CULTURALLY COMPETENT CARE:
Conocimiento cultural de su paciente
Maternal health disparities

Maternal Mortality

in the US dropped dramatically from the 1930s to the early 1980s, but there has been no significant decrease in the past few decades, and definitely none in recent years. While the vast majority of women in this country experience healthy births, our maternal mortality ratio is far higher than the goals set for our nation in the 2010 Health Objectives and higher than many other industrialized countries. Most disturbing is the racial gap in maternal death in the US. Among African-American women there are 34.8 deaths for every 100,000 live births, while there are 10.2 for Hispanic women, and 9.1 for white women.

Recently in Washington, DC, I brought together some of the brightest minds in the US and the world, who comprise our expert Maternal Mortality Work Group. Together, we began an action plan for The College and ACOG to address all aspects of the complex maternal mortality issue in the US. Highlights from our first meeting are described on page five. We particularly plan to address the disparities in maternal death.

One way every ob-gyn can improve maternal health care is to look closely at the cultural variety of our patients and provide culturally sensitive care. Almost every ob-gyn’s local population reflects many forms of cultural difference, including many that go beyond religion and race.

We need to take time to ask our patients open-ended questions, and to practice active listening. Patients appreciate our sensitivity to their unique circumstances, and most importantly, by breaking communication barriers, we are able to deliver better care to women and families who have ethnic or religious differences, face socioeconomic challenges, or have cultural lifestyle issues that affect health-related behaviors. Read more about this on page six.

A major preexisting condition complicating pregnancy is obesity. Disproportionate numbers of maternal deaths are seen in women who are obese. Overweight and obesity affect all age groups and lead to hypertensive disorders, diabetes, and other medical conditions.

Women living in urban settings are more likely to be living in poverty than their suburban counterparts, but, irrespective of demographics or income, urban women are particularly vulnerable to becoming overweight or obese due to limited resources for physical activity and healthy food choices. Our new Committee Opinion, described on page eight, offers suggestions on helping your urban-dwelling patients improve their lifestyles and achieve healthy weight loss and management.

The College will keep pressing forward at the national level to help ensure safe, healthy, and cost-effective births.

INVESTING IN WOMEN AND GIRLS

New report with a message from ACOG President Richard N. Waldman, MD, seeks to raise awareness and create a movement towards positive change for women in developing countries around the world.

Available free in limited supply.
Call 202-484-3321 or email communications@acog.org.
Support our PAC

HANK YOU! The American Congress of Obstetricians and Gynecologists’ Political Action Committee, Ob-GynPAC, is poised to become a million-dollar PAC this year, thanks to support from you and thousands of your colleagues. The ability of ACOG to become more active in the legislative process, and in the election of members to the US Senate and House who will advance our policies, is a direct result of the establishment of a 501(c)(6) organization. Our PAC has been very active in the 2010 elections in supporting national candidates who are committed to improving women’s health. We must continue this support!

Most midterm-election candidates will have depleted their campaign funds by the November elections. These elected officials will be using all means to refill their “war chests” since the next major election cycle is only two years away.

Thanks to the generosity of our members, ACOG has been able to use our PAC funds to help candidates win election. But now the ACOG PAC needs replenishing to sustain our existing support of legislators who can advance women’s health care and to support new members of Congress who share our agenda.

Our Ob-GynPAC is an important venue for us to make a difference in public policy. Therefore, I hope you will continue to help ACOG by donating to the Ob-GynPAC. ACOG must keep working to build on the success of the past, and we can only do that if you, our members, continue your support as well.

Please contribute online at www.obgynpac.org or send your donations made payable to Ob-GynPAC to, PO Box 23498, Washington, DC 20026-3498.

Ralph W. Hale, MD, Executive Vice President
MEDICAL EDUCATION IS FAC-ING many challenges that will require new levels of creativity and innovation. At the undergraduate level, graduates are expected to demonstrate a baseline foundation of knowledge and skills as prerequisites for entry into residency. Residents are soon expected to demonstrate they have certain proficiencies as they progress through training programs. For many residents, these expected competency levels are difficult to attain because of insufficient clinical case volumes, and some individuals require more repetition than others to reach the same levels of competency.

