Guidelines revamped as resource manual for women’s health care

WHAT GUIDELINES SHOULD I FOLLOW WHEN SETTING up an ambulatory care center? What are ACOG’s recommendations regarding using chaperones in the exam room? How do I know if I need parental consent for certain types of care and treatment of my adolescent patients?

Answers to these distinctly different questions can all be found in one place: ACOG’s Guidelines for Women’s Health Care: A Resource Manual. The third edition of this publication will be published in October. Practicing Fellows and practicing Junior Fellows will receive a free copy, and the publication is also available through the ACOG Bookstore.

Info all under one roof
Guidelines for Women’s Health Care is a concise resource covering numerous issues related to women’s health care.

“Fellows may not realize what a goldmine this publication is,” said Fellow Paula J. Adams Hillard, MD, chair of the book’s editorial committee. “Being able to find information all ➤PAGE 7

ABOG to present free webcast on maintenance of certification

BEGINNING JANUARY 1, THE American Board of Obstetrics and Gynecology will institute its new maintenance of certification system.

It’s important that all board-certified obgyns who have time-limited certificates become familiar with the new system to fulfill ABOG requirements to maintain their board certification. (Those with lifetime certificates are exempt from maintenance of certification.)

To help ob-gyns understand the new requirements, ABOG will present a “Maintenance of Certification” webcast at no charge on Tuesday, November 27, from 1 to 2 pm Eastern Time.

The webcast will be presented by ABOG Director of Evaluation Larry C. Gilstrap III, MD, and hosted by ACOG through the College’s webcast program. There will be an opportunity to ask Dr. Gilstrap questions.

Although there is no charge, participants will need to register at least 24 hours in advance to receive log-in instructions. To register, look under “Announcements” on ACOG’s home page, www.acog.org.
EXECUTIVE DESK

30-minute rule is not a requirement

ONE OF THE MOST COMMON questions that ACOG’s Practice Activities Division receives relates to the so-called “30-minute rule.” Guidance that all hospitals offering labor and delivery services should have the capability to perform a cesarean delivery within 30 minutes from the time of decision first appeared in Guidelines for Perinatal Care, second edition, in 1988, co-published by ACOG and the American Academy of Pediatrics.

Certainly, there are instances that may mandate more expeditious delivery, such as hemorrhage from placenta previa, abruptio placentae, prolapsed umbilical cord, and uterine rupture. Conversely, there are other situations when a cesarean delivery can be appropriately accomplished well beyond 30 minutes from the time of decision.

The required personnel should be in the hospital or readily available to perform emergency cesarean delivery. This “readily available” phrase was intended to be a guideline that could be implemented nationally, including in rural settings. ACOG recognizes that each institution should define “readily available” based on its resources and geographic location.

A recent study from the National Institute of Child Health and Human Development was designed to measure decision-to-incision intervals and related maternal and neonatal outcomes. The study found that the vast majority of cesarean deliveries for an “obstetric accident,” such as cord prolapse, placental abruption or previa, or uterine rupture, met the 30-minute guideline. Hence, it could be concluded that this supports the need for a “30 minutes-or-less” guideline. Certainly, there are instances that may mandate more expeditious delivery, such as hemorrhage from placenta previa, abruptio placentae, prolapsed umbilical cord, and uterine rupture. Conversely, there are other situations when a cesarean delivery can be appropriately accomplished well beyond 30 minutes from the time of decision.

The NICHD results also found that in the great majority of cases, obstetricians effectively triage emergency cesarean deliveries when given the capability to begin the operation within 30 minutes, which is what was intended when the ACOG/AAP guideline was promulgated.

The ACOG/AAP guideline on emergency cesarean delivery does not establish the 30-minute interval to be a requirement that all cesarean deliveries must be performed within 30 minutes of the decision. Too often, not performing a cesarean delivery within 30 minutes is used in the courtroom as a measure of substandard obstetric care with the implication that delivery within 30 minutes would have prevented unfavorable infant outcomes. The recent NICHD data found that most infants delivered for emergency indications were born before 30 minutes, less than or more than 30 minutes from the decision to operate.

The NICHD also concluded that “...there is no evidence that a 30-minute or less interval adversely affects maternal or neonatal outcomes, and there is no evidence favoring a 30-minute interval.”

Stanley Zinberg, MD, MS, FACOG
Deputy Executive Vice President

Obstetrics & Gynecology HIGHLIGHTS

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

- Viral Hepatitis in Pregnancy (Obstetrics Practice Bulletin #86, revised)
- Disclosure and Discussion of Adverse Events (Patient Safety and Professional Liability Committee Opinion #380, new) For more information, see page 14
- Subclinical Hypothyroidism in Pregnancy (Obstetrics Committee Opinion #381, new) For more information, see page 10
- Fetal Monitoring Prior to Scheduled Cesarean Delivery (Obstetrics Committee Opinion #382, new)
- Evaluation of Stillbirths and Neonatal Deaths (Genetics Committee Opinion #383, revised)
Past President Dr. Schmidt dies

ACOG Past President Richard T.F. Schmidt, MD, of Cincinnati, died August 18 at the age of 88. Dr. Schmidt, a Founding Fellow, was ACOG president in 1977–78 and ACOG treasurer in 1971–76. He was also active on numerous College committees and task forces and active in the American Medical Association and on the Council of Medical Specialty Societies.

