

How to manage abnormal cervical cytology

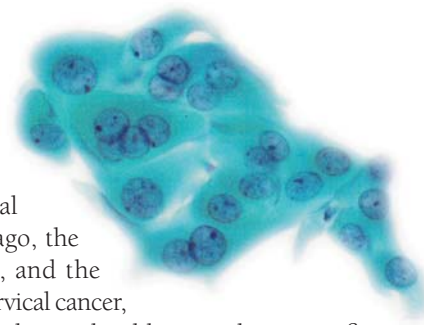


CONFUSION OVER THE management of cervical cytology abnormalities can lead to both overtreatment and undertreatment of women. With overtreatment, patients may experience unnecessary visits, procedures, and added anxiety. However, with undertreatment, significant lesions may progress to invasive cancer, according to a new ACOG document.

The new Practice Bulletin, *Management of Abnormal Cervical Cytology and Histology*, provides recommendations on how to manage the various cer-

vical cytology abnormalities. The document was published in the September issue of *Obstetrics & Gynecology*.

“With the changes in cervical cytology guidelines two years ago, the increasing usage of HPV tests, and the evolving data on HPV’s link to cervical cancer, it can be confusing as to how an ob-gyn should respond to a specific cytologic abnormality,” said Fellow Walter K. Kinney, MD, co-author of the document. “This new Practice Bulletin goes over each of the abnormalities—using the 2001 Bethesda System nomenclature—and explains the appropriate follow-up. It’s important to note that colposcopy with directed biopsy remains the gold standard for detecting disease.”



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Ob-gyns share their love of the specialty with medical students

ACOG links medical students with ob-gyn mentors

SANDRA A. CARSON, MD, an ob-gyn professor at Baylor College of Medicine in Houston, encourages medical students to spend a night on call with her in the labor and delivery department.

Patrick S. Ramsey, MD, MSPH, assistant ob-gyn professor at the University of Alabama at Birmingham, interacts with medical students frequently as the faculty sponsor of the UAB Medical Student Ob-Gyn Interest Group.

Joseph S. Sanfilippo, MD, professor of ob-gyn and reproductive sciences at the University of Pittsburgh School of Medicine, advises students on the direction of their careers, and his university hosts a “Meet the Professor” session for medical students in-

terested in ob-gyn at the end of their third year of med school.

These ACOG members are just a few of the ob-gyns helping to promote the specialty through the ACOG Medical Student Mentoring Program, which is part of ACOG’s Medical Student Initiative.

“We are so privileged to practice in the most interesting field of medicine. It is only through our mentoring medical students that this world opens up to them,” Dr. Carson said. “Participation in the delivery of a baby allows medical students to experience the intimacy and trust of a doctor-patient relationship very early in their career. The science, emotion, and rewards can be confusing to the

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▲ Medical student Lisa May Olson, Portland, OR, on the right, chats with Immediate Past JFCAC Chair Leah A. Kaufman, MD, during the Medical Student and JFCAC Reception at this year’s ACM, one of the ACOG events to unite medical students with ob-gyn mentors.



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EXECUTIVE DESK

Flu season is approaching: Are you immunizing your pregnant patients?

IN NOVEMBER LAST YEAR, the Committee on Obstetric Practice issued a Committee Opinion called *Influenza Vaccination and Treatment During Pregnancy*. I hope everyone who cares for pregnant women has read this important document. As the Committee Opinion states, "Influenza vaccination is an essential element of prenatal care."

The Committee Opinion supports the expanded recommendations issued by the Centers for Disease Control and Prevention last year that state that an intramuscular, inactivated vaccine may be used in all three trimesters. The ideal time to vaccinate pregnant women is October and November. However, any time throughout the influenza season is appropriate—the flu season runs from October 1 through mid-May.

At a recent conference sponsored by ACOG, a number of the country's experts discussed maternal immunizations. On several occasions, the experts pointed out that immunizing the mother offers some immunity to her infant as well. Because there is no influenza vaccine or antiviral therapy approved for infants younger than six months, immunization of the mother offers a two-for-one advantage.

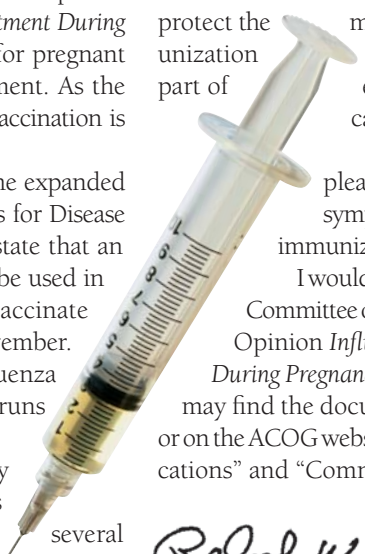
Flu shots should be routine prenatal care

In obstetrics we utilize many preventive measures to protect the mother and help her child. Immunization for influenza should also be every ob-gyn's routine prenatal care.

As influenza season nears, please familiarize yourself with the symptoms and offer your patients an immunization.

I would also encourage you to reread the Committee on Obstetric Practice's Committee Opinion *Influenza Vaccination and Treatment During Pregnancy* (#305, November 2004). You may find the document in the 2005 *Compendium* or on the ACOG website, www.acog.org, under "Publications" and "Committee Opinions." ♀

Ralph W. Hale, MD, FACOG
Executive Vice President



IN MEMORIAM

Ramesh H. Deopuria, MD • Scranton, PA • 6/05

Stuart Allan Eigen, MD • New York City • 4/05

Neil D. Jackson, MD • Providence, RI • 4/05

Franklin W. Kapke, MD • Venice, FL • 6/05

Landrum B. Shettles, MD • St. Petersburg, FL

Correction

Call for papers, posters, films for 2006 ACM

The dates provided to *ACOG Today* for the paper/poster and film festival abstracts in the August 2005 issue were incorrect. The deadlines for online submission for the 2006 Annual Clinical Meeting are:

Paper/poster abstracts: **September 30**

Film festival abstracts: **November 21**



Obstetrics & Gynecology HIGHLIGHTS

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

Management of Abnormal Cervical Cytology and Histology

(Practice Bulletin #66, new)

See page 1 for more information

The Importance of Preconception Care in the Continuum of Women's Health Care

(Committee Opinion #313, new)

See page 11 for more information

Meningococcal Vaccination for Adolescents

(Committee Opinion #314, new)

Obesity in Pregnancy

(Committee Opinion #315, new)

See page 10 for more information

Plum magazine wins multiple international awards

ACOG'S *PLUM* MAGAZINE recently received seven awards in four separate international competitions.