The ACOG Simulations Consortium, launched by Sterling B. Williams, MD, MS, ACOG vice president for education, aims to provide simulations-based obstetrical and surgical skills training to ob-gyns. The consortium's mission is to develop and implement unique simulations-based curricula to augment traditional, procedure-oriented, education in ob-gyn.

The consortium, chaired by Kay I. Daniels, MD, co-director of OBSim, department of ob-gyn at Stanford University Medical Center, convened recently in Washington, DC. "This initiative has brought together many of the nation's simulation leaders to explore how we can best use simulation for education at all levels of practice," Dr. Daniels said. "Simulation centers from across the nation and the military are represented. Each brings a unique view, but we share a vision that simulation training can have a profound impact on the future of ob-gyn patient care. The consortium's next step is the development and refinement, within the centers, of an ob-gyn simulation curriculum for residency training."

Nine fully-functioning simulations centers were initially selected as members of the consortium, all based at major academic medical centers throughout the US. Seventeen consortium member institutions now exist.

"By incorporating simulations systems into medical school and residency training programs, it is probable we can produce safer, more confident, and more highly-skilled physicians," Dr. Williams said, "even before their substantive clinical encounters with actual patients."

The consortium recognizes the importance of including simulations-based education in medical education curricula at all levels. The consortium began its work at the graduate medical education (residency) level. The value of simulation training is that it gives residents opportunities to train in clinical simulation environments without fear of harm to patients, and it provides opportunities to do reflective learning.

"It was clear, from the start, however, that our simulated educational programs could ultimately serve as educational adjuncts in the important re-entry, re-licensing, re-credentialing, and maintenance of certification systems that are under closer scrutiny today," Dr. Williams said.

Kay I. Daniels, MD

ACOG consortium advances simulation training

Are you recently board certified?
Reminder! Are you a Junior Fellow who was board certified between November 2009 and January 2010? If so, in order to remain an active member, you must submit an application for Fellow status prior to December 31, 2010. Please contact membership@acog.org or call 202-314-2343 if you have questions.

Stump the professors!
Submit your cases by November 19th for “Stump the Professors,” the popular, unpredictable ACM panel session. Visit www.acog.org/questionnaire/stumpProfessors.cfm
As part of his 2010-2011 Presidential Initiative, ACOG President Richard N. Waldman, MD, convened an expert, international work group to develop an agenda to decrease maternal deaths and severe maternal morbidity and to improve patient safety. The group met and discussed clinical, educational, and legislative actions ACOG and The College can take to address this challenge.

During the last two decades, there has been no improvement in the maternal mortality ratio in the US, and there are significant and persistent disparities in the maternal mortality ratios for black, Hispanic, and white women. Furthermore, surveys of maternal mortality indicate that many of these deaths are preventable through changes in systems and practices within both medical and societal domains.

“In spite of the fabulous medical care available within the US, approximately 500 women die every year during pregnancy or within a year of the end of pregnancy,” said Jeffrey C. King, MD, chair of the ACOG Maternal Mortality Special Interest Group, and professor and director, division of maternal-fetal medicine, University of Louisville.

Meeting participants examined ways to tackle several critical issues: inadequate data collection, racial disparities, supporting and reviving maternal mortality review committees, quality improvement in hospital and office settings, and clinical care guidelines for such conditions as postpartum hemorrhage, deep vein thrombosis, hypertensive crisis, obesity and other preexisting conditions.

“The best aspect of our meeting was the multidisciplinary participation and representation from many states, plus the experience from the UK. It was the beginning of a partnership. We hope this partnership will have a major impact on maternal mortality and morbidity, and improve quality of life for women and families,” said work group member Mary E. D’Alton, MD, department of ob-gyn, Columbia University, New York Presbyterian Hospital.

One major problem is that national data on maternal mortality is inconsistent and incomplete due to lack of standardized reporting. Meaningful data is needed for the US to make progress toward lowering maternal mortality and reversing racial disparities. Data on maternal deaths currently is collected at state or municipality levels and then reported to the National Center for Health Statistics (NCHS). But death certificates, like birth certificates, are not uniform across all states. Only 18 states currently use pregnancy checkboxes on their death certificates. For the past decade, The College has supported the inclusion of checkboxes on death certificates indicating whether a deceased woman was pregnant within the past year. To eliminate variations across jurisdictions and help our nation gather accurate and complete data, The College encourages state adoption of the new standard certificate of death issued by NCHS that incorporates this checkbox, along with electronic data collection by the National Vital Statistics System.