Dr. Schmidt received his medical degree from the University of Cincinnati College of Medicine in 1943 and completed his residency at the University Hospitals of Cleveland. He served in the US Army as chief of the women’s division of Halloran General Hospital and chief of ob-gyn at the 183rd General Hospital.

Dr. Schmidt was director of the ob-gyn department at Good Samaritan Hospital from 1966 until 1987, when he retired, and taught at the University of Cincinnati College of Medicine from 1962 until 1987. He was also a chief clinician at Cincinnati General Hospital and an ob-gyn at The Christ Hospital and Bethesda Hospital in Cincinnati. He was a former president and treasurer of the Cincinnati Obstetrical and Gynecological Society.

District IV service award winner dies

Life Fellow Charles Herbert Gilliland Sr., of Gainesville, FL, died on March 4 at the age of 95.

Dr. Gilliland received ACOG’s National District Service Award in 1987 for his service to District IV. He was a former chair and vice chair of District IV and a former chair of the Florida Section and served on ACOG’s committees on finance, nominations, and insurance.

Dr. Gilliland received his medical degree from the University of Iowa in 1941. He was a naval flight surgeon during World War II and remained on active duty after the war until 1954, when he became Gainesville’s first board-certified ob-gyn. He was a founding trustee of the North Florida Regional Hospital and a retired clinical professor of ob-gyn at the University of Florida.

New Clinical Updates on thrombosis

The latest issue in the Clinical Updates in Women’s Health Care series, Thrombosis, Thrombophilia, and Thromboembolism, addresses all the various conditions relating to venous thromboembolism that an ob-gyn may encounter. The content and concepts can serve as a ready reference when a patient presents with a coagulation condition.

Because thrombophilies are relatively common, ob-gyns should understand the basics of the coagulation mechanism, how the risks differ among patients, and how to prevent, diagnose, and treat thrombotic events.

ACOG has published several new adolescent health resources:

- Weight Management: A Guide to Caring for Adolescent Patients, which includes fact sheets, ACOG guidelines, and a BMI chart
- The new fact sheet Adolescent Facts: Pregnancy and STDs
- The revised booklet Strategies for Adolescent Pregnancy Prevention
- The fourth edition of Adolescent Sexuality: A Presentation Resource Kit

Pocket guide of latest women’s health statistics available

Copies of ACOG’s annual pocket guide Women’s Health: Stats and Facts are available from the College’s Office of Communications at no charge. The 50-page pocket guide is updated every year and provides the latest data in women’s health for use by Fellows and journalists.

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- The pregnancy fact sheet and the Pregnancy Prevention and Weight Management booklets are available to download on the ACOG website: www.acog.org/goto/teens. A limited number of hard copies are available at no charge at adolhlth@acog.org
- The resource kit and hard copies of the fact sheet and booklets can be purchased through the ACOG Bookstore: http://sales.acog.org; 800-762-2264

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- communications@acog.org; 800-673-8444, ext 2560
Help shape the future of the specialty

Join Ob-Gyns for Women’s Health

Decisions made in the nation’s capital affect the future of the specialty. Join Ob-Gyns for Women’s Health, ACOG’s advocacy arm on Capitol Hill, to make sure Congress votes the right way on issues such as ultrasound access, physician payment, and coverage of the uninsured—issues that affect your practice every day.

Ob-Gyns for Women’s Health was created by ACOG and dedicates its entire operations to lobbying and political work, helping elect ob-gyns and ob-gyn supporters to the US Congress.

Join on dues statement
OGWH President Steven J. Fleischman, MD, urges ACOG Fellows and Junior Fellows to join: “OGWH is how we get things done in Washington, and I urge each of you be a part of the solution by joining OGWH on your 2008 ACOG dues statement.”

Join or renew your membership in Ob-Gyns for Women’s Health in November when you receive your ACOG dues renewal. OGWH 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.

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www.obgynsforwomenshealth.org

Fellow voting begins in December

Ten the 2008 Fellow District and section officer elections will be held online, with voting beginning December 15.

Fellows will be able to access online ballots by using their last name and their ACOG ID number, which can be found on all ACOG mailings or obtained by contacting the ACOG Membership Department. 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.

Voting begins December 15:
https://eballot3.votenet.com/acogfellow

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➔ For your ACOG ID, contact the Membership Department: membership@acog.org; 800-673-8444
➔ For election updates, on the ACOG website, www.acog.org, under “Membership,” click on “District and Section Activities”
➔ For questions about elections, contact Megan Willis Mazur: 800-673-8444, ext 2531; mwillis@acog.org

ACOG’s Congressional Leadership Conference

February 24–26 • Washington, DC

Plan now to join nearly 200 ACOG members in lobbying Congress when ACOG’s 26th Annual Congressional Leadership Conference convenes February 24–26 in Washington, DC.

