August 2005], this very good article should have also mentioned that Erb's Palsy, not a rare consequence of shoulder dystocia, and for which the OB is usually blamed, can occur spontaneously.

Unfortunately, some of our textbooks, in the early discussion of complications, state that Erb's Palsy is frequently caused by excessive lateral traction on the head, which, of course, may be true in some cases; they may

only mention other causes elsewhere and they only mention spontaneous Erb's as an intrauterine accident. The lawyers have had a field day (and made a fortune) with that "excessive lateral traction" phrase, and editors of the texts should change the wording in such a way as to make it clear that the doctor is not always the culprit. Having been sued myself for an Erb's Palsy (and won), and having reviewed several cases where the obstetrician clearly did nothing wrong, this is very important.

—Paul R. Packer, MD, FACOG  
New Rochelle, NY

**TO WHOM IT MAY CONCERN:**

Thank you for the very kind words regarding the Missouri tort reform bill ["Five states achieve medical liability reform wins, *ACOG Today*, August 2005]. I would add a perspective that you may not be aware of that may serve as a lesson to others.

The two pieces of legislation passed by the General Assembly and vetoed by former Gov. Bob Holden were significantly weaker than that which was passed by current Gov. Matt Blunt. The lesson for trial attorneys is perhaps they would have been far ahead of the game had they had any sense of fairness or reality. They knew (or as they are wont to say, should have known) Gov. Holden had a very good chance of being only a one-term governor. They also knew (or should have known) that Gov. Holden had a very good

chance of being replaced by a Republican, pro-tort reform candidate (Gov. Blunt).

The lesson for physicians: don't ever give up. The lesson for all of us is that the legislation was the result of a long-term coalition of ACOG's Missouri Section, the Missouri State Medical Association, the Missouri Hospital Association, and the business community in Missouri. Although each group has differences of opinion in various areas, we did not allow that to prevent us from joining together for legislation to benefit all of us, as well as all Missourians.

Also, a correction to the article: Mr. Holden is not a lawyer.

Thanks again for the kind words.

—Gordon M. Goldman, MD, FACOG  
Chair, Missouri Section



Sign up on your  
ACOG November  
dues statement

*Want to get  
politically involved?*

**Join Ob-Gyns for  
Women's Health**

**W**ANT TO HAVE A REAL IMPACT on what happens in Washington? Join Ob-Gyns for Women's Health, ACOG's advocacy arm on Capitol Hill.

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

To help ob-gyns get more politically involved, ACOG leaders created Ob-Gyns for Women's Health, formerly known as Physicians for Women's Health. With a tax-exempt status different from ACOG's, the advocacy group has fewer legal restrictions on its lobbying activities.

Since OGWH was formed five years ago, thousands of ob-gyns have joined and great strides have been made in congressional work on ob-gyn issues.

**Join or renew on your November dues statement**

When you receive your ACOG dues renewal mailing in November, join or renew your membership in Ob-Gyns for Women's Health. Membership is just \$40 a year. Join the thousands of ob-gyns who have already added their names to this powerful organization, and take charge of your future. ♀

**info**

→ To learn more about OGWH, visit  
[www.obgynsforwomenshealth.org](http://www.obgynsforwomenshealth.org)

## ACOG task force to produce immunization education campaign

**A**N OUNCE OF PREVENTION is worth a pound of cure. This old adage is a quick definition of the value of immunization in today's health care. As a method of public health prevention, few interventions have been as successful. We only need to look at smallpox, yellow fever, polio, and rubella successes, to name a few, in order to understand the scope of these achievements.

Unfortunately, as we have seen the disappearances, or sporadic occurrence, of these diseases, we have become less aware of why they disappeared. In the near future, an HPV vaccine will be introduced, and ob-gyns will be the physicians most involved in its administration.

The new ACOG Task Force on Immunization held its first meeting in August, with a full agenda. The task force began by reviewing current statistics and records of immunization practices as well as recommendations from the Advisory Council on Immunization Practices.

Because the number of ob-gyns actively involved in immunization programs is still below 50%, task force members felt that a major education program must be implemented as soon as possible. Initially, the task force hopes to produce a monograph on important immunization issues for physicians and patients. The

group also plans to produce a toolkit and other aids to assist ob-gyns. Resources will be developed for formal presentations and educational meetings. Through such methods, the task force hopes to greatly increase the number of ob-gyns who offer the full range of immunizations to their patients.

Your role as a primary care provider to your patient makes it critical that you help them prevent disease. By offering immunization services, the task force believes it can help ob-gyns accomplish this goal. ♀



## ACOG cosponsors National Depression Screening Day

**A**COG IS COSPONSORING THE 15TH ANNUAL NATIONAL Depression Screening Day on October 6 in an effort to raise awareness about postpartum depression. To draw attention to this oft-overlooked condition, this year's NDSD kits include a postpartum depression screening test for the first time in the program's history. Screening kits also include tests for depression, bipolar disorder, generalized anxiety disorder, and post-traumatic stress disorder.

Nearly 1,000 Fellows have joined with approximately 7,000 community health organizations and primary care providers offering their practice as a community screening site. Those unable to participate on October 6 can still get involved and register to hold a screening in the future as part of NDSD's year-long mental health screening initiative. ♀

### info

- [www.mentalhealthscreening.org/events/ndsd/index.aspx](http://www.mentalhealthscreening.org/events/ndsd/index.aspx)
- ACOG Office of Communications: 800-673-8444, ext 2560; [communications@acog.org](mailto:communications@acog.org)

## Fellow elections to be held online

**A**COG HAS INSTITUTED online voting for the 2006 Fellow district and section officer elections. Voting will begin Nov 16, 2005, for section elections and Dec 16, 2005, for district elections. Fellows will be able to access online ballots by using their last name and their ACOG ID number, a seven-digit number that can be found on all ACOG mailings. Paper ballots will be offered only by request.

More information will be provided in the November/December issue of *ACOG Today*, as well as in monthly resource mailings, on the ACOG website, and by email.

### ► Online Section Elections:

Voting begins on November 16 at:  
<https://eballot3.votenet.com/acogfellow>

### ► Online District Elections:

Voting begins on December 16 at:  
<https://eballot3.votenet.com/acogfellow>

### info

- For your ACOG ID, contact the Membership Department: [membership@acog.org](mailto:membership@acog.org); 800-673-8444
- For election updates, on the ACOG website, [www.acog.org](http://www.acog.org), under "Membership," click on "District and Section Activities"
- For questions about elections, contact Megan Willis: 800-673-8444, ext 2531; [mwillis@acog.org](mailto:mwillis@acog.org)

## ACOG seeking info on ob-gyn retraining programs

**A**COG IS INTERESTED IN finding programs that are available for retraining of ob-gyns who have been away from clinical practice for a period of time. If any of our members have a program and are willing to share information on it, contact ACOG Executive Vice President Ralph W. Hale, MD, at [rhale@acog.org](mailto:rhale@acog.org) or 202-638-5577. ♀

Two out of three ob-gyns burned out

## Survey finds burnout rate high among ob-gyns

**A**mong the 863 ob-gyns who responded to a 2004 District III survey on burnout, 64% reported symptoms of burnout. Vincent A. Pellegrini, MD, FACOG, reported the survey findings at the ACOG Annual Clinical Meeting in May.

