Ob-gyns change practice because of liability rates, fears

Increasing professional liability premiums and the fear of lawsuits continue to cause ob-gyns to make changes to their practice, according to results from the 2006 ACOG Survey on Professional Liability. The survey illustrates the continuing impact that the medical liability crisis is having on the specialty and on women's access to health care.

Seventy percent of ob-gyns surveyed by ACOG have made changes to their practice because of the lack of available or affordable professional liability insurance, and 65% have made changes because of the risk or fear of liability claims or litigation. In both instances, ob-gyns significantly decreased the number of high-risk obstetric patients and stopped performing or offering VBACs. In addition, about 8% stopped practicing obstetrics altogether. ➤ PAGE 11

Research support needed to investigate preterm birth

A Institute of Medicine report calls for increased research into the causes, prevention, and outcomes of preterm birth, recognizing that preterm birth has increased by 30% since 1981.

In 2004, 12.5% of US live births were preterm (born before 37 weeks of gestation), compared with 9.4% in 1981, according to Preterm Birth: Causes, Consequences, and Prevention, released earlier this year. ACOG was a cosponsor of the report.

Preterm birth is a “complex cluster of problems with a set of overlapping factors of influence,” rather than one specific disease or condition, the report explains. Causes are unknown, there are no tests to accurately predict it, and “treatment” simply focuses on delaying delivery as long as possible. Causes may include individual behavioral and psychosocial factors, neighborhood characteristics, environmental exposures, medical conditions, infertility treatments, biological factors, and genetics. ➤ PAGE 12
ACOG makes health care records available for EMR developers

Even for those ob-gyns who cannot afford the expense of a complete EMR system, it is hoped that this initiative—in conjunction with ASTM’s Continuity of Care Record—will provide a clinical data model of ob-gyn care that will ultimately be portable among EMR vendors, transferable into a patient-owned personal health record, and interoperable between ambulatory and inpatient systems.

ACOG, as always, remains committed to excellence and safety. Use of the ACOG forms contributes to quality care and patient safety. We believe that taking this step is the right thing to do for Fellows and patients.™

Albert L. Strunk, JD, MD, FACOG
Vice President of Fellowship Activities

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

Using Preimplantation Embryos for Research (Committee Opinion #347, revised)

For more information on the following documents, see page 14:

Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign (Committee Opinion #349, new)

Breast Concerns in the Adolescent (Committee Opinion #350, new)

The Overweight Adolescent: Prevention, Treatment, and Obstetric-Gynecologic Implications (Committee Opinion #351, new)
ACM 2007: Discover San Diego

San Diego appeals to guests of all ages as it provides a variety of things to see and do. Take the opportunity to discover the wide array of activities offered in San Diego during the 2007 Annual Clinical Meeting, to be held May 5–9.

With an idyllic climate, San Diego has 70 miles of beaches, an abundance of recreational activities, and world-class family attractions. There are more than 90 golf courses located throughout the San Diego region, and Golf Digest named the city “One of the Top 50 Golf Destinations in the World.”

Downtown, the historic Gaslamp Quarter is one of the city’s most quintessential entertainment spots, featuring more than 80 nightclubs, restaurants, theaters, and galleries. One of the must-see theaters is the Old Globe, built in 1935. Modeled after William Shakespeare’s Globe Theatre in London, this theater holds various performances and plays. The theater is located within Balboa Park, the nation’s largest urban cultural park, also home to beautiful gardens and 15 major museums, including the Museum of San Diego History and the San Diego Air & Space Museum. With free admission to all visitors, the 1,200-acre park was ranked among the best parks in the world in 2003 by the Project for Public Places for its mixture of horticulture and art and culture.

Most visitors make sure to spend time at the famous San Diego Zoo. Home to a new baby elephant born in September and more than 4,000 other rare and endangered animals representing more than 800 species and subspecies, the zoo is a world-famous conservation organization. Visitors can then venture out to SeaWorld San Diego and catch a glimpse of Shamu, the killer whale, and many other species of the sea.

Unique venue to host ACM President’s Dinner Dance

The President’s Dinner Dance at the Annual Clinical Meeting will have a special location in 2007: The annual event will be held on the aircraft carrier the USS Midway, the longest-serving aircraft carrier in US Navy history and now home to the San Diego Aircraft Carrier Museum. The USS Midway is located in downtown San Diego at Navy Pier.

ACOG President Douglas W. Laube, MD, MEd, welcomes ACM attendees to dress casual and bring their children to the dinner dance, which will be held on Tuesday, May 8. The event will begin with a reception on the flight deck, from 6:30 to 7:45 pm, followed by a buffet dinner and dancing in the hangar, from 8 to 11 pm.

Adults and kids alike will enjoy tours of the aircraft carrier and other entertainment, including the use of flight simulators. There is an additional fee to attend the President’s Dinner Dance, and advance registration should be done when registering to attend the ACM. Tickets cannot be purchased on site.

