THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

NOVEMBER/DECEMBER 2005

Hurricanes displace Fellows, close practices

ACOG Fellow Bruner B. Bosio Jr, MD, stands in all that remains of his house along the Gulf Coast in Pascagoula, MS.

FOR MOST OF US, HURRICANE Katrina was viewed through news coverage of the approaching storm and its aftermath. We watched with disbelief and horror, feeling helpless and worrying about the people in the path of the storm. However, for a few hundred ACOG members, Hurricane Katrina—and Hurricane Rita almost a month later—were all too real. In this issue of *ACOG Today,* we share some of their personal stories with you.

Approximately 400–450 ACOG members lived in the areas hit by the storms. A survey by the University of North Carolina School of Public Health estimated that approximately 272 ob-gyns in just a 10-county area in Louisiana and Mississippi were displaced by Katrina alone.

Like others in the area, ob-gyns are trying to deal with insurance claims, disaster relief registration, home repairs, finding a place to live, loss of income, and more.

ACOG has waived the 2006 national, district, and section dues for all members in areas with zip codes that begin with 369, 393, 394, 395, 396, 700, 701, 703, 704, and 706. In addition, ACOG has worked with *HEALTHe*CAREERS Network to create www.healthecareers.com/katrina, a website to help ob-gyns find permanent or temporary jobs. The College has established a special section on the ACOG website to disseminate information about treating displaced patients

➤PAGE 4

Ob-gyns work around the clock during Hurricane Katrina

AS HURRICANE KATRINA approached the Gulf Coast, destined for landfall early on Monday, August 29, ob-gyns across Louisiana, Mississippi, and Alabama took actions similar to those of other residents in the storm path. Some boarded up their homes. Some evacuated. And some reported for work.

Approximately 400–450 ACOG members lived in the areas hit by the storm. Several were among those who stayed put at hospitals in New Orleans and elsewhere. They worked around the clock despite their own fatigue and dehydration, delivering babies and taking care of pregnant women, new moms, newborns, and other patients, and doing so without electricity, air conditioning, or an adequate water supply.

The situation quickly worsens

Second-year Louisiana State University resident Stacey L. Holman, MD, was on the "gray team" on call for disasters at University Hospital in New Orleans, where both Tulane University and LSU ob-gyn residents trained. Staff assigned to the gray team reported for work at 7 am on that Sunday, the day before the storm hit.

"We still had power, and our goal was to try to get as many patients delivered as possible," said Dr. Holman, who remained at the hospital all week, until the Friday after the storm when the hospital was finally evacuated.

After New Orleans' levees broke on Tuesday, flooding the hospital's generators, the situation turned dire. After several hours with no electricity at all, "one small generator for labor and

➤PAGE 6

PHOTO BY KEVIN HIMEL, A VOLUNTEER WITH THE NEW ORLEANS POLICE DEPARTMENT

Memorial Medical Center in New Orleans was flooded after the city's levees broke.

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EXECUTIVE DESK

ACOG members share remarkable stories of Hurricanes Katrina, Rita

WHEN HURRICANE KATRINA slammed into the Gulf Coast in August, thousands of lives changed overnight. People lost friends and family members, their homes, and their jobs. Among those hit by Hurricane Katrina—and Hurricane Rita almost a month later—were hundreds of ACOG members. In this issue of *ACOG Today,* we recognize just a few of the Fellows and Junior Fellows affected by the storms and share their stories with you.

It comes as no surprise to me that several ob-gyns were among the medical personnel who remained at their hospitals, taking care of patients during the storm and its aftermath. They delivered babies and treated patients in trying circumstances.

Beginning on page 1 and continuing on pages 4–6 and page 14, you can read about how the storms affected members and residency programs and how ob-gyns in Baton Rouge and Houston helped care for evacuees.

At ACOG, the Executive Committee decided to waive the 2006 dues for all members in the areas devastated by Hurricane Katrina, and we have established a special section on the College website, www.acog.org, to disseminate information about treating displaced patients and volunteering medical services. In addition, the College has teamed up with *HEALTHe*CAREERS Network to create a website to help ob-gyns find permanent or temporary jobs, at www.healthecareers.com/katrina.

ACOG is also developing plans to send back issues of *ACOG Today* and the Green Journal to members who were displaced or who live in areas where mail delivery was halted. At ACOG headquarters, we have hired an extra employee, an evacuee to DC who was made homeless by Katrina, and our Government Relations staff has successfully lobbied to change some federal regulations to help our Fellows in the wake of this devastation.

As ob-gyns and their patients put their lives back together, they will need our help and support. I urge you to continue to donate your time and money to efforts that are helping evacuees rebuild their lives. Our members' resilience, strength, and commitment to their patients is a lesson to us all. ♀

Ralph W. Hale MD

Ralph W. Hale, MD, FACOG
Executive Vice President

Hurricane Katrina forces SGO annual meeting to relocate to Palm Springs

THE ANNUAL MEETING OF THE Society of Gynecologic Oncologists has been rescheduled and relocated in the aftermath of Hurricane Katrina. The 37th Annual Meeting on Women's Cancer, originally scheduled for Mar 4–8, 2006, at the New Orleans Marriott, has been rescheduled for Mar 22–26, 2006, at the Palm Springs Convention Center in Palm Springs, CA. Updates will be available on the SGO website, www.sgo.org. ♀

Obstetrics & Gynecology HIGHLIGHTS

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

Partnering with Patients to Improve Safety
(Committee Opinion #320, new)
See page 7 for more information

Maternal Decision Making, Ethics, and the Law
(Committee Opinion #321, new)

Compounded Bioidentical Hormones
(Committee Opinion #322, new)
See page 9 for more information

Elective Coincidental Appendectomy
(Committee Opinion #323, replaces #164)

Perinatal Risks Associated with Assisted Reproductive Technology
(Committee Opinion #324, new)
See page 9 for more information

Antiphospholipid Syndrome
(Practice Bulletin #68, replaces Educational Bulletin #244)

ACOG radio spots educate millions about hormone therapy

A menopause education campaign conducted during the 2005 Annual Clinical Meeting reached women across the country through a radio satellite tour. In all, ACOG delivered its message to an estimated audience of 131 million. The interviews by ACOG Fellows ran on stations that target local, national, military, and minority audiences.

The campaign, which aimed to improve knowledge nationwide about menopause and its symptoms, was made possible in part by an unrestricted educational grant from Wyeth Pharmaceuticals.

"The amount of information about hormone therapy can be overwhelming, and women continue to have questions about the best action to take to alleviate their symptoms. These radio spots were instrumental in ACOG's efforts to educate women about the risks, benefits, and alternatives to hormone therapy," said Penny Murphy, MS, director of ACOG's Office of Communications.

In October 2004 ACOG released the *Hormone Therapy Report*, a thorough, evidence-based evaluation of the risks and benefits of hormone therapy developed by the ACOG Task Force on Hormone Therapy. This report was used as a basis for the message points highlighted in the interviews. These included:

- There are no hard and fast answers about who will experience menopausal symptoms. In general, about seven out of 10 women going through menopause will experience hot flashes at some point.
- The severity of symptoms can vary widely from woman to woman.
- To date, hormone therapy is still the most effective treatment for problems such as hot flashes and vaginal dryness.
- If a woman does choose hormone therapy, she should work with her physician to find the lowest possible dose that works for her and try it for the shortest time possible. ♀

Cognate program deadline approaching

THE ACOG AWARD FOR Continuing Professional Development for the three-year cycle 2003–05 will be issued in January. Be sure to submit all data for this cycle by December 31 to be included in the initial processing of this cycle's award. Late submissions can be added, but your award certificate will be delayed.

You can view your continuing medical education credits and print a transcript on the ACOG website, www.acog.org/myacog/. After logging in, your personal page will pop up, and you can access your transcripts and the brochure about the ACOG Program for Continuing Professional Development or Cognate Program.

This is the last year to submit data for the 2001–03 cycle. After Dec 31, 2005, ACOG can no longer accept any submissions for that cycle. ♀

info

- Fax submissions to 202-484-1586 or mail to ACOG Cognate Department, PO Box 96920, Washington, DC 20090-6920
- Questions? Contact cognates@acog.org; 800-673-8444, ext 2405

Tennessee Section secretary/treasurer dies

Elizabeth "Ellie" Craver Pryor, MD, Johnson City, TN, died on August 29 after a five-month battle with pancreatic cancer. Dr. Pryor, age 43, was the secretary/treasurer of ACOG's Tennessee Section.