Following two days of advocacy training at the CME-accredited conference, ACOG Fellows and Junior Fellows will urge congressional action on key issues. Participants will learn to communicate with legislators at federal and state levels, gain valuable knowledge from Washington insiders about legislation that affects the specialty and patients, and lobby members of Congress.

Fellows and Junior Fellows are sponsored by their district or section chairs to attend the conference. Sponsorship covers travel, registration, lodging, and incidental expenses. Participants who aren’t sponsored can attend by paying a $300 registration fee, plus travel and lodging expenses.

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➔ Contact your district or section chair if you’re interested in attending. For more information, contact ACOG’s Government Affairs staff at 800-673-8444, ext 2509

➔ For election updates, on the ACOG website, www.acog.org, under “Membership,” click on “District and Section Activities”
➔ For questions about elections, contact Megan Willis Mazur: 800-673-8444, ext 2531; mwillis@acog.org
Guidelines revamped as resource manual for women’s health care

in one place is really helpful to Fellows. This should be the go-to publication whenever ob-gyns are looking for ACOG guidelines on any aspect of women’s care. If this book doesn’t have the answer, it points you in the right direction with numerous resources.”

Book is now in resource format

There are several significant changes with the new edition. The publication was revised to make it more of a resource, rather than a textbook. There are now three main sections:

- Governance and Administration
- Organization of Services
- Patient Care

Under the governance section, information has been added about patient safety, quality improvement, confidentiality and consent issues for adolescents, and legal obligations under EMTALA (Emergency Medical Treatment and Active Labor Act) and HIPAA (Health Insurance Portability and Accountability Act).

“The information addresses the things that physicians and patients are asked to do—there’s more emphasis on Joint Commission requirements, for example,” Dr. Hillard said.

New information in the “organization of services” section covers electronic patient records and patient communication, and the infection control section has been expanded.

New section on patient care

The third section, on patient care, has been combined from the previous edition’s two parts on patient care and selected issues in women’s health care. The new section covers both routine care and selected women’s health topics that may go beyond the scope of cases seen by the typical generalist. Each subsection has been updated and provides brief management information on a particular topic and offers resources for more information.

Guidelines for Women’s Health Care is used not only by physicians. Nurses, hospital administrators, and other health care personnel use the resource to guide their ob-gyn services.

“This is a user-friendly, accessible, useful, and important publication,” Dr. Hillard said.

info ➜ http://sales.acog.org; 800-762-2264

Green Journal creates online archives

BY THE END OF THE YEAR, Green Journal readers will be able to search all of the journal’s previously published content through the new Lippincott Williams & Wilkins’ Journal Legacy Archive at www.greenjournal.org or gateway.ovid.com.

Obstetrics & Gynecology was launched in January 1953. Currently, for older content, visitors to the journal’s website can access only the table of contents or abstracts. When the Legacy Archive launches, users will have access to articles in PDF format, with searchable headers and abstracts. The PDFs will include easy-to-read text and images.

CME available again for Clinical Expert Series

Beginning with the November issue, Obstetrics & Gynecology will reinstitute its CME program for readers of the “Clinical Expert Series,” a series of practical, clinical articles written by outstanding experts in the specialty. The articles give the reader strategies for work-up and management of clinical problems based upon the author’s clinical expertise and evidence-based references.

Online, readers can find links to CME quizzes for Clinical Expert Series articles published from August 2005 through December 2006. When the CME program restarts in November, readers will be able to take the quizzes online for the most recently published articles.


Early-bird registration opening soon

NEW ORLEANS • MAY 3–7

2008 ACM

Register on the ACOG website at www.acog.org/acm
Register early and save on registration fees and make your hotel reservation


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Mapping the fetus genome

Since the human genome was mapped, technology has advanced so rapidly that in a few decades pregnant women may know in the first trimester whether their baby will have inherited metabolic conditions, diseases, or disorders such as mental retardation, partial blindness, an endocrine disorder, a rare blood disease, or even a predisposition to diabetes, endometriosis, or cancer later in life.

“I think where this technology is heading is to a point where we can comprehensively sequence the fetus’s entire genome early in pregnancy,” said Aleksandar Rajkovic, MD, PhD, associate professor of ob-gyn at Baylor College of Medicine in Houston and a member of ACOG’s Committee on Genetics. “Technologies are emerging that may change the landscape of what obstetricians diagnose and when we diagnose it.”

Although sequencing of the whole fetal genome in utero may still be some years away, today there are DNA microarray technologies that experts believe will soon replace conventional karyotype. Using DNA microarrays and the concept of comparative genomic hybridization—called CGH—genetic mutations can be revealed by overlapping an individual’s DNA pattern with a normal DNA pattern. Current research has used the technology to determine potential genetic causes for a child’s mental retardation after he is born, but such technology will likely not be limited to pediatrics.