Early-bird registration now open

SAN DIEGO • MAY 5–9

“Guiding the New Direction of Women’s Health Care”

› Register on the ACOG website at www.acog.org/acm
› Register early and save on registration fees and make your hotel reservation
Pill still misunderstood after all these years

Despite its proven track record, the Pill is still dogged by myths and misconceptions about its safety and efficacy. To enhance women's awareness and knowledge about oral contraception, ACOG's Office of Communications convened experts in New York City in October for a media briefing with major news outlets and top women's magazines.

"The Pill works; it's safe; it's easy to use; and it even provides noncontraceptive health benefits," said ACOG President Douglas W. Laube, MD, MEd. "Our goal is to reach women with the basics—The ABCs of OCs. When it comes to birth control, the Pill might very well be a woman's best friend."

The Pill leads the way as the most popular method of reversible birth control and is used today by more than 11 million women in the US. ACOG's experts answered top consumer questions about oral contraceptives and provided updates on the various brands available, hormonal contraception for women with special health concerns, attempts to limit women's access to contraception, how to choose birth control over a woman's lifespan, and newer methods of hormonal contraceptives.
LEARN HOW TO COMMUNICATE with state and federal legislators and advocate for women’s health issues on Capitol Hill during the 2007 ACOG Congressional Leadership Conference. Registration is open until January 24 for this year’s conference, which will be held February 25–27, in Washington, DC.

Most Fellows and Junior Fellows who attend the conference are sponsored by districts or sections. Fellows and Junior Fellows who are not sponsored are able to attend and pay for their own travel and accommodations. Conference participants gain valuable knowledge from Washington insiders and congressional representatives, and the conference provides effective lobbying and communication techniques to prepare ob-gyns to become active in state and federal advocacy efforts. The conference culminates in a visit to Capitol Hill, where participants meet with their state delegations to discuss key legislative ob-gyn issues.

info
→ Contact your district or section chair or Stephanie Cherkezian at ACOG: 800-673-8444, ext 2566; scherkezian@acog.org

AS 2006 DRAWS TO A CLOSE, ACOG asks you to give serious consideration to including the College in your year-end giving plans. Annual gifts to the Development Fund allow the College to participate in and initiate new programs and projects that would otherwise be out of reach.

Whether you are contributing for the first time or renewing your membership in one of the giving societies, your charitable donation ensures that ACOG is prepared and able to meet the challenges we face in providing the best possible health care for women.

Each of the four giving societies offers outstanding recognition of your generosity and unique benefits (see below).

Your contribution to the Development Fund reaffirms your commitment to ACOG’s ongoing mission and future. With your help, the College will continue to advocate quality health care, maintain the highest clinical and educational standards, promote patient education, and increase awareness of issues affecting women’s health care.

info
→ Mail your end-of-year charitable donations to ACOG Development Department, 409 12th Street SW, Washington, DC 20024
→ For more information or assistance: 800-673-8444, ext 2546; development@acog.org

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*nontransferable  **second ticket is non-tax-deductible  ***non-tax-deductible

Fellow election voting begins this month

The 2007 Fellow district and section officer elections will be held online, with voting beginning Nov 20, 2006, for section elections and Dec 20, 2006, for district elections.

Fellows will be able to access online ballots by using their last name and their ACOG ID number, a seven-digit number that can be found on all ACOG mailings. Paper ballots will be offered only by request.

Online Section Elections
Voting begins on November 20:
https://eballot3.votenet.com/acogfellow

Online District Elections
Voting begins on December 20:
https://eballot3.votenet.com/acogfellow

Districts and sections with elections this year

Districts
• District III
• District VI
• Armed Forces District

Sections
• Alberta (VIII)
• Atlantic Provinces (I)
• California Section 1 (IX)
• California Section 7 (IX)
• Central America (VIII)
• Idaho (VIII)
• Kansas (VII)
• Kentucky (V)
• Maine (I)
• Maryland (IV)
• Minnesota (VI)
• Missouri (VII)
• Montana (VIII)
• Navy (AFD)
• New York Section 2 (II)
• New York Section 5 (II)
• New York Section 8 (II)
• New York Section 9 (II)
• North Carolina (IV)
• Ohio (V)
• Pennsylvania (III)
• Saskatchewan (VI)
• South Dakota (VI)
• Texas (VII)
• Utah (VII)
• Vermont (I)
• Washington (VII)
• West Indies (IV)
• West Virginia (IV)

info
→ For your ACOG ID, contact the Membership Department: 800-673-8444; membership@acog.org
→ 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
Wealth of info available on ACOG section websites

Recognizing the increasing demand for quick and easy access to important information, several ACOG sections have developed their own websites.

The sites are housed on the College’s main website, www.acog.org, and are overseen by the section chair, who usually appoints a webmaster to keep the site up-to-date with pertinent information.

Virginia Section webmaster Melanie Gerheart said, “I think more people are getting comfortable with the Web and are realizing that it is easier to get information online instead of through the mail.”

Addressing health and legislative issues online

The Virginia Section website includes information on the state’s Birth Injury Fund; upcoming meetings, courses, and seminars; and news about state regulations and programs, as well as information on staying connected to state legislators.

Ms. Gerheart said including legislation information and updates is something that section members find very relevant and useful.

