THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

acog TODAY

NEWS AND INFORMATION IMPORTANT TO YOU AND YOUR PRACTICE

MAY/JUNE 2008

For American Indians, health care needs grow, money doesn't

ON THE FORT APACHE RESERVATION IN ARIZONA, a pregnant woman who is a tribal member—usually Apache, Navajo, or Hopi—can get free prenatal care at the Whiteriver Indian Hospital. But women there who want and would benefit from tubal ligation are out of luck. The 40-bed US Indian Health Service hospital does not have surgical capabilities and doesn't have enough money to pay for the surgery somewhere else.

IHS funding has not kept pace with either medical costs or the growth of the population it serves. Per capita spending is less than half that of Medicaid and 36% that of the total US population. The gap has widened every year.

"From day to day we have to do workarounds to find ways to meet the challenges," according to Fellow Neil J. Murphy, MD, the IHS chief clinical consultant for ob-gyn services, who practices at the Alaska Native Medical Center in Anchorage.

David A. Yost, MD, the Whiteriver hospital's clinical director, echoed that perspective and explained how his hospital handles the

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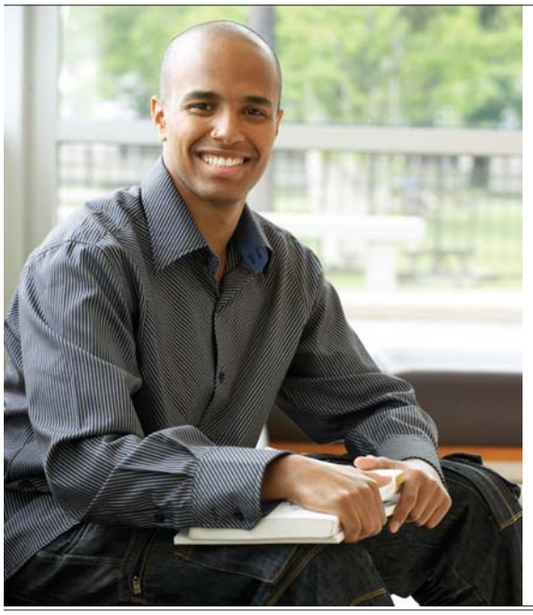

Match numbers remain strong

THE PERCENTAGE OF OB-GYN residency positions filled by US medical seniors remained steady in 2008. In the National Resident Matching Program Residency Match, 99% of ob-gyn residency positions were filled, with 72% filled by US medical students, the same percentage as last year. A total of 1,163 ob-gyn residency positions were offered, eight more than in 2007.

"As in the last several years, the residency match again offers good news for women's health, as medical students continue to select ob-gyn as their top choice," said ACOG Executive Vice President Ralph W. Hale, MD, FACOG. "At all levels of the College, Fellows and Junior Fellows have made a concerted effort to mentor medical students and create programs and opportunities that introduce them to ob-gyn and show them how special and rewarding women's health care can be."

ACOG medical student recruitment efforts include hosting an ob-gyn residency fair and offering a medical student course, booth, reception, and hands-on courses at the Annual Clinical Meeting. ♀

acogTODAY

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EXECUTIVE DESK

Young physicians in ACOG

A FEW YEARS AGO, ACOG REACHED out to a group of its members who didn't have specific representation or activities tailored just for them—those physicians who had passed their boards and were no longer Junior Fellows but were now Fellows just starting out in practice.

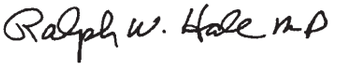
As this is a time of great transition, these particular Fellows face many issues that are unique to this period of their life. Often, these issues are so specific that they can be overlooked in the other major issues facing ACOG. However, for these Fellows these are important issues and they need ACOG to help.

One of the first steps the College took to recognize these "young physicians" was to amend the ACOG Bylaws to elect two young physicians to the Executive Board. Officially, these representatives are "Fellows-at-Large," but they are also called "young Fellows." These are Fellows who are younger than 40 or who have been in practice for eight years or less. In deciding how to define this group of physicians, ACOG decided to utilize the definition of the American Medical Association, which had extensive information on how to delineate this grouping.

These Executive Board terms are two years, and the terms overlap so that one representative is elected each year. The representatives' charge is to bring to the Executive Board issues of concern that are affecting the young physicians of ACOG and to present the young physician point of view to the Executive Board.

Recently, these Fellow-at-Large representatives conducted a survey of other young physicians, using the term "young Fellow." We received a number of comments about this "new category" of Fellowship. Most felt that they did not want to lose their Fellow status. Let me set the record straight—there is no membership category of "young Fellow." These are officially Fellows but have been called "young Fellows" or "young physicians" to recognize their unique issues. ACOG recognizes that young physicians may have different concerns and needs than the majority of our Fellows do and that these needs could be going unrecognized.

Since we created these Executive Board positions, the young physicians have added tremendously to the Board and have brought significant issues for discussion and decision. Current young physicians on the Executive Board are Camille A. Clare, MD, from District II, and, starting in May, Dane M. Shipp, MD, from District IX. They are very interested in hearing from young physicians about issues they should bring to the Executive Board. They can be reached at camille_clare@hotmail.com or dshipp100@earthlink.net. ♀



Ralph W. Hale, MD, FACOG
Executive Vice President

IN MEMORIAM

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Aurora, OH ▫ 2/08

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Ipswich, MA

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Chicago

John M. Tortora, MD
Madeira Beach, FL

Obstetrics & Gynecology
HIGHLIGHTS

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

Ovarian Tissue and Oocyte Cryopreservation
(Gynecologic Committee Opinion #405, new)
For more information, see page 12.

Coping with the Stress of Medical Professional Liability Litigation
(Professional Liability Committee Opinion #406, revised)

Low Bone Mass (Osteopenia) and Fracture Risk
(Gynecologic Committee Opinion #407, new)
For more information, see page 12.

Diagnosis and Management of Vulvar Skin Disorders
(Gynecologic Practice Bulletin #93, new)
For more information, see page 13.