Workload tended to be a major culprit in burnout. On average, respondents worked 59 hours a week, not counting nights on call. Twenty-nine percent said they were physically exhausted. Among ob-gyns who said their workload had increased, the burnout rate was 76%, but it was 46% for the small number who reported a decrease.

Overall, 16% of ob-gyn respondents said they wanted to quit medicine, and 40% planned to retire early because of the medical environment.

### Burnout—a process over time

The earliest symptoms of burnout are subtle—fatigue not relieved by rest, irritability, anxiety, poor concentration, and forgetfulness.

“Often a physician’s family members, especially the spouse, will be the first to recognize those symptoms,” said Peter S. Moskowitz, MD, director of the Center for Professional & Personal Renewal in Palo Alto, CA, and a faculty member of ACOG’s Career Transitions course offered at the ACM.

Later symptoms include withdrawal from friends and family, procrastination, cynicism, loss of sexual desire, and apathy, which can develop into clinical depression, extreme fatigue, and physical ailments.

Changes in the health care system have increasingly put physicians at risk for burnout, according to Dr. Moskowitz. “The control of practice, the satisfaction of the physician-patient relationship, the financial rewards of medicine—all of those things have eroded.”

### Increased workload

Workload was high among the burdens reported by ob-gyns who participated in two District III wellness retreats conducted during Dr. Pellegrini’s 2001–04 term as District III chair.

“The thing that came up repeatedly among participants was the feeling of being overwhelmed by the volume of work,” said Dr. Pellegrini. “They were spinning wheels and could never get to the top of the pile. Most people at the retreat had revved up their volume by 20–30% to maintain their level of income, or even to keep it from dropping more than 20%. They had a feeling of never being able to win.”

**“They were spinning wheels and could never get to the top of the pile. ... They had a feeling of never being able to win.”**

—Dr. Vincent A. Pellegrini



### Other important factors

According to John-Henry Pfifferling, PhD, loss of autonomy, disrupted sleep, liability concerns, unpredictable practice environments, and feeling trapped because of financial obligations can all add to the risk of burnout among ob-gyns. Dr. Pfifferling, director of the Center for Professional Well Being in Durham, NC, facilitated the wellness retreats in District III.

### What ob-gyns can do

Dr. Pfifferling advises physicians concerned about stress to read about the burnout syndrome. “They need to identify the self-care behaviors they have neglected, find what nurtures them, and develop a specific burnout treatment plan that takes advantage of things that energize them.”

Getting help early is important. “Physicians need to reach out and ask for help,” Dr. Moskowitz said, “but that’s the most difficult part, because the culture of medicine has trained doctors not to admit vulnerability.” ♀



## Five obstacles to overcoming burnout

**D**R. MOSKOWITZ REPORTS that the following obstacles are common among professional clients who consult him for help with burnout.

- 1. Holding on to perfectionism.** It’s difficult to make changes if you are very rigid and expect yourself to do everything perfectly.
- 2. Isolation.** Many physicians have only one or two close friends—who are also physicians. It’s really healthy to find friends who are outside health care; they can give you a different perspective on life and values.
- 3. Overcommitment.** Physicians just have too much on their plate. Usually everything on the plate is something worthwhile, so it’s hard to say no, and you end up doing too many things—even good things. Take something off your list of commitments.
- 4. Undiagnosed addictions.** In response to stress, many may “self-medicate” with alcohol, prescription drugs, gambling, or other addictions. If those addictions are present they have to be addressed before lifestyle balance can occur.
- 5. Financial overextension.** Physicians use time and money in similar ways—those overextended on time are often overextended on money as well. Your financial picture may need to be assessed by a professional.

### info

- *The Truth about Burnout* (1997, Josey-Bass): Available from bookstores
- *Medical Practice Divorce*: Available from the AMA bookstore: 800-621-8335 or [www.amapress.org](http://www.amapress.org)
- *Burnout: Effectively Managing a Grief Syndrome*. Available from the Center for Professional Well Being, 919-489-9167 or [www.cpwb.org](http://www.cpwb.org)
- Center for Personal & Professional Renewal: 800-377-1096 or [www.cppr.com](http://www.cppr.com)

## Paperless practices

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### Understanding the lingo

Supporters of electronic health records say they will save time, money—and lives. Patient safety advocates say adopting health technology will reduce medical errors because papers won't be lost or misfiled, sloppy handwritten prescriptions and medical records will be eliminated, and physicians will no longer be dependent solely on a patient's memory of past surgeries and illnesses.

But there are several hurdles that the industry must leap before EHRs become as ubiquitous as cell phones. The terminology alone can be intimidating. "Electronic medical records" and "electronic health records" are often used interchangeably, but they can mean different things.

An EMR usually refers to the electronic version of individual patient medical records that physicians already have now as paper records. However, an EHR is a patient's complete health record, with medical records from different physicians, lab results, hospital records, X-rays, and health information that the patient provides. According to Dr. Zabrek, it's important that physicians use the term EHR when shopping for software programs to ensure that the system will not be a stand-alone program and can share data with EHR systems in other practices, clinics, and hospitals.

Another word doctors should become familiar with is "interoperability," which is the backbone of the vision of electronically sharing patient records, lab results, and X-rays with other physicians and hospitals.

"Interoperability is the ability of a software program in a physician's practice to 'talk to' a colleague's program," Dr. Zabrek explained. "Currently, EMR systems have different software from different manufacturers; there's no guarantee that they're compatible, making it impossible to share EMRs from one practice to another."

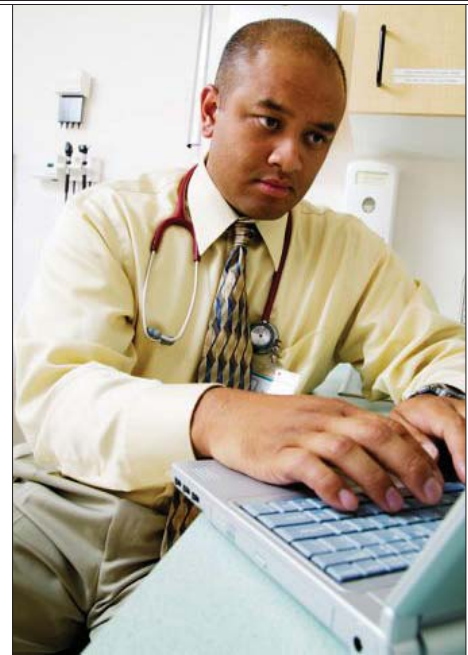
Dr. Brailer's office is working with manufacturers to develop interoperable programs.

### Overcoming cost barrier

A leading barrier to EHR implementation is cost. According to Dr. Zabrek, an EHR program can cost \$50,000 to \$100,000 per doctor.

A 2004 Commonwealth Fund survey of more than 1,800 physicians showed that just 13% in solo practices use EMRs, compared with 57% in practices of 50 or more physicians. Start-up costs was cited as the No. 1 reason that physicians weren't adopting information technology.

