Fighting against a silent killer

Patients unaware of heart disease risks

Heart disease is the No. 1 killer of women.

While ob-gyns may know this, their patients may not. Women tend to perceive breast cancer as their biggest health threat, according to the American Heart Association, even though statistics show that 1 in 29 deaths among women are due to breast cancer, compared with 1 in 2.4 deaths due to cardiovascular disease. In an AHA survey released earlier this year, only 46% of women knew that heart disease was the leading cause of death for women—although this is an improvement over 34% in 2000 and 30% in 1997.

Heart disease is just one of the many cardiovascular diseases that kill almost 500,000 women a year. Traditionally thought of as a man's disease, cardiovascular disease has killed more women than men in every year since 1984, according to AHA.

Ob-gyns are in a prime position to educate their patients about their risk of heart disease, says ACOG Fellow Vivian Lewis, MD, associate chair for ambulatory women's health and professor of ob-gyn, University of Rochester Medical Center, Rochester, NY.

"We should be screening patients and counseling them about their specific risks," Dr. Lewis said. "We're in a perfect position to educate patients about a healthy lifestyle, including diet, exercise, and weight maintenance. A healthy lifestyle is the first line of defense against heart disease."

2005 ACM: San Francisco here we come

While in San Francisco, be sure to reserve some time to see the city ranked as the No. 1 travel destination in the US by Conde Nast Traveler readers.

With a reputation for charming ambience, top-rate restaurants, a dynamic arts scene, diverse shopping, and friendly people, it's no wonder San Francisco is everybody's favorite city.

From the towering Golden Gate Bridge to the quiet parks of Russian Hill, San Francisco is a city of contrasts. Mornings begin with great plumes of fog, descending quickly and obscuring all but the highest buildings. The steep roller coaster hills that rise and fall throughout the city seem oddly erratic against the deliberate lines and angles of the city's high-rise horizon.

Mark your calendars: the 2005 ACOG Annual Clinical Meeting will be held May 7–11 in beautiful San Francisco. The meeting will provide an abundance of education through scientific sessions, clinical seminars, luncheon conferences, and much more.
End-of-year giving to ACOG ensures support for vital programs

As ACOG members, you are constantly showing your faithful dedication to the College through personal monetary contributions.

I am proud to announce that personal contributions increased again in 2004, thus ensuring continued support for College programs and projects and continued advocacy on your behalf on numerous issues, including medical liability reform.

By relying on contributions from individuals, corporations, and foundations to support certain programs, ACOG can continue to keep its annual membership dues among the lowest in the medical field.

Over the years, your contributions have supported such vital programs as:
- Medical liability reform advocacy efforts
- Medical liability litigation recovery course
- ACOG/Central America Save the Mothers Project
- Workshop on new technologies in residency training
- Workshop on medical and ethical issues related to substance abuse in pregnancy
- Slide lecture on elder abuse
- Vaccination guides for residency programs

New giving societies established

This year ACOG has developed three new individual giving societies that honor ACOG’s founding officers and their contributions to the specialty.

The Beacham Society, honoring ACOG’s first president, Dr. Woodard Beacham, is dedicated for our annual donors of $1,000 or more.

The Reiss Society, honoring Dr. Ralph A. Reiss, the first editor-in-chief of *Obstetrics & Gynecology*, is for our annual donors of $250 to $999, while the Schmitz Society, honoring Dr. Herbert E. Schmitz, the first treasurer of the ACOG Executive Board, is reserved for our donors of gifts up to $250.

Exciting benefits have been established for our society members. Beacham Society members will receive free registration for the 2005 ACM, to be held May 7–11 in San Francisco; access to the VIP Lounge during the ACM; and a complimentary ticket to the President’s Dinner Dance. Additionally, all Beacham Society members will be acknowledged in *ACOG Today.*

Reiss Society members will have access to the VIP Lounge at the ACM. All Beacham, Reiss, and Schmitz society members will be recognized in the College’s Annual Report.

Reaffirm your commitment to our future

As we approach the end of 2004 and look toward 2005, I hope you will give serious consideration to making a meaningful gift to ACOG. Your support reaffirms your commitment to ACOG’s mission and its future and ensures the continued support of programs and projects that educate ob-gyns, provide health care to women, and advocate for medical liability reform.

Ralph W. Hale, MD, FACOG
Executive Vice President

Mail your end-of-year charitable donations to:
ACOG, Development Department, 409 12th Street, SW, Washington, DC 20024-2188
Questions on stock gifts? Call 800-673-8444, ext 2546 or 2479

Road to Maintaining Excellence materials needed

Attention district and section officers:

Your help is needed in developing the Road to Maintaining Excellence program that was presented at the College Advisory Council meeting at the ACM in May in Philadelphia. ACOG and ABOG are developing this education-based program for Fellows to evaluate their own practice activities.

Please return the Road to Maintaining Excellence module attestations and program reviews as soon as possible to Megan McReynolds, ACOG, PO Box 96920, Washington, DC 20090-6920 or fax to 202-863-4992.

If you need more Road to Maintaining Excellence materials, email mmcreynolds@acog.org
ACOG’s Office of Communications is developing the first-ever pregnancy magazine for women 35 and older. Plum is a unique blend of an informative medical journal and a full-color, large-format, glossy, lifestyle magazine. It will be provided free to ACOG Fellows, Junior Fellows, and Educational Affiliates to hand out to patients.

The magazine will help give the 35+ mom-to-be the support she needs throughout her pregnancy and into the first three months of her baby’s life. She will be informed, entertained, and moved as she learns about the best health care practices, the hottest trends, and the most poignant personal stories.

Every article written for Plum will be reviewed and approved by ACOG, which has created a medical advisory board specifically for the magazine. The advisory board, chaired by ACOG President Vivian M. Dickerson, MD, will ensure accuracy and relevance and will provide advice and direction to the magazine.

“ACOG recognizes that women who choose to have children later in life face different health risks and have different concerns than younger moms,” said Penny Murphy, MS, director of ACOG’s Office of Communications. “Plum magazine is a unique ACOG patient education tool that members will be able to personally present to their patients.”