Five ob-gyn departments receive Pitkin Awards

OBSTETRICS & GYNECOLOGY HAS ANNOUNCED the five winners of the 2007 Roy M. Pitkin Awards, which honor ob-gyn departments that promote and demonstrate excellence in research. The award provides a $5,000 unrestricted grant to each department whose faculty, fellows, or residents published one of the most outstanding manuscripts in the Green Journal in the past year. Both the authors and the departments are recognized for the quality of research and publication of the results.

The editors selected articles from all those published in 2007, and a panel of former *Obstetrics & Gynecology* editorial board members selected the winners by ranking the papers on the basis of scientific merit, importance to the specialty, study design, methodology, presentation of results, soundness of conclusions, and writing style. ♀

COLUMBIA UNIVERSITY • NEW YORK, NY

Westhoff C, Heartwell S, Edwards S, Zieman M, Cushman L, Robilotto C, Stuart G, Morroni C, Kalmuss D, for the Quick Start Study Group. *Initiation of Oral Contraceptives Using a Quick Start Compared With a Conventional Start: A Randomized Controlled Trial*. Obstet Gynecol 2007;109:1270–6 (Mary E. D'Alton, MD, chair).

STONY BROOK UNIVERSITY • STONY BROOK, NY

Elimian A, Garry D, Figueroa R, Spitzer A, Wiencek V, Quirk JG. *Antenatal Betamethasone Compared With Dexamethasone (Betacode Trial): A Randomized Controlled Trial*. Obstet Gynecol 2007;110:26–30 (J. Gerald Quirk, MD, PhD, chair).

COLUMBIA UNIVERSITY • NEW YORK, NY

Berkowitz RL, Lesser ML, McFarland JG, Wissert M, Primiani A, Hung C, Bussel JB. *Antepartum Treatment Without Early Cordocentesis for Standard-Risk Alloimmune Thrombocytopenia: A Randomized Controlled Trial*. Obstet Gynecol 2007;110:249–55 (Mary E. D'Alton, MD, chair).

UNIVERSITY OF ALABAMA AT BIRMINGHAM

Lin MG, Reid KJ, Treaster MR, Nuthalapaty FS, Ramsey PS, Lu GC. *Transcervical Foley Catheter With and Without Extraamniotic Saline Infusion for Labor Induction: A Randomized Controlled Trial*. Obstet Gynecol 2007;110:558–65 (John C. Hauth, MD, chair).

UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS

Pates JA, McIntire DD, Leveno KJ. *Uterine Contractions Preceding Labor*. Obstet Gynecol 2007;110:566–9 (Steven L. Bloom, MD, chair).

Section V receives Wyeth award

CALIFORNIA'S SECTION V IN District IX has been named the 2007 winner of the Wyeth Pharmaceuticals Section Award for the section's efforts in establishing a limited-English-proficiency program that improves communication with patients who have limited or no English language skills. Section V represents the Beverly Hills and Pasadena areas.

Section V began its LEP project in 2004, supported by a grant from the California Endowment Program, to explore how the section's ob-gyns communicated with their patients who speak little or no English. The section conducted focus groups of physicians and patients and issued a survey of District IX's membership to determine how doctors dealt with these patients.

Survey results showed that physicians relied heavily on bilingual office staff and their own language skills to communicate with patients who speak little or no English. Other frequent approaches included relying on interpretation by patients' family members, including children, or professional interpreters.

An advisory panel was created and recommended the following:

- Eliminate the use of children as interpreters
- Strongly discourage the use of family members as interpreters except in emergencies or if the patient insists against the physician's advice
- Assess language skills of bilingual physicians
- Validate language and interpreting skills of bilingual staff who serve as interpreters
- Provide interpreter training for bilingual staff and for physicians who work with interpreters ♀

DR. WAH RECEIVES TOP HONOR

ACOG Fellow Robert Wah, MD, chief medical officer and vice president at Computer Sciences Corporation in Falls Church, VA, was honored recently as No. 10 on the "50 Most Powerful Physician Executives in 2008" list by *Modern Healthcare* magazine.

Serving for more than 23 years in the Navy, Dr. Wah was the associate chief information officer for the Military Health System and was the deputy national coordinator for health IT at the US Department of Health and Human Services. Dr. Wah was elected as ACOG's candidate to the American Medical Association board of trustees in 2005. He has served on the ACOG Executive Board, as chair of the Junior Fellow College Advisory Council, and on numerous committees and commissions. ♀

New website helps ob-gyns care for patients with disabilities

YOUR PATIENT IS DUE FOR A mammography but she doesn't know if the involuntary spasms from her cerebral palsy will allow her to be properly screened. Another patient cannot lift herself out of her wheelchair and onto the table so that you can examine her. An adult patient with developmental disabilities mentions a partner but has little knowledge about sex and contraception.

These scenarios may not be daily occurrences in your office, but every day across the country women with disabilities struggle with access to health care. Most women with disabilities live in the community, not institutions. They require the same reproductive and women's health care services as women without disabilities, but the provision of those services may require adaptation. How can you appropriately treat these patients when they show up in your practice?

ACOG is launching a new website in May to help clinicians effectively and compassionately treat patients who have physical, sensory, and developmental disabilities. The Reproductive Health Care for Women with Disabilities website will be an interactive recorded presentation and will debut with two parts: an introduction and a section on routine gynecologic health care for patients with disabilities. Four more parts are being developed that will cover special medical considerations, such as contraception and pregnancy; health issues specific to the type of disability; improving access; and resources. Each part is broken down into several modules.

"Most ob-gyns in general practice see only an occasional patient with a disability, so they may not be aware of the special considerations," said Elisabeth H. Quint, MD, clinical professor of ob-gyn at the University of Michigan and lead faculty for the website. "This interactive website will help physicians address the special needs of their patients in order to provide them with quality health care. This is an important issue; a lot of practitioners across the country are struggling with how to deal with this underserved population of women."

The website is part of a collaborative project between ACOG and the Centers for Disease Control and Prevention's National Center on Birth Defects and Developmental Disabilities to increase ob-gyns' awareness of the needs of women with disabilities in accessing health services and to enhance physicians' skills in meeting those needs. ♀

ISSUE OF YEAR WINNER TO EXPLORE FUTURE OF RESIDENCY EDUCATION

DISTRICT II JUNIOR FELLOW Chair Larry Rand, MD, has been selected to receive the 2007 ACOG Issue of the Year award, which addresses "The Future of Residency Education in Obstetrics and Gynecology—How Should We Prepare Doctors for Tomorrow's Demands in Women's Health Care Services?"