Dr. Brailer recognizes the adoption gap and has said that his office continues to evaluate how to decrease the costs of implementation, particularly for smaller practices and hospitals. ♀



### Shopping for an EHR system

**W**HETHER YOU ARE seriously looking to buy an EHR system or just familiarizing yourself with choices, you should ask manufacturers these key questions:

#### 1. Is this program interoperable?

While practices may not currently be sharing electronic health records with one another, experts predict such exchanges in the near future. An EHR system must have "interoperability" in order to be able to share data with software programs at other practices, labs, hospitals, etc.

#### 2. Does this program use HL7?

HL7, or "Health Language 7," is the standard computer language for health care systems. An EHR system must use HL7 to be compatible with any other system. Physicians also need to make sure that the EHR system they're considering is compatible with their billing software. Older billing software may not use HL7, which means physicians may also need to buy a newer practice management system.

## ACOG committee evaluating EMRs for Fellows

**T**HE NEWLY FORMED ACOG Committee on Electronic Medical Records is evaluating how best to assist Fellows in selecting the right software for their practice.

The committee, which was established last year, wants to ensure that Fellows choose software that is not only appropriate to their needs but that reflects ACOG guidelines.

The committee is also evaluating the creation of standard nomenclature for EMRs and monitoring EMR efforts by the government and third-party payers.

"The committee wants to assist Fellows in selecting the right product for their practice and is working on some ways to do that.

Right now there are many different products with different standards that don't communicate with each other," said Committee Chair Paul R. Ziaya, MD. "Our job is to make sure that ACOG has a voice in how standards are being developed, how funding occurs, and that our Fellows' and their patients' needs are met."

ACOG and other medical specialty societies are members of the Physicians' Electronic Health Record Coalition, which is striving to make EMRs affordable for small and medium practices. Also, ACOG is assisting in the development of an obstetric extension to a continuity of care electronic record. ♀

# ACOG plays active role in creation and valuation of CPT codes

**T**HE PROCESS THAT CREATES CPT codes is important to every ob-gyn practice because it's this process that helps determine how much a physician will be reimbursed.

ACOG's Health Economics Department and the Committee on Coding and Nomenclature serve as advocates for ob-gyns for fair reimbursement by participating in updating the Medicare physician fee schedule each year. Although many ob-gyns may not receive much of their income from Medicare, it's important to recognize that many private payers also use the Medicare fee schedule. ACOG's participation in this process has led to significant increases in the "relative value units" that are assigned to a particular code; the more RVUs there are, the higher the reimbursement. The College has also helped develop new codes and advocates "gender equity," calling for ob-gyn codes to be valued the same as other specialties' codes for similar procedures.

However, it's not only committee members and ACOG staff who play a critical role in establishing ob-gyn codes and values: "All Fellows play an important part in the development of CPT codes," said Fellow Barbara S. Levy, MD, a member of the coding committee, "whether it's by notifying the coding committee about areas where new codes are needed or informing us about codes thought to be misvalued. Responding to the surveys ACOG conducts to determine the work and time involved in procedures is essential to ACOG's success in this process." (For more on the surveys, see the sidebar at right.)

## Determining the value of a code

Each year, specialty societies recommend new or revised codes to the Current Procedural Terminology Editorial Panel of the American Medical Association. If the panel approves a code, it becomes the responsibility of the specialty societies interested in that service to recommend a value to the Relative Value Scale Update Committee, or the RUC, for consideration. ACOG has a permanent seat on the RUC and is currently represented by Dr. Levy. The

RUC's recommendations are presented to the Centers for Medicare & Medicaid Services, which establishes RVUs for new CPT codes every year.

In the past, CMS has accepted more than 95% of the RUC's recommendations.

## Reviewing the value of an existing code

In addition to the creation of new codes each year, CMS conducts reviews of RVUs every five years. As part of that process, CMS and specialty societies may request a review of existing codes that are believed to be misvalued. The specialty societies must present compelling evidence for a code to be reviewed. Compelling evidence can include:

- ▶ Documentation of change in physician work
- ▶ An anomalous relationship between code values
- ▶ A change in technology
- ▶ Analysis of other data on time and effort measures
- ▶ Evidence that incorrect assumptions were made in the previous valuation of the service

"There has to be something that has changed in order for you to bring it forward for review," Dr. Levy said. "The first hurdle we have is to demonstrate the compelling evidence."

During the current review, ACOG recommended that 14 codes be reviewed, and CMS recommended five more ob-gyn codes for review. ACOG conducted surveys of ob-gyns this past summer to gather data to support the College's request to increase the values of these codes.

ACOG presented its recommendations to the RUC earlier this month, and the RUC will give its recommendations of all reviewed specialty codes to CMS by October 31. CMS will determine the values in 2006, and any changes will take effect January 2007. ♀

## info

→ Kim Longworth: 800-673-8444, ext 2456; klongworth@acog.org

## How an ob-gyn procedure code is established

Anyone can suggest a new or revised CPT code to the CPT Editorial Panel of the AMA, but suggestions primarily come from specialty societies, including ACOG

If a code is approved by the CPT Editorial Panel, the Relative Value Scale Update Committee, or the RUC, begins the process to determine the value of a code

ACOG evaluates the suggested ob-gyn codes by surveying ob-gyns and conducting research

ACOG's representative presents the recommendations at a RUC meeting

The RUC can accept or modify the recommended values or refer them back to ACOG

The RUC's final recommendations are forwarded to the Centers for Medicare & Medicaid Services each May

CMS reviews the recommendations and publishes the final codes and their values each fall

New and revised codes take effect on January 1 every year

(SOURCE: AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS, AMA, 2004)

## Member surveys vital for code development

**E**VERY YEAR AS CPT CODES are being developed, ACOG has the opportunity to recommend the value of a code, which helps determine how much the Centers for Medicare & Medicaid Services will reimburse providers for a procedure. Many other health plans use the system for their reimbursement system also.

ACOG surveys ob-gyns to gather data about the time, intensity, and complexity of the procedure. ACOG is required to use a standardized survey and provide survey data from at least 30 people.

"It's important for Fellows to know that our work is valued by the time and intensity of the procedure," Dr. Levy said. "These surveys are invaluable and should not be taken lightly."

Often, Fellows are selected for surveys because they've specifically expressed interest in helping ACOG. Members are sometimes asked to respond to surveys based on their subspecialty.

## Emergency Contraception

### ► PAGE 1

and regulatory affairs. “These refusal laws are not new, although they’re gathering momentum in some areas. The first refusal law was enacted in South Dakota in 1998. Since then, similar laws have been passed in Arkansas, Georgia, and Mississippi.”

No refusal laws were enacted this year, although refusal bills introduced in Tennessee and Vermont will carry over into 2006 when the two states’ legislatures meet again. In Arizona, both legislative houses passed a refusal bill, but Democratic Gov. Janet Napolitano vetoed the legislation.

ACOG supports increased access to EC and continues to urge ob-gyns to provide advance prescriptions for EC to all reproductive-age women at every office visit.

In a statement developed by ACOG in 1999 the College says that “pharmacists who are unwilling to dispense EC should at a minimum be obligated to refer a woman to another pharmacy that will fill her prescription.”