Dr. Pryor was an assistant professor of ob-gyn at East Tennessee State University in Johnson City. She earned her medical degree from the University of North Carolina-Chapel Hill and completed her ob-gyn residency at the University of Miami and Jackson Memorial Hospital in Miami. She was in private practice in Miami and Eden and Greensboro, NC, before completing a fellowship in maternal-fetal medicine at Wake Forest University in Winston-Salem, NC. She joined the faculty at East Tennessee State University in 2001.

"Ellie Pryor was a vibrant and nurturing individual with a 'can-do' attitude that was an inspiration to those around her," said Martin E. Olsen, MD, Tennessee Section chair and ob-gyn department chair at East Tennessee State University. "She was devoted to her students, residents, and patients and to women's health. She is deeply missed."

Dr. Pryor was an APGO/Solvay scholar and had done research in women's health education. ♀

IN MEMORIAM

Joseph W. Baggett, MD
Fayetteville, NC • 8/05

Joseph H. Bellina, MD
Metairie, LA • 8/05

H. Kent Bennett, MD
High Point, NC

Charles W. Butler, MD
Atlanta • 1/05

Gene A. Croce, MD
Cranston, RI • 4/05

Vernon L. Dennis, MD
Chicago

R. Hugh Douglas, MD
Weirsdale, FL

John C. Dumler, MD
Easton, MD

Hurricanes displace Fellows, close practices

Walt Adams, CEO of the Adams Group, leads a tour of the damaged Charity Hospital in New Orleans in October.

PHOTO BY CHRIS GRAYTHEN, GETTY IMAGES

➤PAGE 1

and volunteering medical services to the devastated areas. More information can be found by clicking on "Katrina Information" on the ACOG home page, www.acog.org.

Finding temporary or new housing, looking to future

ACOG Fellows and Junior Fellows in the areas affected by the two hurricanes are piecing their lives back together.

"There are those whose hospital and home were OK, but they don't have any patients. And then there are those who lost their hospital, their home, and their office," said Louisiana Section Immediate Past Chair Michael L. Kudla, MD.

PHOTO BY KEVIN HIMEL, A VOLUNTEER WITH THE NEW ORLEANS POLICE DEPARTMENT

Staff at Charity Hospital, with military personnel, wait to be evacuated a few days after the storm.

Dr. Kudla practiced in Lake Charles, LA, which was not affected by Hurricane Katrina but was hit hard by Rita on September 24.

"We need to wait for water, power, and sewage systems to come back," he said on September 30, adding that because the two Lake Charles power plants were destroyed, the most optimistic date for the city to get electricity back was October 13.

Until Hurricane Rita hit, physicians in Lake Charles were caring for New Orleans patients who had been displaced. "But since then, we had to leave too, so the patients we were taking care of have had to go somewhere else," Dr. Kudla said.

He and his wife initially stayed with his mother in Austin, TX, and were en route to stay with relatives in Baton Rouge. "Until we can go home, I'll see what kind of work I can do there, possibly helping out with evacuees," he said.

In Pascagoula, MS, the home of Fellow Bruner B. Bosio Jr, MD, was completely destroyed by Katrina.

"Of the eight ob-gyns in my practice, only one is living in his home," he said. "Three of us lived on the street facing the Gulf and have nothing standing."

Dr. Bosio, who has practiced only gynecology for the past year, said his office had minimal damage and has stayed open, but "there's not a lot of gynecology going on. A lot of patients don't have homes to come back to."

But, he said, the situation is gradually getting back to normal. "It will take awhile. I'm not leaving the area," he said.

Elizabeth R. Lapeyre, MD, evacuated from New Orleans with her husband and four kids, ages 20 months to 11 years, to Atlanta, where she enrolled the older children in school.

A few weeks after the storm she returned to work in New Orleans, staying with a friend. But her husband and children were forced to stay in Atlanta because the kids' New Orleans school was not open, her husband's law office was closed, and their house needed repair and did not have adequate water service.

Dr. Lapeyre has continued to help her patients who have settled elsewhere.

"It's great to be able to personally call my colleagues through ACOG and say, 'This is my patient—can you take her?'"

Many patients who had her email address have contacted her, and she has been helping them by calling in prescriptions and providing counseling by phone and email. She hopes her family will be able to return to New Orleans in January.

New Orleans medical system in disarray

The disaster has forced New Orleans to rebuild its health care system. Louisiana State University has declared both Charity and University hospitals unsalvageable. The two hospitals took care of the city's poorer citizens, and Charity was the only Trauma 1 Center in the area.

Even if the hospitals are rebuilt, no one is sure how many of the city's displaced residents—or physicians—will return.

"The New Orleans medical infrastructure does not exist," Fellow Vincent A. Culotta Jr, MD, of Metairie, just outside New Orleans, told *ACOG Today* on September 29. "The infrastructure in Jefferson Parish is hanging on by a thread, and every day another doctor is going broke or leaving for greener pastures. Our hospital (East Jefferson General Hospital) had a very active cardiovascular surgery service but has lost two CV surgeons and possibly a third. I know of two of our active ob-gyns who are not returning on our staff, and two [we haven't heard from]."

Thomas E. Nolan, MD, LSU ob-gyn department chair, expressed similar sentiments: "Our traditional infrastructure in New Orleans has been taken away. I don't want to paint a picture of total disorganization, but I will just tell you that it is chaotic," he said on September 28.

But both physicians noted progress. "There are signs that life is returning to normal in Jefferson Parish—Wal-Mart and Home Depot are open, and people are making repairs to their homes," Dr. Culotta said.

East Jefferson General Hospital is reestablishing clinics for prenatal care, and nearby physician office buildings are reopening.

"Every day the level of chaos goes down a little bit," Dr. Nolan said. "New Orleans is reopening, slowly but surely. Every day there is a little more structure. We're moving forward." ♀

Baton Rouge: 'Everyone really pulled together'

Woman's Hospital in Baton Rouge started receiving women and babies from New Orleans hospitals the day after Hurricane Katrina struck. The largest woman's hospital in the state, it was designated by the Louisiana Office of Emergency Preparedness as the staging hospital for all OB and NICU patients evacuated from New Orleans.

Fellow Kenneth E. Brown, MD, was in charge of triage and assessment for pregnant and postpartum women at Woman's Hospital, while another hospital in town took many of the gynecologic postoperative patients.

In the chaotic conditions that first week, the hospital "had no idea who was coming or when," Dr. Brown said. "Sometimes we'd be told they were coming by helicopter, but instead they came by ambulance and vice-versa. In a number of cases, we got them off the helicopter and flagged down physicians to help with C-sections and deliveries."

Dr. Brown described one of the early transfers: "On the first day, we received four or five postpartum women who had their babies with them. The oldest baby was 24 hours old. A barge had pulled up to their window on the second floor and took them to a waiting helicopter to come to us. They were just totally lost. It was such a great feeling to help these women."

The hospital received help from volunteer ob-gyns from New Orleans. "One guy came in and said 'I'm here, and I'm here to help,'" Dr. Brown said. That was ACOG Fellow Thomas J. Kennedy, MD, of Metairie, LA, who then contacted some of his colleagues. He and five other New Orleans area ob-gyns worked 12-hour shifts throughout the week. The hospital subsequently helped them find a place for their families and afforded them some office space so they could care for their patients who had come to Baton Rouge.

Between August 30 and September 4, the hospital admitted 821 women and 243 babies and had 175 deliveries. Babies needing intensive care stayed at Woman's, and well babies were transferred elsewhere.

PHOTOS COURTESY KENNETH E. BROWN, MD

New Orleans staff assist a patient arriving in Baton Rouge.

Three weeks later, although the hospital was "full to the hilt from Katrina," it took in more transfers because of Hurricane Rita.

"With the initial volunteer evacuation from Rita we took 10 babies and 20 moms out of Lake Charles, [Louisiana]. Then there was a mandatory evacuation, and we took an additional 40," Dr. Brown said. "I'll tell you, in a time of crisis, everyone really pulled together. There was no one saying 'no' to anything." ♀

Busloads of evacuees treated by volunteer physicians in Houston

PHOTO BY TERRY TURNER, HARRIS COUNTY HOSPITAL DISTRICT

"The degree of despair I witnessed in the thousands of people stepping off the buses from New Orleans was almost unbearable. But the outpouring of support was also beyond description," said John W. Riggs, MD, a Houston Fellow who was an integral part of the clinic operations set up at the Houston Astrodome complex for New Orleans evacuees.