Dr. Rand

Dr. Rand is an assistant professor of ob-gyn at Mount Sinai School of Medicine in New York City and a maternal-fetal medicine subspecialist. As recipient of the Issue of the Year award, Dr. Rand is required to develop a thoroughly researched and referenced background paper of 50–100 pages.

"Education has always been my passion, both on the medical student level and the resident level," Dr. Rand said. "We're at both an exciting and challenging time in ob-gyn. We have a plethora of new technology and a movement into the age of informatics as well as a move toward robotics and simulators, but on the challenging side young physicians face the difficulty of working within a culture of defensive medicine, medicolegal strain, and lack of clarity about how to implement less tangible training competency requirements such as 'professionalism.'"

Dr. Rand outlined a number of areas he wants to explore. Among them:

- **The way students study**
  "There is a significant change in the learning resources that trainees (and practicing physicians) now use, as well as how they are accessed," Dr. Rand said. "Hard-copy textbooks are being phased out, with electronic versions and myriad other digital resources replacing them. Everything is available online." Trainees' curricula should take these changes into account, including their advantages and potential for audiovisual and interactive educational tools, Dr. Rand said.
- **Professionalism and compassion**
  With terms such as "professionalism" and "compassion" now mandated as core competencies, the question remains: Can these qualities be taught? Dr. Rand plans to explore adapting the ancient Indian theory of "guru-kul" to teaching in medicine, in which the teacher fosters, recognizes, and nurtures students' skills and demonstrates professional behavior to be respected, learned from, and emulated.
- **Diminishing skills**
  Some technical ob-gyn skills, such as vaginal breech delivery and forceps-assisted vaginal delivery, are not performed and taught as much anymore. Dr. Rand plans to evaluate how to preserve and perpetuate these important technical skills. ♀

Essay winner recalls the grace of a special obstetric patient

DURING A CHAOTIC MONTH in labor and delivery, Junior Fellow Maria Isabel Rodriguez, MD, met an obstetric patient whom she still thinks about from time to time because of the courage the patient showed.


Dr. Rodriguez

The patient had suffered three miscarriages in Mexico but had never been allowed to see the malformed fetuses. She and her husband had traveled to the US seeking better medical care but still had another miscarriage. In her second trimester, an ultrasound showed a severely malformed fetus without a heartbeat. The patient looked at Dr. Rodriguez and said in Spanish "I want to hold my baby in my arms." Her husband, who had seen the earlier misshapen fetuses, tried to talk her out of it, but she was steadfast.

"I nervously picked up the baby and wrapped it in a blanket," Dr. Rodriguez writes in an essay. "I was shaking as I placed the baby in its mother's eager arms; I had no idea what her reaction would be. She looked down at the baby in her arms and burst into tears. She rocked back and forth, consumed by sorrow. 'Mira, mi amor, mi bebe, mi bebe!'"

Dr. Rodriguez's moving essay was selected as the national winner from the 10 district winners in the Junior Fellow essay contest, "Special Delivery." Dr. Rodriguez is a fourth-year resident at Oregon Health & Science University in District VIII. Each district winner received $500, and Dr. Rodriguez was given an extra $500 plus a trip to the Annual Clinical Meeting in May to present her essay.

"This patient stood out because of her grace and courage in facing a tragic situation," Dr. Rodriguez told *ACOG Today*. "It's hard to imagine a more devastating or challenging situation to endure, not once but several times. I was impressed by her resilience and kindness despite her personal anguish. As ob-gyns, we see women dealing with tragedy and crises frequently; some women respond with anger, bitterness, denial, or withdraw from others around them. But she had the courage to face her grief and remain open and caring to others."

The patient returns to her mind when Dr. Rodriguez encounters people who have suffered a loss, especially stillbirth. She also recalls the patient's courage when she's challenged in her own life.

"I remember her grace and strength to this day when I am faced with disappointment, tragedy, or loss," Dr. Rodriguez writes in her essay. "Who we choose to be in these moments defines us; my patient chose to accept the truth of her pregnancy with open eyes and heart and love her baby for who it was." ♀

District essay winners

The winning essays from each district can be read in their entirety in the May issue of *Obstetrics & Gynecology.*

District I: Melissa J. Sherman, MD
District II: Nisha Bansal, MD
District III: Kurian Thott, MD
District IV: Christopher C. Sundstrom, MD
District V: Chia-Ling Nhan-Chang, MD
District VI: Todd R. Lovgren, MD
District VII: Brandy R. Patterson, MD
District VIII: Maria Isabel Rodriguez, MD
District IX: Neelu Arora, MD
Armed Forces District: Luissa V. Fisteag-Kiprono, MD

The future through the eyes of the JFCAC

By Rajiv B. Gala, MD, JFCAC chair

TWO YEARS AGO, I WAS GIVEN the task of deciding what exactly it was that I wanted to accomplish as the Junior Fellow College Advisory Council chair. The challenge at face value seemed easy enough, but it was not until I took the test (serving as chair) that I appreciated the unwritten lesson I was taught.

At the end of the day, this was not about finishing more projects than others did or about going to more meetings or being on more committees. The goals that our JFCAC has accomplished have nothing to do with any one person. In reality, the collaboration and support of others are what makes the JFCAC, ACOG, and organized medicine successful.

Thanks to ACOG leaders

Through these years, I've had the good fortune of being supported 100% by four ACOG presidents, two JFCAC advisors, the Executive Board, Executive Vice President Dr. Ralph W. Hale, ACOG Vice Presidents Drs. Albert L. Strunk and Sterling B. Williams, more than 30 talented Junior Fellow officers, the amazing staff at ACOG (Mary Behneman, Chris Himes, and Wanda Proctor), and most importantly, my family. Thank you.