### Illinois governor prohibits pharmacist refusals

Illinois made one of the strongest statements for EC access when Democratic Gov. Rod Blagojevich issued an emergency rule, later made permanent, that prohibits pharmacists from refusing to fill prescriptions, including all forms of contraception. The governor issued the rule after women in Chicago complained that pharmacists were refusing to fill their contraception prescriptions.

“Unfortunately, this story is not unique to Chicago or to Illinois,” Gov. Blagojevich said in April. “Cases like this have been popping up all over the country. Now I don’t believe this is a coincidence. I have a sneaking suspicion that in all likelihood, this is part of a concerted effort to deny women access to birth control.”

In California, the Legislature passed a bill that would not allow pharmacists to refuse to fill any prescription, including one for EC, unless they had previously stated their moral or religious objection in writing to their employer, who would then be required to refer the patient to another pharmacy that would be able to fill the prescription quickly. At press time, the bill was awaiting a decision by Republican Gov. Arnold Schwarzenegger.

In New Hampshire, legislators enacted a law that will allow pharmacists to dispense EC under collaborative arrangements with physicians. To be eligible, pharmacists must follow certain guidelines, such as completing EC education and training and distributing an EC fact sheet along with the drug. ACOG’s New Hampshire Section will be involved in developing the guidelines.

In Massachusetts, the Legislature overrode a veto by Republican Gov. Mitt Romney to also enact a law allowing pharmacists to dispense EC under collaborative agreements, although the state public health department must write regulations before the law can take effect. Including Massachusetts, eight states now allow patients without prescriptions to obtain EC directly from a pharmacist.

Hawaii will expand public awareness with a new law that establishes a temporary health department work group to develop a program that will inform the public about EC availability. New laws in New Jersey and Texas will require hospitals to inform sexual assault victims about EC and provide EC upon request.

### District II wages strong campaign

In New York, a bill that would have allowed pharmacists and nurses to dispense emergency contraception to women and teenagers was vetoed by Republican Gov. George E. Pataki. Although the veto was a disappointment, getting the bill passed in the Republican-controlled Senate was a tremendous victory. During the previous two years, the bill had passed in the Democratic-controlled Assembly only to be stalled by the Senate.

District II actively lobbied for the legislation, and Fellows served as medical resources to legislators, explaining the safety and efficacy of EC.

“We heard time and time again the misperceptions about EC,” said Fellow Marc E. Heller, MD, medical director for Planned Parenthood Mohawk/Hudson. “We heard that it was an abortifacient. We heard it was unsafe for teenagers. We heard it would encourage teenagers to engage in more sexual activity. By having direct contact with legislators and their staffs, we were able to educate them about EC and correct these misperceptions.” ♀



## FDA continues to delay EC decision

**P**LAN B HAS BEEN AVAILABLE since 1999 by prescription only. In May 2004, Barr Pharmaceuticals’ application to sell it over the counter was rejected by the Food and Drug Administration on the basis of insufficient data related to safety, even though the agency’s own expert advisory panel and medical review staff supported the switch to over-the-counter.

In response to Barr’s supplemental application, the FDA has now acknowledged that women age 17 and older can safely use Plan B as an OTC drug, but nonetheless has introduced new excuses as reasons to postpone making a decision.

“What this amounts to is a quintessential shell game in which women are the losers. Unplanned pregnancy remains a major public health issue in the US. Emergency contraception offers a safe and effective way to prevent unplanned pregnancy and reduce the number of abortions in this country,” said ACOG President Michael T. Mennuti, MD.

### Send your comments to FDA by November 1

The FDA has established a 60-day public comment period to address the regulatory and policy issues related to allowing a drug to be sold OTC to one age group but as a prescription to another. ACOG encourages you to share your comments with the FDA before the November 1 deadline and to encourage your patients to make their voices heard also by posting the information below in your practices.

All submissions must include the agency’s name (FDA) and Docket #2005N-0345. Comments may be submitted in one of three ways:

► **Fax:** 301-827-6870

► **Mail:**

Division of Dockets Management  
5630 Fishers Lane, Room 1061  
Rockville, MD 20852

► **Online:** [www.fda.gov/ohrms/dockets](http://www.fda.gov/ohrms/dockets)  
In the lefthand column under “Dockets” click on “Submit Electronic Comments.” Click on “docket search” and search for the docket ID 2005N-0345 for comment form



## ACOG communicates with state legislators about medical liability crisis

**A**COG ADVOCATED AN important liability ballot initiative at the National Conference of State Legislators in August. With the annual conference held in Seattle this year, it provided the perfect opportunity to speak with legislators and their staffs about a Washington ballot initiative as well as the medical liability crisis across the country.

**PUTTING PATIENTS FIRST!**  
**Yes 330 No 336**

ACOG Government Relations staff attend the conference every year. This marked the fourth straight year that the College united with other medical organizations to sponsor a booth, where they urged legislators to “stop the crisis.”

The booth showcases the devastating effects that increasing medical premiums are having on women’s health care.

On November 8, Washington state voters will be heading to the polls to vote on two ballot initiatives. Initiative 330 is backed by the Washington State Medical Association and a coalition of medical and health groups, while Initiative 336 is supported by the Trial

Lawyers Association.

Washington physicians have waged a campaign to alert voters to vote for I-330 and against I-336. The physician-backed initiative includes a cap on noneconomic damages of \$350,000 to \$1.005 million, depending on the number of defendants; a limit on attorney contingency fees; structured payout of awards; and collateral source reform (making juries aware of other sources



ACOG Government Relations staff at the “Stop the Crisis” booth.

of payments received by patients or their families). The initiative would also encourage voluntary arbitration and mandatory mediation.

The lawyer-supported initiative includes heavy insurance oversight and regulation and a “three strikes, you’re out” law, which would revoke the license of any physician receiving three or more judgments.

The Washington Section of ACOG has been encouraging Fellows to get involved by wearing buttons; displaying brochures, counter plaques, posters, bumper stickers, and yard signs; and discussing the initiatives with their patients. ♀

## Enrollment in new Medicare drug plan begins in November

**I**N NOVEMBER, ALL MEDICARE recipients can begin enrolling in Medicare’s new prescription drug coverage program. With 41 million Americans receiving health insurance coverage through Medicare, patients may ask their physicians about the program, which will begin Jan 1, 2006. Patients may have questions about enrollment or need help selecting a plan. Some patients may be unaware of the program altogether or believe they aren’t eligible. The Centers for Medicare & Medicaid Services is asking physicians to help educate their patients about this important benefit.

Medicare’s prescription drug program, also known as Medicare Part D, was created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

All Medicare recipients are eligible for the program, which will allow them to select one of several prescription drug plans and

pay a monthly premium. Plans may differ in the cost of deductibles, the cost of drugs, which drugs are covered, and which pharmacies can be used.

In October, the companies that have been selected to offer plans will be allowed to begin marketing efforts. Enrollment begins November 15 and continues through May 15, 2006. Enrollment is voluntary. However, anyone not signed up by May 15 will not be allowed to enroll until November 15, 2006, and will have to pay higher monthly premiums.