The work group also discussed instances of “near misses,” or women who experience life-threatening conditions during pregnancy, childbirth, and the following year. These events are more common than death from similar causes and the work group agreed that analyzing near misses would be productive.

“While maternal death is rare, vigilance toward the identification of patients at risk for postpartum hemorrhage—multifetal gestations, grand multiparity, hydramnios, etc.—and the use of sequential compression devices (SCDs) for the prevention of embolism in all patients undergoing cesarean delivery will provide an opportunity to reduce the number of pregnancy-related deaths,” Dr. King said.

The College believes that uniform reporting and review of every pregnancy-related death by a qualified committee in each state is critical to understanding the role in maternal death of geography, age, preexisting conditions, access to appropriate care, as well as race and ethnicity, community education, and services. The College urges Fellows to become involved to make maternal mortality review meaningful in their states, and to use multidisciplinary review together with improved patient safety practices in hospitals.

Plan to attend!

All ACOG members, particularly District and Section leaders, are encouraged to attend the Maternal Mortality Special Interest Group forum to be held Sunday, May 1, 2011, 10 am to 3 pm at the ACM in Washington, DC, which will focus on maternal mortality and morbidity, and review observed trends in cause of death. This yearly five-hour session, presented collaboratively with the CDC, will again feature representatives from the CDC, public health agencies, national and international maternal and child health organizations, and ob-gyn experts.
“We had the dilemma of watching the situation deteriorate, and we were afraid the baby might die unless we took the mother to the OR in time,” recalls Dr. Cox, now the chair of ob-gyn at St. Agnes Hospital in Baltimore. “I didn’t feel I was connecting properly with the patient.”

So Dr. Cox took the patient’s husband outside and asked him privately if there was something he was not understanding. Only then did he learn what he had to do to persuade his recalcitrant patient: speak to the tribal leader in the community in Nigeria from which she had recently emigrated. So Dr. Cox placed a call to a remote location in Nigeria, reached the tribal leader, and obtained consent.

He could have insisted the patient have surgery or acquiesced to her refusal and hoped that all would turn out for the best. But instead, Dr. Cox asked the right questions, listened to his patient and her husband, and resolved the situation in a way that worked for everyone. “If I hadn’t asked the question, I would never have known,” he said. “If you don’t take the time to find out what’s important to a patient, you will never connect with her.”

Cultural competence has become a growing issue in American medicine. From 1990–2000, there was a 74% increase in the Asian population, a 58% increase in individuals of Hispanic or Latino origin, a 92% increase in American Indians and Alaskan Natives, and a 21% increase in the African-American population. The white non-Hispanic population increased by only 5%.

With health care reform opening doors to medical care for those who were previously uninsured and lacked access to the health care system, it’s likely that an already diverse patient population will become even more so. Is American ob-gyn care, and maternity care in particular, up to the challenge?

Put simply, cultural competence means an ability to communicate and interact effectively with people from different backgrounds than your own—different races, ethnicities, national origins, religious traditions, languages, sexual orientation, ages, and classes. It might be summed up as “meeting people where they are.”

There are two key elements to cultural competence: learning the unique makeup of the community in which you practice and understanding the communication skills that bridge all cultures.

“If I had a magic wand that I could wave over the health care system to help achieve cultural competence, I would recommend that every organization—hospital, doctor’s office, whatever—do a needs assessment of the population they serve with an eye toward understanding three things: language issues, literacy issues, and cultural issues,” said Dr. Cox.

A rural community in the deep South will have different language, literacy, and cultural issues than an inner-city neighborhood in Baltimore, or a small town in Nebraska. It’s up to the physician practicing there to know who his or her patients are and what they need.

At Women and Infants Hospital in Providence, RI, Maureen G. Phipps, MD, MPH, cares for a diverse set of
Culturally competent care:

patients including Latina women from many different countries, African-American women, Southeast Asian women, American Indian, and non-Hispanic white women. “I have learned that many of my Hispanic patients have concerns about prenatal testing,” said Dr. Phipps, vice-chair and director of the division of research in the department of ob-gyn, and associate professor of ob-gyn and community health at The Warren Alpert Medical School of Brown University.