Houston doctors got word on a Wednesday, two days after Hurricane Katrina hit, that the people in the New Orleans Superdome were going to be evacuated to Houston. Overnight, a clinic was put in place, including a large pharmacy, medical record department, patient registration, complete laboratory services, mobile radiology, and social services.

According to Dr. Riggs, one of the most impressive achievements was the rapid creation of a complete computer network. "A large patient registration area was the backbone, and all the clinical areas were connected wirelessly to the [Harris County] Hospital District's clinical information system, which proved essential to track these huge numbers of patients, their pharmaceutical orders, and their lab and radiologic results."

On Thursday, September 1, triage units were set up in the parking lots as the buses arrived.

"The medical services that were most urgent were due to dehydration, psychological stress, and simply having missed crucial medications and treatments such as antiseizure medication, insulin, and dialysis," Dr. Riggs said.

By Thursday night the clinic added about 24 beds to the initial 14 exam cubicles.

Volunteer response matches need

Thousands of medical volunteers from across the country showed up to help. "There was no need for recruiting," Dr. Riggs said. "The support by the medical community was overwhelming!"

The clinic at the Astrodome complex saw 2,000 patients that Friday alone. By Friday afternoon, the flood of people prompted city officials to open the Houston convention center as a second large shelter. Fellow Larry C. Gilstrap, MD, ob-gyn chair at the University of Texas, was among the Houston-area ob-gyns who helped set up and run the convention center clinic.

"The suffering of the people who evacuated from New Orleans was heartbreaking, but the medical community rose incredibly to the task," Dr. Riggs said. ♀

Working around the clock during storm

➤PAGE 1

delivery gave us a couple of hall lights and plug-ins for lamps. Patient rooms don't have windows, so with no electricity and AC, everyone kind of moved toward their doorways, trying to get some air, trying to get some light," Dr. Holman said.

The situation worsened by Wednesday morning, when the hospital lost its water source. Patients and staff were given a daily allotment of two bottles of water to be used for both drinking and hygiene. Dr. Holman said, "New babies could never get clean. Moms could not clean up."

That same day the staff was told that all of the ob-gyn patients, on the third and fourth floors of the hospital, would be evacuated. Staff packed up the mothers and babies and led them down the stairs to the ground floor where they were expecting boats to arrive. After everyone was on the first floor, they were told there had been a mistake—the boats weren't coming.

"All these women, fanning themselves in the dimly lit hallway, just waiting, and all we could do was tell them 'you've got to go back upstairs.' We felt like they were being abandoned. At that point people really started to get anxious," Dr. Holman said.

Delivering patients in dire conditions

In the tenuous conditions after losing power and water, University Hospital staff delivered three patients, including women at 24 weeks and 31 weeks. The 24-week patient was being monitored in the antepartum unit for ruptured membranes and went into labor after the round-trip trek to the first floor on Wednesday.

"The neonatologist did an awesome job for that baby," Dr. Holman said, adding that generator power was diverted to the nursery so the baby could be ventilated until evacuation on Friday.

A 41-week patient with a large fetus was the "most complicated and concerning patient the whole time we were there," Dr. Holman said. After about 14 hours of labor, "we brought her to the OR in case we needed to do a C-section. The anesthesiologist had to wait until right before she delivered to give her an epidural because we didn't have electricity to run the pumps."

Dr. Holman credits maternal-fetal medicine specialist Gary A. Dildy III, MD, an ACOG Fellow, with doing a wonderful job in a successful forceps delivery.

At East Jefferson General Hospital in Metairie, just outside New Orleans, Fellow Vincent A. Culotta Jr, MD, took care of patients in the delivery unit from Sunday, August 28, to Sunday, September 4.

"East Jefferson never closed its doors during the ordeal," Dr. Culotta said. "At one point we lost our nursery staff and neonatologist, and I delivered 34-week twins that were promptly transferred to Baton Rouge."

Fellow Alfred E. Robichaux III, MD, chair of the Department of Obstetrics and Gynecology at Ochsner Clinic in New Orleans, remained at the clinic after the storm, along with a gynecologic oncologist, a generalist ob-gyn, a maternal-fetal medicine specialist, and three ob-gyn residents.

"Our homes were inaccessible, so nobody left for pretty much the first five to seven days," Dr. Robichaux said.

Although Ochsner Clinic's main hospital sustained some damage during Katrina, it fared better than most hospitals in New Orleans and was able to continue accepting both maternal and neonatal transports in the week following the storm. Ochsner has its own well, which meant water was available for bathing and for the toilets after the city water supply failed. In addition, the hospital's internal phone and email systems continued to work.

One patient was admitted to Ochsner with a retained placenta. She had been rescued from a hotel on a makeshift raft, Dr. Robichaux said. A nurse at the hotel had attended the delivery and tied off the umbilical cord with a shoestring. Ochsner staff performed extensive repair of a severe vaginal laceration.

Several patients delivered at Ochsner during the hectic week. Dr. Robichaux reported that one was a patient who came in shortly after the hurricane passed with prolonged ruptured membranes, a prior cesarean delivery, fever, and a nonreassuring fetal heart rate. The mother and baby did well following an emergency cesarean delivery, but "the OR was so hot the obstetrician barely finished and fainted as she left the room."

PHOTO COURTESY OCHSNER CLINIC

Evacuees gather at the I-10 Causeway interchange in New Orleans. Fellow Stephen A. Champlin, MD, took care of evacuees, particularly pregnant women, at this interchange, where many people were dropped off after being rescued from floodwaters.

Special talents and team effort shine through

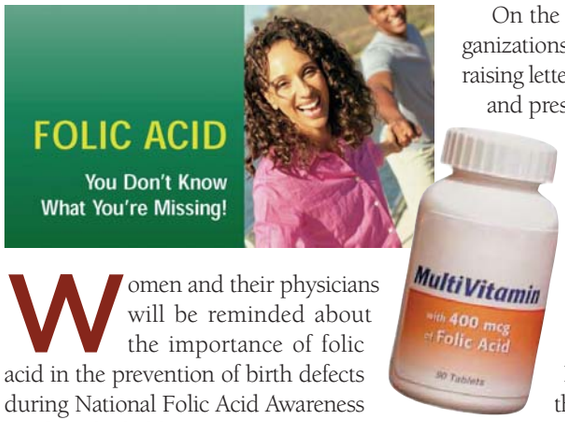
In addition to providing his obstetric services, Dr. Culotta contributed a much-needed skill: "When the hospital lost telephone and Internet connection, the only way to communicate with the outside world was by ham radio, and they were looking for operators. Well, I'm a licensed operator; there were only two of us [licensed] in the hospital. I manned the radio, relaying requests for diesel fuel, parts for generators, and other requests to the state's Office of Emer gency Preparedness for a day and a half until we got a ham operator from Baton Rouge to come and assist us."

Dr. Culotta emphasized the extraordinary team effort at East Jefferson during the crisis. Other ACOG Fellows involved included Louisiana Section Chair John E. Hevron Jr, MD, who helped run the delivery unit, and Stephen A. Champlin, MD, who worked at the infamous I-10 Causeway interchange, assisting the sick, especially pregnant women.

At Ochsner, Dr. Robichaux praised the hospital administration for its work during the disaster. Every individual on site was registered and received a color-coded wrist band to identify them as staff, patient, patient family member, or storm victim—people who just "migrated in." For the first week, the administration held meetings twice a day with clinical leaders to report on maintenance, staffing, security, and other key issues. The administration was also responsible for feeding 2,200 people a day.

"I am extremely proud of the Ochsner staff," Dr. Robichaux said. "Everyone flexed and helped out." ♀

Stress folic acid importance during National Folic Acid Awareness Week



Women and their physicians will be reminded about the importance of folic acid in the prevention of birth defects during National Folic Acid Awareness Week, to be held January 9–15.

The National Council on Folic Acid sponsored the first awareness week last January. With the theme "Folic acid: You don't know what you're missing!" this year's event will focus on health disparities, especially among Hispanic women, who have higher rates of spina bifida and anencephaly.

On the event website, physicians and organizations can download samples of a fund-raising letter, letter to the editor, proclamation, and press release to use in their communities. In addition, free consumer materials can be ordered through the website. A brochure, bookmark, and poster are available in both English and Spanish.