Developed by the ACOG Office of Communications, *Plum* is the first-ever magazine specifically targeting pregnant women age 35 and older. It is available free to ACOG members, who then distribute it to their patients.

Plum won two Crystal Awards of Excellence and two Awards of Distinction from The Communicator Awards and a 2005 Gold Quill Award of Excellence for publication design from the International Association of Business Communicators.

The publication also won an Award of Merit in the 2005 Dalton Pen Communications Awards competition and an APEX 2005 Grand Award for Excellence.

In the Communicator Awards program, of the 5,078 entries, only about 13% won the coveted Crystal Award of Excellence, and about



19% won the Award of Distinction. In the Gold Quill competition, of nearly 1,000 entries from 26 countries, only 34 Awards of Excellence were given.

“We are delighted that *Plum* has been recognized by so many leaders in the communications field,” said Penelope Murphy, MS, ACOG’s director of communications and editorial director for the magazine. “Our sole objective was to create a useful educational tool for the ever-increasing demographic of older women having children in the US. *Plum* not only delivers much-needed medical information to these women, but visually, it is a beautifully designed magazine. We have received such an overwhelming amount of appreciation and praise for the magazine

from our ob-gyn members that we feel satisfied that we hit our mark with *Plum*.”

Plum is independently published by New York-based Groundbreak Publishing Inc, in cooperation with ACOG. ♀

ACOG links medical students with ob-gyn mentors

PAGE 1 student, and the guidance of a mentor relieves the anxiety and channels the experience into a wonderful event.”

ACOG developing mentor list

Medical students can find ob-gyn mentors through a list on the ACOG website. The College is continually adding to the list as more ACOG members volunteer to serve as mentors. The goal is to have one Fellow and one Junior Fellow mentor at each US medical school.

If there is no mentor listed from their school, medical students can still benefit from the program. Many of the mentors have developed ongoing email correspondence with med students, answering their specific questions about the field and describing their experiences as an ob-gyn.

“I have had a number of Junior Fellows and med students contact me for specific program advice as well as career direction,” Dr. Sanfilippo said. “If a student goes to a program other than the University of Pittsburgh, they still ask me for advice. The importance of the mentor program is for many of us to share the enthusiasm we have for our specialty and the rewards of OB as well as the surgical aspects of gynecology.”

Promoting the specialty

As mentors interact with students in groups or one-on-one, they should present the ob-gyn field realistically and be prepared to answer questions about call duty or professional liability. It’s also important that male students recognize that men are wanted and needed in the

specialty. Physicians should also explain why they became an ob-gyn and describe the diversity of the specialty, from primary care to subspecialties to surgery.

“We need to share our thoughts and experiences about ob-gyn as a career with students so they can gain full appreciation for the diversity of the specialty and the pivotal role of an ob-gyn as a women’s health care specialist,” Dr. Ramsey said. “This is immensely important to provide students with insights into ob-gyn as a career choice.” ♀

Candidates for mentors should:

- ▶ Commit to a minimum of one year of involvement in the program
- ▶ Have a positive outlook on how ob-gyns can make a difference
- ▶ Have weekly or daily contact with medical students, preferably those in their first or second year of medical school
- ▶ Be faculty or staff at a medical school or a community physician in practice
- ▶ Be someone who loves being an ob-gyn and who can pass along that enthusiasm to students
- ▶ Be available for students to shadow
- ▶ Be energetic and responsible, with good communication skills

info

Email Colleen Flood at student@acog.org to learn more about ACOG’s Medical Student Mentoring Program or to recommend an ob-gyn for the program
List of mentors: On the ACOG website, www.acog.org, under “Membership,” click on “Medical Students”



AMA young physicians discuss cord blood banking, pharmacist right-of-refusal

Erin E. Tracy, MD, MPH
Representative to the AMA Young Physicians Section

THE AMERICAN MEDICAL Association Young Physicians Section has asked the AMA to evaluate two emerging topics affecting ob-gyns and their patients: private cord blood banks and the scenarios in which pharmacists refuse to dispense medication because of their personal beliefs. The section adopted these two resolutions during the AMA's annual meeting in June.

As part of the cord blood banking resolution, the young physicians asked the AMA to study issues related to the ethics of marketing cord blood banks; the informed consent process; and the advisability of federally mandated regulatory oversight of cord blood bank processes to ensure safety and compliance with specific uniform standards.

Currently, there are no national uniform quality control standards and no central regulation of private cord blood banks. It is anticipated that the AMA House of Delegates will debate this issue at its November interim meeting.

The second resolution of interest was written in response to numerous reports of pharmacists refusing to fill legally written prescriptions for medications, namely emergency contraception and oral contraceptive pills.

The resolution as adopted asks the AMA to call on the American Pharmacists Association, the American Society of Health System Pharmacists, and other appropriate organizations to vigorously reaffirm and take positive steps to enforce their own policies. These policies support the estab-

lishment of systems that protect a patient's right to obtain legally prescribed, medically indicated therapy when an individual pharmacist exercises the right of conscientious refusal. The resolution also calls on the AMA to monitor developments in state "conscience clause" legislation and work with state medical societies to prevent passage of statutes or regulations that impinge on patient access to legally prescribed, medically indicated therapies.

The Obstetrics and Gynecology Section Council to the AMA supports these resolutions. Please don't hesitate to contact me if there are any items of concern you would like the AMA to address. ♀

info

eetracy@partners.org



Section develops post-residency speaker series

TO PREPARE JUNIOR FELLOW residents for life after residency, the Massachusetts Section developed a speaker series. Initiated by the Junior Fellows in the section, the dinner series has increased professional and social interactions among

the resident Junior Fellows, while also educating them about key post-residency issues, including personal finance, first-time home buying, fellowship opportunities, and contracts and negotiations.

"The section generously agreed to fund the series for a year, and it has been quite a success!" said Erica E. Marsh, MD, past Junior Fellow chair of the section. "Most of us had never met fellow ob-gyn residents from the other programs in Boston, and many of the residents knew very little about ACOG, so it was a great opportunity to meet one another and learn about ACOG as an organization."

The section also wants to expose medical students to ACOG, ob-gyn residents, and practicing ob-gyns to help the students gain firsthand knowledge of the diversity of options available in the specialty.