CMS announced in August that, because of competitive bidding among companies offering drug plans, the average monthly premium is lower than expected. The average monthly premium is \$32.20, about \$5 less than estimated. People with limited income may qualify for extra help in paying for drug costs. The amount of help is based on income and resources. ♀

Have limited income?  
Social Security can help  
with prescription costs.

Find out if you are eligible.  
Call 1-800-772-1213  
(TTY 1-800-325-0778)  
and ask for help with  
Medicare prescription costs.  
Complete your application  
for help today.  
[www.socialsecurity.gov](http://www.socialsecurity.gov)

Refer your patients to:  
**800-MEDICARE**  
[www.medicare.gov](http://www.medicare.gov)

### info

→ Medicare offers detailed information, free posters, a brochure, and a physician toolkit on the CMS website: [www.cms.hhs.gov/medlearn/drugcoverage.asp](http://www.cms.hhs.gov/medlearn/drugcoverage.asp)

## Wanted: intriguing cases for Stump the Professors

**H**AVE YOU EVER COME ACROSS a case that stumped you and your colleagues? Have you managed a case that was unique, challenging, and exciting?

The quest is on for cases relating to women's health that are intriguing, mind-boggling, and difficult for the Stump the Professors program at the 2006 Annual Clinical Meeting, which will be held May 6–10 in Washington, DC. You must be a Junior Fellow to submit a case. Cases should require thought and attention to potential change in practice and represent the depth and breadth of ob-gyn.

Several cases will be presented for discussion at the ACM. The event will be held from 9:30 to 11 am on Tuesday, May 9.

Each presenter will receive free Junior Fellow ACM registration fee, coach airfare, and two to three days per diem for room and board.

Cases must be submitted online. Submissions should consist of a one page-summary of 700 words or less, including final diagnosis. Deadline for submissions is December 1. ♀

### info

- On the ACOG website, [www.acog.org](http://www.acog.org), under "Membership," click on "Junior Fellows"
- Chris Himes: 800-673-8444, ext 2561; [chimes@acog.org](mailto:chimes@acog.org);



## Essay about mentor due by November 15

**S**HOWCASE A POSITIVE relationship you had with an ob-gyn mentor in this year's Junior Fellow essay contest. Essays focusing on "How My Ob-Gyn Mentor Influenced Me" must be submitted online by November 15.

The contest is open to all Junior Fellows. Essays should be between 500 and 750 words and should not mention the names of any mentors.

One winner will be selected from each district and will receive \$500. A grand-prize winner will be selected from the district winners and will receive an additional \$500 plus an expenses-paid trip to the 2006 Annual Clinical Meeting in Washington, DC, May 6–10. (The prize includes Junior Fellow ACM registration fee, coach airfare, and two to three days per diem for room and board.) ♀

### info

- On the ACOG website, [www.acog.org](http://www.acog.org), under "Membership," click on "Junior Fellows"
- Chris Himes: 800-673-8444, ext 2561; [chimes@acog.org](mailto:chimes@acog.org)

## CREOG UPDATE

*By Dian Fogle, MD, and Whitney You, MD, resident representatives to CREOG*

### MED STUDENT VISITS TO RESIDENCY PROGRAMS

The CREOG Council has unanimously endorsed a recommendation that residency programs require medical students to make only one interview visit to a program. The concern is that the time and cost of multiple visits can be a burden on medical students. The request to consider one visit as the standard originally came from the Association of American Medical Colleges' Group on Student Affairs. It has been endorsed by the leadership of the Organization of Program Director Associations, which requests that residency program directors attempt to ensure that both the applicant and the program fit all required components of an interview into just one visit.

### ONLINE WRITTEN BOARD EXAM

The American Board of Obstetrics and Gynecology is striving to develop an online written board exam by 2007. The oncology subspecialty written exam may be available online by June 2006.

### EDUCATIONAL OBJECTIVES

The eighth edition of *Educational Objectives: Core Curriculum in Obstetrics and Gynecology* was published earlier this year and has been sent to all ob-gyn residency programs and residents. The objectives are also online in both Spanish and English (see info at right). CREOG plans to update the objectives every three years. Residents, faculty, and program directors are encouraged to use them as a training guide.

### RESIDENT WORKSHOPS

CREOG plans to again offer resident workshops three times in 2006. CREOG's *Workshop for Ob-Gyn Residents: Preparing to be Teachers & Leaders* was offered three times this year and had more than 220 participants. The workshops provide great tips about teaching and adult learning that residents can incorporate into their individual training program. The 2006 workshops will be held:

- ▶ April 21–23, San Francisco
- ▶ May 5–7, Washington, DC
- ▶ May 19–21, Chicago

### info

- For more information on CREOG, on the ACOG website, [www.acog.org](http://www.acog.org), under "Education," click on "CREOG"



## What does the JFCAC do for me?

By May Hsieh Blanchard, MD, JFCAC chair

**T**he Junior Fellow College Advisory Council represents all ACOG Junior Fellows in training and practice. The JFCAC consists of three national officers—the chair, past chair, and vice chair, who is the chair-elect—and the Junior Fellow chair and vice chair from each of the 10 ACOG districts.

The JFCAC is supported by a JFCAC advisor, who is a current district chair elected by the Council of District Chairs. Administratively, the JFCAC is supported by Mary Behneman, ACOG's director of district and section activities; Chris Himes, ACOG's manager of the Department of Junior Fellow Services; and Alexandra Khalaf, project coordinator in the Department of Junior Fellow Services. The entire JFCAC meets twice a year: at the Interim Meeting (typically in January in Washington, DC) and at the Annual Clinical Meeting in May.

Since the ACM in May, the JFCAC has been hard at work. In addition to planning for and directing Junior Fellow activities and meetings held at each of the Annual District Meetings this fall, the council is also working on several other projects.

### Strategic plan for the JFCAC

Using the ACOG Strategic Plan developed by the Executive Board as a springboard, the JFCAC is critically assessing its role, function, and mission as representatives of the Junior Fellow membership at large. As a primary outcome, we hope that this will focus the direction of future initiatives and address the needs of our constituency more effectively.

### ACGME duty-hour restrictions

While many current Junior Fellows in training have always worked under the duty-hour restrictions instituted in June 2003 by the Accreditation Council for Graduate Medical Education, challenges remain in balancing the clinical/educational opportunities and responsibilities of residency or fellowship with the limitations engendered by time constraints.

The JFCAC is now gathering data from Junior Fellows in residency and fellowship training to try to ascertain the true impact of the duty-hour restrictions on day-to-day activities. The information will allow us to develop an armamentarium of novel solutions that have proven to be successful and that could be implemented across training programs.

### Impact of the professional liability crisis

The JFCAC is finalizing a survey to be distributed to fourth-year residents on the impact that professional liability issues have had on their post-residency plans. It is hoped that the survey will provide additional solid data that can be used in our continued push for meaningful medical liability reform.

### Business of medicine ACM course

A course on the business of medicine will be held during the 2006 ACM, May 6–10 in Washington, DC. The course will be targeted toward Junior Fellows and young Fellows. At the 2005 ACM, ACOG unveiled the new primer *The Business of Medicine: An Essential Guide for Obstetrician-Gynecologists*. The book was developed at the request of, and with input from, the JFCAC's Business of Medicine Task Force.