“T’ve no doubt it will be applied to prenatal care,” said Deborah A. Driscoll, MD, professor and chair of the department of ob-gyn at the University of Pennsylvania in Philadelphia.

Anthony R. Gregg, MD, director of maternal-fetal medicine and medical director of genetics at the University of South Carolina and chair of ACOG’s Committee on Genetics, provided an analogy to explain the leap forward that CGH technology provides: Imagine you have a bookshelf with a set of encyclopedias on it. A karyotype offers a bird’s eye view of those books from 30 to 40 feet away. You can determine if a book is missing or if there is an extra book that doesn’t belong. Now, imagine that bird’s eye view becoming fine enough that you can read actual sections and paragraphs in one of the books—that’s what CGH offers, according to Dr. Gregg.

However, Dr. Gregg said, two things need to happen before DNA microarrays are ready for “prime time” in prenatal screening. First, researchers need to catalog the links between ultrasound findings and conditions tested for on the microarray. Second, the cost of implementing the technology must be reduced before CGH can be considered an appropriate screening tool.

Parsing the ethical issues

As the technology develops, the medical field—and society as a whole—will likely debate the surrounding ethical issues. Some of these questions are the same ones that have been debated with newborn screening. Do you screen for disorders and conditions that have no cure? Do you screen all patients for rare diseases? How many diseases will patients be tested for?

“So many genes have been identified; the question is ‘Where do we draw the line?’” Dr. Driscoll said.
She pointed out, however, that knowledge can be power for parents. Just as some patients undergo Down syndrome diagnostic testing so that they can be prepared for a baby with Down syndrome, so too will patients choose genetic testing so they can know what to expect and line up specialists and research their child’s special needs.

**How technology will affect ob-gyn**

If the number of prenatal screening tests continues to increase—and along with that, the need for genetic counseling—what does that mean for ob-gyns, who are already trying to squeeze in more tests, history taking, and counseling into shorter visits?

“In the future, obstetricians may be called upon to discuss with their patients what these tests mean,” Dr. Rajkovic said. “And, genetic counselors will need a lot of help understanding these tests. Clearly, this is going to be a large learning curve.”

Genetic counselors will likely play a greater role as more tests are developed, supporting ob-gyns by educating patients about test results and their options. Unfortunately, there may not be enough genetic counselors to meet the demand (see sidebar below).

The emerging technology will likely have an effect on gynecology and primary care as well. Dr. Driscoll pointed out that patients are already screened for breast cancer genetic mutations. Will there also be tests for genetic predisposition to asthma, hypertension, and diabetes?

“I think there will come a time when genetics will play a much bigger role in general health care,” she said.

Dr. Gregg agreed: “I do see us implementing testing more routinely. We’ll utilize the family history, including early heart attack, placenta abruption, thrombosis, and unexplained stillbirth, and follow up with genomic testing at the bedside to evaluate for inherited disorders.

“These findings will guide the discussion regarding the need for antiplatelet agents, anticoagulation, ultrasound testing, and, potentially, fetal heart testing,” he continued. “It has implications for the mother’s and family’s long-term health. I see the patient’s reproductive history being a window into her health care.”

**“So many genes have been identified; the question is ‘Where do we draw the line?’”**

**Demand for genetic counselors increasing**

With the advances in genetic testing, Rose Giardine, MS, doesn’t have to worry about job security. As a genetic counselor at the University for Pennsylvania Medical Center for 21 years, Ms. Giardine has seen prenatal genetics screening and diagnosis become more and more complex.

“When I first started, there were very few things we could do DNA testing for,” said Ms. Giardine. “If there was cystic fibrosis in the family, you would tell them their odds, but the testing was very antiquated. It’s much more straightforward testing now, and that’s true with many disorders. But with more technology and more options, patients can be overwhelmed.”

Ms. Giardine is a member of ACOG’s Committee on Genetics. ACOG created her position on the committee in recognition of the increasing need in ob-gyn for input from genetic counselors. Genetic counselors can help patients navigate their options and guide them to medical specialists and specialty organizations. Genetic counselors meet with patients to discuss aneuploidy screening and diagnostic testing, as well as other genetics tests. They meet with patients who have a family history of a genetic disorder, with couples for preimplantation testing, and with egg and sperm donors to take an extensive history.

“The general ob-gyn doesn’t have the time to stay on top of all these screening tests and what it means for patients, so they refer patients to us. We have a good relationship with our obstetricians,” Ms. Giardine said.

“There already is a huge need for more genetic counselors,” said Anthony R. Gregg, MD, chair of ACOG’s Committee on Genetics. “I think it’s a significant need in health care and not just in obstetrics, but for gynecology and oncology.”
Immunize patients and staff against flu

With the arrival of flu season, ACOG reminds obstetricians that an intramuscular, inactivated flu vaccine should be given in any trimester to women who will be pregnant during the flu season. The ideal time to vaccinate pregnant women is October and November, but any time throughout the influenza season is appropriate—the flu season runs from October 1 through mid-May, usually peaking in February.