“I remember one Hispanic patient who really wanted to have the quad screen done, but her mother said no. I probed further, and it turned out that the mother knew someone who’d had the testing done and the baby had an anomaly. She felt that the test had caused the problem, so it was up to me to help them understand that a screening test cannot cause a chromosomal anomaly.” In the end, the patient still refused the quad screen, but Dr. Phipps felt more comfortable that she did so based on accurate information.

While such things as interpreter staffing needs are unique to a community—one hospital may require Hmong, Mandarin, and Arabic speakers, while another may need only Spanish speakers—there are some communication issues that bridge all cultures.

“One is learning how to be respectful and listen to your patient,” said Dr. Cox. “It’s as simple as, when you first walk in the door, introducing yourself and letting the patient know that you care about her. Making that connection—that’s the first step in achieving cultural competence, overcoming literacy issues, and overcoming language issues.”

The next step is listening to the patient and asking questions that invite her to tell you what her needs are. For example, many patients are frequently late for appointments, frustrating doctors and office staff. “Instead of just throwing up our hands, we need to try to find out what complications in their life are keeping them from getting to their visit,” said Dr. Phipps. “Do they have to take two buses, drop a child off at school, or miss work when they don’t have any paid time off? Rather than being frustrated with a patient not following your directions, find out what the real situation is and try to help.”

“We also have to be sensitive to the fact that people from some backgrounds and cultures think that doctors here operate on patients too quickly or that we’re experimenting on them,” said Dr. Cox. “Things like the Tuskegee syphilis studies, and the case of Henrietta Lacks (whose cells were taken without her consent during treatment for cervical cancer, and now form the basis of countless cell lines used throughout the country for research), make it hard for various cultures to trust our health care system. We have to realize that it’s up to us to communicate in order to rebuild that trust.”

Cultural competence isn’t just about being politically correct and sensitive, said Dr. Cox. Ultimately, its goal is much more essential: improved maternal and child health outcomes. “We know that a significant percentage of those outcomes are related to things that we consider social determinants of health,” he said. “If we truly want to reduce disparities in health, then we have to create an environment of comfort and open communication for the people seeking our care.”

Questions to Ask Yourself

While you’re asking questions of your patient during an exam, there are a few key questions to ask yourself to ensure that you’re providing culturally competent care:

- Am I asking the right questions? In addition to talking with the patient about her symptoms and your care plan, you should ask her about other factors in her life that may be affecting her health.
- Am I talking to the right person? In many cultures, other family members have a major voice in a woman’s medical care, so you may need to speak with her husband, her mother or even her husband’s mother.
- Am I the right doctor? People of certain religious faiths are uncomfortable with a woman being cared for by a male doctor, particularly for obstetrics and gynecologic care.
- Am I speaking the right language? Make sure your hospital and/or practice have interpretation services readily available for commonly-spoken languages. Patients prefer in-person interpreters to phone services when possible.
- Am I giving a complete explanation? Don’t assume your patient understands what you’ve just said simply because she nods and says yes. According to the American Medical Association Foundation, 90 million Americans can’t read, write, or understand well enough to follow a doctor’s instructions.
Ob-gyns need to appreciate the unique challenges facing their overweight and obese urban patients when it comes to counseling them about diet and exercise. In new recommendations, The College said physicians and public health officials should also take into consideration individual behaviors as well as the broader community obstacles to healthy lifestyles in order to help women lose weight.

Approximately one-half of women in the US are overweight or obese. More than one-third are obese, according to the CDC. All women are at high risk for becoming obese, but minority women, low-income women, and women in urban areas are at particularly high risk, said The College. Obesity is a risk factor for numerous health conditions including diabetes, hypertension, high cholesterol, stroke, heart disease, certain cancers, and arthritis. A person with a body mass index (BMI) of 25 or higher is considered overweight and is considered obese if it’s 30 or greater.

“The flu is a highly infectious virus and can be especially serious for the very young, those with certain medical conditions, and pregnant women,” said Richard N. Waldman, MD, president of The College. “Pregnant women were disproportionately affected by flu complications last year—some went into premature labor, some developed pneumonia, and unfortunately, some died.”