The section sponsored four sessions in 12 months in the Boston area. Each session included a round of "ACOG Jeopardy," in which the attendees had the opportunity to answer questions about ACOG at the national, district, and section level and win a small prize. ACOG pamphlets and membership applications were available at each session.

The goals of the speaker series include:

- ▶ Preparing residents for the transition from residency to life after residency
- ▶ Making residents fully aware of post-residency options
- ▶ Familiarizing residents and medical students with the structure, leadership, services, and goals of ACOG
- ▶ Facilitating networking and mentorship between medical students, residents, and practicing ob-gyns in the community ♀



▲ Two Tufts University residents listen to a presentation about a family planning fellowship at a speaker series event.

ACOG seeks award nominations

Deadline: September 30

Outstanding District Service Award

It's time to honor Fellows for their unwavering service to their districts. ACOG is seeking nominations from each district for the Outstanding District Service Award.

Forward your nomination to one of your section or district officers before your Annual District Meeting this fall. District chairs will submit nominations with a letter of recommendation to ACOG. Nominations are due at ACOG by September 30.

Nominees must:

- ▶ Be a Fellow who has made a significant contribution within the district, in government, research, teaching, or patient care
- ▶ Have provided service to the district sufficient to receive national ACOG recognition

Deadline: November 30

Wyeth Pharmaceuticals Section Award

Section chairs are asked to consider exceptional section projects for nomination for the 2005 Wyeth Pharmaceuticals Section Award. Section chairs may select one outstanding activity conducted within the section during 2005 and submit an activity report to their district chair. All reports are due to the chair before the district's fall Advisory Council Meeting. Individual district advisory councils will discuss nominations at the fall district meetings, and district chairs will submit nominations with a letter of recommendation to ACOG. Nominations are due two weeks post-ADM or by November 30.

info

District and Wyeth awards:

Click on the "District and Section Activities" link under "Membership" on the ACOG website, www.acog.org, or contact Marlena Wyandt: 800-673-8444, ext 2332; mwyandt@acog.org

Distinguished Service Award and Honorary Fellowship:

Terrie Gibson: 800-673-8444, ext 2515; tgibson@acog.org

Deadline: Feb 1, 2006

Distinguished Service Award and Honorary Fellowship

ACOG is seeking nominations for the College's Distinguished Service Awards and Honorary Fellowships to be presented in 2007.

Send a recommendation letter and the nominee's CV to Terrie Gibson in ACOG's Office of the Executive Vice President by Feb 1, 2006. Nominations will be considered by the ACOG Committee on Honors and Recognitions at its May 2006 meeting.

Criteria for the Distinguished Service Award

- ▶ Must be an outstanding individual in ob-gyn who has made important contributions within the College or in government, research, training, or direct patient care
- ▶ May include individuals in maternal and child health
- ▶ Should be an individual living within the geographic confines of the College
- ▶ May be any person who has made an outstanding contribution to the College and/or the discipline of ob-gyn

Criteria for Honorary Fellowship

- ▶ Must have made an outstanding achievement in ob-gyn or an allied discipline in any country
- ▶ Must have obtained national and international recognition (achieved distinction and recognized for a leadership position by being elected president or a senior officer of a national or international ob-gyn society or organization)
- ▶ May be an editor of a major international ob-gyn journal
- ▶ May be involved in international public service (may have achieved major leadership in international organizations that relate to ob-gyn)
- ▶ May be a non-ob-gyn who has distinguished himself or herself internationally in an area that affects women's health and the specialty
- ▶ Should have a relationship with US activities involving women's health care ♀

Monthly ACOG webcasts bring continuing education direct to your office

FOR MORE THAN A YEAR, ACOG has been offering monthly webcasts to educate ob-gyns and their staff about practice management, coding, and professional liability issues.

Held on the first Tuesday of each month, the sessions allow physicians and their staff to stay updated on important issues without leaving the office. The webcasts are presented in real time over the telephone with accompanying slide presentation on the Internet. All webcasts are held from 1 to 2:30 pm ET.

Upcoming webcasts include:

OCTOBER 4: MANAGING ADVERSE OUTCOMES will address the significance of patient rapport and communication in minimizing professional liability; how to discuss an adverse outcome with a patient and her family; informed consent; and regulatory requirements for disclosure of unanticipated outcomes

NOVEMBER 1: COMPLICATIONS OF LAPAROSCOPIC SURGERY will cover the factors predisposing to complications; how to counsel patients about the risks and benefits; and technical issues

DECEMBER 6: PREVIEW OF NEW CODES FOR 2006

How to participate

Participants need a telephone and a computer with Internet access. The cost for each webcast is per site, allowing several people to take part at the same location for one price. Continuing medical education credits are available for each webcast. ♀

info

Webcast registration: ACOG website, www.acog.org.

Under "Meetings," click on "Postgraduate Courses and CPT Coding Workshops"

Suggestions for future webcast topics: email adiamond@acog.org



2006 WEBCASTS

Held on the second Tuesday of each month

2006 topics will include:

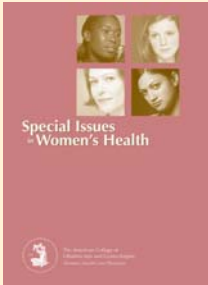
- ▶ Pay-for-performance
- ▶ Coding
- ▶ Fetal heart rate interpretation
- ▶ Physician employment contracts
- ▶ Neonatal encephalopathy and cerebral palsy

ACOG book fills a need

ACOG'S NEW BOOK *Special Issues in Women's Health*, which was mailed to all Fellows and Junior Fellows in May, has met a receptive audience.

"People at a recent adolescent health coalition meeting were excited to see a book on women's health that also had a focus on adolescents," according to Lisa Goldstein, MS, ACOG director of adolescent health care and health care for underserved women.

The book addresses substance abuse, smoking cessation, domestic violence, and sexual assault, and discusses health care in special populations such as lesbian and bisexual women, women with disabilities, and incarcerated females. Adolescent care is specifically addressed within many of the topics.



"We wanted to highlight that ob-gyns are seeing women with these special issues and in these special populations every day but that physicians may not immediately recognize this," Ms. Goldstein said.

Using the book to find referrals

The new publication features extensive lists of resources and can help ob-gyns find local referrals.