Flu shots should be a part of routine prenatal care. Immunizing the mother offers some immunity to her infant also.

Most patients, not just those who are pregnant, can benefit from the flu vaccine. The federal Advisory Committee on Immunization Practices recommends that vaccine providers give the vaccine to anyone who wishes to reduce his or her likelihood of getting the flu or transmitting the flu to others, while specifically targeting patients 50 and older for vaccination.

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. Breastfeeding mothers can choose either vaccine.

Physicians, staff should get vaccine too

It’s important for all health care personnel—physicians and their staffs, hospital employees, and even medical students who have contact with patients—to be vaccinated so that they don’t infect patients.

Estimated vaccination coverage remains low, at less than 50%, among pregnant women, health care personnel, and other groups for which routine annual vaccination is recommended, according to the Centers for Disease Control and Prevention. The 2007 ACIP flu recommendations advise health care facilities to consider the level of vaccination coverage among health care personnel to be a measure in a patient safety program and implement policies to encourage vaccination, such as obtaining signed statements from employees who decline flu vaccination.

Don’t screen all pregnant patients for subclinical hypothyroidism

In a new Committee Opinion, Subclinical Hypothyroidism in Pregnancy, ACOG recommends against routine screening during pregnancy for subclinical hypothyroidism, stating that with no evidence to show that identifying and treating pregnant women improves maternal or infant outcomes, routine screening is premature.

Instead, ACOG recommends thyroid testing in pregnancy for symptomatic women and those with a personal history of thyroid disease or other medical conditions associated with thyroid disease. Assessing the thyroid-stimulating hormone level first is most appropriate in women tested during pregnancy. Women with established overt thyroid disease should be appropriately treated to maintain a euthyroid state throughout pregnancy and the postpartum period.

Interest in subclinical hypothyroidism has increased in recent years as reports suggest that thyroid deficiency in pregnancy can result in impaired neurodevelopment in the patient’s baby. Some have called for routine screening, but data haven’t shown whether treating these women improves outcomes.
Providing the best health care to lesbians and bisexual women

To provide the best care for lesbian and bisexual patients, ob-gyns need to be aware of behavioral risk factors and offer appropriate counseling, while creating a welcome office environment. However, ob-gyns may not know which of their patients are lesbian or bisexual, making it a “catch-22,” said ACOG Fellow Kirsten M. Smith, MD, primary author of ACOG’s new slide lecture, Health Care for Lesbian & Bisexual Women.

“Physicians in a busy office practice can’t screen for everything—it’s a matter of time management,” Dr. Smith said. “The counseling we do varies from patient to patient based on what we perceive to be the risk factors.”

Dr. Smith emphasizes that lesbian and bisexual women have some of the same health issues that heterosexual women have, but, as with other women, health behaviors and how the patient interacts with the health care system can increase or decrease a patient’s risk of certain diseases.

Make the practice welcoming

Many lesbians delay seeking care because they feel alienated by providers. A 1999 Institute of Medicine report on lesbian health stated that 53% to 72% of lesbians do not disclose their sexual orientation to physicians when they seek medical care. Personal and cultural attitudes of both providers and patients can contribute to the lack of disclosure.

Dr. Smith suggests the best way to address patient fears is to start by making sure that your office is welcoming to lesbian and bisexual patients.

“In my waiting area I have a nondiscrimination statement posted on the wall that doesn’t look like a bureaucratic form,” she said.

Such a sign could state “This office appreciates the diversity of women and does not discriminate on the basis of race, age, religion, ability, marital status, sexual orientation, or perceived gender.”

Dr. Smith added, “Intake forms are a fantastic way to allow lesbians to disclose who is a significant other in their life.”

On the form, include “life partner” or “significant other” rather than just “husband” or “spouse” in the relationship category.

Be alert to biased language

Sometimes questions that are commonly posed during a patient encounter or as part of a patient intake questionnaire may cause barriers to open communication with lesbian and bisexual patients. Examples are routine questions such as “Are you sexually active?” followed by “What do you use for contraception?”

To facilitate communication, try asking “Are you sexually active?” “Do you have sex with men, women, both, or neither?” and “Do you need contraception?”

Be aware of risk factors

Both health care providers and lesbians and bisexual women may have misunderstandings about health care risks that lesbian and bisexual women face.

“Many lesbians don’t think they need to have Pap tests,” Dr. Smith said, pointing out that patient education about their risks is an important part of caring for lesbian women.

Ob-gyns should consider screening all lesbian and bisexual women for STDs on the basis of the patient’s risk factors. Most lesbians—78% to 80%—have been sexually active with men at some point in their lives, and 21% to 30% report having had sex with men in the past one to five years, according to ACOG’s slide lecture. In addition, some STDs can be transmitted by exclusive lesbian sexual activity. 