“We always have the legislation part on the site,” she said. “I think it is a fantastic way for the members to get up-to-date information on issues coming up in the Legislature and what bills are being introduced.”

The Wisconsin Section website also highlights legislative news, including the section’s position paper about a new law that licenses certified professional midwives to provide out-of-hospital maternity care services.

“If doctors and other people believe strongly in a position and if they are interested in finding out how we feel about an issue, then they should be able to go to the website and view our position,” said Dawn L. Mærker, the section’s executive secretary and webmaster. “The fact that I can put information on the site so quickly makes it a wonderful and instant way to communicate.”

Cognate program deadline approaching

The ACOG Award for Continuing Professional Development for the three-year cycle 2004–06 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 at www.acog.org, and are available through ACOG’s main website. Visit www.acog.org and click on “ACOG Development, or Cognate Program.”

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Keep current through district websites

Stay updated on the latest district news and ACOG opportunities through your district’s website. All 10 ACOG districts have their own websites, available through ACOG’s main website. Visit www.acog.org and click on “ACOG Districts” in the “Quick Links” box on the left side of the home page.

Using websites for patient education

Gordon M. Goldman, MD, who has been the Missouri Section webmaster for four years, said the section recognizes that there are two audiences that look at the sections web page: ACOG members and the public.

“Because of the amount of information overload and the limited time we have in our patient office visits, it is useful to refer patients to the public side of the Missouri website for follow-up information,” Dr. Goldman said. “All too frequently, patient recall of conversations may be inaccurate, and the website offers a place they can go to corroborate their thoughts of what was said or to clear up any misconceptions. The time savings with respect to patient calls for repeated explanations and the ease of access to valid information for the patient make this an invaluable tool for patient and physician alike.”

The Missouri site offers patients information on mandated insurance coverage, recommended health screening examinations, and links to other helpful sites. Members have access to PowerPoint presentations provided by speakers at section meetings and grand rounds from across the state. A special arrangement has been made with the University of Missouri-Kansas City ob-gyn department to provide many of its grand rounds presentations for the site.

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Needs assessment will help direct Junior Fellow council efforts

By Patrick S. Ramsey, M D, M SPH, JFCAC chair

It’s been an ambitious and successful year for the Junior Fellow College Advisory Council as we look ahead to 2007. The first JFCAC meeting of the new year will be held in early January, and we have several ongoing and new initiatives that we’re working on.

The recent survey of fourth-year US residents has been completed and analyzed. The survey results reveal important insights into the impact of the medical liability crisis on both short- and long-term career choices among Junior Fellows. Data from this survey have already been used to highlight to legislators in states with a medical liability crisis the concerns of these young physicians as they relate to patient access to ob-gyn care. Survey results will be available in a future issue of ACOG Today.

The JFCAC has finalized plans for a Junior Fellow survey to assess the impact of the Accreditation Council for Graduate Medical Education’s duty-hour restrictions on resident job satisfaction, work ethic, and professionalism. JFCAC members agree that this is a high priority for evaluation, given the substantial changes in the ob-gyn residency work environment over the past three years.

**Medical student recruitment**
The JFCAC remains active with efforts to enhance medical student recruitment and has established a Subcommittee for Medical Student Initiatives and Recruitment, which will continue to advance efforts to improve recruitment and retention of students into our specialty.

Recruitment activities planned for the upcoming year include encouraging medical students to take advantage of ACOG’s free medical student membership, expanding medical student activities at section, district, and national ACOG meetings, and continuing to promote medical student ob-gyn interest groups. Finally, to optimally focus the efforts of the JFCAC on behalf of all Junior Fellows, a Junior Fellow needs assessment is being developed and will be implemented in the next few months. This needs assessment, in addition to the newly formed task forces for Junior Fellows in practice and international Junior Fellows, will help direct our efforts to high-priority areas of need.

AS YOU PREPARE TO TAKE your American Board of Obstetrics and Gynecology examinations, keep in mind that help is available on the ACOG website. “Preparing for the Boards” is a PowerPoint presentation developed by members of the Junior Fellow College Advisory Council.

The presentation provides:
- Examples of traditional and accelerated timelines to follow for applying and preparing for the oral and written exams
- Information on how to collect case lists and what they should include
- General guidelines and advice, including stressing that you shouldn’t procrastinate and that you should allow ample time for required sign-off on medical records

On the ACOG website, www.acog.org, click on “Junior Fellows” in the “Quick Links” box on the left side of the home page. Then, click on “Preparing for the Boards.”

**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 2007 Annual Clinical Meeting, to be held May 5–9 in San Diego.

Submissions must be submitted online by December 1 and should consist of a one-page summary of 700 words or less, including final diagnosis.

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

**Online presentation helps with Boards prep**

On the ACOG website, www.acog.org, click on “Junior Fellows” in the “Quick Links” box on the left side of the home page

Chris Himes: 800-673-8444, ext 2561; chimes@acog.org
Simulation training used to improve patient safety

As the second-year resident realized the baby’s shoulder was stuck, he started to sweat and his heart rate shot up. Although the “mother” was a mannequin and the “baby” was a doll, the resident’s anxiety over the shoulder dystocia was not unusual—simulation-based drills and training can be so lifelike that participants react as if they were in the midst of a real emergency.