ACOG is a founding member of the National Council on Folic Acid, which was created in 1998 to educate the public about the benefits of folic acid. ACOG recommends that all women who may become pregnant take 0.4 milligrams of folic acid daily. Women who have previously had a child with a spine or skull defect should take 4 milligrams daily. ♀

info

➜ www.folicacidinfo.org

ACOG patient safety document emphasizes communication

A NEW ACOG COMMITTEE Opinion encourages ob-gyns to establish partnerships and create a meaningful dialogue with their patients to increase patient safety.

Partnering with Patients to Improve Safety was developed by the Committee on Quality Improvement and Patient Safety and published in the November issue of *Obstetrics & Gynecology*.

The document stresses that nearly half of all American adults have difficulty understanding and acting upon health information. Ob-gyns can facilitate communication by speaking slowly and using nonmedical language, using teach-back or show-me techniques to confirm that the patient understands, limiting the amount of information and repeating it, and providing written materials to reinforce verbal explanations.

In addition, it's important to recognize that medication errors are the largest cause of preventable adverse events, according to the document. When medications are prescribed, physicians should be clear about the dosage and usage. Physicians should also develop a tracking system for test results and encourage their patients to contact the doctor's office if they have not heard back about their test results.

"Partnering with patients to improve communication results in increased patient satisfaction, increased diagnostic accuracy, enhanced adherence to therapeutic recommendations, and ultimately, improved health quality," the document states. ♀

Online polls opening for section, district elections

ACOG has instituted online voting for the 2006 Fellow district and section officer elections. Polls open Nov 16, 2005, for section elections and Dec 16, 2005, for district elections. You can access online ballots from any computer with Internet access. To log in, you will need only your last name and ACOG ID number. Paper ballots will be offered on a request-only basis.

Online Section Elections

Polls open November 16:
https://eballot3.votenet.com/acogfellow

Online District Elections

Polls open December 16:
https://eballot3.votenet.com/acogfellow

Look for your seven-digit ACOG ID number on all ACOG mailings and election email notifications. Or contact the ACOG Membership Department at membership@acog.org or 800-673-8444. When calling, make sure that the Membership Department has your current contact information.

Districts and sections with elections this year

Districts

District I • District IV • District VII

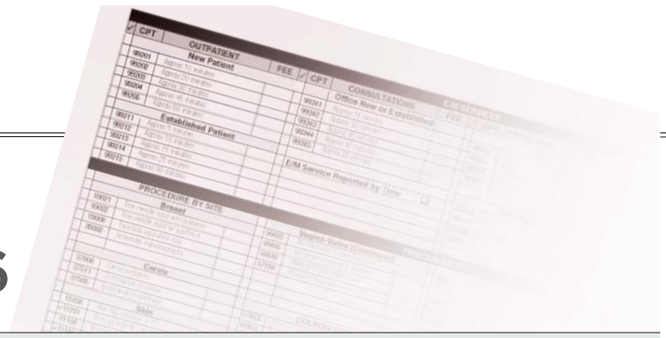
Sections

Arkansas
Army
British Columbia
California Section 2
California Section 3
California Section 6
Colorado
Connecticut
Georgia
Hawaii
Indiana
Iowa
Manitoba
Mississippi
New Hampshire
New Jersey
New Mexico
New York Section 1
New York Section 4
New York Section 7
North Dakota
Ontario
Oregon
Puerto Rico
Tennessee
Virginia

info

➜ 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: 800-673-8444, ext 2531; mwillis@acog.org



New CPT codes set for 2006

THE CURRENT PROCEDURAL TERMINOLOGY code set for 2006 includes new and revised codes as well as the elimination of confirmatory consultations and subsequent inpatient consultations. The changes take effect January 1. HIPAA requires providers to use the medical code set that is valid at the time the service is provided. Therefore, insurers must accept new codes beginning January 1. ♀

Revision of vaginal graft

In 2005, add-on code +57267 was created to report insertion of mesh or other prosthesis for repair of pelvic floor defect. In 2006, new code 57295 will be added for revision (including removal) of prosthetic vaginal graft, vaginal approach, when complications occur.

Endometrial biopsy

At the suggestion of the Centers for Medicare and Medicaid Services, ACOG's Committee on Coding and Nomenclature developed an endometrial biopsy add-on code to be reported only when the biopsy is performed at the same session as a colposcopy. The new code includes Relative Value Units only for the intraservice physician work. The pre- or postoperative services would be included in the colposcopy code.

- Code +58110 is for endometrial sampling (biopsy) performed in conjunction with colposcopy. (List separately in addition to code for primary procedure.)
- Notes will be added under colposcopy codes 57420, 57421, and 57452–57461 indicating that if an endometrial biopsy is also performed code +58110 is reported
- In addition, the description for code 57421 will be revised to clarify that an endometrial biopsy is not included in this code. The changed wording will be:
  - 57420: Colposcopy of the entire vagina, with cervix if present
  - 57421: With biopsy(s) of vagina/cervix

Laparoscopic enterolysis

Code 44200, laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure), will be renumbered to 44180 because of a formatting change made to the laparoscopy heading within the digestive system subsection. New headings, such as incision, excision, and repair, have been added. The goal is to make the laparoscopy subsection more consistent with other subsections within the surgery section of CPT. The code description will remain the same.

Injections and infusions

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required a review of codes for administration of drugs. In 2005, Medicare required temporary HCPCS codes to be used for reporting infusions and injections during this review. In 2006, the CPT code set will include new codes for reporting these services. Therefore, HCPCS codes G0349–G0354 will be deleted. In most cases, the HCPCS code descriptions have been incorporated into the new CPT codes.

Intravenous infusion codes

CPT's descriptions for codes 90780 and +90781 previously stated "intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician." In 2005, HCPCS codes G0345, G0346, G0347, G0348, G0349, and G0350 were introduced to differentiate between infusions for hydration and infusion of a drug or other substances and between concurrent and sequential infusions. The reference to administration or supervision by a physician was deleted. These G codes will be deleted for 2006 and replaced by the following CPT codes:

- 90760: Intravenous infusion, hydration; initial, up to 1 hour
- +90761: Each additional hour, up to eight hours. (List separately in addition to code for primary procedure.) Use 90761 in conjunction with 90760. Report 90761 to identify hydration if provided as a secondary or subsequent service after a different initial service (90760, 90765, 90774, 96409, 96413) is provided
- 90765: Intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); up to 1 hour
- +90766: Each additional hour, up to eight hours. (List separately in addition to code for primary procedure.) Report 90766 in conjunction with 90765, 90767
- +90767: Additional sequential infusion, up to 1 hour. (List separately in addition to code for primary procedure.) Report 90767 in conjunction with 90765, 90774, 96409, 96413 if provided as a secondary or subsequent service after a different initial service. Report 90767 only once per sequential infusion of same infusate mix
- +90768: Concurrent infusion. (List separately in addition to code for primary procedure.) Report 90768 in conjunction with 90765, 96413

Injection codes

CPT's descriptions for codes 90782, 90783, and 90784 previously stated "therapeutic, prophylactic, diagnostic injection" and a method of delivery. In 2005, HCPCS codes G0351, G0353, and G0354 were introduced to differentiate between intravenous push, single or initial injection, and additional sequential injections. These G codes will be deleted for 2006 and replaced by the following CPT codes:

- 90772: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- 90773: Intra-arterial
- 90774: Intravenous push, single or initial substance/drug
- +90775: Each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure.) Use 90775 in conjunction with 90765, 90774, 96409, 96413

Confirmatory and follow-up inpatient consultations

The confirmatory consultation codes (99271–99275) will be eliminated in 2006. These codes were rarely reported because in most cases the physician provided face-to-face counseling with the patient, not a physical examination; confirmatory consultation codes could not be reported based on time. These services will be reported using the appropriate inpatient or outpatient Evaluation and Management code.

The follow-up inpatient consultation codes (99261–99263) will also be eliminated in 2006. If an initial inpatient consultation requires a follow-up visit, these services can now be reported using the subsequent hospital care codes (99231–99233). The RVUs for the hospital care codes are slightly higher than those for the deleted follow-up consultation codes.

info

→ Savonne Alford, RHIT: 800-673-8444, ext 1459; salford@acog.org
→ On the ACOG website, www.acog.org, under "Quick Links" on the left side of the page, click on "CPT Coding"

DMPA use and skeletal health

THE INJECTABLE CONTRAceptive depot medroxyprogesterone acetate, or DMPA, is currently used by more than 2 million women in the US, including approximately 400,000 teenagers. The prevalence of this highly effective birth control method—sold as Depo-Provera by pharmaceutical company Pfizer—has been linked to recent declines in teen pregnancy and abortion rates.