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• ACOG’s slide lecture Health Care for Lesbian & Bisexual Women: order at http://sales.acog.org; 800-762-2264
• The section “Primary Care of Lesbians and Bisexual Women in Obstetric and Gynecologic Practice” in ACOG’s Special Issues in Women’s Health: www.acog.org/publications/specialissuesinwomenshealth
Wanted: intriguing cases for 2008 Stump the Professors

HAVE YOU EVER COME ACROSS a case that stumped you and your colleagues? Have you managed a case that was extremely unique, challenging, and unforgettable?

The quest is on for cases directly relating to ob-gyn that are intriguing, mind-boggling, and difficult for The Gerald and Barbara Holzman Stump the Professors program at the 2008 Annual Clinical Meeting, which will be held May 3–7 in New Orleans.

The 2008 session will be endowed by Gerald and Barbara Holzman. Gerald B. Holzman, MD, was ACOG’s vice president for education from 1994 to 2001.

Submitting cases
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.

Four cases will be presented for discussion at the ACM. The event will be held from 9:30 to 11 am on Tuesday, May 6. Each presenter will receive free Junior Fellow ACM registration, coach airfare, and 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 November 30.

EDUCATIONAL INITIATIVES
There is a continuing resident-driven effort to implement health policy and advocacy education as part of formal residency training. This endeavor by Junior Fellows was applauded by Sterling B. Williams, MD, MS, ACOG vice president for education, and Haywood L. Brown, MD, CREOG Council chair, at the CREOG Council meeting in August.

CREOG is also currently discussing the need to expand curricula and teaching tools in the areas of ultrasound training and fetal heart rate monitoring. These teaching tools should prove to be the most useful for residency program directors to more formally address topics in ob-gyn that have yet to be standardized.

During the Council meeting, it was reported that the business of medicine lunch series at the 2007 Annual Clinical Meeting was a huge success. As a result, the JFCAC plans to develop a companion training manual for residents, which is expected to be available in early 2008.

EXAMINATION COMMITTEE
The Council discussed the results from the annual CREOG exam, which is a “secure exam,” meaning the questions used cannot be released, ensuring integrity from year to year. Following scrutiny analysis, it was determined that there was no evidence of cheating on the exam as administered. Dr. Williams reminded everyone that the exam’s purpose is for self-assessment, “not reward or punishment.”

It was noted that more than 5,000 residents completed their residency between 2003 and 2007, with work-hour restrictions applied throughout their training. Much has been said about the presumed impact on patient care, but little is known about the impact on resident education. The survey from the 2007 CREOG exams revealed an overall positive opinion of work-hour restrictions on the part of the residents. The survey also revealed, however, a sense that professionalism is not being uniformly taught, or is under-emphasized, in US residency training programs.

RESIDENT REPORT
The way in which maternity and paternity leave for residents is handled varies greatly from one residency program to the next. ACOG’s Junior Fellow College Advisory Council is developing a survey to examine this issue further. When preparing for leave, residents are encouraged to become familiar with ABOG residency requirements, as well as their individual institutions’ policy and the federal Family and Medical Leave Act.

For more information on CREOG, on the ACOG website, www.acog.org, under “Education,” click on “CREOG”.

Submission deadline: November 30
JFCAC establishes four working groups

By Rajiv B. Gala, MD, JFCAC chair

For the last four years, the Executive Committee of the Junior Fellow College Advisory Council has had the opportunity to convene after ACOG's Executive Board meeting in July to set the stage for the upcoming year. This year, our Executive Committee formed working groups to address four areas of importance:

- Increasing legislative activism
- Medical student recruitment
- Increasing outreach to Junior Fellows in practice
- Junior Fellow needs assessment

Legislative activism

Building an appreciation for the importance of legislative activism must start early in a physician's career. More often than not, the biggest obstacle to getting involved is not knowing where to start.

Ironically, not advocating on legislative issues means a majority of us are failing to highlight our daily struggles involved with advocating for our patients. I hope that the forthcoming legislative primer Your Practice, Your Priorities, Your Future: Getting Involved in Government Affairs serves as an effective foundation for us as we expand our grassroots network, starting as early as residency.

Medical student recruitment

The JFCAC continues to work hard to expand our medical student recruitment efforts.

The Council is planning to expand the educational and recruitment opportunities for medical students at the 2008 Annual Clinical Meeting, to be held May 3–7 in New Orleans. Not only will we again host an Ob-Gyn Residency Fair and the medical student course, but, to increase student-faculty interactions, we are planning on conducting small-group workshops that would complement ongoing sessions. In addition, the JFCAC is diligently working to update our medical student recruitment video.

Junior Fellows in practice

The transition period between residency and ACOG Fellowship represents some of the most stressful years in our medical career. We lose the gentle reminders from our program coordinators and must rely on email and word-of-mouth as our primary source of professional information.

The JFCAC is committed to improving our ability to communicate with our Junior Fellows in practice. Visit the redesigned Junior Fellow in Practice web page at www.acog.org. Click on “Junior Fellows” in the “Quick Links” box on the left side of the page and then, under “Latest News,” click on “Junior Fellows in Practice.” We are also developing a business of medicine webcast to air in February.