“You can talk and talk about an emergency, but until you walk through it, perform each maneuver, and coordinate with all the team members, it just isn’t real, nor does it truly sink in,” said Junior Fellow Tamika C. Auguste, MD, of the Washington Hospital Center, Washington, DC. “And the simulation can be so real; it causes the physicians and support staff to respond as if the mannequin was a real patient, including getting sweaty palms and an anxious feeling as when a real obstetrical emergency begins.” Dr. Auguste uses simulation training to teach residents and is helping to develop simulation-based training for the hospital’s Perinatal Patient Safety Program.

Enhancing communication and teamwork

More and more hospitals and residency programs are using simulators to address patient safety issues, improving not just clinical skills but systems and procedures, communication and teamwork.

Simulators include computer-driven, life-size maternal and neonate mannequins, with physiologic responses that can be used for training on shoulder dystocia, forceps deliveries, breech deliveries, postpartum hemorrhage, or edamamma. The mannequins simulate breathing and blood pressure, can be intubated, can respond to medications “given” to them via microchips, and allow for incisions and chest tubes.

Simulators are not all mannequins: Virtual reality simulators allow for training in gynecologic procedures such as laparoscopy and hysteroscopy. Physicians perform the procedures using the appropriate tools while watching their progress on a computer screen with 3-D graphics.

“Simulation training helps improve our processes in our hospitals and, ultimately, helps improve patient safety,” said Fellow Andrew J. Satin, MD, chair of the ob-gyn department at Uniformed Services University, Bethesda, MD, which houses the National Capital Area Simulation Center. “It provides an environment where you’re not afraid to make a mistake and you learn from your mistake.”

Adds Dr. Auguste: “Some crises cannot be averted, but what can make them go better is the teamwork. Simulation-based teamwork training helps to clearly identify what roles each person has in the case of an emergency and helps us realize what our intervention should be to ensure the best outcomes for the mother and the infant.”

At Harvard University, the Center for Medical Simulation began with anesthesia simulation training in the early 1990s and developed a one-day course in labor and delivery team training in 2002.

“We created OB scenarios based on some of our claims experiences, so its very relevant,” said Fellow Roxane Gardner, MD, MPH, assistant professor in ob-gyn at Brigham and Women’s Hospital, Boston, and a simulation faculty member at Harvard’s simulation center. “The labor and delivery teams run drills for high-acuity, low-frequency events. The scenarios are videotaped and then the teams debriefed. We use the videotapes to identify where we did well, how we could do better next time, and how to apply it to the real clinical setting.

“The training helps to unmask systems issues that you never thought to question, such as helping you realize there isn’t a consistent way to call for help or helping you learn how to get the right people in place at the right time,” Dr. Gardner said. “At Brigham and Women’s Hospital, our simulation-based drills helped us to improve the way we page everyone to come help with an obstetrical emergency. Those lessons are invaluable to patient safety.”

Liability carriers take note

As simulation-based training gains ground, professional liability carriers are recognizing the potential for increases in patient safety and decreases in medical liability costs.

Harvard University’s liability insurer, CRICO/RMF, established an incentive program for obstetricians that offers a 10% discount on a physician’s annual premium if the physician meets risk-reduction requirements, including taking a simulation-based team training course.

The Harvard simulation center also works with liability carrier ProMutual Group, which developed a risk-reduction incentive program that offers an 8% annual premium reduction. ProMutual Group has since expanded the program outside Massachusetts.

The potential of simulators continues to grow as the technology evolves and new training programs and centers are developed. Dr. Satin sees simulators being used one day for physician reentry and recredentialing.

“I wouldn’t be surprised if in the future it doesn’t become required in ob-gyn residency training to train on a simulator,” Dr. Auguste said. “This is the wave of the future.”

info

- National Capital Area Simulation Center:
  http://simcen.usuhs.mil
- Harvard’s Center for Medical Simulation:
  www.harvardmedsim.org/cms
New CPT codes set for 2007

The current procedural terminology code set for 2007 includes several new and revised codes of interest to ob-gyns, including new codes to report for laparoscopic supracervical hysterectomy and nuchal translucency.

The changes take effect January 1. Because of HIPAA requirements, there is no grace period for the use of discontinued codes. Therefore, insurers must accept new codes beginning January 1.

ACOG’s Committee on Coding and Nomenclature proposed the CPT changes to the American Medical Association CPT Editorial Panel, which approved them for 2007.™

Laparoscopic hysterectomy
Five new codes were established for 2007 to describe various laparoscopic hysterectomy procedures. Codes 58541 through 58544 describe laparoscopic supracervical hysterectomy, while code 58540 describes laparoscopic radical hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling. The new codes are:
- 58541: Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less;
- 58542: with removal of tube(s) and/or ovary(s);
- 58543: Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams;
- 58544: with removal of tube(s) and/or ovary(s);
- 58548: Laparoscopy, surgical, radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed.