Vaccination early in the flu season is optimal, but can be given at any time during this period, regardless of the stage of pregnancy. There have been no studies showing adverse effects of the inactivated flu vaccine for pregnant women or their children, according to The College. Millions of pregnant women have received the flu vaccine over the past 45 years, and no studies have shown harm to them or their babies.

Committee Opinion #468, Influenza Vaccination During Pregnancy, is published in the October 2010 issue of the Green Journal.

Urban women face diet and exercise challenges

The flu until they are six months old, but they receive antibodies from their mothers which help protect them until they can be vaccinated.

“All pregnant women, regardless of trimester, should receive the influenza vaccination during the flu season, according to new recommendations issued by The College. The College emphasizes that preventing the flu during pregnancy is an essential element of prenatal care and that it is imperative that physicians, health care organizations, and public health officials improve their efforts to increase immunization rates among pregnant women.

The CDC, along with The College and other medical organizations, encourages all physicians and health care providers to urge their pregnant and postpartum patients to get vaccinated against the seasonal flu.

Annual flu vaccination is crucial for pregnant women because the immune system changes during pregnancy, which results in women being at increased risk of serious complications if they get the flu. Flu vaccination performs double duty by protecting both pregnant women and their babies. Babies cannot be vaccinated against

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Performing gynecologic surgery in disadvantaged areas abroad

There is growing recognition of global disparities in the health of women. These disparities increasingly attract the attention of gynecologists who are motivated to use their skills to address deficiencies in international women’s health care. Such humanitarian efforts have the capacity to provide specific surgical expertise to women who would not receive care otherwise.

In a new Committee Opinion (#466), The College’s Committees on Ethics and Global Women’s Health highlight particular ethical issues our Fellows should consider when providing care in low-resource settings. Women in these countries deserve high-quality medical care that can prevent illness and restore health, but the constraints of low-resource settings and the vulnerability of patients can make this goal difficult to obtain.

Health care professionals should take the necessary steps to ensure that patients benefit from, and are not harmed by, their efforts. They should be certain they have the necessary surgical competence and training, including sufficient mentorship, before functioning as a primary surgeon abroad. Before surgery, they should make sure that patients have access to adequate medical resources and preoperative and postoperative care. They should be prepared to postpone surgery when the standards of ethical medical care cannot be met and the surgical team believes the best interest of the patient cannot be achieved with available resources.

“Practicing medicine abroad introduces a set of unique challenges for health care professionals,” said Ruth M. Farrell, MD, assistant professor of medicine at the Cleveland Clinic Lerner College of Medicine. “This document helps provide guidance to Fellows as they take on humanitarian efforts to improve the health of women in all areas of the world.”

Committee Opinion #466, Ethical Considerations for Performing Gynecologic Surgery in Low-Resource Settings Abroad, is published in the September 2010 issue of the Green Journal and online under Publications at www.acog.org.

NIH’s national children’s study recruiting women who are or may become pregnant

The National Children’s Study is recruiting women who are pregnant or may become pregnant in the next few years.

The study is the largest long-term examination of children’s health ever conducted in the US. It will follow 100,000 children from before birth to age 21 to learn how the environment influences children’s health, development, and quality of life. Researchers expect to analyze information they collect for years to come, to gain new understanding of how environmental factors, such as foods people eat, chemicals they may be exposed to, and other aspects of daily life might interact with genes to affect health and development.

Women who are or may become pregnant in the next few years and who live in a study area may be eligible to participate. Information about locations, volunteering, and eligibility criteria is available at www.nationalchildrensstudy.gov.

“The National Children’s Study provides a wonderful opportunity to track the impact of a woman’s environment and health, both before and during pregnancy, on pregnancy outcome,” said Hal C. Lawrence, III, MD, ACOG vice president of Practice Activities. “ACOG recognizes this study may produce significant information affecting obstetric and pediatric practice in the future.”

“The study is an investment in the future of America’s children,” said Alan Guttmacher, MD, director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health. “Through their participation, women and their families can help in the search for information to improve the health, development, and well-being of future generations.”