The JFCAC has long recognized that education on business and financial topics is often lacking during residency and fellowship training, and thus, we're excited to see this course happen.

### Medical student ACM course

An ongoing priority of the JFCAC is ob-gyn recruitment of medical students. In conjunction with ACOG's Membership Department, the JFCAC is working with districts and sections to provide ob-gyn exposure and mentorship to students and student interest groups. Furthermore, recognizing that many medical students attended the 2005 ACM, the JFCAC is structuring a course specifically for medical students to be held at the 2006 ACM. ♀



## Making sense of liability policies

**W**ITH A HIGH RISK OF lawsuits, ob-gyns rely heavily on their professional liability insurance. However, reviewing policies and insurance terms can be confusing and tedious. Here's an introduction:

### Choosing the type of coverage

- ▶ **Occurrence coverage** covers you for all claims related to events that happen during the time the policy is in effect, regardless of when the claim is filed. These policies are desirable to ob-gyns because obstetric claims may be filed years after the event happened, but such policies may be hard to come by.
- ▶ **Claims-made coverage** covers you for claims from incidents that occurred and were reported during the policy period. Both conditions are required.
- ▶ **Claims-paid coverage** covers you only for claims in which all events related to the claim happened during the same policy year—incident, claim filing, insurer notification, and damages paid. Because this is an unlikely scenario, claims-paid coverage is relatively uncommon among ob-gyns.

### Selecting tail vs. nose coverage

Because both claims-made and claims-paid coverage do not cover you once you no longer have that policy, it's essential that you purchase a "reporting endorsement policy," or "tail coverage," from your current insurer or a "prior-acts policy," or "nose coverage," from your subsequent insurer. ♀

### info

→ To learn more about tail and nose coverage and selecting insurance, see chapter 10 in *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists*. Order at <http://sales.acog.org>; 800-762-2264, ext 192



## Obesity & Ob-Gyn part of an ongoing series

### New Committee Opinion calls on ob-gyns to calculate BMI for all women

**O**B-GYNS SHOULD EVALUATE ALL WOMEN for obesity by calculating their Body Mass Index and offering appropriate interventions or referrals, according to a new Committee Opinion.

Committee Opinion #319, *The Role of the Obstetrician-Gynecologist in the Assessment and Management of Obesity*, addresses obesity in the nonpregnant adult woman. The document was published in the October issue of *Obstetrics & Gynecology*. (A Committee Opinion addressing obesity in pregnant women was published in the September issue of the Green Journal.)

With approximately one-third of all US women classified as obese—defined as a BMI of 30 or greater—obesity is the fastest growing health problem in the US. Obesity is associated with increased morbidity, including type 2 diabetes, hypertension, infertility, heart disease, gallbladder disease, osteoarthritis, and a variety of cancers, including breast, uterine, and colon cancers. In addition, obese women are five times more likely than nonobese women to develop endometrial cancer.

The Committee Opinion calls on ob-gyns to review a patient's medical, social, and family history for weight-related conditions and calculate a patient's BMI. If a patient's BMI is 30 or greater, the severity of obesity (class I, II, or III) should be noted.

"Reinforcing the importance of weight loss and exercise and assessing the patient's readiness to make behavioral changes should be the initial approach," the document states. "The clinician should inform the patient in a sensitive manner that her weight is a health concern and assist her in developing a weight loss and exercise plan."

If available, referral for further evaluation and treatment should be considered whenever the resources of the clinician are insufficient to meet the needs of patients with a BMI of 40 or greater or a BMI of 35 or greater with comorbidities and who have not been successful with appropriate prior interventions.

The document also addresses the use of the two most studied obesity drugs, orlistat, marketed as Xenical, and sibutramine, marketed as Meridia. ♀

### FDA places severe restrictions on acne drug Accutane

**U**NDER NEW REQUIREMENTS by the Food and Drug Administration, women and teenagers wishing to use the acne drug Accutane or its generic equivalents must enroll in a registry and agree to pregnancy testing and counseling.

The drug isotretinoin, marketed as Accutane, carries a significant risk of birth defects if taken during pregnancy. The risk exists until 30 days after a woman stops taking the drug. In 2004, at a joint meeting of two FDA advisory committees, committee members called for a stricter distribution program to ensure that no pregnant woman takes the drug and that women taking the drug don't become pregnant.

It is important that ob-gyns know if any of their patients take Accutane. Counseling about contraception and sexual intercourse is especially important for teenagers taking the drug to ensure that they understand the importance of not becoming pregnant while taking Accutane. ACOG has several resources

to help providers speak with teens about contraception and sex. Teen fact sheets on issues such as acne and contraception can be accessed on the ACOG website, and the Tool Kit for Teen Care can be purchased through ACOG's bookstore (see info at left).

Beginning December 31, under the new program known as iPLEDGE, all physicians and patients will have to register before prescribing or using the drug and must agree to comply with requirements for office visits, counseling, birth control, and other responsibilities. Beginning October 31, wholesalers and pharmacists must register with iPLEDGE to obtain the drug from a manufacturer.

A reporting and collection system for serious adverse events associated with the drug has also been implemented. All pregnancy exposures to isotretinoin must be reported immediately to the FDA through MedWatch, at 800-FDA-1088, or through the iPLEDGE website (see info at left). ♀



**Physicians urged to keep drug out of hands of pregnant women**

#### info

- Teen fact sheets: [www.acog.org/goto/teens](http://www.acog.org/goto/teens)
- Tool Kit for Teen Care: Order at <http://sales.acog.org>; 800-762-2264, ext 192
- Table on sexual history taking: Committee Opinion #300, *Cervical Cancer Screening in Adolescents*. On the ACOG website, [www.acog.org](http://www.acog.org), under "Publications," click on "Committee Opinions"
- [www.ipledgeprogram.com](http://www.ipledgeprogram.com)

## Vaccinate all pregnant women and health care workers against the flu

**W**ITH THE FLU SEASON ARRIVING OCTOBER 1, ACOG REMINDS ob-gyns about the importance of giving all pregnant women a flu shot if they will be pregnant during any part of the flu season.

ACOG supports the expanded influenza vaccination recommendations issued last year by the Centers for Disease Control and Prevention that include any woman who will be pregnant during the flu season. An intramuscular, inactivated vaccine may be used in all three trimesters.

Immunizing the mother offers some immunity to her infant as well. This is especially important because there is no influenza vaccine or antiviral therapy approved for infants younger than six months.

While the ideal time to vaccinate pregnant women is October and November, it's important to remember that the flu season often peaks in February and can run until mid-May.

### All health care workers need flu shots

It's also important for all health care workers—physicians and their staffs—to be vaccinated so they don't infect patients. The CDC is placing special emphasis on the vaccine recommendation for health care workers this year because of the number of patients who become infected by health care workers.