Resection of recurrent malignancy
Codes 58957 and 58958 will be added to report the performance of radical resection of recurrent ovarian, tubal, primary peritoneal, or uterine malignancies. The term “tumor debulking” is included in the descriptors for these codes to assist in differentiating the use of them from the codes for primary malignancy resections (58950–58952).

To further differentiate initial resection of an ovarian, tubal, or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy from the recurrent resection described by codes 58957–58958, codes 58950–58952 will be revised to include the term “initial” in their descriptors to emphasize that these procedures refer to the timing of the surgery rather than the classification of the malignancy. The new codes are:
- 58957: Resection (tumor debulking) of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal, retroperitoneal tumors), with omentectomy, if performed;
- 58958: with pelvic lymphadenectomy and limited para-aortic lymphadenectomy.

Nuchal translucency
Two new codes were created to report for nuchal translucency measurement, an ultrasound procedure performed for the detection of Down syndrome. This procedure can be performed using either a transabdominal or transvaginal approach. Code 76813 is reported when nuchal translucency is performed in a single or first gestation. Add-on code 76814 is assigned for each additional gestation. The codes are:
- 76813: Ultrasound, pregnant uterus, real time with image documentation, first-trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
- 76814: each additional gestation (List separately in addition to code for primary procedure.)

Revision of vaginal graft
In 2006, code 57295 was created to report for revision (including removal) of prosthetic vaginal graft; vaginal approach when complications occur. In 2007, code 57296 has been established to report the open abdominal approach for revision (including removal) of a prosthetic vaginal graft.

Hymenotomy
Code 56720, hymenotomy, simple incision, has been renumbered to 56442 because it was incorrectly placed under the “Excision” subheading of the “Vulva, Perineum, and Introitus” subsection. New code 56442 will be under the “Incision” subheading of the “Vulva, Perineum, and Introitus” subsection because the code refers to an incisional procedure. The code descriptor remains the same.

Dilation and curettage of cervical stump
Code 57820, dilation and curettage of cervical stump, has been renumbered to code 57558. Code 57820 was inappropriately placed under the “Dilation and Curettage of Cervical Stump” subsection. New code 57558 will be placed in the “Dilation and Curettage of Cervical Stump” subsection because the code refers to an incisional procedure. The code descriptor will remain the same.

Learn more about practice management on the ACOG website
Find information on:
- Electronic health systems
- Ob-gyn financial and income trends
- Responding to inappropriate payor denials
- Protecting assets
- Starting a practice
- Assisting hearing-impaired and non-English-speaking patients

Do you have a coding question?
Facing a coding conundrum? Help is available. Fellows or their staff can submit specific questions to ACOG’s coding staff.
Submit questions by email to coding@acog.org or by fax to 202-484-7480.

Coding online
On the ACOG website, www.acog.org, click on “CPT Coding” in the “Quick Links” box on the left side of the home page.
NEW TOOLS ARE AVAILABLE to help patients understand procedures that ob-gyns recommend to them, while providing enhanced documentation of the informed consent process.

The Committee on Professional Liability recently reviewed such a tool—an interactive program that can be accessed online by the patient. A key word here is “interactive,” according to Fellow Dennis H. English, MD, whose 40-physician practice, Womancare Associates, has used the program to enhance the informed consent process for the last three years. The program the practice uses was purchased by the University of Pittsburgh Medical Center and has components for neurosurgery, orthopedics, anesthesia, and other clinical areas, in addition to ob-gyn.

How it works
For the program that Dr. English uses, the physician gives the patient an access code to use the program, which has animation and audio explanations of the procedure, instructions for preparation, and descriptions of the risks, benefits, and alternatives. At numerous points, the patient is prompted to confirm that she understands, and she has the opportunity to enter questions for the doctor and to flag any specific risks or instructions that she has questions about.

Risk management is a second important aspect of such a program. The software archives the patient session and can recreate what the patient heard, saw, and responded to. The physician receives a confirmation that the patient used the program, along with a list of questions from the patient and any topics flagged for more information.

Patients can use the program at any computer with Internet access. Dr. English said his patients can view it in his office, at the hospital’s patient education center, at a public library, as well as in their home.

“The amazing thing to me is that I have yet to find a patient who doesn’t have access to a computer—even elderly patients,” he said, adding that his practice has had a lot of positive feedback from patients.

Modules are available for a long list of common ob-gyn procedures and education areas, such as prenatal care, childbirth, cesarean delivery, abdominal or vaginal hysterectomy, breast biopsy, tubal ligation, and hysteroscopic procedures.

Better informed patients
Dr. English notes that the program really helps patients understand what to expect.

“They can view it at their own pace, go through it more than once, and reflect on the information,” he said. “It’s not a replacement for informed consent by any means. We strongly advise our physicians to do the same informed consent process they did before, but patients often don’t remember a lot of what was discussed in the office—that’s where an interactive program like this can play a significant role.”

Sindhu Srinivas, MD, a member of the Committee on Professional Liability, agrees. She has not used such a program in her practice but was impressed by the demonstration at the committee meeting.