To order copies of the first issue of Plum for your patients, visit: www.plummagazine.com/ordercontact.html. Download an order form, and fax it to ACOG’s Office of Communications at 202-479-6826.

Free magazine available in winter ‘04

ACOG launching Plum for older moms-to-be

Young Fellows: Get involved!

By Erin E. Tracy, MD, MPH, young Fellow representative on the ACOG Executive Board

There are some exciting changes happening in ACOG. For the first time, the College has created two positions on the Executive Board reserved for young Fellows—defined as Fellows who are 40 years old or younger and in the first five years of fellowship.

The addition was advocated by the Task Force on Women and Young Fellows in ACOG Leadership, which examined ways to increase the involvement of young physicians—both men and women—in the leadership of ACOG. The task force also addressed how to ensure that the College remains relevant to young physicians.

New website, ACM forum

ACOG has placed an emphasis on getting young Fellows involved in the College in a number of ways.

A new website has been developed specifically for young Fellows and can be accessed through the member-access section of the ACOG website, www.acog.org. Click on “Young Fellows” under “Member Services” on the right side of the member-access homepage.

All young Fellows are invited to the first-ever Young Fellows Forum, to be held in conjunction with the ACM on May 10 in San Francisco. It will be a wonderful opportunity to network with other Fellows, learn about ACOG, and discuss issues of importance to young Fellows.

The renewed emphasis on young Fellows has led some districts to investigate the possibility of having an at-large Fellow or young Fellow on their advisory council to allow young Fellows to be more involved in policy development.

I am very eager to hear from anyone who is interested in getting more involved in the College. Any ideas or suggestions you may have would be most welcome.

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• To order copies of the first issue of Plum for your patients, visit: www.plummagazine.com/ordercontact.html. Download an order form, and fax it to ACOG’s Office of Communications at 202-479-6826.

• eetracy@partners.org; 617-724-3360
Fellows and lobbyists share strategies at state roundtable


While the medical liability crisis was the chief topic of discussion, participants also discussed other key legislative issues popping up around the country.

"I learned more about our political system at the roundtable in two days than I had in my previous 15 years as a practicing OB," said Fellow Stan Davis, MD, of Edina, MN.

Medicaid cuts was a common theme as states struggle with economic problems. Several participants reported that their states are slashing fees as well as patient benefits and eligibility requirements for low-income pregnant women.

Participants were also worried that states were rolling back health mandates. Colorado faces challenges by health plans to its ob-gyn direct access law, and Texans lost their contraceptive equity mandate. Georgia faced an ultimately unsuccessful rollback effort that could have wiped out a number of important women’s health mandates such as cancer screenings and ob-gyn direct access.

**Medical liability reform**

As for medical liability, Texas was congratulated on its tort reform success. With a new $250,000 cap on noneconomic damages, the Texas legislation has already led the largest carrier in the state to reduce its rates by 12% and another company to cut rates by 11.5%.

"The only effective way to influence the legislative process is to be a part of the decision-making."

—Fellow Harvey M. Cohen
Lakewood, CO

Physicians in four states will learn the fate of tort reform at the ballot box in November. Nevada, Oregon, and Wyoming have physician-sponsored ballot initiatives to establish caps on noneconomic damages. In Florida, a state medical society proposal seeks to limit attorney fees. In Florida and Nevada, the trial attorney lobbyists have voter initiatives competing against the tort reform legislation.

"It was useful to learn that physicians are having difficulty everywhere enacting liability reform, and it strengthens the need for federal legislation," said Fellow Robert L. Vermillion, MD, Roanoke, VA.

Participants stressed the importance of physician advocacy to improve women’s health care.

"The only effective way to influence the legislative process is to be a part of the decision-making," said Fellow Harvey M. Cohen, Lakewood, CO. “At all times our message should be that our concern is for women’s health issues.”

—Francine E. Sinofsky, MD, New Jersey
—Harold C. Pollard III, MD, North Carolina
—Left to right, Michael P. Woods, MD, Nebraska, and Harvey M. Cohen, MD, Colorado
—Left to right, Michael P. Woods, MD, of Nebraska, and Harvey M. Cohen, MD, of Colorado
—Francine E. Sinofsky, MD, of New Jersey
—Harold C. Pollard III, MD, of North Carolina
Ever since the Accreditation Council for Graduate Medical Education endorsed the six core competencies in ob-gyn for residents in 1999, there has been a need for developing simple, practical methods for assessing the competencies. Effective evaluation methods can provide residents with constructive feedback as well as be used to improve the quality of education.

The six core competencies are:
- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

This important issue was one of many addressed by the CREOG Council in July at the annual CREOG Education Retreat. The Council is chaired by ACOG Fellow Patrick Duff, MD, of Shands Hospital of the University of Florida College of Medicine.

**Assessment tools**

Residency programs must use at least two methods to properly evaluate each of the competencies, as required by the Obstetrics and Gynecology Residency Review Committee.

CREOG has developed examples of methods and posted them on the CREOG website (see info below). Residency programs may choose to use these or other methods.

In addition, a new questionnaire for assessment of professionalism developed by the Association of American Medical Colleges was reviewed and appears to be innovative and promising.

**Educational resources**

The CREOG Education Committee has been working on a new edition of *Educational Objectives* as well as the online quiz series, which currently has 112 quiz items. (Individual quiz items are reviewed every two years.)

The Technical Skills Task Force continues to develop a curriculum in the areas of hysteroscopy, laparoscopy, and operative obstetrics, that will include computerized simulators that may help advance surgical training.

**Resident retention and medical student recruitment**

The council also discussed the challenges of resident retention and medical student recruitment, naming as factors in both areas:
- Work hours during and after residency
- Professional liability
- Gender issues

Results of the last National Resident Matching Program, as well as pluses and minuses of a possible “Second Match” system, were shared.

**CREOG here to address your concerns**

It is an honor to be a part of the CREOG Council and to represent the resident’s perspective. In this time of significant changes to residency education and to the specialty of ob-gyn, I urge you to look to the CREOG Council as a resource.