Find a way to get involved

What I'll remember most about this year is the passion for advocacy in every Junior Fellow I've met. The fight to improve the future of ob-gyn and the care we provide will never be successful through the efforts of one. With that, I leave you my challenge: find a way to get involved—locally, regionally, or nationally—because that is how we will continue to leave this better than we found it. ♀

Making labor and delivery reliable by reducing variability

"WALK INTO ANY Starbucks and ask five baristas how to make a latte, and you get one answer. But in many hospitals, asking five L&D nurses how to run an induction will get you five different answers," said Fellow Peter H. Cherouny, MD, of the University of Vermont, making the point that labor and delivery practices, even at a single hospital, are all over the map.

Reducing such practice variability is at the heart of the reliability approach to patient safety—ensuring that *every* patient receives the right care *every* time. Dr. Cherouny is the chair and lead physician in a national program based on reliability science called the Idealized Design of Perinatal Care.

Sponsored by the Institute for Healthcare Improvement, the perinatal program began in 2006 with 28 hospitals that joined IHI's IMPACT perinatal community. More than 50 ob-gyn departments now participate.

Each hospital implements processes aimed at reducing birth trauma events to zero. Some of the patient safety activities include creating high-functioning teams, implementing effective communication techniques, and holding joint physician-nurse electronic fetal monitoring training. The hospitals also adopt agreed-upon clinical processes called "bundles," groups of evidence-based actions related to a specific aspect of clinical care. The bundles standardize the care so that it is reliably performed each time.

Use of oxytocin targeted

The first bundles established for perinatal care were for elective induction and for augmentation because use of oxytocin is highly associated with (although not always causative) of perinatal trauma. A review of obstetric liability claims had shown that more that 50% of them involved the use of oxytocin.

The elective induction bundle, which must be followed for *every* elective induction—has four required elements:

- A gestational age ≥39 weeks
- A reassuring fetal status
- A pelvic assessment that includes a Bishop's score and a general assessment of pelvic adequacy
- A recognition and management of hyperstimulation

Physician compliance with the 39-week requirement for gestational age proved to be the most challenging element for some hospitals.

"It's human nature to push the envelope just slightly. Physicians often don't recognize a difference between 39 weeks and 38 weeks and five days because bad outcomes are not that common," Dr. Cherouny said. "So we got pushback. At the University of Vermont, we revisited the data and validated that 39 weeks is the threshold that makes a difference. Newborns end up on ventilators about twice as often at 38 weeks than at 39 weeks."

> ***"In obstetrics, there are preventable poor outcomes and those that are not preventable. With standardization, every chart reflects accurately the evidence-based care that was given."***

Ob-gyn departments joining the IMPACT community typically start with implementing the induction and augmentation bundles. Other initiatives being undertaken are implementation of the vacuum delivery bundle, an assessment of adverse events, and the creation of simulations for responding to rare events such as massive hemorrhage and emergency cesarean delivery.

Standardized processes lead to good outcomes

Dr. Cherouny acknowledges that changing processes is hard.

"You have to build these process changes into the normal workflow so it is easy to be compliant. The reason you get one answer about lattes at Starbucks is not an accident—recipes and reminders about the critical parts of the process are posted. For L&D, such aids could include standard order sheets, common equipment, checklists, and feedback about compliance."

Each hospital has its own culture and must establish local process changes. Dr. Cherouny's own hospital tried three different ways to ensure that the elective induction bundle was used for every patient.

Redundancy must be built into the system to achieve reliability. Like making a latte at Starbucks, standardization of key processes is essential.

"Some people said, 'Isn't that just cookbook medicine?' But in fact, practice variation is limiting advances in safety," Dr. Cherouny said.

He points out that standardized processes enhance defensibility—a huge motivation for physicians.

"In obstetrics, there are preventable poor outcomes and those that are not preventable. With standardization, every chart reflects accurately the evidence-based care that was given."

Data collected at IMPACT hospital alpha sites show that the program is working. The birth trauma rate dropped by 90% over a three-and-a-half-year period at three health care systems. These systems represent six hospitals of differing size and patient demographics and have a combined total of more than 12,000 births annually. ♀

info

- www.ihi.org/IHI/Topics/PerinatalCare
- Committee Opinion *Patient Safety in Obstetrics and Gynecology* (#286, October 2003): www.acog.org/publications/committee_opinions/co286.cfm
- Committee Opinion *Communication Strategies for Patient Handoffs* (#367, June 2007): www.acog.org/publications/committee_opinions/co367.cfm

For American Indians, health care needs grow, money doesn't

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financial shortfall. The hospital receives about $10 million from IHS, but it costs about $35 million a year to run. The difference is made up by billing Medicare and Medicaid. So, one of the workarounds at Whiteriver is to help patients enroll in Medicaid.

"We live in an impoverished community, so about 75% qualify for Medicaid," Dr. Yost said, adding that eligibility for Medicaid coverage swings dramatically from season to season due to the availability of summer employment in the forest industry. "We have 23 people in the [hospital] business office to help patients try to navigate the red tape of Medicaid and Medicare processing. It's to our benefit."

Lack of funds restricts care

While finding the money to run the Indian health care facilities can be difficult, the real money crunch is in the "contract health services" budget used to pay for services provided outside the IHS system, such as tubal ligations for women from the Apache reservation.

"The contract health services budget is not indexed to growth," Dr. Yost said. "We have essentially the same budget we had 15 years ago, while our population has grown by 70%. The money has to be prioritized to meet life-threatening matters."

Tony Ogburn, MD, the incoming chair of ACOG's Committee on American Indian Affairs, offers an example of how the shortage in contract services funding affects women who need elective gynecologic surgery. Pine Ridge Indian Hospital in South Dakota does not have an ob-gyn on staff and doesn't have enough funds to pay a locum tenens to do elective surgeries. When Dr. Ogburn and a colleague from the University of New Mexico volunteered to do surgery for a week at Pine Ridge, they operated on about 15 patients, some of whom had been profoundly anemic for years. Dr. Ogburn said that although the women's condition "was not acutely life-threatening, it certainly was life-altering."

Geography, poverty present challenges

Dr. Murphy said the biggest challenge of providing health care is "the remote nature of our practice."

"Our patients [in Alaska] live in primarily rural areas—in many cases off the road system."