For example, among the resources listed at the end of the chapter on substance abuse is the website www.samsa.gov, operated by the Substance Abuse and Mental Health Services Administration. By clicking on a map, the website visitor can locate both public and private drug and alcohol abuse treatment programs in a specific geographic area. ♀

info

Order at: <http://sales.acog.org>; 800-762-2264, ext 192

ACOG research grant applications due October 1

APPLICATIONS FOR ACOG research fellowships and awards are due October 1. Applicants must be ACOG Fellows or Junior Fellows. Awards are available in many women's health areas, including:

- ▶ Menopause
- ▶ Ultrasound
- ▶ Contraception
- ▶ PMS/PMDD
- ▶ Basic research
- ▶ Health policy ♀

info

On the ACOG website, www.acog.org, under "Education," click on "Research Fellowships and Awards"

Lee Cummings: 800-673-8444, ext 2577; lcummings@acog.org

Executive Board Orientation

New members of ACOG's Executive Board gathered before the July board meeting for an orientation about the College.



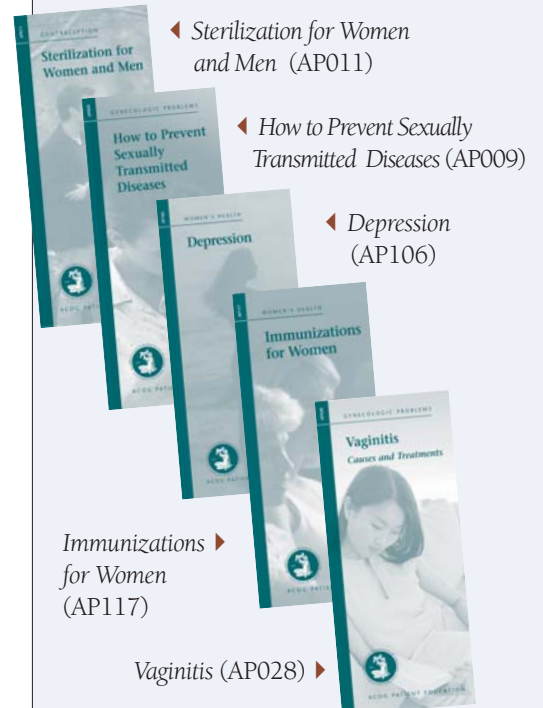
▶ Michael P. Nageotte, MD, new ex officio representative for the Society for Maternal-Fetal Medicine; Patrick S. Ramsey, MD, new Junior Fellow College Advisory Council vice chair; and Laura A. Dean, MD, new Fellow-at-large



▶ Dr. Ralph W. Hale, ACOG executive vice president, explains ACOG procedures to new board members.

◀ District V Chair-Elect J. Craig Strafford, MD, and District V Vice Chair-Elect Robert P. Lorenz, MD

Newly revised Patient Education Pamphlets available



◀ *Sterilization for Women and Men* (AP011)

◀ *How to Prevent Sexually Transmitted Diseases* (AP009)

◀ *Depression* (AP106)

▶ *Immunizations for Women* (AP117)

▶ *Vaginitis* (AP028)

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Wisconsin Supreme Court declares cap unconstitutional



ACOG IS URGING THE

Wisconsin Legislature to reinstate a cap on non-economic damages in medical liability cases after the Wisconsin Supreme Court declared the cap unconstitutional in July.

“The Legislature must act immediately to fashion a new statutory system that provides the legitimate justification that the court found lacking in current law,” said ACOG Fellow and State Rep. Sheldon A. Wasserman, MD, (D-Milwaukee).

Liability insurance premiums in Wisconsin have remained relatively stable: In 2004, ob-gyns paid slightly more than \$23,000 annually for medical liability insurance compared with ob-gyns in parts of nearby Illinois, where annual premiums increased to more than \$230,000.

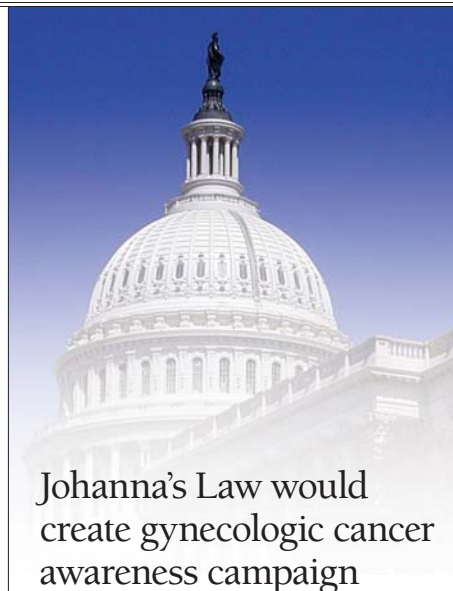
“As a result of Wisconsin’s cap on pain and suffering compensation enacted in 1995, Wisconsin has been largely protected from the medical liability insurance crisis sweeping the country,” said ACOG President Elect Douglas W. Laube, MD, Madison, WI. “Our state has been a relative oasis, unlike neighboring Illinois, where medical liability insurance premiums have soared, forcing many specialists, especially ob-gyns, to leave the state.”

Wisconsin instituted a \$350,000 cap in 1995 that was adjusted annually for inflation. Before it was thrown out, the cap was \$445,775. Wisconsin also has a statewide risk pool, or patient compensation fund, that physicians and other health professionals and entities are required to pay into. The fund protects physicians from high-cost claims and helps stabilize insurance premiums and keeps them low. It also ensures that injured patients receive full economic compensation for their injuries.

The goal of the patient compensation fund is to ensure availability of medical liability insurance by paying for large losses in just a few cases. However, without a cap, the fund is in jeopardy.

“While the rest of the country is seeking to fix what is broken with our tort system through the enactment of caps, the Wisconsin Supreme Court has thrown them out,” Dr. Laube said. “This decision will destroy a health care system that has proven to be effective for the people of Wisconsin. We urge the Wisconsin Legislature and Governor Jim Doyle to take immediate steps to correct this untenable situation.”

The Wisconsin Legislature is one of the few state legislatures that meet year-round, and as such, it could act on the cap this fall. ♀



Johanna’s Law would create gynecologic cancer awareness campaign

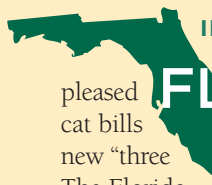
A BILL INTRODUCED IN Congress would provide money to develop an awareness campaign about gynecologic cancers. “Johanna’s Law: The Gynecologic Cancer Education and Awareness Act of 2005” was reintroduced earlier this year in the US Senate and House of Representatives. The bipartisan bill, HR 1245 and S 1172, was in committee at press time. ACOG is urging House and Senate committees to take action on this legislation this year.