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**Business of Medicine Update**

ACOG is producing a primer that will answer many questions about the business of medicine.

Though designed with ob-gyn residents in mind, the publication will also be useful for physicians who are changing jobs or increasing administrative responsibilities.

Want advice on personal financial planning? Have questions on liability insurance? Need help finding the perfect job? The primer can help with your most important questions.

The development of the primer, which was requested by the Business of Medicine Task Force of the Junior Fellow College Advisory Council, is being created by ACOG’s Department of Health Economics. The publication will be available for distribution by May 2005.
You Asked, We Answered

First, it’s important to note that informed consent is both a legal doctrine and a process; it is not a form.

The legal doctrine requires a physician to obtain consent to render treatment, to perform an operation, or to carry out diagnostic procedures. Although documentation is necessary for good medical care and legal defense, a consent form cannot replace the personal exchange of dialogue between a patient and physician.

In this nondelegable exchange of information the physician should disclose to the patient the reason why a particular course of treatment is being suggested, as well as the risks, benefits, and alternatives, including nontreatment and the risks and benefits of the alternatives. This is known as the “materiality” or “reasonable patient viewpoint” standard. The physician must also make allowance for the patient’s level of health literacy and cultural background.

It is helpful to have the patient articulate her understanding of essential elements of this patient-physician exchange. This discussion should ultimately culminate in the patient accepting or refusing a specific treatment or procedure. A consent form merely documents this process.

Getting help with documentation

The College has not developed printed informed consent forms for specific procedures, nor do any of ACOG’s guidelines regarding informed consent include such forms.

Informed consent laws can vary from one state to another, as can common-law case precedent. Moreover, the increasing tendency of courts to adopt the “materiality” or “reasonable patient” standard makes preprinted forms less useful.

However, ACOG has a number of resources to assist you in understanding the informed consent process and in developing consent forms if you so choose (see box below). It is important that physicians base informed consent discussions with their patients on current guidelines and data. ACOG also produces Patient Education Pamphlets that can be helpful in the explanation process.

Check legal requirements

If you are interested in developing consent forms for specific procedures, find out whether your state has any laws on informed consent and whether a specific form is required.

Your attorney should review any consent form you develop before it is used in your practice. Make sure the reviewing attorney understands your state’s informed consent laws as well as medical professional liability in general.

If you or your attorney has questions about what is required, contact your state medical society, your medical liability insurance carrier’s legal counsel, or your hospital’s attorney. In many instances, medical liability insurance carriers have developed their own informed consent doctrines and forms; you may wish to contact your carrier for examples.

Finally, remember that individual informed consent policies and forms should undergo periodic review and update.

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liability@acog.org

ACOG Resources on Informed Consent

The following can be ordered at http://sales.acog.org; 800-762-2264, ext 192

- Guidelines for Women’s Health Care, second edition
- Guidelines for Perinatal Care, fifth edition
- Professional Liability and Risk Management: A Resource for Obstetrician-Gynecologists in Training and in Practice
- Ethics in Obstetrics and Gynecology, second edition, which contains an “Informed Consent” chapter
- The Assistant: Information for Improved Risk Management, which contains two relevant chapters, “Informed Consent” and “Informed Consent Forms”

Additional College Resources

- Committee Opinion Informed Refusal.
  Find by doing an “advanced search” on the member-access section of the ACOG website, www.acog.org
- ACOG Resource Center: 202-863-2518
How to achieve the ideal consultation

Whether working in an outpatient office or a hospital setting, practicing ob-gyns most likely have experienced or witnessed an imperfect consultation—either from the viewpoint of the requesting physician, the consulting physician, or both.

Consultants might create problems by ordering tests that the patient already had or by prescribing medicines while unaware of other medications the patient is taking. Consultants might also fail to discuss the next steps with the requesting physician or simply take over the case without being asked to do so.

Requesting physicians might not adequately prepare their patient for the consultation, fail to provide adequate background information to the consultant, or delay requesting a consultation when the diagnosis or management is in doubt.

Many of the problems that lead to flawed consultations can be linked to a lack of communication between the requesting and consulting physicians, according to Mark E. Deutchman, MD, a liaison to the ACOG Committee on Professional Liability and a professor in the Department of Family Medicine at the University of Colorado Health Sciences Center at Fitzsimons, Aurora, CO.

To facilitate communication and encourage synergetic consultations, Dr. Deutchman has developed a presentation on the “Ideal Consultation.”

“Consultations are a common and potentially immensely helpful patient care tool in the modern medical environment because no single physician can be expected to know everything,” Dr. Deutchman said. “Like any tool, the consultation must be employed and managed properly to obtain the maximum benefit.”

Misunderstandings and lack of communication between requesting and consulting physicians can lead to frustration and anger from physicians and can be a factor in patient lawsuits, according to Dr. Deutchman.

“People don’t sue because of a bad outcome alone,” he said. “People sue because of a bad outcome and because they feel like they weren’t treated well. Confusion of responsibility and decision-making among the members of the health care team can adversely affect the patient’s care or the perception of that care.”

Be clear on type of consultation being sought

The first step toward achieving an ideal consultation is for requesting physicians and consulting physicians to speak personally, according to Dr. Deutchman.

If a nurse or office staff member has to relay information back and forth, it becomes a version of the children’s game of “telephone,” in which words are misheard and phrases changed, which risks confused intentions and the loss of information.

The criteria for consultation need to be agreed upon in advance by the two physicians and stated clearly in writing. At the end of the consultation, a summary of the consultation should also be put in writing and included in the medical record, as well as sent to the requesting physician as a letter or report.

Problems can arise when requesting physicians don’t specify the type of consultation they are seeking or when consulting physicians don’t respect requesting physicians’ wishes or don’t understand what they are being asked to do, Dr. Deutchman said.

He pointed to situations in which the consulting physician took over the case without the requesting physician’s knowledge. Suddenly, the requesting physician learns the patient has had additional tests done, has been referred to other physicians, or is having surgery—without the consulting physician first discussing the options with the requesting physician.