Lack of transportation limits access even more. Dr. Yost said that on the Apache reservation in Arizona, "about 25% of our patients have access to vehicles, and there is no public transportation on the reservation." He clarified that "access to vehicles" could mean that 12 people who live with each other share a car. To get to the clinic, patients may walk five miles and then hitchhike.

Recruiting physicians and other professionals to these rural locations is difficult. The IHS reports a 17% vacancy rate for physicians, 18% for nurses, and 31% for dentists. Dr. Ogburn points out that the loan repayment program, which is used as an incentive to recruit graduating residents, is underfunded.

"The amount of money given is not enough to truly pay off someone's loans, and the program also doesn't have enough money to accept everyone who applies," he said.

The sparsely populated nature of rural locations also affects the services available. In the area of the Whiteriver hospital area there are only about 325 pregnancies a year. Women with high-risk pregnancies must go 30 miles away—over a mountain pass—to be delivered, and some will be transferred to Phoenix, about four hours away by ground.

Health disparities recognized

The health status of American Indians and Alaska Natives is lower than that of other Americans. Infants die at a rate of nearly 12 per 1,000 live births, compared to 7 per 1,000 for all races in the US. The overall life expectancy is 2.4 years less than that of all others in the US.

"Their baseline health is not as good," Dr. Ogburn said. "People in poverty don't have ready access to preventive care and don't get diagnosed as early."

About 16.3% of American Indian/Alaska Native adults have diabetes, compared with 8.7% of whites, and the death rate from diabetes is three times higher than that of the general US population.

Progress has been made

Admitting that he prefers to look at the glass as half full, Fellow William H.J. Haffner, MD, points to the tremendous progress that has been made in health care among American Indians since the 1970s.

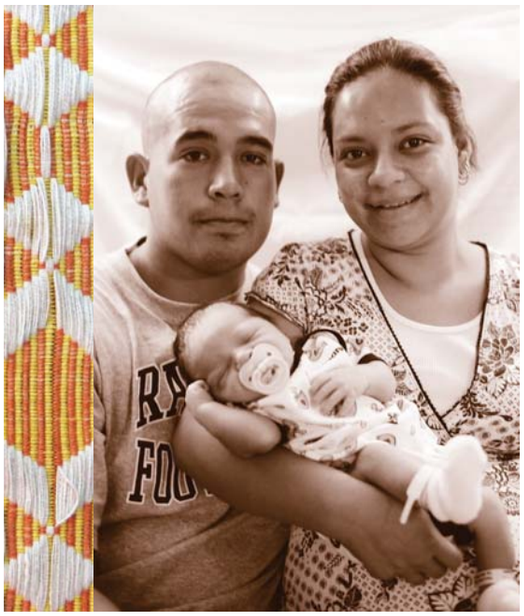
"Deliveries are safer. Newborns are born healthier."

Dr. Haffner brings a longtime, firsthand perspective to the issue. In 1971 he began a 10-year stint at the Gallup Indian Medical Center in New Mexico and then during the 1980s served as the IHS chief clinical consul-

tant for ob-gyn. He has continued to be involved in Indian health affairs and is currently a member of ACOG's Committee on American Indian Affairs.

"In the 1970s the obstetric issues were preeclampsia and eclampsia, with a significant number of maternal deaths related to hypertension," Dr. Haffner said.

This was addressed through improving prenatal and hospital care, he said.



Dr. Haffner credits the "conscientious partnership between the IHS leadership and tribal leadership" with improving health care.

"Initially, IHS ran everything in a centralized model. The partnership has evolved, and the tribes' taking a much stronger lead has been highly successful," Dr. Haffner said.

Dr. Murphy added that staff has a sense of mission and work hard.

"They work with the challenges. Most important, the native people themselves are very resilient and have worked hard."

Indian health care bill needs congressional action

Reauthorization of the Indian Health Care Improvement Act is a critical and long-overdue step needed to address the health care needs of American Indians. Since the act's original passage in 1976, it has been reauthorized every 5–7 years, but the last reauthorization, in 1992, has long since expired.

This February the US Senate passed a reauthorization bill that would expand health coverage and services.

"This is the first reauthorization where there's been a massive rewriting of the 1976 act," Dr. Yost said. "The health care picture looked very different in the 1970s. Diabetes was just an emerging problem. The act that passed in the 70s didn't recognize drug abuse and was very light toward preventive health care."

The Senate-passed bill would provide programs to recruit and train health professionals, address mental and behavioral issues such as substance abuse and suicide, and enhance prevention programs such as those dealing with diabetes and obesity. As *ACOG Today* went to press, a similar bill was pending in the House. ACOG supports the bill and urges members to contact their congressional representatives to ask them to support it. ♀

info

- On the ACOG website, www.acog.org, under "Women's Issues," click on "Indian Health Service"
- Indian Health Service: www.ihs.gov

About the photos used in this article

THE COVER PHOTO AND the photos on these pages decorate the walls of the Whiteriver Indian Hospital Birthing Center in Whiteriver, AZ. All the children in the portraits were patients at the hospital. The photos were taken in 2007 by one of the nurses, Jessica Bledsoe, an amateur photographer, after the staff wanted to add portraits of their patients to the walls of their newly remodeled birthing center.

"We wanted our birthing center to reflect the fact that this was a place for Native American women, and specifically for White Mountain Apache women and their families. We wanted patients to feel that the birthing center belonged to them because, in essence, it does," explains LeeAnn Beach, RN, SCN, the center's supervisory clinical nurse.

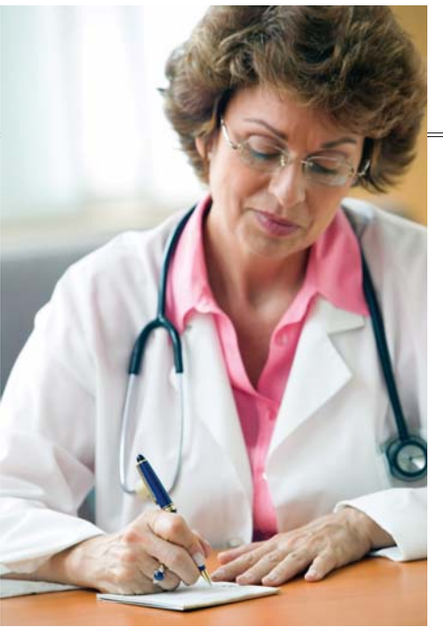
The cover photo shows a newborn in a "cradleboard," commonly used among the White Mountain Apache to carry their children. ♀

SHORT-TERM OB-GYN PLACEMENT AT INDIAN HOSPITALS

Since the mid-1970s ACOG has run a program to place ob-gyns at Indian hospitals for brief periods. ACOG Fellows Serving Native American Women provides coverage for ob-gyns on staff at Indian Health Service hospitals when they go on vacation or are participating in continuing medical education or when staff positions are vacant.