Nearly 80,000 women in the US will be diagnosed with gynecologic cancer each year, and about 29,000 will die, according to the American Cancer Society. Most women are unaware of the risk factors and symptoms of gynecologic cancers such as cervical cancer, ovarian cancer, uterine cancer, and vaginal and vulvar cancer.

The legislation, which ACOG supports, would provide \$15 million to develop an awareness campaign through the US Department of Health and Human Services and \$30 million for demonstration grants for outreach and education strategies aimed at women and health care professionals.

“By helping women learn about the signs and symptoms of these diseases, we can begin protecting all women and help reduce the number of unnecessary deaths these cancers claim,” said ACOG Fellow Beth Y. Karlan, MD, president of the Society of Gynecologic Oncologists. ♀

Copypat bills strike out across US



IN STATE LEGISLATURES

across the country, ACOG was pleased **FL** not to see a swarm of copypat bills modeled after Florida’s new “three strikes, you’re out” law. The Florida law revokes the license of any physician who has had three or more incidents of medical liability.

A “three strikes, you’re out” bill did get through the Washington Legislature and will appear as a ballot initiative in November. However, similar legislation was proposed in only a handful of states, where it was fended

off by opponents, said Kathryn Moore, ACOG’s director of state legislative and regulatory affairs.

“It wasn’t the huge battle we thought it would be across the country,” Ms. Moore said.

In Florida, the Legislature was tasked with clarifying the “three strikes, you’re out” law, which passed by ballot initiative last year.

The Legislature narrowed the scope of the law, determining that it doesn’t include settlements and will apply only to incidents occurring after Nov 2, 2004, the date that the ballot initiative passed. ♀

Hospital laborist offers new ob-gyn practice model

PROPOSERS OF THE NEW laborist model of ob-gyn practice believe it's a concept whose time has come. Patient safety, a better lifestyle for ob-gyns, and decreased liability for hospitals are the three pluses mentioned most frequently.

"The No. 1 thing is patient safety," said Philadelphia Fellow Louis Weinstein, MD, whose editorial in November 2003 in the *American Journal of Obstetrics and Gynecology* proposed the laborist as a solution to a host of challenges facing the specialty. "Suppose a patient rolls in at 8:30 in the morning with substantial vaginal bleeding with an abruption. In the hospital with a laborist on staff, she's in the OR being delivered in five minutes."

Laborist role varies by hospital

The laborist is an ob-gyn employed by the hospital to manage laboring patients and obstetric emergencies. Beyond those basics, responsibilities vary according to the institution.

Fellow Duncan R. Neilson Jr, MD, said that a key element of the laborist program at Salmon Creek Hospital in Vancouver, WA, is to staff a high-risk pregnancy service. The laborists also provide back-up for family physicians and midwives, who have had increasing difficulty in obtaining coverage by ob-gyn practices because of liability concerns.

At academic institutions, the laborist may have teaching duties. In other hospitals the laborist functions as an "ob-gyn hospitalist," assisting with inpatients on other services who develop a gynecologic problem, in addition to responsibilities in labor and delivery.

Ob-gyns turning to laborist positions in mid-career

The laborist presents a major shift from the traditional obstetric practice and, apparently, a welcome one.

"More than 260 ob-gyns responded to our recruitment ad for laborists," said Dave Joyce, president of Delphi Healthcare Partners, which provides physician staffing services to hospitals. "Most had been in practice 15–25 years. They were tired of the hassle—dealing with escalat-

ing overhead costs, reimbursement, HMOs, and liability insurance. And they're sick and tired of being on call."

Dr. Neilson reported a similar experience: "In one week we had 60 responses from all over the country. It was amazing. They were almost entirely mid-career ob-gyns who really love to do obstetrics. They were tired of practice management issues and worried about being able to continue obstetrics because of the liability environment."

The laborist practice also will appeal to medical students interested in ob-gyn but leery of the hours they see in current practices, accord-



ing to Dr. Weinstein. He believes the shift-work aspect of the position offers a more appealing lifestyle to "gen X and Y" physicians.

Effects on private-practice ob-gyns

The presence of the laborist benefits ob-gyns in private practice, Dr. Neilson said.

"The problem in ob-gyn practice is trying to balance labor-room care against office hours, surgery, and time with the family. The laborist allows the ob-gyn group to have their patients covered if they wish or if they can't get to the hospital in time."

Another aspect of the in-house laborist seen as a plus for many communities is that private-practice ob-gyns are relieved of emergency call for unassigned patients.

As Mr. Joyce said, "There's no more rotating call list to cover the emergency department."

"I hear the argument all the time that private patients don't want another physician to deliver them," Dr. Weinstein said. "It's nice to have somebody you know, but the bottom line is to have the safest environment you can. So patients will accept it."

The physicians who won't like working with the laborist model are those with controlling personalities, according to Dr. Neilson.

"That kind of person wouldn't want a laborist 'interfering' with their patient. But it is well-recognized in medicine that excessive autonomy is bad for patient safety."

Reducing liability seen as plus by hospitals

Reducing liability is the primary driver for hospitals to use the laborist model.

"Averting a single \$10 million lawsuit would pay for the laborist program for years in a self-insured institution," Dr. Neilson said.

The hospital benefits from reduced defense costs also. "When you look at the hospital's liability costs, it's not just the payouts to the patients; it's the defense that costs so much money," Dr. Weinstein said.

Laborist offers new options

In his inaugural address in May, ACOG President Michael T. Mennuti, MD, said, "We must begin to explore the options of hospitalists, laborists, and ob-gyns who do only ambulatory care. And, we must develop models of practice that will meet the needs of patients but also the needs of a new and different generation of ob-gyns."

He closed his speech by expressing his optimism that ob-gyns will be up to the challenge of changing what is "known and comfortable."

Those who are exploring the laborist model understand that it challenges traditional, and perhaps comfortable, practice patterns. But they think it's a positive change.