### Inactivated vs. live vaccine

The inactivated influenza vaccine is safe for people six months and older, including those with high-risk conditions. The live, attenuated influenza vaccine, marketed as FluMist, is approved for use among healthy people ages 5 to 49, but is not recommended for pregnant women. ♀

#### info

- CDC vaccination information for health care professionals: [www.cdc.gov/flu/professionals/vaccination/index.htm](http://www.cdc.gov/flu/professionals/vaccination/index.htm)
- Committee Opinion *Influenza Vaccination and Treatment During Pregnancy* (#305, November 2004). You may find the document in the 2005 *Compendium* or on the ACOG website, [www.acog.org](http://www.acog.org), under "Publications" and "Committee Opinions"



## ACOG endorses National Infertility Awareness Week

**T**he 2005 National Infertility Awareness Week in 2005 will be held October 23–29. The week is sponsored by RESOLVE: the National Infertility Association and is supported by ACOG.

This year's theme is "Infertility Considerations for Diverse Populations: How Cultural and Economic Status Affect Your Family Building Options."

National Infertility Awareness Week is a nationwide effort to raise awareness of infertility through educational events and media coverage. RESOLVE will also offer online chats for the public that aim to provide questions for people to consider before making decisions about medical treatment and family planning options. Documents on adoption, medical conditions, medication, and testing are also available to download online. ♀

#### info

- [www.resolve.org](http://www.resolve.org)

## CDC, Tulane team up for West Nile Virus study in pregnant women

**T**ULANE UNIVERSITY AND THE CENTERS for Disease Control and Prevention are asking clinicians to help enroll pregnant women infected with West Nile Virus in a prospective study. CDC and Tulane also urge clinicians to report women infected with WNV during pregnancy promptly to their local or state health department.

In 2003 CDC organized a surveillance registry to assess pregnancy outcomes for women infected with WNV during pregnancy. Because the results have not established or ruled out a link between WNV infection during pregnancy and adverse birth outcomes, additional information is needed. As a result of Hurricane Katrina, Tulane's campus, located in New Orleans, is temporarily closed. Therefore, CDC is currently the primary contact for the study

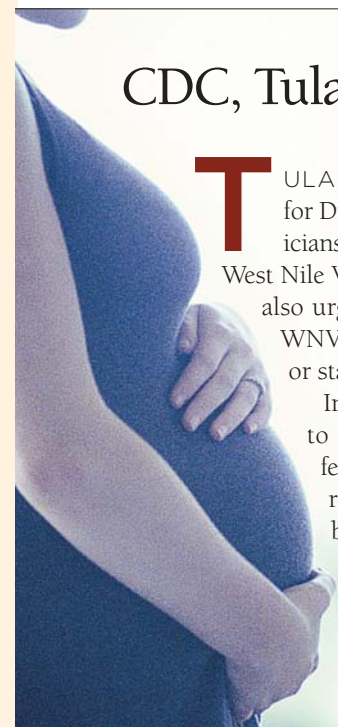
and has begun to enroll eligible women. The "West Nile Virus Infection and Outcomes of Pregnancy in Humans" prospective study will assess the incidence of adverse birth and developmental outcomes.

Researchers are asking clinicians to consider WNV infection in the differential diagnosis of women presenting with unexplained fever and/or neurologic illness during pregnancy in areas where WNV transmission is occurring. Such women should be tested for WNV infection by measuring serum IgM antibody to WNV. The test can be performed rapidly at most state public health laboratories, according to CDC.

In 2002, CDC published the first report of intrauterine WNV transmission in which the infant had congenital abnormalities, although a causal relationship was not proved. In 2003, the agency began tracking more than 70 pregnant women infected with the disease. ♀

#### info

- Contact Alison Hinckley, CDC: 970-266-3558



YOU ASKED, WE ANSWERED

## Ensuring proper risk management and patient follow-up

**Q WHOSE RESPONSIBILITY** is it to see that a patient gets her mammogram, visits the consultant I recommended, has lab work done, or returns for a repeat Pap test?

**A DON'T LEARN THE HARD WAY** that most jurors would consider it your responsibility, not the patient's. Your duty to provide care extends to making reasonable efforts to ensure that the patient receives the care you recommended. What is a reasonable effort? It varies with the circumstances. In general, the more serious or potentially serious the condition the more intensive your follow-up should be. Every ob-gyn should have systems in place to ensure appropriate follow-up.

### Laboratory tests and diagnostic procedures

How can a busy practice keep track of all the tests and procedures that are ordered? An effective solution can be simple and inexpensive:

- ▶ List all tests ordered in a notebook, by date
- ▶ Check entries off as results come in and are forwarded to you for review
- ▶ At set intervals, review the log for results that are past due
- ▶ If test results are missing, contact the facility to see if the test was done
- ▶ If the test was not done, contact the patient to remind her to undergo the test
- ▶ Document in the patient's chart all follow-up on missing results

Other effective methods include placing all patient charts awaiting test results in a central location for periodic staff review and follow-up. In addition, electronic medical record systems routinely include features for tracking tests and procedures.

### Consultations and referrals

Reduce the risk of not seeing or receiving critical information from another physician, or

not knowing if your patient does not follow up on your recommendation for a referral or consultation, by following these strategies:

- ▶ Explain to the patient why you are referring her to another physician and the importance of promptly following through on the referral
- ▶ Be specific about whether the other physician will be taking over her care or will be making recommendations to you that you will discuss with her at another visit
- ▶ Have your staff make the appointment for her before she leaves your office
- ▶ If you are expecting a report from a consultant, flag the chart
- ▶ Maintain a log of consultations and referrals. Have staff follow up on missing consultant reports

### Return appointments

While you may think it is the patient's responsibility to return for a follow-up appointment, patients have argued successfully that if they had known the importance of the follow-up care, they might have obtained it. How can you protect yourself from this type of allegation? First, make sure you tell patients clearly and specifically why you want them to return and what could happen if they do not. Be sure to document this conversation. Then, take reasonable steps to ensure that patients comply by:

- ▶ Scheduling a patient's return appointment before she leaves the office
- ▶ Scheduling postoperative and postpartum visits before you discharge a patient from the hospital
- ▶ Designating a staff member to follow up missed appointments every day
- ▶ Sending a registered or certified letter if a patient does not respond to a telephone reminder about returning for follow-up care for a potentially serious condition ♀

### info

→ [liability@acog.org](mailto:liability@acog.org)



## How you can fight for medical liability reform

**H**OW MANY TIMES HAVE YOU thought about getting involved in the fight for meaningful medical liability reform at either the state or national level but just weren't sure how to start?

Here are a few simple steps to get involved in tort reform efforts:

- ▶ Contact your section leaders to find out who your section's tort reform advocates are. Some sections employ state lobbyists, and some have very active legislative committees you can get involved with
- ▶ Contact your state medical society to find out how to get involved
- ▶ Join Ob-Gyns for Women's Health, ACOG's advocacy arm in Congress (see page 3)
- ▶ Visit the Protect Patients Now website, [www.protectpatientsnow.org](http://www.protectpatientsnow.org), developed by Doctors for Medical Liability Reform, a coalition ACOG is a member of that advocates federal legislation that would institute a cap on noneconomic damages in medical liability cases
- ▶ Sign up for ACOG's "The Inside Scoop," which is emailed to Fellows interested in learning more about, and being active in, ACOG's congressional and state legislative advocacy. To subscribe, email [keycontact@acog.org](mailto:keycontact@acog.org)
- ▶ Contact ACOG's Department of State Legislative and Regulatory Activities to request the State Legislative Tool Kit, which provides tips on how to advocate for state medical liability reform. Email [stateleg@acog.org](mailto:stateleg@acog.org) or call Kathryn Moore at 800-673-8444, ext 2506 ♀

The information in this article should not be construed as legal advice. As always, physicians should consult their personal attorneys about legal requirements in their jurisdiction and for legal advice on a particular matter.