Fellows or Junior Fellows who are US citizens and have recent experience in high-risk obstetrics may be eligible for assignments of 3–4 weeks or more. ACOG encourages members to participate in this program. For more information, visit the ACOG website (see "info" above). ♀

When should you prescribe drugs for osteopenia?



A NEW ACOG COMMITTEE Opinion offers some guidance for ob-gyns trying to decide whether to prescribe prescription drug intervention to patients with low bone mass.

The new Committee Opinion *Low Bone Mass (Osteopenia) and Fracture Risk* recognizes that a diagnosis of low bone mass can cause confusion for physicians and patients alike. An estimated 26 million women in the US have osteopenia, defined as bone mineral density T-scores between –1 and –2.5. Bone mineral density alone cannot determine a patient's fracture risk; age, fracture history, and risk of falling should also be considered, according to the document, which was published in the May issue of *Obstetrics & Gynecology*.

The Committee Opinion supports ACOG recommendations for pharmacotherapy for:

- Postmenopausal women who have experienced a fragility or low-impact fracture
- Postmenopausal women with no risk factors who have a BMD T-score by central DXA of less than –2
- Postmenopausal women with risk factors for fracture who have a BMD T-score by central DXA of less than –1.5

The document includes a box highlighting risk factors, which include Caucasian race, smoking, family history of osteoporosis, and low weight and BMI.

"Clinicians must be careful, as the diagnosis of osteopenia is often interpreted as indicating a pathologic skeletal condition or significant bone loss, neither of which is necessarily true," states the Opinion. "Until better models of absolute fracture risk exist, postmenopausal women in their 50s with T-scores in the osteopenia range and without risk factors may well benefit from counseling on calcium and vitamin D intake and risk factor reduction, with a delay to initiation of pharmacologic intervention."

The National Osteoporosis Foundation recently released new clinician guidelines on the prevention and treatment of osteoporosis that use a new algorithm called FRAX to determine a person's 10-year absolute fracture risk. The tool, which was developed by the World Health Organization, takes into account nine specific clinical risk factors for osteoporosis. ACOG's new Committee Opinion was developed before the osteoporosis foundation released its new guidelines, but the Committee Opinion states that the WHO tool may become the standard. ♀

info

- Committee Opinion *Low Bone Mass (Osteopenia) and Fracture Risk* (#407, May 2008): www.acog.org/publications/committee_opinion/co407.cfm
- Practice Bulletin *Osteoporosis* (#50, January 2004): www.acog.org/publications/educational_bulletins/pb050.cfm
- The National Osteoporosis Foundation's new *Clinician's Guide to Prevention and Treatment of Osteoporosis*: www.nof.org/professionals/Clinicians_Guide.htm

Egg freezing should be offered only in research setting

WOMEN WHO WANT TO delay childbearing into their late 30s, 40s, and beyond may be considering freezing their eggs. Some companies market oocyte cryopreservation as a way for women to beat their biological clock and have the ability to choose when they want to have children later in life.

Cryopreservation of ovarian tissue and oocytes has also garnered interest for preserving fertility for women with cancer who undergo chemotherapy and radiation treatment.

A new ACOG Committee Opinion cautions that while cryopreservation of ovarian tissue and oocytes holds promise for fertility preservation, the procedures are currently investigational and should be offered only with appropriate informed consent in a research setting and under the auspices of an institutional review board.

Ovarian Tissue and Oocyte Cryopreservation, which was published in the May issue of *Obstetrics & Gynecology*, states that further research is needed to determine patient selection, methods of tissue collection, and optimal cryopreservation protocols.

"For women who have cancer who wish to preserve their fertility, freezing embryos and later undergoing embryo transfer is the most successful option," said Lynda J. Wolf, MD, partner of Reproductive Medicine Associates of Michigan and a member of the Committee on Gynecologic Practice that wrote the Committee Opinion. "However, research is under way to see how these women respond to IVF after egg freezing. Currently, pregnancy rates are much lower with egg freezing than the rates are for frozen embryos. Eggs are extremely delicate, and the meiotic spindle can easily be damaged by ice formation."

The number of live births from egg freezing is limited, with one report calculating a 4% live birth rate. Current data are insufficient to provide any valid estimate of success for any one individual patient. ♀

NIH trials seeking pregnant patients to enroll

THE MATERNAL-FETAL MEDICINE Units Network at the National Institute of Child Health and Human Development is enrolling pregnant women for trials regarding hypothyroidism and also the prevention of preterm delivery in women with a short cervix. Participants in both trials need to be affiliated with one of the network sites.

"Ob-gyns can play an important role in connecting their pregnant patients to clinical trials," said Fellow Catherine Y. Spong, MD, chief of the Pregnancy and Perinatology Branch at NICHD and a liaison member of the ACOG Committee on Obstetric Practice. "Please consider helping your patients enroll in NIH trials to help further the research of perinatal medicine. Even if you are not at a network site, there are obstetric studies supported by NIH and other foundations that need patients."