Junior Fellow needs assessment

Many changes have occurred in our professional climate since the last national ACOG needs assessment in 1998. We now deal with the 80-hour duty restrictions, a declining interest in ob-gyn among top medical students, the liability insurance crisis, and changing practice preferences.

The JFCAC acknowledges that focusing on every important issue may not yield the biggest bang for our buck. Hence, our council finalized the 2007 Junior Fellow Needs Assessment as a tool to help us understand where you would like to see the council focus its efforts.

When you receive the online survey by email in the near future, please take five minutes out of your busy day to provide us with the information needed to help us better serve you.

Your district leaders are what make the Council so productive. Our best ideas come from you, and I encourage each of you to remain active with ACOG so that we can continue to be the best advocates for women's health.

Advance your career with ACOG’s online job bank

Career Connection, ACOG’s official online job bank, has several features to make your career search or career advancement easier than ever. All features are free to job seekers.

An easy-to-use resume builder allows you to create a resume online or upload your existing resume. You can store multiple resumes, post your resume online (confidentially, if desired), and create and send a cover letter along with your resume. A “My Site” section allows you to easily create and maintain your own password-protected career website, where you can:

- Create a home page
- Upload a photo
- Post your resume
- List references
- Upload or link to articles you’ve written or published
- Provide your unique website address to anyone you wish, including potential employers
- Brand your site as a member of ACOG
**New Committee Opinion addresses disclosure**

**A NEW ACOG COMMITTEE Opinion** outlines the value of disclosure and communication after a preventable or nonpreventable adverse event and provides guidance for these conversations with patients and their families.

*Disclosure and Discussion of Adverse Events* was developed by the ACOG Committee on Patient Safety and Quality Improvement and published in the October issue of *Obstetrics & Gynecology.*

“This document is important as it reinforces to physicians the importance of open, honest communication with their patients as it relates to outcomes,” said Patrice M. Weiss, MD, a member of the patient safety committee. “The document accurately describes for clinicians why full, open disclosure is not only ethically required but may actually strengthen the physician-patient relationship and trust.”

Barriers to full disclosure include shame, fear of lawsuits, and lack of training in how to disclose. But surveys show that patients want and expect timely and honest disclosure and that they are actually more likely to sue if they perceive such a disclosure was absent.

“When patients are informed immediately about adverse events and situations, they are more likely to trust their health care providers,” Dr. Weiss said. “Open, honest, and forthright communication provides people with the information that they seek to understand.”

The document cautions physicians to remember the difference between expressions of sympathy and apology. While expressions of sympathy are always appropriate, the appropriateness of an apology will vary from case to case, according to the Committee Opinion. When considering an apology, the physician may want to seek advice from the hospital’s risk manager or the physician’s medical liability carrier. Physicians should also be aware of their state’s laws on apology and disclosure.

According to the Committee Opinion, health care institutions should have written policies that address the timing, content, communication, and documentation of disclosure. Organizations should educate their providers on the policies and consider the need for additional resources and training.

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**Joint Commission policy allows physicians to report hospital concerns without fear**

**P HYSICIANS AND MEDICAL staff should be able to report their concerns about the safety and quality of care at their hospital without fear of retaliatory disciplinary action, according to explicit new rules from The Joint Commission.**

The Accreditation Participation Requirement previously referred only generally to hospital staff.

Now, the revised requirement, which will become effective January 1, spells out that accredited hospitals must inform hospital staff and medical staff that any employee or physician who has concerns about the safety or quality of care provided in the hospital may report these concerns to The Joint Commission and that no disciplinary action will be taken.

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**Online patient safety learning program**

**A NEW ONLINE PATIENT Safety Improvement Program offers health care personnel the opportunity to learn how to improve patient safety in any clinical setting.**

Developed by the American Board of Medical Specialties and HealthStream, the program fulfills maintenance of certification requirements and focuses on identifying and analyzing errors, determining improvements based on best practices, and implementing changes.

The program incorporates key patient safety topics, methods of assessment, case scenarios, and improvement activities for individual physician practices such as the following:

- Patient safety scenarios highlight key themes of patient safety that cut across disciplines, such as medication errors, handoffs, and teamwork
- Patient safety curriculum comprehensively covers epidemiology, systems, communication, and safety culture
- Quality improvement fundamentals provide the tools and techniques to make improvements in practice
- Patient safety improvement activities introduce changes to areas, such as hand hygiene, medication lists, allergy lists, critical test results, correct person/site/procedure, safer prescription writing, and discharge communication