“A multimedia product can never replace the physician’s role in talking with the patient to explain the procedure she will have and describe the risks, benefits, and alternatives,” Dr. Srinivas said. “But [the program] draws it out for the patient and allows her to soak in some of the risks and benefits at her own pace.”

Risk reduction benefit
Dr. English finds the risk management aspects of the program to be an important advantage.

“It audits who watches it and how many times they watched it,” he said. “Our goal is to have it offered to all our patients, and we’re almost at our current 90% target now. We believe this is a quality initiative for Womancare Associates, so we follow it and track it like any other quality improvement component.”

Multimedia presentations are not new, but Dr. English notes that videos or CDs “don’t have the risk-reduction component and aren’t very personalized—there’s no opportunity for interaction with the patient. In addition, they tend to become outdated quickly.” Constant updating with current practice guidelines is a feature of the program Dr. English uses.

Dr. Srinivas also considers the comprehensiveness of the information provided a plus:

“The program standardizes what every physician tells patients.”

info

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Survey: Ob-gyns change practice

The average age at which physicians stopped practicing OB was 48 years—an age once considered near the midpoint of an ob-gyn’s professional career.

“While the long-term impact of professional liability litigation and the cost of liability insurance cannot be stated in precise terms, it is apparent that the current medical-legal environment continues to deprive women of all ages—especially pregnant women—of experienced women’s health care physicians,” said Albert L. Strunk, JD, MD, ACOG vice president of fellowship activities.

“By any measure, quality health care for women suffers a significant negative impact, reflected in a decrease in obstetric services, a reduction in gynecologic surgery, and an increase in the practice of defensive medicine,” Dr. Strunk continued.

All practicing Fellows, Junior Fellows surveyed

The survey covers the period from 2003 through 2005 and is the ninth professional liability survey by the College since 1983. For the first time, the entire population of ACOG Fellows and Junior Fellows in practice in the 50 states, Washington, DC, and Puerto Rico were surveyed, using a combination of online and mailed questionnaires. In total, 28,958 Fellows and Junior Fellows in practice were surveyed. Results represent the 10,659 survey respondents.

Obstetric practice changes

Of those who reported making changes to their obstetric practice because of lack of available or affordable professional liability insurance, nearly 29% reported increasing the number of cesarean deliveries, 26% decreased the number of high-risk obstetric patients, and 26% stopped performing or offering VBACs. Additionally, 12% decreased the number of total deliveries, and 7% stopped practicing obstetrics altogether.

Gynecologic practice changes

Of those who reported making changes in their gynecologic practice because of lack of available or affordable professional liability insurance, 13% decreased gynecologic surgical procedures, 4% stopped performing major gynecologic surgery, and nearly 2% stopped performing all surgery.

Claims experience

Eighty-nine percent of respondents had at least one claim filed against them during their professional careers, for an average of 2.62 claims per ob-gyn. Of the claims, 62% were for OB care, and 38% were for gynecologic care. Of those who had claims filed against them, 37% reported at least one claim filed against them as a result of care rendered during residency training.

A full summary of the survey results is scheduled for publication in the March/April 2007 edition of ACOG Clinical Review.

ACOG HAS DEVELOPED A new resource guide on how to understand and deal with an adverse event and subsequent medical liability claim. The CD-ROM “From Exam Room to Courtroom: Navigating Litigation and Coping with Stress” addresses the mechanics of civil litigation—from incident to verdict—as well as the emotional impact that litigation can have on one’s personal and professional life.

By December, all Junior Fellow residents in training will receive a complimentary copy of the CD-ROM, which is also available to purchase through the ACOG Bookstore. The production and distribution of the CD-ROM is possible thanks to a grant from ACOG’s Development Fund.

The guide was designed to empower physicians to effectively navigate the legal system, recognize and cope with the accompanying symptoms of litigation stress, and emerge from such painful experiences intact.

Primary content areas include handling an adverse event, dealing with the lawsuit, understanding pretrial discovery, deciding whether to settle, getting through the trial, life after the trial, and stress relievers and tools.

Those who complete the program will be eligible for continuing medical education credits. ACOG is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. ACOG designates this educational activity for a maximum of 12 AMA PRA category 1 credits™ or up to a maximum of 12 Category 1 ACOG cognate credits. Physicians should only claim credit commensurate with the extent of their participation in the activity. Credit is available through 2009.

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New CD-ROM on navigating litigation available

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Senate passes PREEMIE Act

ACOG IS URGING THE US House of Representatives to pass HR 2861, the PREEMIE Act—Prematurity Research Expansion and Education for Mothers who Deliver Infants Early—which calls for the creation of a federal plan to intensify research on the causes and strategies to help prevent preterm birth.