“The bottom line is that physicians need to communicate with each other, treat each other with respect, and work together to provide the best care possible for the patient,” Dr. Deutchman said.
Millions of Americans suffer from chronic obstructive pulmonary disease, or COPD, yet remain undiagnosed. Twelve million adults age 25 and older have been diagnosed with COPD, according to the US National Heart, Lung, and Blood Institute. Yet another 12 million may have the disease, which includes chronic bronchitis and/or emphysema.

Advocacy organizations are striving to bring more attention to COPD during COPD Awareness Month in November.

COPD is the fourth-leading cause of death in the US and is expected to climb to the No. 3 spot by 2020. More than 123,000 people died from COPD in 2001, according to the National Center for Health Statistics.

However, in a survey in May by the National Women's Health Resource Center, 51% of those surveyed had never even heard of the disease, and 72% did not identify COPD as one of the top five deadly diseases.

The death rate for COPD increased 148% from 1979 to 2000, according to the women's resource center, with women accounting for a major portion of the jump. However, of those surveyed, 66% believed that more men than women died from COPD.

Smoking is the most frequent cause of COPD, but only 16% of smokers surveyed put a high priority on seeking medical care for their smoker's cough. While there is no cure for COPD, medication can help manage the condition, and if sufferers stop smoking, they can reduce the decline of lung function.

The Centers for Disease Control and Prevention has developed an online “flu gallery” where physicians can access free patient education materials about influenza, including information on this year’s vaccine shortage.

Two new fliers Vaccination Is Not the Only Way to Help Prevent the Flu and Who Should Get a Flu Vaccination? were developed after officials learned of the vaccine shortage in October.

The priority list for vaccines this year, issued by the CDC, includes:

- Women who will be pregnant during the flu season
- Health care providers involved in direct patient care
- Adults age 65 and older
- Adults with chronic medical conditions
- Children aged 6 to 23 months

The flu gallery was developed before this year's vaccine shortage and also offers vaccine information statements, vaccine dosage charts, brochures, fliers, posters, logos, table tents, a sticker template, and a button template.

In related news, ACOG Fellows were mailed a flu vaccination pocket guide in October. Developed before the shortage by the Immunization Action Coalition, the guide can be easily updated. For instructions visit www.immunize.org/influenza/pocketguide.htm.

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The mobility of Alcatraz is accessible by a short ferry ride. Visitors can explore the infamous federal prison as well as learn about the Indian occupation of 1969–71, early military fortifications, and the West Coast’s first lighthouse.

Back in the city, stroll through a few of the 1,000 acres of Golden Gate Park. Among the park’s trails, forests, and lakes are the Japanese Tea Garden, botanical gardens, California redwoods, and the Conservatory of Flowers.

Stay tuned to ACOG Today in the following months for an ACM preview and registration information.
A new ACOG Committee Opinion recommends the use of rapid HIV testing for women in labor who have undocumented HIV status, recognizing that this may further reduce the number of infants infected with HIV through mother-to-child transmission.

If a rapid HIV test is positive, it should be followed up with a confirmatory test, but physicians should immediately initiate antiretroviral prophylaxis—with consent—without waiting for the results of the confirmatory test.

Studies have shown that the sooner a mother and newborn receive antiretroviral drugs during or after labor, the less likely it is that the infant will become HIV-positive through vertical transmission.

The new Committee Opinion, *Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations* (#304), was published in the November issue of *Obstetrics & Gynecology*.

“Some women will show up in labor with no prenatal care. Before the rapid HIV test, ob-gyns had no way of learning before the birth whether women with undocumented HIV status were HIV-positive or not,” said Laura E. Riley, MD, chair of the ACOG Committee on Obstetric Practice and a member of ACOG’s Perinatal HIV Expert Work Group. “The HIV test allows physicians to learn a woman’s HIV status in about an hour, which allows them to immediately dispense antiretroviral drugs instead of waiting for results from a conventional test, which takes about two weeks to process.”

In labor and delivery it is easier for physicians to use rapid HIV tests that can be performed with whole blood instead of tests using serum or plasma, which are better suited for the laboratory, according to the opinion.

**ACOG recommends universal prenatal HIV testing**

The Committee Opinion also reaffirms ACOG’s support of the opt-out approach for prenatal HIV testing. The opt-out approach calls for universal HIV testing with patient notification as a routine part of prenatal care. The Centers for Disease Control and Prevention recently changed its guidelines to also recommend the opt-out approach.

The opinion recognizes that some state laws prevent this approach and recommends physicians become aware of and follow their state’s prenatal HIV screening requirements. Ob-gyns can verify specific requirements with their state and local public health departments.

Studies show that the opt-out approach leads to greater testing rates when compared with the opt-in approach, which requires specific informed consent before conducting an HIV test. Currently, no states have adopted an opt-out approach, although some have instituted variations and some are reviewing the opt-out approach, according to the Committee Opinion.

**Repeat testing in third trimester**

In areas with high HIV prevalence among women of childbearing age, health care facilities may want to consider repeat testing in the third trimester. In addition, repeat testing in the third trimester, preferably before 36 weeks of gestation, is recommended for women at high risk of acquiring HIV (as permitted by state guidelines).

Candidates may also include women who declined testing earlier in their pregnancy. Physicians should use conventional HIV tests for third-trimester testing instead of waiting to give patients a rapid HIV test during labor.

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**ACOG distributes perinatal HIV packet**

Hospitals, public health departments, and ACOG leaders will receive a perinatal HIV packet from the College in November. The packet will include the new Committee Opinion *Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations* (#304), as well as several other educational materials. The Committee Opinion was published in the November issue of the Green Journal.

The packet also includes:

- A tearpad titled *HIV and Other Important Pregnancy Tests*
- A laminated card: *Physician Information on Perinatal HIV Testing*
- A Spanish and English copy of ACOG’s Patient Education Pamphlet *HIV Testing and Pregnancy* (AP113 and SP113)
- ACOG’s Statement of Policy *Joint Statement on Human Immunodeficiency Virus Screening*

The packet will be sent to ACOG national officers, district and section chairs, US hospitals that have more than 300 deliveries a year, and state public health departments.