# 2005-06 CALENDAR

## OCTOBER

4

### ACOG WEBCAST: Managing Adverse Outcomes

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

15-20

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

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

20-24

### Academy of Breastfeeding Medicine Annual Meeting

Denver  
www.bfmed.org/meeting.html

28-30

### ACOG District II Annual Meeting

New York City  
518-786-1529

28-30

### ACOG District III Annual Meeting

Los Cabos, Mexico  
916-920-8100

28-30

### ACOG District IV Annual Meeting

Los Cabos, Mexico  
916-920-8100

28-30

### ACOG District IX Annual Meeting

Los Cabos, Mexico  
916-920-8100

30-Nov 2

### ACOG Armed Forces District Annual Meeting

Seattle  
800-673-8444, ext 2540

## NOVEMBER

1

### ACOG WEBCAST: Complications of Laparoscopic Surgery

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

4-8

### American Medical Association Interim Meeting

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

11

### 2nd Annual Advanced Practice Lectureship (in conjunction with the Amazing Newborns ... Prematurity and Beyond Conference)

Sponsored by the March of  
Dimes and the University of  
New Mexico Neonatology  
Outreach Program  
Albuquerque, NM  
www.neonatology-outreach.  
org  
505-272-1322

9-12

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

Chicago  
www.aagl.org  
562-946-8774

## DECEMBER

### ACOG District VI Annual Meeting—Junior Fellows

Minneapolis  
800-673-8444, ext 2540

6

### ACOG WEBCAST: Preview of New Codes for 2006

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

## 2006

## MARCH

2-5

### CREOG and APGO Annual Meeting

Orlando, FL  
CREOG: 800-673-8444, ext  
2558  
APGO: 410-451-9560

5-8

### 19th European Congress of Obstetrics and Gynaecology

Torino, Italy  
www.ebcog2006.it

## NOVEMBER

5-10

### FIGO World Congress of Gynecology and Obstetrics

Kuala Lumpur, Malaysia  
www.figo.org

## ACOG COURSES

1. For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit [www.acog.org](http://www.acog.org). Under "Meetings" click on "Postgraduate Courses and CPT Coding Workshops."

2. For Coding Workshops, visit [www.acog.org](http://www.acog.org). Under "Meetings" click on "Postgraduate Courses and CPT Coding Workshops." Telephone registration is not accepted for Coding Workshops.

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

## OCTOBER

7-9

### CPT and ICD-9-CM Coding Workshop

Las Vegas

## NOVEMBER

11-13

### Practice Management Update for the Obstetrician- Gynecologist

Coronado, CA

12-13

### No Frills—Operative Hysterectomy

Chicago

18-20

### CPT and ICD-9-CM Coding Workshop

Washington, DC

**SOLD OUT**

## DECEMBER

1-3

### Complications in Obstetrics

New York City

2-4

### CPT and ICD-9-CM Coding Workshop

Sante Fe, NM

8-10

### Pearls from Ob-Gyn

Chicago

## 2006

## JANUARY

12-14

### The Mature Woman: From Perimenopause to the Elderly Years

Vail, CO

## FEBRUARY

13-15

### Practical Ob-Gyn Ultrasound: Spotlight on Chronic Pelvic Pain

St. James, Jamaica

16-18

### Complex Gynecologic Surgery: Prevention and Management of Complications

St. James, Jamaica

## APRIL

1-2

### No Frills—Operative Hysterectomy

Las Vegas

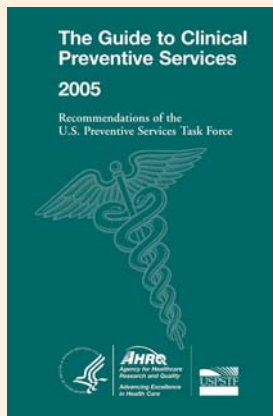
## JUNE

22-24

### The Art of Clinical Obstetrics

Kohala Coast, HI

## AHRQ releases clinical prevention recommendations



**T**HE AGENCY FOR HEALTHCARE RESEARCH and Quality has released *The Guide to Clinical Preventive Services 2005*, which highlights current recommendations of the US Preventive Services Task Force. The free guide makes recommendations that cover the prevention and early detection of cancer, infectious diseases, injury and violence, and obstetric and gynecologic conditions.

Ob-gyn recommendations include when to screen for bacterial vaginosis in pregnancy and how to promote breastfeeding through education and counseling. ♀

**info**

- [www.ahrq.gov/clinic/pocketgd.htm](http://www.ahrq.gov/clinic/pocketgd.htm)
- 800-358-9295

## Online teaching program on chronic vulvar pain

**T**HE NATIONAL VULVODYNIA ASSOCIATION has released the second edition of its teaching program on chronic vulvar pain for health care professionals. The free online program includes a self-guided presentation on the differential diagnosis, treatment, and etiology of vulvodynia. In addition, a historical overview of the evolving terminology of classification is included. After watching the program, viewers can download resources such as medical journal articles and patient handouts. Chronic unexplained vulvar pain can be difficult to cure or manage effectively. ACOG Practice Bulletin *Chronic Pelvic Pain* (#51, March 2004) addresses the differential diagnosis and reviews the evidence about treatment options. ♀

**info**

- <http://learn.nva.org>



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## Task force releases preventive services guide

**T**HE TASK FORCE ON COMMUNITY Preventive Services has created the first edition of *The Guide to Community Preventive Services: What Works to Promote Health?*

The independent task force, which is supported by the Centers for Disease Control and Prevention, has developed recommendations for interventions that promote health and prevent diseases in the nation's communities and health care systems.

The publication addresses the effectiveness, economic efficiency, and feasibility of interventions to combat risky behaviors such as tobacco use among pregnant women and adolescents, physical inactivity, and violence. Social determinants of health such as education, housing, and access to care are also explored. ♀

**info**

- [www.thecommunityguide.org](http://www.thecommunityguide.org)



## AHA offers online CME courses about heart disease

**T**HE AMERICAN HEART ASSOCIATION has developed an online Professional Education Center where physicians can earn Continuing Medical Education credits while learning about heart disease in women.

Physicians can earn CMEs through taking web-based courses, watching satellite broadcasts, or participating in distance learning via printed material, DVD, or CD-ROM.

After attending or completing an educational offering, physicians can claim their CME credit hours and print a CME certificate. The website will track physicians' participation, and physicians can view their transcripts at any time. ♀

**info**

- [www.professionaleducationcenter.americanheart.org](http://www.professionaleducationcenter.americanheart.org)