"I think this is going to be something very important for the profession and for our continued ability to attract people into it," Dr. Neilson said. ♀

D-M	DESCRIPTION	625.3
89.02	NECOLOGIC	625.3
789.37	Abdominal Pain	625.3
795.0	Abdominal Mass	621.3
626.8	Abnormal Pap Smear	215
626.0	Abnormal Uterine Bleed	611.6
616.3	Amenorrhea	098
618.2	Amniotic Abscess	V72.3
610.1	Breast Abscess	
611.7	Breast Cancer	
611.71	Candidiasis	
112.1	Cervical Dysplasia	

New codes must be used beginning October 1

EVERY OCTOBER 1, THE NEW ICD-9-CM CODE revisions take effect. Previously, practices could continue to use discontinued ICD-9-CM codes until December 31. No longer. Under new HIPAA rules, new codes must be used beginning October 1. Order new code books, *ICD-9-CM Abridged, Diagnostic Coding in Obstetrics and Gynecology, 2006*, or *ICD-9-CM Professional Edition for Physicians, Volumes 1 and 2, 2006 edition*, through ACOG's online bookstore, <http://sales.acog.org>. ♀

Other metabolic and immunity disorders

To differentiate between overweight, obesity, and morbid obesity, ICD-9 will expand the titles of category 278 and subcategory 278.0 to include the term "overweight." In addition, one code will be added to the overweight and obesity subcategory (278.0):

- ▶ Overweight (278.02)

Other diseases of intestines and peritoneum

Many changes will take place to enable separate reporting of peritonitis and retroperitoneal infections. The title of category 567 will be expanded to "Peritonitis and Retroperitoneal Infections."

Four new codes will be added to the subcategory 567.2 (other suppurative peritonitis):

- ▶ Peritonitis (acute) generalized (567.21)
- ▶ Spontaneous bacterial peritonitis (567.23)
- ▶ Peritoneal abscess (567.22)
- ▶ Other suppurative peritonitis (567.29)

A new subcategory 567.3 (retroperitoneal infections) will be created with the addition of three new codes:

- ▶ Psoas muscle abscess (567.31)
- ▶ Other retroperitoneal infections (567.39)
- ▶ Other retroperitoneal abscess (567.38)

Three new codes will be added to the 567.8 (other specified peritonitis) subcategory:

- ▶ Choleperitonitis (567.81)
- ▶ Other specified peritonitis (567.89)
- ▶ Sclerosing mesenteritis (567.82)

Other diseases of the urinary system

Two new codes will be added to enable separate coding of urinary obstructions:

- ▶ Urinary obstruction, unspecified (599.60)
- ▶ Urinary obstruction, not elsewhere classified (599.69)

Complications related mainly to pregnancy, labor, and delivery

A new code will be added within the multiple gestation (651) category to enable reporting of a continuing pregnancy following fetal reduction:

- ▶ Multiple gestation following (elective) fetal reduction (651.7X)

Congenital anomalies

The inclusion term for Gartner's duct cyst will be moved from anomalies of fallopian tubes and broad ligaments (752.11) to anomalies of cervix, vagina, and external female genitalia (752.41).

Symptoms, signs, and ill-defined conditions

The inclusion terms following code 795.09 (other abnormal Pap smear of cervix and cervical HPV) will be revised:

- ▶ Cervical low-risk human papillomavirus (HPV) DNA test positive

Persons with potential health hazards related to personal and family history

New codes will be added to the V13.0 (disorders of urinary system) subcategory to capture personal history of urinary tract infection and nephrotic syndrome:

- ▶ Personal history of urinary (tract) infection (V13.02)
- ▶ Personal history of nephrotic syndrome (V13.03)

The V17.8 (family history of other musculoskeletal diseases) subcategory will be expanded to allow coding for:

- ▶ Family history of osteoporosis (V17.81)
- ▶ Family history of other musculoskeletal diseases (V17.89)

A new subcategory code will be created for family history of certain other specific conditions (V18) to allow coding for:

- ▶ Family history, genetic disease carrier (V18.9)

Persons encountering health services in circumstances related to reproduction and development

To enable more specific reporting of genetic testing and counseling, the procreative management subcategory V26.3 (genetic counseling and testing) will be expanded into three new codes:

- ▶ Testing for genetic disease carrier status (V26.31)
- ▶ Genetic counseling (V26.33)
- ▶ Other genetic testing (V26.32)

Persons encountering health services for specific procedures and aftercare

A new subcategory will be added to the donors category (V59) to enable reporting of egg donors by age and recipient status.

- ▶ Egg (oocyte) (ovum) (V59.7)
- ▶ Egg donor under 35, designated recipient (V59.72)
- ▶ Egg donor, unspecified (V59.70)
- ▶ Egg donor 35+, anonymous recipient (V59.73)
- ▶ Egg donor under 35, anonymous recipient (V59.71)
- ▶ Egg donor 35+, designated recipient (V59.74)

Persons encountering health services in other circumstances

The subcategory for vaccination not carried out (V64.0) will have new codes to indicate why the procedure was not performed:

- ▶ Vaccination not carried out, unspecified reason (V64.00)
- ▶ Vaccination not carried out, acute illness (V64.01)
- ▶ Vaccination not carried out, chronic illness or condition (V64.02)
- ▶ Vaccination not carried out, immune compromised state (V64.03)
- ▶ Vaccination not carried out, allergy to vaccine or component (V64.04)
- ▶ Vaccination not carried out, caregiver refusal (V64.05)
- ▶ Vaccination not carried out, patient refusal (V64.06)
- ▶ Vaccination not carried out, religious reasons (V64.07)
- ▶ Vaccination not carried out, patient had disease being vaccinated against (V64.08)
- ▶ Vaccination not carried out, other reason (V64.09)

Persons without reported diagnosis encountered during examination and investigation of individuals and populations

A new code will be added to the pregnancy examination or test (V72.4) subcategory to enable reporting of a positive pregnancy test. This code should be reported when the pregnancy is confirmed during the visit but the antepartum record is not initiated:

- ▶ Pregnancy examination or test, positive result (V72.42)

To enable reporting for a blood typing visit, a new code will be added to the other specified examinations (V72.8) subcategory:

- ▶ Encounter for blood typing (V72.86)

A new category will be created for reporting Body Mass Index for persons older than 20:

- ▶ Body Mass Index (V85)

Obesity & Ob-Gyn part of an ongoing series



Counseling and treating obese patients during pregnancy

THE INCREASE OF OBESITY IN THE US in recent years means ob-gyns are seeing more patients who are obese and pregnant or planning on becoming pregnant.

A new ACOG Committee Opinion addresses the increased health risks obese women face in pregnancy and encourages ob-gyns to provide preconceptional counseling and education to patients about possible complications. In addition, ob-gyns should encourage obese patients to undergo a weight-loss program before attempting pregnancy, according to *Obesity in Pregnancy*, which was published in the September issue of the Green Journal.