Support for the work of ACOG’s Perinatal HIV Expert Work Group and distribution of the educational materials were possible thanks to a grant from the Centers for Disease Control and Prevention.

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To access any of these items, conduct an “advanced search” for the title on ACOG’s member-access website, www.acog.org
Screening and educating patients

Does a patient smoke? Is she overweight or obese? Does she have high blood pressure or high cholesterol? While patients likely know that smoking and being overweight are not healthy behaviors, they may not know the specifics: that smoking and being overweight can increase their risk of heart disease. In addition, women may not know their blood pressure level and may never have had their cholesterol level checked.

Patients should be counseled about their individual risk factors and encouraged to modify their lifestyle to reduce their risks, as recommended in ACOG’s Guidelines for Women’s Health Care, second edition.

Blood pressure is checked as a routine part of care and if it’s high, it provides ob-gyns with a good opportunity to counsel a patient about her risk of heart disease, Dr. Lewis said. Ob-gyns can also screen and treat women with high cholesterol, while educating them about how high is too high and how to reduce their level.

In the AHA survey, 70% of women did not know their levels of low- and high-density lipoproteins. ACOG recommends that women 45 and older obtain a lipid profile assessment every five years. Beginning in January, Medicare will begin to cover cardiovascular screening blood tests for patients once every five years (see article on page 12).

Calculating a patient’s specific heart disease risk

Earlier this year, AHA released new guidelines on preventing heart disease among women. The guidelines, which were developed in cooperation with ACOG, outline prevention and treatment based on whether a woman is at low, intermediate, or high risk for heart disease, determined by a scoring method known as the Framingham Risk Score.

The Framingham method uses a point system to determine a woman’s 10-year risk for heart disease, assigning a value to five risk factors: age, total cholesterol, HDL cholesterol, systolic blood pressure, and whether or not a woman smokes.

Once a woman’s risk is identified, physicians can use the guidelines to determine whether patients need lifestyle modifications and/or drug therapy to reduce their risk of heart disease.

Go Red for Women toolkits available to physicians

A free toolkit is available to help physicians implement the American Heart Association guidelines for the prevention of heart disease in women.

The toolkit is part of the Go Red for Women campaign, launched by AHA in February 2004 in conjunction with the release of the new AHA guidelines.

Order at www.staywell.com/go-red.asp; 800-203-8607
http://my.americanheart.org/portal/professional (Click on Go Red for Women logo at the bottom right of the page.)
COG’s District II has taken aim at heart disease. Recognizing that the disease is the No. 1 killer of women, the district has developed an initiative that provides education and training to ob-gyns and other physicians in New York on how to evaluate heart disease risks in their patients.

The district started the Women and Heart Disease: Physician Education Initiative two years ago in partnership with the New York Chapter of the American College of Physicians and the New York State Department of Health. The initiative aims at increasing the number of physicians who screen and counsel their female patients about the risk of heart disease as well as educating primary care physicians about how heart disease affects men and women differently. “Ob-gyns see women throughout their childbearing years, typically before they develop coronary heart disease,” said Christine Rutan, project director of the District II initiative. “They are in an opportune position to prevent coronary incidences by engaging patients in dialogue about risk reduction.”

Physician resource guide

The district developed a physician resource guide, which provides the necessary tools and information to implement women-specific heart disease prevention strategies in practices. The resource guide includes:

- National guidelines to prevent and treat high blood pressure and cholesterol
- National tobacco cessation and weight management guidelines
- Articles and website references
- Perforated tracking forms and patient education sheets adapted from American Heart Association materials

The resource guide, which was initially mailed to 16,000 physicians throughout New York, can be purchased from District II (see info below).

Educational conferences

Earlier this year, the district and the New York Chapter of the American College of Physicians co-sponsored two regional conferences on cardiac risk prevention and management in women. The conferences focused on a wide variety of topics related to heart disease, including obesity, coding issues, genetics, tobacco cessation, polycystic ovary syndrome, heart disease in pregnancy, and managing blood pressure. “These conferences increased awareness and knowledge of heart disease prevention among ob-gyns and other primary care providers,” said ACOG Fellow Vivian Lewis, MD, conference clinical program chair and associate chair for ambulatory women’s health and professor of ob-gyn, University of Rochester Medical Center.

“The audience learned the latest information on these important topics as well as an appreciation of the challenges faced by other specialties.”

Also as part of the initiative, the district has:
- Held 24 grand rounds
- Focused on heart disease during its annual legislative health forum
- Sponsored a heart disease screening booth at its annual Women’s Health Expo
- Partnered with AHA to launch its national Go Red for Women campaign in New York

Next steps

District II is now developing an office-based model for heart disease risk assessment by collecting data from an ob-gyn practice during the next year. The district also plans to develop educational material that explains the effect that the Women’s Health Initiative hormone therapy findings have had on heart disease screening. “The success of the heart disease project is seen in our ability to provide much needed education to New York Fellows while simultaneously strengthening District II’s desired relationship with state agencies,” said Donna Montalto Williams, MPP, executive director of District II. “The state is looking to ACOG New York to continue this call to action and focus new efforts on hypertension and cholesterol.”

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GoRed for women

Red will be the color of choice at the Afternoon Tea for All Spouses on Monday, May 9, during ACOG’s Annual Clinical Meeting, to be held May 7–11 in San Francisco. This year’s tea will present a special program on women and heart disease, and all guests are encouraged to wear red in support of heart health. The event will highlight the importance of the American Heart Association’s national Go Red for Women campaign, which aims to raise awareness about women and heart disease—the No. 1 killer of women. Be sure to join ACOG President Vivian M. Dickerson, MD, her family, and spouses of all former ACOG presidents for this inspiring event. Stay tuned to ACOG Today and the ACOG website for more information.
New CPT codes set for 2005

Seven new and three revised Current Procedural Terminology codes relevant to your practice will take effect in January. After evaluating Fellows’ suggestions, ACOG’s Committee on Coding and Nomenclature proposed the CPT changes to the American Medical Association and the CPT Editorial Panel, which approved them for 2005.