The US Senate passed the bill in August. The bill also authorizes federal support for education and services related to prematurity. The bill would:
- Establish an interagency coordinating council on prematurity in the US Department of Health and Human Services
- Establish a multicenter clinical program on prematurity at the National Institutes of Health
- Expand studies on prematurity at the Centers for Disease Control and Prevention
- Enhance the collection of maternal-infant clinical and biomedical information
- Test strategies for distributing the most recent information on preterm birth to health providers and the public

The bill had been referred to the House Committee on Energy and Commerce at press time.™

ACOG RESOURCES

- Practice Bulletin Assessment of Risk Factors for Preterm Birth (#31, October 2001)
- Practice Bulletin Perinatal Care at the Threshold of Viability (#38, September 2002)
- Committee Opinion Perinatal Risks Associated with Assisted Reproductive Technology (#324, November 2005)

Research for preterm birth needed

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“ACOG is pleased to be a part of efforts to address this complicated issue,” said Gary D.V. Hankins, MD, chair of ACOG’s Committee on Obstetric Practice. “In particular, the College strongly supports the IOM recommendation for an increase in federal funding for research into the causes and prevention of preterm birth.” (See sidebar on PREEMIE Act at left.)

Report recommendations

Some of the recommendations are:
- Establishing federal and private integrated multidisciplinary research centers to focus on understanding the causes and outcomes of preterm birth
- Promoting the collection of improved prenatal data
- Encouraging the use of ultrasound early in pregnancy to establish gestational age
- Improving methods for identification and treatment of women at increased risk of preterm labor

Infertility treatment

The report recommends the creation of guidelines to reduce the number of multiple gestations and calls for research into the causes and consequences of preterm births that occur because of fertility treatments. Among infants conceived using fertility treatments, 62% of twins and 97% of triplets and other high-order multiples are born preterm, according to the IOM report.

The IOM report states that “particular attention should be paid to the transfer of a single embryo and [to] the restricted use of superovulation drugs and other nonassisted reproductive technologies for infertility treatments.”

ACOG supports 2004 guidelines by the American Society for Reproductive Medicine that outline the number of embryos to be transferred based on the patient’s age and the prognosis of a successful transfer.

Late preterm births

One of the key lessons learned in developing the report, according to the IOM, was that infants born near term—at 32 to 36 weeks of gestation—are at increased risk for adverse health and developmental outcomes that should not be ignored. These infants represent the greatest number of infants born preterm, the report said.

Racial and ethnic disparities

The report calls for research on prevention of preterm births among certain populations. The preterm birth rate is highest among black women, at 17.8%, and is 11.9% for Hispanic women, 11.5% for white women, and 10.5% for Asian women.

Socioeconomic differences and maternal behaviors cannot fully account for these disparities, according to the IOM.

“ACOG has been addressing the prevention of preterm birth for many years as one of the top obstetric challenges,” Dr. Hankins said. “ACOG’s Committee on Obstetric Practice is reviewing the IOM report and evaluating the recommendations.”™

Visit www.nap.edu and do a search for “preterm birth”
ACOG issues guidelines for stem cell research

A NEW COMMITTEE OPINION proposes ethical guidelines to follow when using preimplantation embryos for research, including stem cell research. Using Preimplantation Embryos for Research was developed by the Committee on Ethics and published in the November issue of Obstetrics & Gynecology.

ACOG supports embryonic research within 14 days after evidence of fertilization, under the limits of the Committee Opinion guidelines. The College also supports somatic cell nuclear transfer for research but opposes reproductive cloning.

“The document recognizes the potential promise and interest in stem cell research,” said Jeffrey L. Ecker, MD, chair of ACOG’s Committee on Ethics. “We wanted to provide an ethical framework appropriate to use in addressing issues related to using preimplantation embryos for research and in talking to patients about this issue.”

Potential benefits of embryo research include an improved understanding of fertilization, implantation, and early pregnancy biology, and with this, possibly fewer undesired outcomes, such as miscarriage, according to the document. Research also offers the possibility of more effective therapies for infertility and early and accurate diagnoses of heritable genetic diseases.

The document’s guidelines include:
- An embryo that has undergone research will be transferred to a uterus only if the original research was to prepare the embryo for selection or placement or improve chances for implantation and only if specific consent for transfer is obtained
- Embryo donors should be provided with the opportunity to provide informed consent for the disposition of any excess embryos, whether for eventual destruction, donation for attempted implantation by another individual or couple, or scientific research. If gamete donors differ from the embryo donors, then embryos may be donated for research only if the gamete donors also have given explicit consent for donation for research
- Those donating excess frozen embryos for embryonic stem cell research must be adequately informed of the goals, anticipated benefits, and potential hazards
- For research or therapy involving somatic cell nuclear transfer, oocyte donors and somatic cell donors must give informed consent for use of their eggs or somatic cells
- The document states that physicians should not be required to participate in embryo research if they find it morally objectionable but that it’s important for them to be aware of the medical and ethical issues.

Ethics revisions

The new Committee Opinion Using Preimplantation Embryos for Research revises and updates the “Preembryo Research” chapter in Ethics in Obstetrics and Gynecology, second edition. The College is updating all chapters in this book and revising them as Committee Opinions. After all chapters are revised, the Ethics book will be withdrawn. Until then, when clicking on the chapter links on the ACOG website, users will be directed to the new Committee Opinions as they are published.