Studies of obese pregnant women have shown increased risks of gestational hypertension, preeclampsia, gestational diabetes, fetal macrosomia, and cesarean delivery. Operative and postoperative complications include increased rates of excessive blood loss, operative time greater than two hours, wound infection, and endometritis, according to the document.

The document says ob-gyns should consider screening for gestational diabetes during the first trimester and repeat testing later in pregnancy if the initial screening is negative.

Ob-gyns are also encouraged to conduct an anesthesiology consultation antepartum because obese pregnant women have an increased risk for emergent cesarean delivery and anesthetic complications

such as difficult epidural and spinal placement and intraoperative respiratory events from failed or difficult intubation.

Bariatric surgery and pregnancy

Although early case reports described pregnancy complications after bariatric surgery, recent studies suggest that the surgery is not linked to adverse perinatal outcomes, according to the Committee Opinion.

Researchers have recently determined that complications of gestational diabetes, hypertension, macrosomia, and cesarean delivery are less likely in pregnancies after bariatric surgery than pregnancies of obese women who have not had the surgery.

The document recommends the following counseling for women who have had bariatric surgery:

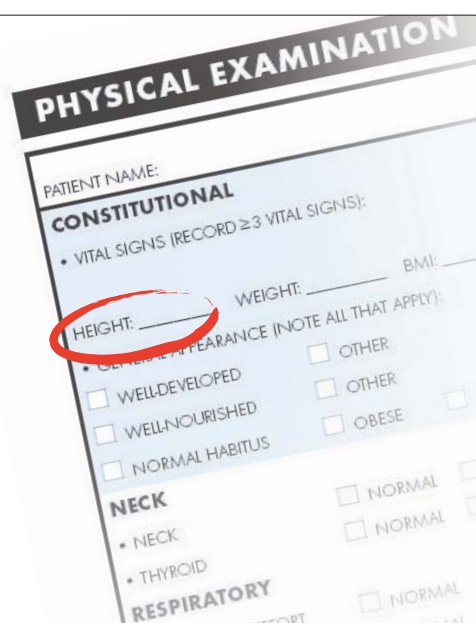
- ▶ Patients with adjustable gastric banding should be advised that they are at risk of becoming pregnant unexpectedly after weight loss following surgery
- ▶ All patients are advised to delay pregnancy for 12–18 months after surgery during the rapid weight-loss phase
- ▶ Patients should be followed by their general surgeons during pregnancy because adjustment of the band may be necessary
- ▶ Patients should be evaluated for nutritional deficiencies and vitamin supplementation ♀

BODY MASS INDEX CATEGORIES

ACOG'S NEW Committee Opinion recommends that height and weight be calculated for all women at the initial prenatal visit to calculate their Body Mass Index.

Online BMI calculator:
www.nhlbisupport.com/bmi

- 18.5–24.9 = normal weight
- 25–29.9 = overweight
- 30+ = obesity
- Obesity Class I = 30–34.9
- Obesity Class II = 35–39.9
- Obesity Class III (extreme obesity) = 40+



Don't forget her height!

BODY MASS INDEX IS THE RECOMMENDED tool to screen your patients for overweight and obesity. The BMI chart's categories of normal, overweight, and obese are helpful to initiate discussions about goals for weight loss, if needed, or appropriate weight gain during pregnancy. Although BMI is now commonly used in clinical guidelines, consumer materials, and research on overweight and obesity, it is still not consistently used in clinical practice.

“One reason may be that both height and weight are needed to calculate BMI, and documenting height has not always been routine practice in ob-gyn,” said Fellow Laura E. Riley, MD. “If height is not being routinely recorded, ob-gyns should take steps to make that part of the office practice.” Dr. Riley is medical director of

labor and delivery at Massachusetts General Hospital and past chair of ACOG's Committee on Obstetric Practice.

Make sure your women's health record form has a place to record height. You also might want to consider having a BMI chart in every exam room for handy reference. BMI charts are helpful in working with a patient to raise her awareness of risks associated with being overweight. An online calculator is available at www.nhlbisupport.com/bmi.

Written materials for patients can reinforce your instructions and provide helpful guidance. A BMI chart is included in numerous ACOG Patient Education Pamphlets including *Weight Control*, *Keeping Your Heart Healthy*, and *Healthy Eating*. ♀



Ob-gyns should develop reproductive health plan with patients

EVERY WOMAN of reproductive age should have a “reproductive health plan,” covering areas such as medical conditions, immunization history, nutrition, genetic risk, and social issues, according to a new ACOG Committee Opinion, *The Importance of Preconception Care in the Continuum of Women’s Health Care*. The document was published in the September issue of the Green Journal.

Approximately half of all pregnancies in the US are unintended. Therefore, it’s important to discuss reproductive health with all reproductive-age women, even those not seeking care specifically in anticipation of a planned pregnancy, according to the document. By doing so, some adverse health effects can be prevented. For example, women should take folic acid before conception to reduce the risk of neural tube defects. Also, adequate glucose control in a known diabetic is important before conception and through pregnancy to decrease maternal and neonatal risks.

Reproductive health plans require an ongoing assessment as a woman’s life plans change over time. Ob-gyns should address with patients:

- ▶ The patient’s readiness for pregnancy
- ▶ An evaluation of her overall health and opportunities for improving her health
- ▶ The significant impact that social, environmental, occupational, behavioral, and genetic factors have in pregnancy
- ▶ Identification of women at high risk for an adverse pregnancy outcome ♀

PAGE 1

Screening for cervical cytology abnormalities

ACOG’s 2003 cervical cytology screening guidelines call for women to receive annual cervical cytology screening beginning approximately three years after initiation of sexual intercourse, but no later than age 21. Women younger than 30 should receive annual screenings.

Women 30 and older who have had three consecutive negative cervical cytology screening test results—and who have no history of CIN 2 or CIN 3, are not immunocompromised, are not HIV infected, and were not exposed to diethylstilbestrol in utero—can be screened every 2–3 years.

Women 30 and older may also be screened with the combination of a Pap test and HPV test no more frequently than every three years if both tests are negative.