The SCAN trial is a double-masked, placebo-controlled trial to determine whether 17α hydroxyprogesterone prevents preterm birth in nulliparous women with a short cervix. Participants don't have to deliver at a network hospital, but if they deliver or get care elsewhere, there will need to be an arrangement for them to continue to get weekly shots. This includes getting shots during any hospitalization, which will require the participating hospital to have approval from its institutional review board. Participants must also meet the following criteria:

- Be between 16 and 22 weeks of gestation
- Be pregnant with one fetus
- Have never delivered a baby after 19 weeks of pregnancy
- Have a cervix that measures less than 30 mm

The TSH trial is a double-masked, placebo-controlled trial to determine whether thyroxine treatment for subclinical hypothyrodisim or hypothyroxinemia diagnosed during the first half of pregnancy is associated with intellectual improvement in offspring, as measured each year until age five. Participants will need to attend one of the clinics where screening is taking place and deliver at a network hospital. Participants must also meet the following criteria:

- Be between 8 and 20 weeks of gestation
- Be pregnant with one fetus
- Have a blood test that shows their thyroid gland is mildly underactive, resulting in subclinical hypothyrodisim or hypothyroxinemia ♀

RESEARCH LOCATIONS

The 14 participating sites are in the following states:

- Alabama
- Illinois
- Michigan
- New York
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Rhode Island
- Texas
- Utah

info

→ MFMU Network and a list of the 14 clinical sites: www.bsc.gwu.edu/MFMU/projects/brieftrl.cgi

→ NIH-supported research in pregnancy and perinatology: www.nichd.nih.gov/about/org/cdbpm/pp/index.cfm

Conduct biopsy for vulvar skin disorders

IN PATIENTS PRESENTING WITH skin conditions of the vulva, the threshold for biopsy should be low because changes on the vulva are often subtle and can be overlooked, according to a new Practice Bulletin.

"Many ob-gyns aren't trained specifically in handling vulvar skin disorders, and this Practice Bulletin gives providers practical information for women presenting with lesions or symptoms such as vulvar pruritus and pain," said Fellow Lori A. Boardman, MD, ScM, director of the colposcopy and vulvar clinics at Brown University, who helped write the new document, which appears in the May issue of *Obstetrics & Gynecology*.

"Vulvar cancers, for example, are often not diagnosed in a timely fashion because providers are reluctant to biopsy," Dr. Boardman continued. "Furthermore, many vulvar skin disorders (eg, lichen planus) cannot confidentially be diagnosed without a biopsy. Even if not malignant, many disorders cause significant pain and discomfort, and determining the correct therapy is essential."

The document offers information on how to do a biopsy and the type of anesthesia to use and details the various skin conditions patients may have.

Providers should be aware that women presenting with vulvar disorders may be suffering from systemic diseases, such as Crohn's disease. Approximately one-third of women with Crohn's disease present with gynecologic complications, including enteric fistulas to both the upper and lower genital tract, granulomatous salpingitis and oophoritis, as well as vulvar inflammation, edema, granulomas, abscesses, and ulcerations, according to the Practice Bulletin.

Numerous studies have also shown a strong association between lichen sclerosus and a variety of autoimmune-related disorders. ♀

July webcast for the generalist about ovarian cancer

WOMEN WITH OVARIAN cancer often see several physicians and undergo multiple diagnostic procedures before being diagnosed with ovarian cancer and referred to a gynecologic oncologist.

An ACOG webcast in July will help the generalist ob-gyn recognize a woman's risks for ovarian cancer and understand how to appropriately refer patients. "Ovarian Cancer: Information for the Generalist Ob-Gyn" will be held on July 8, from 1 to 2:30 pm Eastern Time. The webcast's program director is ACOG Fellow Molly Brewer, MD, associate professor and director of the division of gynecologic oncology at the University of Connecticut Health Center.

At the conclusion of the webcast, participants should be able to:

- Recognize common signs and symptoms of ovarian cancer
- Recognize risk factors for ovarian cancer
- Determine who should be referred and why
- Determine if a woman is high risk
- Understand why a high-risk woman should be referred
- Be aware of minimally invasive surgery options for early-stage ovarian cancer

The webcast will be presented in real time over the Internet. Participants will need a computer with an Internet connection and speakers to access the presentation. An archived presentation will be available approximately one week after the live event.

ACOG webcasts are offered on the second Tuesday of every month. ♀

info

➜ To register for a webcast or access the webcast archives: On the ACOG website, www.acog.org, under "Meetings," click on "Postgraduate Courses and CPT Coding Workshops"

YOU ASKED, WE ANSWERED

Protecting yourself while working locum tenens

Q I AM CONSIDERING LOCUM tenens work before committing to a permanent practice location. What are the relevant issues concerning liability insurance?

A ONE OF THE MOST IMPORTANT considerations when contracting with a locum tenens company is professional liability insurance coverage. Before accepting an assignment, make sure the type and amount of coverage being provided is specified in your locum tenens contract.

Medical liability advisers suggest that you do not accept policies from any company that has less than a B+ rating by A.M. Best. Once you know you have a solid company with a good rating, determine the type of insurance policy, whether occurrence or claims-made. An occurrence policy covers events that occur during the policy period regardless of when they are reported as claims. Claims-made policies provide coverage for claims that are reported during the policy period but do not provide coverage for claims made after the policy expires, unless a tail policy is purchased.

State requirements vary in terms of the amount of medical liability insurance a provider must carry. Most states require ob-gyns to carry policy limits of $1 million/$3 million. Make sure your policy limits conform to the requirements in the state in which you will be practicing.

Don't forget the tail

Because locum tenens companies are not required by law to buy extended reporting or "tail" coverage for a claims-made policy, a medical liability tail must either be negotiated as part of the locum tenens agreement or purchased separately. Tail coverage is simply an endorsement to your policy that extends the period of time the company will cover claims that have not yet been reported to the insurance company.

The duration of the tail is an option that should be spelled out in the policy. A tail with an unlimited time period, if available, is recommended. Once you buy tail coverage you may not change the duration. For example, you can't buy a two-year tail and, when it expires, ask the company to extend it.

Tail policies can also vary in the amount of coverage they provide. An important element of a tail policy is the aggregate amount it will pay out over the life of the tail. This should be at least as much as the original policy.

As with any legal document, signing a locum tenens contract is serious business. Make sure all of your questions are answered satisfactorily and ask to see proof of insurance coverage before signing any agreement. If you are unsure about what you are getting, take a copy of the company's policy to an insurance broker you trust or have an attorney familiar with medical liability insurance review it with you. ♀

The information in this article 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.