[www.abms.org/Products_and_Publications/Performance_Improvement/PSIP.aspx](www.abms.org/Products_and_Publications/Performance_Improvement/PSIP.aspx)
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<thead>
<tr>
<th>Month</th>
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<tr>
<td>October</td>
<td>3-5</td>
<td>American Academy of Family Physicians Scientific Assembly</td>
<td>Chicago</td>
<td><a href="http://www.aafp.org">www.aafp.org</a> 800-926-6890</td>
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<td>3-9</td>
<td>North American Menopause Society 18th Annual Meeting</td>
<td>Dallas</td>
<td><a href="http://www.menopause.org">www.menopause.org</a> 440-444-7657</td>
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<td>5-7</td>
<td>ACOG District VI Junior Fellows Annual Meeting</td>
<td>Lake Geneva, WI</td>
<td>800-673-8444, ext 2588</td>
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<td>6</td>
<td>Sixth New York University School of Medicine Reproductive Psychiatry Conference</td>
<td>New York City</td>
<td>212-263-5295</td>
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<td>7-11</td>
<td>American College of Surgeons 93rd Annual Clinical Congress</td>
<td>New Orleans</td>
<td><a href="http://www.facs.org">www.facs.org</a> 312-202-5240</td>
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<td>ACOG WEBCAST: Negotiations with Payers</td>
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<td>800-673-8444, ext 2498</td>
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<td>10-14</td>
<td>Pacific Coast Obstetrical and Gynecological Society Las Vegas Meeting</td>
<td>Henderson, NV</td>
<td><a href="http://www.pcogs.org">www.pcogs.org</a></td>
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<td>11-14</td>
<td>Academy of Breastfeeding Medicine 12th Annual International Meeting</td>
<td>Fort Worth, TX</td>
<td><a href="http://www.bfmed.org">www.bfmed.org</a></td>
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<td>November</td>
<td>2-7</td>
<td>Association of American Medical Colleges Annual Meeting</td>
<td>Washington, DC</td>
<td><a href="http://www.aamc.org">www.aamc.org</a> 800-798-8432</td>
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<td>8-10 2nd International Society for Gynecologic Investigation Summit</td>
<td>Valencia, Spain</td>
<td><a href="http://www.sgioline.org">www.sgioline.org</a></td>
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<td>9-11 ACOG District III Annual Meeting</td>
<td>Santo Domingo, Dominican Republic</td>
<td>800-673-8444, ext 2574</td>
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<td>10-13 American Medical Association Interim Meeting</td>
<td>Honolulu</td>
<td><a href="http://www.ama-assn.org">www.ama-assn.org</a> 800-673-8444, ext 2516</td>
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<td>11-13 ACOG Armed Forces District Annual Meeting</td>
<td>Louisville, KY</td>
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<td>2-3 2nd National Summit on Preconception Health and Health Care</td>
<td>Oakland, CA</td>
<td><a href="http://www.marchofdimes.com/california/4947_25340.asp">www.marchofdimes.com/california/4947_25340.asp</a> 415-217-6380</td>
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<td>15-17 Council of Medical Specialty Societies Annual Meeting</td>
<td>Chicago</td>
<td><a href="http://www.cmss.org">www.cmss.org</a> 847-295-3456</td>
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<td>15-17 American College of Physicians Foundation’s National Health Communications Conference</td>
<td>Washington, DC</td>
<td><a href="http://foundation.acogonline.org/74/conferences.htm">http://foundation.acogonline.org/74/conferences.htm</a></td>
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<td>December</td>
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<td>ACOG WEBCAST: Preview of New Codes for 2008</td>
<td>1-2:30 pm ET</td>
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<td>The Mature Woman: From Perimenopause to the Elderly Years</td>
<td>Chicago</td>
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<td>28-30</td>
<td>ACOG WEBCAST:</td>
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<td>ICD-9-CM and CPT Coding Workshop</td>
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ACOG COURSES

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

2. For Coding Workshops, visit www.acog.org and click on “Postgraduate Courses and CPT Coding Workshops” under “Meetings.” Telephone registration must be received one week before the course. On-site registration subject to availability.
Free teenage behavioral health toolkit

A toolkit focusing on teenage behavioral health is available online at no charge. Behavioral Health: An Adolescent Provider Toolkit is part of the Adolescent Provider Toolkit series from the Adolescent Health Working Group, based in San Francisco.

The toolkit examines common teenage mental health and substance use issues and includes:
- Screening and assessment tools
- Twelve mental health and substance use issue briefs
- Brief office interventions and counseling guidelines
- Health education materials for teens and their parents/caregivers
- Online resources and hotlines

info

⇒ www.ahwg.net/resources/toolkit.htm

New resource compiles intimate partner violence assessment tools

The Centers for Disease Control and Prevention has developed a new resource that compiles assessment tools for intimate partner violence and sexual violence into one publication.

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings provides practitioners with the most current inventory of assessment tools as well as information on how to decide which tools are most appropriate for a particular population. The guide can aid practitioners in making appropriate referrals for both victims and perpetrators.

info

⇒ To download the guide: www.cdc.gov/injury
⇒ For free hard copies: cdcinfo@cdc.gov; 1-800-CDC-INFO

FDA safety resources

The US Food and Drug Administration offers several online resources that provide updated safety information on prescription drugs and medical devices:
- The FDA’s MedWatch website: www.fda.gov/medwatch/index.html
- Subscribe to FDA’s MedWatch LISTSERV notification or RSS news feeds: www.fda.gov/medwatch/elist.htm