Medicare to cover preventive care

For the first time ever, Medicare will cover initial preventive physical exams.

Beginning in January, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination dubbed the “Welcome to Medicare Physical.”

The initial preventive physical will consist of a comprehensive examination, which will allow the physician to diagnose problems earlier—at a time when treatment is more effective.

In addition, Medicare will begin to cover cardiovascular and diabetes screening tests:

- A cardiovascular screening blood test will include testing for total cholesterol high-density lipoprotein, and triglycerides. The test will be covered once every five years, and the Medicare deductible or co-pay will be waived.
- A diabetes screening is covered up to two times a year and will include a fasting plasma glucose test and postglucose challenges. The Medicare deductible or co-pay will be waived.

info

- www.medicare.gov
- 1-800-medicare

Pelvic floor defect

Code +57267 is an add-on code that will be used to describe insertion of mesh or other prosthesis for a repair of pelvic floor defect via vaginal approach. List this code separately in addition to the code for the primary procedure.

Vaginal colpopexy

Previously, there was a single code to report for a vaginal colpopexy, 57282, which described sacrospinous ligament fixation. For 2005, the code was revised and code 57283 was added. The changes will allow for reporting of both an extra-peritoneal and intra-peritoneal approach.

- Code 57282 will be revised to read “Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)”
- Code 57283 will be added for “Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)”

Endometrial cryoablation

Code 58356 will be added for endometrial cryoablation with ultrasonic guidance, including endometrial curettage when performed. Uterine cryoablation therapy was previously reported with Category III code 0009T. The procedure uses extreme cold and ultrasound in contrast with thermal ablation, which uses heat and hysteroscopy (code 58563).

Hysteroscopy

Code 58565 will be added to report surgical hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. Because this procedure avoids abdominal incisions it is considered less invasive than more traditional methods of sterilization.

Bilateral salpingo-oophorectomy

Code 58956 will be added for reporting bilateral salpingo-oophorectomy with total omentectomy and total abdominal hysterectomy for malignancy. The procedure is performed in women with gynecological malignancies such as endometrial, ovarian, tubal, and primary peritoneal, with omental metastasis.

The new code joins the other total abdominal hysterectomy for malignancy codes (58951, 58953, 58954, 58956). Each code is reported for total abdominal hysterectomy with different combinations of other procedures, such as salpingo-oophorectomy, lymphadenectomy, and omentectomy.

Doppler velocimetry

Code 76820 will be added for Doppler velocimetry, fetal umbilical artery, and code 76821 will be added for Doppler velocimetry, fetal middle cerebral artery.

The two codes will be added to assess the blood flow of an umbilical artery and the fetal middle cerebral artery in order to evaluate fetal anemia and fetal growth restriction caused by placental vascular resistance.

Umbilical artery Doppler velocimetry is useful in assessing and timing delivery of the growth-restricted fetus. Middle cerebral artery peak velocity is useful in evaluating fetuses at risk of anemia, and it eliminates the risk of fetal loss associated with invasive techniques such as amniocentesis and direct sampling of fetal blood.

Doppler echocardiography

In order to differentiate the services described in the Doppler blood-flow codes, particularly pertaining to the middle cerebral artery, the existing Doppler fetal echocardiography codes 76827 and 76828 have been revised to exclude the general term “cardiovascular system”:

- Code 76827 is for Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display, complete
- Code 76828 is for Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display, follow-up or repeat study
Changes in patient expectations and cervical cancer screening guidelines are leading some ob-gyns to redefine the annual gynecological visit.

Many women consider their ob-gyns their primary care physicians and may not visit another physician. Even if women have another primary care physician, they may still consider their ob-gyn the doctor they turn to as medical issues arise.

“We need to recognize the movement from traditional ob-gyn services to more comprehensive women’s health care services and recognize that many women see us as their primary physicians,” said Mark S. DeFrancesco, MD, vice chair of the ACOG Committee on Practice Management. “Women need a variety of health screenings, such as cholesterol tests, depression screening, and so on. If we don’t do it, it’s not going to be done.”

Confusion over Pap test vs. pelvic exam
Cervical cancer screening guidelines issued by the American Cancer Society in 2002, and supported by ACOG, allow for most women age 30 and older who have had three consecutive negative Pap test results and no history of CIN 2 or CIN 3 to undergo Pap tests every two to three years instead of every year. In addition, combining the Pap test with a test for HPV DNA is an option for women age 30 and older. Those who test negative on both tests can be screened every three years (ACOG Practice Bulletin Cervical Cytology Screening, August 2003). ACOG continues to support annual Pap testing when ob-gyns find it appropriate.

Because many women don’t understand there is a difference between a Pap test and a pelvic exam, they may think they don’t need to return to their ob-gyn for three years because of the new guidelines, said Dr. DeFrancesco, who is in private gynecology practice in Waterbury, CT, and the chief medical officer at Women’s Health Connecticut.

“From a practice management perspective, there will be a lot of doctors who will be afraid to adopt the new guidelines because they fear that patients will only visit their doctor every three years,” he said. “Instead, ob-gyns should adopt the guidelines and explain to their patients the need for the annual exam and the difference between the Pap test and the pelvic exam. This is also a great opportunity to redefine the annual exam, adding preventive care and health screenings to the annual visit.”

Consideration of all health issues
While annual well-woman ob-gyn visits typically consist of a breast exam, pelvic exam, and a Pap test, some ob-gyns have begun to add other health screenings.

“I think you need to consider the total woman. What are her physical risks that need addressing? What are her emotional needs?” —Dr. Binder

“I think you need to consider the total woman,” said ACOG Fellow William Dore Binder, MD, MMM, medical director of the Louisiana Women’s Healthcare Associates in Baton Rouge, LA. “What are her physical risks that need addressing? What are her emotional needs?”

“I’m not saying we need to be experts in internal medicine or psychiatry, but we need to be able to screen for problems and refer the patient to someone who can help her,” Dr. Binder continued.

Ironically, when a woman is pregnant, her ob-gyn tends to become her primary care provider and addresses nongynecologic issues such as diabetes, hypertension, and influenza immunization, said ACOG Fellow Leo J. Dunn, MD, professor and chair emeritus, Virginia Commonwealth University, and previous chair of the former ACOG Committee on Primary Care.