The study is led by the US Department of Health and Human Services, through the NIH and the CDC, and the US Environmental Protection Agency.
ACM endowment and lectureship program offers opportunities to give

THE COLLEGE’S ANNUAL CLINICAL MEETING

Endowment and Lectureship Program allows The College to further its educational and scientific independence, promote quality, and ensure financial stability. In recognition of varied interests and individual financial considerations, giving opportunities include a variety of ACM activities, from courses to current issues updates to luncheon conferences, and range from $5,000 to $500,000. The two options for participation are endowments and lectureships. Both giving vehicles offer members the opportunity to have their names, or the name of a loved one, linked to an area of special interest.

- **Endowments**: Your gift is invested, and only a portion of the average annual investment return is used. An endowed gift will continue to support The College in years to come.
- **Lectureships**: Your gift funds the direct expenses for the duration of a naming opportunity.

A gift of cash is the easiest and most direct way to create an endowment or lectureship with The College. Endowments and lectureships may also be established with gifts of appreciated securities, stipends, or real estate, and it is also possible to create an endowment through a future gift from an estate. Additionally, some commitments to The College may be fulfilled over a period of up to three years. If you would like to learn more about how you can make a meaningful and lasting contribution to your profession, contact Katie O’Connell at 202-863-2546 or koconnell@acog.org.

Endowment for new ACM community service award

The College is very pleased to announce a new endowment, The Pete and Weesie Hollis Community Service Award. The College is grateful to Richard S. (Pete), MD, and Weesie Hollis for their outstanding and continuing generosity to The College and their commitment to recognizing our Fellows’ efforts to care for underserved and poorly-served patient populations. The College welcomes their gift to our growing Endowment and Lectureship Program.

What if I’m sued during residency?

**Q:** I’m a first-year resident and one of my colleagues was just named in a liability lawsuit. I’m afraid I could be the next statistic. **What should I do if this happens to me?**

**A:** Receiving a Summons and Complaint can be a traumatic event, especially if it is served in a public setting, which still happens in some states. Regardless of how upset you may be, you cannot afford to delay responding. The mechanics of civil litigation require that an “Answer to the Complaint” be served immediately—within 10–30 days in most jurisdictions. If your Answer to a Summons and Complaint is not timely, a summary judgment could be entered against you. That is, you might lose the case without a chance to defend yourself.

If you were a practicing physician, you would immediately notify your medical professional liability insurance carrier. As a resident, though, your residency program provides your insurance, so you must work through the institution to respond to a medical liability claim. Do not wait until you have been named in a lawsuit to find out what your program’s procedures are. Make it your job to find out now whom you should notify and to whom you must deliver the Summons and Complaint. The process will vary among different residency programs. For example, in some programs, the hospital’s or medical school’s risk management department or legal affairs office is designated to receive and respond to the documents. In others, the program director or department chair’s office is the first point of contact.

Promptly take the following actions if you are named in a lawsuit:
- Notify your program director
- Make a copy of the documents
- Deliver the Summons and Complaint to the designated person or office immediately
- Obtain a receipt or a signed and dated note

An attorney will be assigned to defend you. It is essential to cooperate fully with your attorney. Information you provide to your attorney is protected by attorney-client privilege and cannot be used as evidence. However, your attorney will be inclined to focus on the facts of the case and is not likely to be able to serve as your main source of emotional support.

Sometimes perceived or potentially real conflicts of interest arise between a resident and his or her assigned defense attorney. You should notify your program director if you feel unable to work effectively with the assigned defense attorney, or if you feel that a conflict of interest exists because your assigned attorney represents other defendants whose interests may be in opposition to your own. Your program director can assist you in determining whether another attorney should and can be assigned.

The information in this article and this publication should not be construed as legal advice. As always, physicians should consult their personal attorney about legal requirements in their jurisdiction and for legal advice on a particular matter.
Nearly one quarter of women of childbearing age in the US are uninsured, and most of these women live well below the federal poverty level. As a result, publicly-funded medical care and family planning services have become increasingly important in providing a safety net for women in need.

“Most of our country has populations with limited access to health care, insurance, or both,” said Mark J. Hathaway, MD, MPH, director of ob-gyn outreach services for Women's and Infants’ Services at the Washington Hospital Center (WHC) in the District of Columbia. “Federal community health care systems are crucial in serving these people. They take care of anyone in need of care who might otherwise fall through the cracks.”