However, after the Food and Drug Administration placed a "black box" warning on Depo-Provera last year about skeletal health concerns, ob-gyns have questioned how and when to offer Depo-Provera to their patients, particularly given the risk of unintended pregnancy for those who discontinue use.

The black box indicates that prolonged use of DMPA may result in significant loss of bone mineral density and that women should use DMPA for longer than two years only if other birth control methods are inadequate for them.

"Because DMPA use reduces ovarian estradiol production, bone mass density does decline in current users," said Fellow Andrew M. Kaunitz, MD, an expert on DMPA. "However, bone mass density appears to recover fully within three years of DMPA discontinuation in adults and more rapidly in teens. Studies in postmenopausal women have found no differences in bone mass density of former and never-users of DMPA."

The decline in bone mass density associated with DMPA use is comparable to that observed in lactating women, he said. Lactation does not result in long-term bone mass density deficits or a higher risk of osteoporotic fractures.

Key points for ob-gyns:

- The current evidence on DMPA use and skeletal health indicates that concerns regarding BMD should not restrict initiation or continuation of DMPA use in adults or teens.
- Because the clinical implications of dual-energy X-ray absorptiometry testing in premenopausal women are not well established, DXA assessment is not recommended for DMPA users, according to Dr. Kaunitz.
- Because the safety of bisphosphonates in reproductive-age women is not established, such medications should not be prescribed to current or former DMPA users.
- Adequate calcium intake should be encouraged, but this recommendation applies for all women regardless of contraceptive use. ♀

Compounded bioidentical hormones

A NEW ACOG COMMITTEE Opinion addresses the safety and efficacy of compounded bioidentical hormones, which some have touted as an alternative to traditional hormone therapy. *Compounded Bioidentical Hormones* was published in the November issue of *Obstetrics & Gynecology.*

Compounded bioidentical hormones are plant-derived hormones mixed and labeled by a pharmacist and are sometimes custom-made based on a physician's specifications. Most compounded products have not undergone any rigorous clinical testing for either safety or efficacy. And because these products are not approved by the Food and Drug Administration, they are exempt from including contraindications and warnings required on FDA-approved hormone therapy products.

"Patients hear about these compounded bioidentical hormones and then ask their doctor about them. Now, ACOG offers a Committee Opinion that can help physicians discuss the issue with their patients," said Michele G. Curtis, MD, past vice chair of the Committee on Gynecologic Practice, which developed the document. "One of our concerns is quality control—there has been little clinical testing on most compounded products to determine whether they're safe or effective."

Advocates recommend the use of salivary hormone-level testing to offer individualized therapy, but hormone therapy drugs do not belong to a class of drugs with an indication for individualized dosing. And, there is no evidence that hormonal levels in saliva are biologically meaningful, according to the document. ♀

Committee Opinion examines perinatal risk with ART pregnancies

A NEW ACOG COMMITTEE Opinion discusses the potential perinatal risks associated with pregnancies by assisted reproductive technology, particularly risks related to multiple gestations. *Perinatal Risks Associated with ART*, which was published in the November issue of *Obstetrics & Gynecology*, was developed by three ACOG committees: the Committee on Obstetric Practice, Committee on Gynecologic Practice, and Committee on Genetics.

The American Society for Reproductive Medicine defines ART as treatments and procedures involving the handling of human oocytes and sperm, or embryos, with the intent of establishing a pregnancy. It includes in vitro fertilization with or without intracytoplasmic sperm injection but, by definition, does not include techniques such as artificial insemination and superovulation drug therapy.

ART helps infertile couples to achieve pregnancies. However, some studies suggest that ART is associated with an increased risk of prematurity and low birth weight and a higher perinatal mortality rate. It is difficult to determine whether these risks are linked to related factors, such as infertility or health issues for the couple, or are increased by the ART procedure. ACOG supports continued research to study the risks and their causes.

Limiting the number of embryos transferred

In the past several years, the number of multiple gestations with ART has decreased. Reducing the risk of multiple gestation is critical to reduce perinatal complications, including preeclampsia, gestational diabetes, preterm delivery, and operative delivery.

The Committee Opinion stresses that the multiple gestation risk of ART can be effectively managed by limiting the number of embryos transferred.

Couples should be counseled about the obstetric risks and informed in advance about the option of multifetal pregnancy reduction in the event that a high-order multiple pregnancy occurs, according to the document. ♀

Teen pregnancy remains key issue for Fellows

SINCE THE EARLY 1990S, THE teen pregnancy rate and teen birth rate in the US have continued to drop. From 1991 to 2003, the teen birth rate decreased 33% to a record low in 2003 of 41.6 births per 1,000 teenagers ages 15–19, according to the National Vital Statistics Reports. The teen pregnancy rate, which includes births, abortions, and miscarriages, declined by 28% between 1990 and 2000 and is expected to have declined by 30% when the latest data are released.

Despite these declines, the US still has the highest teen pregnancy rate of any industrialized country. Since the 1960s, ACOG has made teen pregnancy prevention a long-term goal, maintaining this issue as one of its top priorities.

In 1970, ACOG's Executive Board published its first statement on adolescent pregnancy, and in 1978, the College established the Task Force on Adolescent Pregnancy.

In 1985, then-ACOG President Luella Klein, MD, initiated a nationwide campaign to combat unintended pregnancy. The "I Intend" program provided public awareness and information to adolescents and their parents through television public service announcements.

In that same year, the ACOG Committee on Adolescent Health Care was established as a permanent committee. The committee has consistently focused on the issue of teen pregnancy, developing ACOG documents on sexuality education, adolescent pregnancy, contraception, and confidentiality and creating a presentation resource kit on adolescent sexuality. ACOG established the Adolescent Pregnancy Prevention Network in 1996 for Fellows and Junior Fellows interested in working to decrease the number of teen pregnancies, and in 2003, the committee developed the Tool Kit for Teen Care and published *Health Care for Adolescents*, a guide that includes all of ACOG's documents on adolescents.

Nurturing discussions

ACOG Fellows have been at the forefront of community efforts to prevent adolescent pregnancy by using proven strategies.

Fellow Melisa M. Holmes, MD, a former member of ACOG's Committee on Adolescent Health Care, ensures that girls in middle school are properly informed about healthy sexual development. Through her program "Girlology," Dr. Holmes talks to teens about healthy relationships, reproductive health, sexuality, and decision-making.

In her practice, Dr. Holmes has observed that many parents are reluctant to discuss sexuality with their daughters.

"We face generations of parents whose parents didn't talk openly with them about sex and pregnancy. That leaves a lot of parents feeling uncomfortable and ill-prepared to talk with their own children," she said.

Dr. Holmes created Girlology three years ago in Charleston, SC. The program offers classes that mothers and daughters attend together to gain knowledge and greater comfort discussing sensitive and personal issues.

"When teens can't or won't talk with a parent, I see them reaching out to their teachers, church leaders, school counselors, coaches, and often, their doctor," Dr. Holmes said. "Mentoring teens is an important way that individuals can help with the problem of teen pregnancy.

"I think teen pregnancy is still a problem in the US partly because we have made sex education a political issue rather than a health and wellness issue. Too many of our children never learn important, factual, life-altering information that can help them decide to delay sexual involvement or protect themselves against pregnancy and disease."

Providing care at school

ACOG Life Fellow Nancy K. Johnson, MD, also saw the need for educating and providing health care to teenagers. With a pediatric colleague, Dr. Johnson established a school-based health care center, The Wellness Clinic, at Shaw High School in East Cleveland 10 years ago. It was one of the first such centers in Ohio.

At the time, the clinic was staffed with a full-time nurse practitioner with physician back-up and had part-time physician coverage. The clinic offered health care to students whose parents had given written consent for their participation. The program provided anger management classes, a program for students who were pregnant or were mothers, and mental health consultation.

Recently, because of funding cuts, the clinic's nurse practitioner has been shunted to a nearby metro clinic to help with its overload, thereby restricting availability to Shaw students. In addition, social services and the program for teen moms and pregnant girls have been eliminated. Despite this setback, the clinic continues to prosper, with more than 1,700 student/patient visits last year, according to Dr. Johnson, who is now retired.

Dr. Johnson emphasized that teen pregnancy should not be just a statistic and stressed the importance of school clinics.