“If, during pregnancy, the patient develops a rash or a respiratory infection, ob-gyns will ordinarily provide care to that patient for that condition,” Dr. Dunn said. “On the other hand, some ob-gyns feel if the same patient comes in for the same conditions but is not pregnant, they are not able to provide care. Where is the logic in that?”

Dr. DeFrancesco now speaks to patients about heart health and depression. He asks if they have a family history of colon cancer and recommends colonoscopies to all patients 50 and older, referring them to a specialist.

Defining the role of a PCP
An annual exam is also an opportunity to clarify a patient’s definition and expectations of a primary care physician: Does she see another doctor regularly, not at all, or only when she’s sick?

“Although a patient’s chart may list a primary care physician, it may not be someone the patient sees on a regular basis and doesn’t mean that the patient is receiving primary care screening,” Dr. DeFrancesco said.

The expectation between the patient and ob-gyn is a critical issue, Dr. Dunn said.

Several years ago, in a gyn oncology clinic, Dr. Dunn noticed that a number of patients returned annually after being cured of a pelvic malignancy. The patients considered these visits annual exams with their primary care providers. However, the oncologists thought differently.

“The oncologists were narrowly focused on aspects of the past disease and were unaware that some of these women were well past the age of needing their first mammograms, cholesterol checks, etc.,” Dr. Dunn said.

Dr. DeFrancesco recognizes that ob-gyns may not be comfortable treating some problems that are detected by health screenings.

But, at the very least, he said, ob-gyns can inform patients about particular health issues and the care that they might need, and/or refer them to an appropriate physician.
Former College officer dies

Former ACOG Assistant Secretary William C. Scott, MD, age 83, died Aug. 28 in Sonoita, AZ.

Dr. Scott served as ACOG assistant secretary in 1989–90, was District VIII chair and vice chair, and served on various ACOG committees.

Dr. Scott was in private practice for 20 years before helping to found the ob-gyn department at the University of Arizona Medical School, where he was one of its first faculty members. He was the vice president of medical affairs at the medical school when he retired in 1994, becoming an emeritus associate professor of ob-gyn.

He earned his degrees from Dartmouth College in Hanover, NH, and the University of Colorado School of Medicine.

Former section chair dies

Former Florida Section Chair Eric F. Geiger, MD, died March 2 of Lou Gehrig’s disease. He was 79.

Dr. Geiger, of Pensacola, FL, practiced ob-gyn for nearly 30 years. After retiring from practice, he became the District 1 deputy district administrator for health for the State of Florida, health and rehabilitative services, from 1992–93 and medical director of health and rehabilitative services, Escambia County Public Health Unit, from 1993–96.

He was vice chair of the ACOG Florida Section from 1982–84 and chair from 1985–87 and was past president of the Pensacola Ob-Gyn Society, the Florida Ob-Gyn Society, and the Escambia County Medical Society.

Dr. Geiger graduated from the University of Florida and Tulane University School of Medicine in New Orleans. He completed his ob-gyn residency at Ochsner Clinic in New Orleans.

Birth control advocate dies

A n early advocate for birth control and safe abortions, Selig B. Neubardt, MD, of Larchmont, NY, died August 24 of pneumonia. Dr. Neubardt, age 78, was an ACOG Life Fellow.

Beginning in the late 1960s, Dr. Neubardt began encouraging the use of birth control to the public, writing his first book, A Concept of Contraception, in 1967, which was translated into several languages. He wrote many articles for Cosmopolitan magazine about the birth control pill and abortion procedures, and in 1972, with colleague Harold Schulman, MD, he wrote the medical text Techniques of Abortion, which explained the procedures for first- and second-trimester abortions.

In later years, after abortion was legal and the pill commonplace, Dr. Neubardt continued advocating on women’s health through newspaper columns and as a frequent guest on talk shows such as the “Phil Donahue Show” and “Oprah Winfrey Show.”

Dr. Neubardt was an assistant clinical professor of ob-gyn at the Albert Einstein College of Medicine of Yeshiva University in the Bronx, NY. He also had a private gynecological practice in New Rochelle, NY, for more than 40 years.

Dr. Neubardt graduated from Columbia College and the Syracuse College of Medicine in New York, where he was a member of the Alpha Omega Alpha honor medical society.

Consider accepting military’s health coverage plan

The federal government is encouraging physicians to accept patients covered by TRICARE insurance, the US Department of Defense health care program for uniformed military personnel and their families.

TRICARE covers active duty, National Guard, and Reserve personnel; their families; and retired personnel. While active-duty personnel receive most of their medical care at military treatment facilities, family members and retired service members will likely use private health care at various times in their lives.

TRICARE reports that some beneficiaries have said it can be difficult to find physicians who accept TRICARE patients. One problem is that TRICARE’s reimbursement rates are, by statute, in line with those of Medicare. TRICARE also reports that there may be a general lack of information and frequent misunderstandings about the value of the program.

According to TRICARE, advantages to accepting TRICARE are:

- A large, stable pool of potential patients, with 9 million beneficiaries
- Claims timeliness, with 99% of clean claims processed within 30 days and more than 90% of claims processed within 15 days
- An average turnaround time for electronic claims of five days

Providers can choose to join the TRICARE network or participate as non-network providers, accepting patients on a case-by-case basis. Physicians become a part of the program by becoming TRICARE-certified, which simply entails meeting the licensing and credentialing requirements in the state in which service is rendered.

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In Memoriam

- Lawrence H. Allred, MD • Stockton, CA
- Enrique M. Camps, MD • Houston
- David J. Carty, MD • Santa Maria, CA • 2/04
- Robert E. Dougherty, MD • Knoxville, TN
- Perry B. Klein, MD • Houston
- David McKowen, MD • Baton Rouge, LA • 7/04
- Rita M. O’Brien, RNC • Fenton, MO
- Dean A. Rowley, MD • Mesa, AZ • 6/04
- Jose T. Sanchez Jr, MD • Key West, FL • 1/04
- Josef Z. Scott, MD • Edmonton, AB
- Wendell P. Scott, MD • Dallas • 8/04
- Eugene J. Sweeney, MD • Nashua, NH • 8/04
- Evans S. Voultepsis, MD • Timonium, MD • 7/04
Please contact individual organizations for additional information.