Dr. Hathaway leads a team of 10 ob-gyns and eight midwives who divide their time between the WHC, DC’s largest non-profit hospital, and Unity Health Care, Inc. (Unity), DC’s largest non-profit, federally qualified health center. The organizations are in a unique relationship as the ob-gyns are employed by the WHC but typically work at least three days a week, rotating through several of Unity’s 29 neighborhood-based health centers.

“Our clinicians have the benefit of working for a private, non-profit teaching hospital while serving those most in need,” Dr. Hathaway said. “Most other community health care systems hire their own ob-gyns, who tend to fulfill their commitments and move on. With us, clinicians stay because they have opportunities to develop and grow through additional teaching and research projects at the WHC.”

The partnership between Unity and the WHC began when the WHC hired Dr. Hathaway immediately out of his residency program at the hospital in 1997 and accepted an arrangement for him to work with Unity as part of his hospital duties.

Dr. Hathaway obtained a master of public health degree from Johns Hopkins University in Baltimore, MD, in 2006. “I realized that I wanted to do more to help with system changes to address disparities in family planning access,” he said. He pushed for Unity to become a Title X grantee under the federal family planning program, which it did in 2007.

Now, he is medical director for Unity’s ob-gyn services and oversees the coordination of ob-gyn care at six of Unity’s health centers throughout the DC area. He was integral in the WHC securing a family planning fellowship to start in July 2011.

“Working with Unity provides me with camaraderie and inspiration,” Dr. Hathaway said. “Our chief medical director, Janelle Goetcheus, MD, has an unwavering dedication to the underserved that motivates others to do the same. At Unity, patients are treated with dignity and respect.”

Information
The following College resources can assist Fellows in providing care to underserved populations:

- Health Care for Homeless Women
- Community Involvement and Volunteerism
- Health and Health Care of Incarcerated Adult and Adolescent Females
- The Uninsured

These documents are online under Publications at www.acog.org.

DO YOU KNOW AN EXTRAORDINARY OB-GYN? TELL US ABOUT HIM OR HER IN AN EMAIL TO LHUMPHREY@ACOG.ORG. WE WILL TRY TO FEATURE HIM OR HER IN A FUTURE ISSUE.
MAKING the Rounds

ACOG COURSES AND CODING WORKSHOPS

- **NOVEMBER 9** ACOG Webcast: Cord Blood Gases: From Delivery Room to Courtroom
- **NOVEMBER 19–21** Coding Workshop, Chicago, IL (sold out)
- **DECEMBER 2–4** Practical Obstetrics and Gynecology, Chicago, IL
- **DECEMBER 2–4** Twenty-First Century Obstetrics and Gynecology, New York, NY
- **DECEMBER 3–5** Coding Workshop, Atlanta, GA
- **DECEMBER 14** ACOG Webcast: Preview of New Codes for 2011

2011

- **FEBRUARY 24–26** Practical Obstetrics and Gynecology, Miami, FL
- **FEBRUARY 25–27** Coding Workshop, Lake Buena Vista, FL
- **MARCH 11–13** Coding Workshop, Phoenix, AZ
- **APRIL 1–3** Coding Workshop, Atlanta, GA
- **MAY 5–7** Coding Workshop, Washington, DC
- **JUNE 10–12** Coding Workshop, Indianapolis, IN
- **JULY 8–10** Coding Workshop, Los Angeles, CA

REGISTER ONLINE at [www.acog.org/postgrad/index.cfm](http://www.acog.org/postgrad/index.cfm). To learn about freestanding postgraduate courses, email PGCourses@acog.org. To learn about coding courses and webcasts, call 202-863-2498 or email coding@acog.org.

Practice Updates

**Committee Opinions**
- 472 Patient Safety and the Electronic Health Record (November 2010)
- 471 Smoking Cessation During Pregnancy (November 2010)
- 470 Challenges for Overweight and Obese Urban Women (October 2010)
- 469 Carrier Screening for Fragile X Syndrome (October 2010)
- 468 Influenza Vaccination During Pregnancy (October 2010)

**Practice Bulletin**
- 116 Management of Intrapartum Fetal Heart Rate Tracings (November 2010)

These documents appear in the October or November issue of the Green Journal and are online under Publications at [www.acog.org](http://www.acog.org).