"It is our responsibility to educate them to [wait to have sex] at appropriate times, and if that plan is not always effective, we need to assure them that the adult responsibility that they have chosen will be supported by educating them quickly and effectively to be loving, stable, and financially adequate parents," she said. "The availability and continued care of a dependable provider are instrumental in prevention, diagnoses, and long-term support of teens. School clinics serve this purpose." ♀

Fellow commits career to educating teens about sex

ACOG FELLOW SYLVESTER R. Braithwaite, MD, and his wife, Carla, have made adolescent health care one of their top priorities. After a three-week trip visiting several European countries in 1999 as part of the Advocates for Youth campaign, Dr. Braithwaite returned to the US with a better understanding of why the teenage pregnancy rate in the US is much higher than in other countries.

Dr. Braithwaite, a former member of the ACOG Committee on Adolescent Health Care, said he recognized that in Europe, parents, educators, and the government present a consistent message about sex and teen pregnancy to their adolescents.

Dr. Sylvester and Carla Braithwaite

"I noticed that Europe and Canada have made teen pregnancy more of a health issue than a moral issue," he said. "There have been consistent messages that inform adolescents of the risks of STDs and HIV and about abortion, safe sex, and contraception. They do this because they want adolescents to be knowledgeable and fully aware of the consequences of the choices that they might choose to make."

During his 12 years in practice in Miami, Dr. Braithwaite has recognized that most of his teenage patients are intelligent and career-oriented and want to be successful.

"Often I hear from my young patients that they are in college or that they want to be a doctor, a lawyer," he said. "The thing is, though, most of these young women have not been fully informed about the risks that they might encounter through sexual activity.

"The young have the right to information, and we have to be responsible for the well-being of our youth by making sure that they are fully educated about sex and their health."

Dr. Braithwaite argues that teenagers should be provided accurate information about sex and pregnancy at a younger age—before they may have to deal with an unintended pregnancy.

Dr. Braithwaite created the Reach for the STARS (Sexuality Training and Reproductive Services) Foundation to educate the community about the health risks of sexual activity. Through the foundation, Dr. Braithwaite and his wife have recently started a new project to educate teenagers on how to prevent exposure to STDs and HIV, prevent the transmission of infection to others, and prevent the contraction of STDs if exposed.

Dr. Braithwaite has begun to offer discounted clinical services to teens at his practice, including HIV/AIDS screening and family planning, and has begun to research how to evaluate teens' knowledge of STDs, family planning, and overall reproductive health care.

"I know that it's unrealistic to think that all teens can choose abstinence, but by educating them about sexually transmitted diseases, especially HIV/AIDS, then at least they will be more aware of the possible consequences of their actions," he said.

A teen-friendly environment

Donations have helped Dr. Braithwaite sustain his foundation and have also helped his practice. "With the help of donations, I have given teens special-rate packages, which include a complete physical examination, a complete STD exam, and free condoms and supplied them with an abundance of literature pertaining to teen health and teen pregnancy.

"Above all, I want my patients to feel welcomed and relaxed when they come to my office," he said. "I have made my waiting room teen friendly by posting pictures of teens and providing a comfortable sofa.

"Young people should be viewed as assets rather than problems, and within the community, there needs to be more of a proactive, rather than reactive, approach when dealing with adolescent health," Dr. Braithwaite said. ♀

ACOG RESOURCES

ACOG encourages its members to work in their communities to decrease teen pregnancy rates. The College provides numerous resources to help in these efforts.

info

- www.acog.org/goto/teens
- Lisa Goldstein: adolhlth@acog.org; 800-673-8444, ext 2497

National campaign celebrates decline in teen pregnancy rate

TEN YEARS AGO, The National Campaign to Prevent Teen Pregnancy was established with a lofty goal of reducing the national teen pregnancy rate by one-third over 10 years. That goal is expected to be reached by the end of this year.

The teen pregnancy rate—which includes births, abortions, and miscarriages—declined by 28% between 1990 and 2000 and is expected to have declined by 30% when the latest data are released. However, the US still has the highest rate among industrialized nations, prompting the campaign to set a new goal to reduce the teen pregnancy rate by another third over the next 10 years.

The campaign and its supporters, including ACOG, held a 10th anniversary dinner in Washington, DC, in September to celebrate "the power of prevention" and the country's progress in reducing teen pregnancy and to reinforce the need for continued efforts. ♀

Campaign Director Sarah Brown, former ACOG Executive Board member

ACOG fights to preserve imaging

ACOG CONTINUES TO BATTLE a campaign by radiologists to prevent other physicians from conducting imaging. The American College of Radiology has mounted a campaign in the media and Congress to allow only radiologists to receive Medicare reimbursement for imaging. ACR argues that nonradiologists use the equipment for their own financial gain and conduct imaging of inferior quality, putting patients at risk.

ACOG stresses that ob-gyns are the most trained to perform and interpret ultrasonography in ob-gyn and are the physicians with the in-depth knowledge needed to best assess, diagnose, and treat ob-gyn conditions. In addition, waiting for a radiologist can delay urgent care, such as when imaging is needed during labor complications and ectopic pregnancies or to evaluate pelvic pain and unexplained bleeding.

The Medicare Payment Advisory Commission, an independent federal advisory board that recommends Medicare payment changes to Congress, picked up on the quality argument earlier this year and recommended that Congress set standards for physicians who perform and interpret imaging services, including ultrasound, CT, MRI, and PET. Although no legislation has been introduced, ACR is working hard to include these damaging provisions in must-pass legislation this year and has stepped up fundraising and media efforts.

While Medicare patients are a small but significant part of most ob-gyn practices (15%), new imaging restrictions in Medicare would only accelerate the trend of private insurance crack-downs on imaging and may lead to imaging restrictions in Medicaid as well.

ACOG counters attack

To wage a campaign to preserve imaging by ob-gyns, ACOG and two dozen other specialty societies formed the Coalition for Patient-Centered Imaging. The coalition has fought ACR by providing accurate data and information to Congress, the Bush Administration, and the media. ♀

ACOG needs your help!

Some insurers have already restricted in-office imaging by ob-gyns and other nonradiologists. Has this affected you? Your personal story is important to show Congress why it needs to preserve imaging by ob-gyns. Contact Tara Straw at 800-673-8444, ext 2512; govtrel@acog.org.

Contact your congressional representatives

The Coalition for Patient-Centered Imaging has established a hotline to connect you directly to your representatives' offices: 800-210-7193.

Tell your leaders in Congress that:

- Office-based ultrasound is an integral part of your practice and good patient care
- You oppose any attempt to limit your ability to diagnose and treat Medicare patients using office-based medical imaging
- Women shouldn't have to jump through hoops to get the care they need

District V McCain Fellow delves into legislative issues

DONALD K. BRYAN, MD, A 2005 McCain Fellow from District V, had a rewarding experience during his one-week visit to Washington, DC, earlier this year. A practicing ob-gyn from Columbus, Ohio, Dr. Bryan had the opportunity to address various medical and health issues on Capitol Hill.

Along with staff from ACOG's Government Relations Department, Dr. Bryan attended various meetings with lobbyists and federal government officials and joined them in addressing issues such as professional liability, Medicare reimbursement, information technology, and medical information systems.

Most importantly, Dr. Bryan met with staff in the offices of his Ohio congressional leaders, Sens. Mike DeWine and George V. Voinovich and Reps. Deborah Pryce and Patrick J. Tiberi, to address Medicare.

"With Medicare, the payments are going down and are scheduled to be cut further, and every year we go through the same thing," Dr. Bryan said. "After meeting with staff members in my public servants' offices, I've realized that they were well informed and they brought new material to the table."

As an ACOG member for 35 years and Ohio Section past chair, Dr. Bryan saw the McCain Fellowship as a way to become even more active in the field of ob-gyn and with ACOG.

He said he was glad that he was able to educate policy-makers about issues that concerned him as a practicing physician. "Congress really wants to hear firsthand from practicing physicians how health care is working and not working for us."

Dr. Bryan believes that more ob-gyns need to become involved with informing the government about health issues: "I could tell that the legislators wanted to hear my opinions and concerns."

Dr. Bryan said he feels fortunate that he was able to participate in the legislative process as a practicing ob-gyn.