**2004-2005 calendar**

**November**
- ACOG Webcast: Breast Management and Medical Liability Risk Reduction
  2–3 pm, ET
  800-673-8444, ext 2498
- FIGO-IFFS Joint Conference on Recent Progress in Reproductive Medicine
  5–6
  Barcelona, Spain
  www.pacifico-meetings.com/figo-iffs2004
- Global Congress of Gynecologic Endoscopy
  10–13
  San Francisco
  Sponsored by American Association of Gynecologic Laparoscopists
  www.aagl.com
- Council of Medical Specialty Societies Annual Meeting
  12–13
  Chicago
  847-295-3456
- American Society of Cytopathology’s 52nd Annual Scientific Meeting
  13–17
  Chicago
  www.cytopathology.org

**December**
- American Medical Association Interim Meeting
  3–7
  Atlanta
  www.ama-assn.org
  800-673-8444, ext 2515
- **ACOG Webcast:** Physician-Patient Communications: Reducing Medical Liability Risks
  7
  1–2:30 pm, ET
  800-673-8444, ext 2498
- Council of Medical Specialty Societies Spring Meeting
  18–19
  Chicago
  847-295-3456

**January**
- South Atlantic Association of Obstetricians and Gynecologists
  21–25
  White Sulphur, WV
  904-384-8124
- **ACOG Webcast:** Sixth International Symposium on Osteoporosis
  6–10
  Washington, DC
  Sponsored by the National Osteoporosis Foundation
  www.nof.org
  202-223-2226
- JSOG: Congress of the Japan Society of Ob-Gyn
  2–5
  Kyoto, Japan
  http://jsog.umin.ac.jp/IS/ISindex.htm

**February**
- Society for Maternal-Fetal Medicine
  7–12
  Reno, NV
  202-863-2476
- 2nd NIH International Congress: Advances in Uterine Leiomyoma Research and Clinical Implications
  24–25
  NIH, Bethesda, MD
  919-541-2764
- **ACOG Annual Clinical Meeting**
  7–11
  San Francisco
  www.acog.org/acm2005

**March**
- CCREOG and APGO Annual Meeting
  2–5
  Salt Lake City
  CCREOG: 800-673-8444, ext 2558
  APGO: 410-451-9560
- ACOG Congessional Leadership Conference (formerly Legislative Workshop)
  13–15
  Washington, DC
  800-673-8444, ext 2505
- Council of Medical Specialty Societies Spring Meeting
  18–19
  Chicago
  847-295-3456
- **ACOG Postgraduate Courses**
  *Two ways to register:*
  1 Call 800-673-8444, ext 2540/2541, or 202-863-2540/2541, weekdays 9 am–4:45 pm ET
  2 Go to www.acog.org and click on “Postgraduate Courses” under “Meetings”
- **Registration**
  Oncise registration must be received one week before the course.
  Online registration subject to availability.

**November**
- The Mature Woman: From Perimenopause to the Elderly Years
  11–13
  Boca Raton, FL
- Obstetrics Update: Emergencies
  18–20
  Las Vegas
- CPT and ICD-9-CM Coding Workshop
  19–21
  San Francisco

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

**2005**
- February
  - Practical Obstetrics and Gynecology
    3–5
    Keystone, CO
- CPT and ICD-9-CM Coding Workshop
  11–13
  Orlando, FL
- Patient Safety in Obstetrics: New Approaches to Improving Patient Safety and Reducing Practice Liability—Twin Offering
  14–16
  St. Thomas, Virgin Islands
- Advanced Surgical Approaches to Incontinence and Prolapse—Twin Offering
  17–19
  St. Thomas, Virgin Islands

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 Assess your knowledge of the most recent scientific advances in ob-gyn with the popular ACOG series Personal Review of Learning in Ob-Gyn—known as PROLOG. ACOG is accredited by the Accreditation Council for Continuing Medical Education to provide CME programs for physicians.

Each unit of PROLOG covers a different major aspect of the specialty, presenting clinical evidence in case scenarios. New this January will be the fifth edition of Reproductive Endocrinology and Infertility.

Each PROLOG unit features a multiple-choice test plus a critique book that thoroughly discusses each answer. Answer sheets can be returned to ACOG for 25 CME credits per unit.

ACOG awards CME credit for each unit of PROLOG for its initial three years, including the year of publication. At the end of the three years, the College's content experts reevaluate the unit and, if appropriate, extend credit for an additional three years. An individual can request credit only once for each unit.

PROLOG registrar: 800-673-8444, ext 2569
Order PROLOG units at http://sales.acog.org; 800-762-2264, ext 192

Deadline approaching for Cognate Program Award Cycle 2002–04

The ACOG Award for Continuing Professional Development for the three-year cycle 2002–2004 will be issued in January.

Please be sure to submit all data for this cycle by December 31 to be included in the initial processing of the award for this cycle. Late submissions can be added, but your award certificate will be delayed.

You can view your CME credits and print a transcript on the ACOG website. Visit www.acog.org/myacog. After you log in, your personal page will come up and you can access your transcript and the brochure explaining the details of the ACOG Program for Continuing Professional Development (Cognate Program).

Please note that this is the last year to submit data for the 2000–2002 cycle. After December 31, 2004, ACOG can no longer accept any submissions for that cycle.

Submissions to the Cognate Program can be faxed to 202-484-1586 or mailed to ACOG Cognate Department, PO Box 96920, Washington, DC 20090-6920
Questions? Contact cognates@acog.org; 800-673-8444, ext 2405

New Patient Education Pamphlets:
- Menopausal Bleeding (AP162)
- Cancer of the Cervix (AP163)

Revised Patient Education Pamphlets:
- Pelvic Inflammatory Disease (AP077)
- Keeping Your Heart Healthy (AP122)

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