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CDC revises HIV recommendations

THE CENTERS FOR DISEASE Control and Prevention is calling for all patients in the US ages 13 to 64 to be screened for HIV, a major change from previous recommendations that called for routine testing only for those considered at high risk or those living in areas with HIV prevalence above 1%. CDC also now recommends that general consent for medical care be considered sufficient for HIV testing—a separate written consent is no longer needed—and that pretest counseling no longer be required.

The new recommendations are an attempt to foster earlier HIV detection, which can reduce the number of new HIV infections and help ensure that infected persons have access to life-prolonging treatments as soon as possible. It is estimated that as many as one-fourth of the 1 million people thought to be living with HIV in the US are unaware of their infection.

The revised HIV testing recommendations, released in September, also include revisions for pregnant women to improve rapid diagnosis of HIV infections and further reduce mother-to-child transmission.

ACOG recommendations

ACOG currently supports risk-based testing for nonpregnant adolescents and adults and will reevaluate its recommendations in light of the revised CDC recommendations.

For pregnant women, the revised CDC recommendations are now more in line with ACOG’s existing guidelines, including recommending universal HIV testing, with patient notification, as a routine component of prenatal care (the opt-out testing approach) and the use of rapid HIV testing to screen pregnant women in labor with unknown or undocumented HIV status.

info
- www.cdc.gov/hiv/topics/testing/healthcare/index.htm
- www.acog.org/goto/PHIV
New documents address clinical care for adolescents

THREE NEW ACOG COMMITTEE Opinions focus on how to care for adolescent patients, addressing breast concerns, overweight, and menstruation. The documents were developed by the ACOG Committee on Adolescent Health Care and published in the November issue of Obstetrics & Gynecology.

Breast concerns
In Breast Concerns in the Adolescent (Committee Opinion #350), the committee points out that, in adolescents, benign breast disease overwhelmingly dominates the differential diagnosis and dictates a different protocol for care compared with the care for an adult patient.

The majority of breast masses diagnosed in adolescents are fibroadenomas, according to the document. Given the low risk of malignancy, high likelihood of spontaneous resolution, and risks of deformity in the growing breast, the document states that conservative, nonsurgical management is most often appropriate. The document also addresses breast augmentation, nipple piercing, genetic testing for breast cancer, and the role of breast self-examination, which is not recommended for patients ages 13 to 18.

Menstruation as a vital sign
Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign (Committee Opinion #349) is a joint document with the American Academy of Pediatrics that suggests that clinicians can use the menstrual cycle as a “vital sign” and indicator of other possible medical problems among girls and adolescents.

“Using menarche or the menstrual cycle as a sensitive vital sign adds a powerful tool to the assessment of normal hormonal development and the exclusion of serious abnormalities, such as anorexia nervosa, inflammatory bowel disease, and many other chronic illnesses,” according to the document.

The document points out that adolescents and their parents may be unaware of what constitutes normal menstrual cycles and patterns of bleeding. While menstrual cycles are often irregular in adolescence, there are some irregularities that should be evaluated. Menstrual flow requiring changes of menstrual products every one to two hours is excessive, according to the document. Acute menorrhagia is sometimes associated with von Willebrand disease and other bleeding disorders or other serious problems.

Overweight adolescents
The Overweight Adolescent: Prevention, Treatment, and Obstetric-Gynecologic Implications (Committee Opinion #351) recommends that all adolescents be screened annually for overweight by determining weight and stature, calculating a BMI for age percentile, and asking about body image and eating patterns.

Adolescents with a BMI greater than or equal to the 95th percentile for age should have an in-depth dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease, according to the document. When assessing BMI, clinicians should use a teen BMI calculator—not one for adults. A link to a teen BMI calculator is on the ACOG website: www.acog.org/goto/teens.

The document also addresses health risks and ob-gyn implications for overweight adolescents and provides guidance on discussing healthy eating and physical activity.

Remember to stress folic acid importance
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, January 8–14, sponsored by the National Council on Folic Acid.

With the theme “Go Get Folic Acid Now,” this year’s event will focus on the need for every woman who is able to get pregnant to take 0.4 milligrams of folic acid every day.

On the event website, practitioners can find helpful education resources, including downloadable brochures. In addition, free consumer materials can be ordered through the website, including brochures in Spanish and English, bookmarks, and stickers that providers can wear and share with their patients.

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
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. 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. In January, the fifth edition of Patient Management in the Office will be published.

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To preview these pamphlets, visit www.acog.org/goto/patients

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- What are some of the risks and warning signs?
- What screening tests are available?

**Cancer of the Uterus (AP097)**
- Who is at risk for uterine cancer?
- What are the symptoms?
- How is it treated?

**Dysmenorrhea (AP046)**
- What are some of the causes and symptoms of dysmenorrhea?
- How is it treated?
- How can I relieve the pain?

**HIV and Pregnancy (AP113)**
- How can HIV affect me and my baby?
- How can I lower the risk for my baby?
- What are some of the tests and treatments available for HIV?

**Later Childbearing (AP060)**
- What are some of the health concerns during pregnancy for women older than 35?
- What type of counseling is available?
- What tests are available?

**Human Papillomavirus Infection (AP073)**
- How is HPV infection spread?
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