"I now have a more practical working knowledge," he said. ♀

Guam faces mounting medical liability crisis

The medical liability crisis has extended beyond the 50 states. The US territory of Guam is also struggling with elevated insurance premiums, creating a situation that hinders patients' access to care. Nine ob-gyns are left in Guam today, compared with 16 in 2000, and many of those remaining are nearing retirement age, according to ACOG Fellow Thomas Shieh, MD, Guam's delegate to the American Medical Association and former president of the Guam Medical Society.

The rising insurance premiums, combined with a lack of incentives for physicians, have made it difficult for the current ob-gyns to recruit new doctors to the area, Dr. Shieh said.

"We only have one civilian hospital in Guam and no affordable medical liability insurance for private practicing doctors and as a result, most of the ob-gyns have now left Guam," Dr. Shieh said.

In addition, there is a disparity with the Gross Receipts Tax placed on the private sector: local health insurance companies do not have to pay GRT, but local doctors do. Physicians who work at Guam's only hospital have a cap on noneconomic damages, as well as a cap on the total amount of damages per claimant, but the caps do not extend to local physicians.

"Because of this, it discriminates against community patients and doctors unfairly, not providing equality of coverage," Dr. Shieh said.

In 1950 Guam became an unincorporated, organized territory of the US. With a population of more than 160,000, it is the largest southernmost island in the Marianas Archipelago, in Oceania, north of Australia and Papua New Guinea. In the past, Guam had two medical liability insurance companies to choose from. Now, there is only one that provides medical liability insurance for physicians in private practice, but it is not affordable for most doctors, according to Dr. Shieh. Only two doctors currently in Guam have professional liability insurance.

"I hope that the government officials in Guam will recognize that this problem needs to get resolved before we lose even more of our physicians."

ACOG Fellow Dr. Thomas Shieh addresses the American Medical Association House of Delegates in June about Guam's health care crisis.

The medical liability crisis began three years ago when the insurance companies that have contracts with a local broker on Guam increased their rates by 400–500%. Doctors in Guam went from paying $21,000 a year for minimum coverage to $110,000, with continuing increases of 25% each year, Dr. Shieh said.

Working with the AMA

Dr. Shieh has become a strong advocate for a cap on noneconomic damages in Guam. In June, he outlined Guam's situation at the meeting of the American Medical Association House of Delegates in Chicago. He emphasized that the health disparities in Guam and other US territories that result from the professional liability crisis should be a national concern.

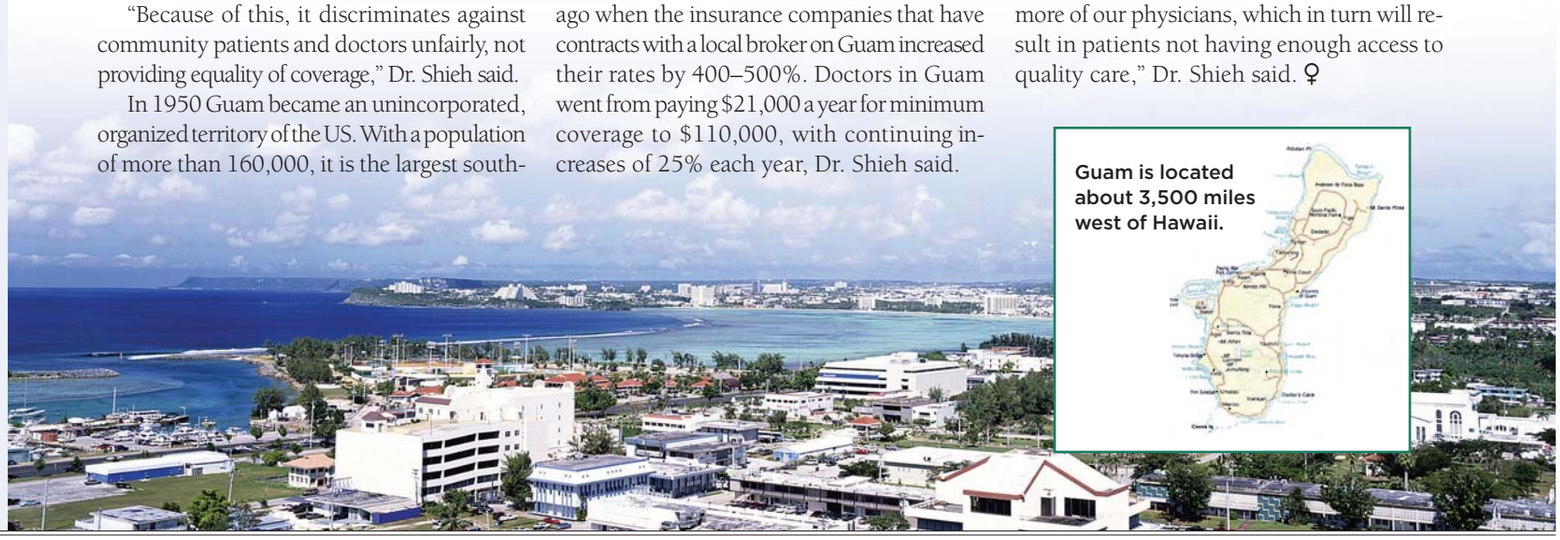
Dr. Shieh introduced 10 resolutions about health care in Guam, including one on professional liability. All 10 received unanimous support from fellow delegates.

Presently, Dr. Shieh is working with the AMA to draft a professional liability bill for Guam.

Representatives of US territories such as Guam do not have voting rights in Congress. Rep. Madeleine Z. Bordallo (D-GU) represents Guam but can only help influence legislation by speaking and participating in committee hearings.

Dr. Shieh hopes that the AMA's support can convince the local government of Guam to recognize that it needs to do something more to help its doctors.

"Once the AMA and I have finished our proposal on this issue to take to the Guam government this November, I hope that the government officials in Guam will recognize that this problem needs to get resolved before we lose even more of our physicians, which in turn will result in patients not having enough access to quality care," Dr. Shieh said. ♀



Guam is located about 3,500 miles west of Hawaii.

Residency programs regroup after Katrina

Residents in two of New Orleans' three training programs began rotations in new sites following Hurricane Katrina's destruction of their New Orleans program sites. The third program, at Ochsner Clinic Foundation, has been able to maintain its rotations at its current sites.

PHOTO BY OMAR TORRES, AFP/GETTY IMAGES

At Tulane University, workers remove debris from Hurricane Katrina in September. The university was shut down temporarily after the storm, forcing the ob-gyn residency program to move to Houston.

Tulane residents head to Houston

Most of the 28 Tulane University ob-gyn residents have transferred to the Houston area, where five training programs formed a consortium to offer a variety of rotations for Tulane residents. ACOG Fellow Amy E. Young, MD, program director at Baylor College of Medicine, organized a meeting with the other Houston-area program directors three days after Katrina hit the Gulf Coast.

"We realized these people had to be placed," she said. "We wanted to offer good educational opportunities, so we came up with some basic principles that would govern the temporary rotations."

The Tulane program director, ACOG Fellow Gabriella Pridjian, MD, retains responsibility for the direction of the Tulane residents' training. Dr. Pridjian worked with the Texas programs to develop the curriculum for Tulane residents in each year of training.

In addition to Baylor, the other southeast Texas ob-gyn programs involved are University of Texas Memorial Hermann Hospital, University of Texas at Lyndon B. Johnson, University of Texas Medical Branch, and Methodist Hospital/St. Joseph.

'Psych-social time'

The Texas programs also developed plans to help the New Orleans residents manage the transition.

"We've assigned 'resident buddies' so that they have someone in the parent program to bond with and help see them through," Dr. Young said.

Friday afternoons are set aside for all the Tulane residents to meet with ACOG Fellow Chi P. Dola, MD, Tulane's associate program director, allowing them to report on their training experiences and spend time together. In New Orleans, Tulane residents had a didactic session every Friday.

In addition, all the Houston programs agreed not to place any Tulane residents on call on Friday nights so that "they can get together for some psych-social time," Dr. Young said.

The initial plan is for the Tulane ob-gyn residents to spend 90–120 days rotating at the Texas institutions. Training in Texas began October 3. But if additional time is needed, the Texas consortium can "place them in our programs for six months, if necessary," Dr. Young said.

Not all Tulane residents are in Houston. After evacuating first to Memphis before the storm, Kristine M. Strickland, MD, a third-year resident and Junior Fellow chair of the Louisiana Section, and her family ended up in Minneapolis, where her sister lives.

"I have family here and a place to stay, and the University of Minnesota is trying to get a rotation together for me," Dr. Strickland said in September.