2008 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

MAY

3–7
ACOG 56th Annual Clinical Meeting
New Orleans
www.acog.org/acm

13
ACOG WEBCAST:
Coding with Modifiers
1–2:30 pm ET
800-673-8444, ext 2498

15–17
American College of Physicians Internal Medicine Meeting
Washington, DC
www.acponline.org
800-523-1546, ext 2600

23–29
American College of Nurse-Midwives 53rd Annual Meeting & Exposition
Boston
www.acnm.org
240-485-1800

JUNE

10
ACOG WEBCAST:
Pay for Call
1–2:30 pm ET
800-673-8444, ext 2498

11–14
Western Association of Gynecologic Oncologists Annual Meeting
Sonoma, CA
www.wagogynonc.org
202-863-1648

14–18
American Medical Association Annual Meeting
Chicago
www.ama-assn.org
202-863-2515

25–29
Society of Obstetricians and Gynaecologists of Canada 64th Annual Clinical Meeting
Calgary, AB
www.sogc.org
613-730-4192, ext 347

JULY

8
ACOG WEBCAST:
Ovarian Cancer: Information for the Generalist Ob-Gyn
1–2:30 pm ET
800-673-8444, ext 2498

18–20
Gynecologic Oncology Group Semi-Annual Meeting
Chicago
www.gog.org
215-854-0770

AUGUST

8–9
ACOG Future Leaders in Ob-Gyn Conference
Washington, DC
202-863-2515

12
ACOG WEBCAST:
Interrupted Pregnancy Coding
1–2:30 pm ET
800-673-8444, ext 2498

14–16
Infectious Diseases Society for Obstetrics and Gynecology 35th Annual Scientific Meeting
Seattle
www.idsog.org/AnnMtg.cfm
202-863-2570

21–23
ACOG District III, VI, and IX Annual Meeting
Banff, AB
202-863-2530

24–28
18th World Congress on Ultrasound in Obstetrics and Gynecology
Chicago
www.isuog2008.com
info@isuog.org
+44(0) 20-7471-9955

SEPTEMBER

4–6
American Urogynecologic Society 29th Annual Scientific Meeting
Chicago
www.augs.org
202-367-1167

5–7
ACOG District I Annual Meeting
Brewster, MA
202-863-2531

5–7
ACOG District IV Annual Meeting
Orlando, FL
202-863-2441

9
ACOG WEBCAST:
E/M Coding and Medical Necessity
1–2:30 pm ET
800-673-8444, ext 2498

11–13
American Gynecological and Obstetrical Society
Carlsbad, CA
www.agosonline.org
202-863-2648

17–20
Royal College of Obstetricians and Gynaecologists 7th International Scientific Meeting
In conjunction with ACOG and the Society of Obstetricians and Gynaecologists of Canada
Montreal, QC
www.rcog2008.com

17–20
Association of Reproductive Health Professionals Annual Meeting
Washington, DC
www.arhp.org
202-466-3825

17–20
Society of Laparoendoscopic Surgeons 17th Annual Meeting & Endo Expo
Chicago
www.laparoscopy.org
305-665-9959

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.

MAY

8–10
ICD-9-CM and CPT Coding Workshop
New Orleans

JUNE

5–7
Quality and Safety for Leaders in Women's Health Care
Chicago

7–8
"No Frills" Emerging Issues in Office Practice: Sexuality, Body Image, and Psychologic Well-Being
Chicago

20–22
ICD-9-CM and CPT Coding Workshop
Portland, OR

26–28
Reawakening the Excitement of Obstetrics and Gynecology
Kohala Coast, HI

27–29
ICD-9-CM and CPT Coding Workshop
San Francisco

JULY

11–13
ICD-9-CM and CPT Coding Workshop
Memphis, TN

17–19
Concepts and Controversies in the Treatment of Perimenopausal and Postmenopausal Women
Vancouver, BC

AUGUST

15–17
ICD-9-CM and CPT Coding Workshop
Richmond, VA

21–23
Practical Obstetrics and Gynecology (in conjunction with the ACOG District III, VI, and IX Annual Meeting)
Banff, AB

SEPTEMBER

12–14
ICD-9-CM and CPT Coding Workshop
Chicago

18–20
Update on Cervical Diseases
Charleston, SC

26–28
ICD-9-CM and CPT Coding Workshop
Dallas

NOVEMBER

6–8
Practical Obstetric and Gynecologic Ultrasonography: Spotlight on Chronic Pelvic Pain
Naples, FL

14–16
ICD-9-CM and CPT Coding Workshop
Atlanta

20–22
New Surgical Approaches to Incontinence and Prolapse
Chicago

Apply for ACOG history fellowship

APPLY NOW FOR THE 2009 ACOG Fellowship in the History of American Obstetrics and Gynecology. Applications are due by October 1. The award carries a $10,000 stipend for expenses while the fellow spends a month in Washington, DC, working full time on the fellow's specific historical research project.

The fellow will have access to the ACOG History Library and is encouraged to use other national, historical, and medical collections in the Washington area. The research results must be disseminated through publication or presentation at a professional meeting. ♀

info

→ 800-410-2264; dscarborough@acog.org

Free birth control booklet, poster

THE US FOOD AND DRUG ADMINISTRATION'S OFFICE of Women's Health has developed a new birth control booklet and poster. The booklet features illustrations of the 18 contraceptive products currently approved by the FDA and on the market in the US and provides information on their risk and effectiveness. It also includes a tear-out sheet for comparing all products at a glance. ♀

info

→ 24-page booklet: www.fda.gov/womens/healthinformation/birthcontrolguide.pdf
→ Poster: www.fda.gov/womens/healthinformation/Birth%20Control%20Poster.pdf

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Save 20% for a limited time. Take advantage of this special offer on ACOG's revised pamphlets.

Bowel Control Problems (AP139)

- The causes of bowel control problems
- How they are diagnosed
- Ways a woman can help regain control of her bowels

Depression (AP106)

- Symptoms of depression
- How it is diagnosed
- How it can be treated

info

→ To preview these pamphlets: www.acog.org/goto/patients
→ To order pamphlets: http://sales.acog.org; 800-762-2264 (use source code DM68 1006)
→ To request a free sample: resources@acog.org