LSU residents stay in state

Louisiana State University officials decided to keep all their programs within the state.

"The whole medical school has been moved to Baton Rouge," said second-year resident Stacey L. Holman, MD. "All the training programs are based there now, and each program is responsible for reorganizing its curriculum and rotations. We were lucky because Baton Rouge and Lafayette were already ob-gyn sites for training."

Dr. Holman is the Junior Fellow vice chair of the Louisiana Section and was on the disaster team working in University Hospital in New Orleans throughout the storm. (See "Ob-gyns work around the clock during Hurricane Katrina," page 1.)

The residents who were on duty at University Hospital for six straight days were given four weeks off and started work October 3, according to Dr. Holman.

"I've lived in southern Louisiana all my life," she said. "I graduated from LSU medical school. My goal is to stay here and see the program rebuilt. A lot of people have family and roots here—that's what makes LSU unique. They're going to do whatever it takes to make it even better."

Offers of help abound

According to Mark M. Allen, MD, Junior Fellow past chair of the Louisiana Section, there was an "outpouring of support to residents, with offers from many programs to take residents on temporary rotations."

Dr. Allen is a fourth-year resident at the Ochsner Clinic Foundation, the only residency program in New Orleans able to continue in the city after the storm.

"Of the three in the city, we fared the best because Ochsner stayed open," Dr. Allen said. "We all still have our jobs and are operating in a pretty normal fashion." ♀

Stump the Professors cases due by December 1

JUNIOR FELLOWS ARE encouraged to submit unique and challenging real-life cases for the next Stump the Professors program at the 2006 Annual Clinical Meeting, to be held May 6–10 in Washington, DC. Submissions are due by December 1 and must be submitted online. ♀

info

→ On the ACOG website, www.acog.org, under "Membership," click on "Junior Fellows"

2005-06 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

2005

NOVEMBER

1

ACOG WEBCAST:
Complications of Laparoscopic Surgery
1–2:30 pm ET
800-673-8444, ext 2498

4–8

American Medical Association Interim Meeting
Dallas
www. ama-assn.org
800-673-8444, ext 2515

9–12

Global Congress of Minimally Invasive Gynecology—34th Annual Meeting of the American Association of Gynecologic Laparoscopists
Chicago
www.aagl.org
562-946-8774

11

2nd Annual March of Dimes Advanced Practice Lectureship (in conjunction with the Amazing Newborns ... Prematurity and Beyond Conference)
Sponsored by the March of Dimes and the University of New Mexico Neonatology Outreach Program
Albuquerque, NM
www.neonatology-outreach.org
505-272-1322

DECEMBER

2–4

ACOG District VI Annual Meeting—Junior Fellows
Minneapolis
800-673-8444, ext 2540

6

ACOG WEBCAST:
Preview of New Codes for 2006
1–2:30 pm ET
800-673-8444, ext 2498

2006

JANUARY

10

ACOG WEBCAST:
Global Surgical Package
1–2:30 pm ET
800-673-8444, ext 2498

29–Feb 1

The South Atlantic Association of Obstetricians and Gynecologists
Orlando, FL
www.saaobgyn.org
904-384-8230

30–Feb 4

Society for Maternal-Fetal Medicine 26th Annual Meeting
Miami Beach, FL
www.smfm.org
800-673-8444, ext 2476

FEBRUARY

9–11

33rd Annual Meeting of the North American Society for Psychosocial Obstetrics and Gynecology
Kohala Coast, HI
www.naspog.org
202-863-2570

14

ACOG WEBCAST:
Misadventures and Complications of Care Coding
1–2:30 pm ET
800-673-8444, ext 2498

MARCH

2–5

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

13–17

American Society for Colposcopy and Cervical Pathology Biennial Meeting
Las Vegas
www.asccp.org/biennial.shtml
800-787-7227

14

ACOG WEBCAST:
Global Obstetrical Package
1–2:30 pm ET
800-673-8444, ext 2498

16–19

The Society for Sex Therapy and Research
Philadelphia
www.sstarnet.org/2006meeting.cfm
800-673-8444, ext 1644

17–18

Council of Medical Specialty Societies Spring Meeting
Chicago
www.cmss.org
847-295-3456

22–25

Society for Gynecologic Investigation Annual Meeting
Toronto, ON
www.sgionline.org
800-673-8444, ext 2544

22–26

Society of Gynecologic Oncologists: 37th Annual Meeting on Women's Cancer
Palm Springs, CA
www.sgo.org
[Please note that this meeting was originally scheduled for Mar 4–8, 2006, in New Orleans.]

30–Apr 1

77th Annual Meeting of the Texas Association of Ob/Gyn and the ACOG Texas Section
San Antonio
www.txobgyn.org
866-935-1959

APRIL

3–5

Society of Gynecologic Surgeons 32nd Annual Scientific Meeting
Tucson, AZ
www.sgsonline.org
901-682-2079

5–8

19th European Congress of Obstetrics and Gynaecology
Torino, Italy
www.ebcog2006.it

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"
2. For Coding Workshops, visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Telephone registration is not accepted for Coding Workshops.

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

2005

NOVEMBER

11–13

Practice Management Update for the Obstetrician-Gynecologist
Coronado, CA

12–13

No Frills—Operative Hysteroscopy
Chicago

18–20

CPT and ICD-9-CM Coding Workshop SOLD OUT
Washington, DC

DECEMBER

1–3

Complications in Obstetrics
New York City

2–4

CPT and ICD-9-CM Coding Workshop SOLD OUT
Sante Fe, NM

8–10

Pearls from Ob-Gyn
Chicago

2006

JANUARY

12–14

The Mature Woman: From Perimenopause to the Elderly Years
Vail, CO

FEBRUARY

10–12

CPT and ICD-9-CM Coding Workshop
Tampa, FL

13–15

Practical Ob-Gyn Ultrasound: Spotlight on Chronic Pelvic Pain
St. James, Jamaica

16–18

Complex Gynecologic Surgery: Prevention and Management of Complications
St. James, Jamaica

24–26

CPT and ICD-9-CM Coding Workshop
Tempe, AZ

New oncology edition available in January

Earn CME credits through PROLOG program

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 PROLOG is designated for a maximum of 25 category 1 credits toward the AMA Physician's Recognition Award or up to a maximum of 25 category 1 ACOG cognate credits. Fellows who submit their answer sheets will automatically have their online transcript credited with the hours claimed. All participants will receive a letter stating hours of CME earned.

In January, the fifth edition of *Gynecologic Oncology and Critical Care* (formerly titled *Gynecologic Oncology and Surgery*) will be available.

Each unit of PROLOG covers a different major aspect of the specialty, presenting clinical evidence in case scenarios, and features a multiple-choice test plus a critique book that thoroughly discusses each answer.

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. ♀

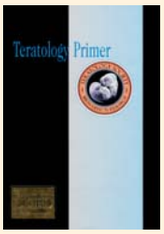
info

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

Unit	Edition	Credit Through
Gynecologic Oncology and Surgery (2001)	4th	2006
Gynecology and Surgery (2004)	5th	2006
Patient Management in the Office (2002)	4th	2007
Reproductive Endocrinology and Infertility (2005)	5th	2007
Obstetrics (2003)	5th	2008
Gynecologic Oncology and Critical Care (2006)	5th	2008

Birth defects book free to students, residents

THE TERATOLOGY SOCIETY has developed a publication to raise awareness about the field of teratology. *Teratology Primer* covers interesting and current topics regarding birth defects and their causes.



The book is intended mainly for medical students to understand the career choices available in the field of teratology. The Teratology Society is offering the book free of charge to medical and graduate students, residents, and fellows. Others may purchase the book for $10.

The primer addresses issues such as how exposure to chemical or physical agents can cause malformations, if exposure to germ cells can affect pregnancy outcome, what infections increase the risk of birth defects, and the effects of alcohol use during pregnancy. ♀

info

- For a copy of the book, contact the Teratology Society: tshq@teratology.org; 703-438-3104

New *Clinical Updates* focuses on dementia

AS MORE AMERICANS GET older and live longer, dementia is increasing. Studies show that more women than men suffer from dementia and that most patients ask for help from their primary care providers, including ob-gyns.

The latest *Clinical Updates in Women's Health Care, Memory Loss and Dementia* (CU017), provides information for ob-gyns on recognizing dementia, evaluating a patient's cognitive functions, and establishing a management and referral plan for patients. ♀

info

- www.clinicalupdates.org
- 800-762-2264, ext 192

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