Managing the most common abnormality

A cytology result of atypical squamous cells is the most common cytologic abnormality and, therefore, precedes the diagnosis of CIN 2/3+ more than does any other result. But,

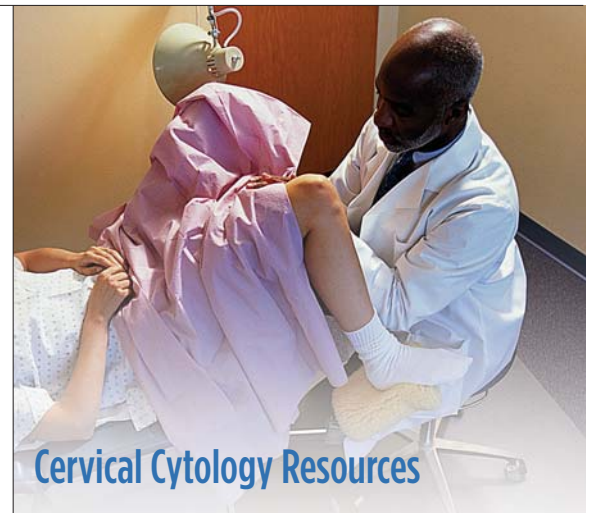
the Practice Bulletin recommends that aggressive investigation be avoided because the diagnosis is poorly reproducible, the risk of cancer is very low, at less than 1%, and the risk of CIN 2/3+ is also low, between 6.4% and 11.9%.

Evaluation options include immediate colposcopy, triage to colposcopy by HPV DNA testing, or repeat cytology screening twice at six-month intervals.

Managing a normal Pap test with a positive HPV test

Combined cervical cytology and HPV testing was introduced recently for women 30 and older. If both tests are negative, women don’t need to be rescreened for at least three more years. However, what should clinicians do if the Pap test is normal but the HPV test is positive?

Because women in these cases have only approximately a 4% risk of CIN 2/3+, colposcopy is not recommended. HPV is often transient and resolves spontaneously. Instead, repeat the combined test in 6–12 months and conduct a colposcopy only if testing remains abnormal, according to the Practice Bulletin. ♀



Cervical Cytology Resources

- ▶ Algorithms for management of cervical cytology abnormalities from the American Society for Colposcopy and Cervical Pathology: www.asccp.org/pdfs/consensus/algorithms.pdf and www.asccp.org/pdfs/consensus/algorithms_hist.pdf
- ▶ *Management of Abnormal Cervical Cytology and Histology* (Practice Bulletin #66, September 2005)
- ▶ *Human Papillomavirus* (Practice Bulletin #61, April 2005)
- ▶ *Cervical Cytology Screening* (Practice Bulletin #45, September 2003)
- ▶ *Cervical Cancer Screening in Adolescents* (Committee Opinion #300, October 2004)

Perinatal Hotline helps physicians treat pregnant HIV-infected women

A PERINATAL HOTLINE IS now providing free 24-hour consultation about management of HIV in pregnant women, HIV testing in pregnancy, and care of HIV-exposed infants. The Perinatal Hotline is staffed by HIV experts who can also refer callers to local clinicians for co-management or transfer of care.

Early identification of HIV-infected pregnant women and advances in anti-retroviral therapies have led to a decrease in mother-to-child transmission, from a 1-in-4 chance of transmission to a 1-in-12 chance.

“Since the hotline started in December 2004, we have helped hundreds of clinicians offer the most up-to-date therapies to their patients,” said Jessica Fogler, MD, assistant director of the Perinatal Hotline. “Perinatal HIV transmission remains a tragic yet largely preventable problem. Although the number of transmissions has dropped, each transmission has enormous personal, family, public health, and economic consequences.”

Based at UCSF/San Francisco General Hospital, the hotline is part of the National HIV/AIDS Clinicians’ Consultation Center of the Health Resources and Services Administration, in partnership with the Centers for Disease Control and Prevention. ♀

info

Perinatal Hotline: 888-448-8765
www.ucsf.edu/hivcntr/hotlines/perinatal.html

HIV/AIDS strikes women hard

THE LATEST DATA RELEASED by the Centers for Disease Control and Prevention on HIV/AIDS reinforce the need for ob-gyns to offer HIV counseling and testing as part of routine care for gynecologic patients.

“It’s estimated that 25% of those with HIV are unaware they’re infected,” said Fellow Denise J. Jamieson, MD. “HIV-positive patients need to know they are infected, not only so they can begin therapy, but also so they do not spread the infection.”

Dr. Jamieson is on the staff at the CDC and a member of ACOG’s Committee on Gynecologic Practice.

Who’s at risk?

In 2003, 27% of all newly diagnosed AIDS cases in the US were women, nearly four times the 1985 percentage of 7%, according to CDC. Also in 2003, 44,461 women ages 15–44 were living with HIV.

Minorities and teen girls have particularly been affected. The rate of HIV/AIDS diagnosis is 19 times higher among black women than among white women. Together, black and Hispanic women make up about 84% of the AIDS cases among women in the US. Among teenagers, girls represented 51% of HIV cases reported in 2002.

“Heterosexual transmission is now the most commonly reported mode of infection among women, with 71% of women infected this way. This is a major change from the early years of the epidemic, when most women became infected by injection drug use,” Dr. Jamieson said.

She emphasized that counseling about prevention needs to be more than a one-time event: “We need to discuss risk factors for HIV infection repeatedly with patients, especially those who are sexually active or may engage in risky behavior.

Young women—ages 13 to 24—and minority women are especially at risk.”

Ob-gyns should not assume that they don’t need to be vigilant if they are outside known areas of high seroprevalence, such as

large urban areas. The latest report showed that most new HIV infections among women occurred in the South. Although only 29% of women live in the South, 76% of new infections among women occur there.

Potential of rapid test not reached

For pregnant patients, ob-gyns are encouraged by both ACOG and the CDC to use the “opt-out” approach for HIV testing unless it is not allowed by their state’s HIV screening requirements.

With the opt-out approach, pregnant women are notified that an HIV test will be routinely included in the standard battery of prenatal tests but that they can decline testing, whereas the “opt-in” approach requires specific informed consent, usually in writing.

The good news about HIV/AIDS is that fewer babies in the US are born infected. Testing, antiretroviral prophylaxis, and cesarean delivery intervention have all contributed to reducing the rate of newborn infection. The rate of maternal-fetal HIV transmission has decreased from a 1-in-4 chance of transmission to a 1-in-12 chance.

Rapid testing, which allows physicians to determine a patient’s HIV status in about an hour, presents another breakthrough that can reduce newborn infections.

“Rapid testing is feasible and delivers accurate and timely results for women in labor with undocumented HIV status,” Dr. Jamieson said.

Both ACOG and the CDC support its use in that situation. But the CDC estimates that rapid testing is available for women in labor in only about one-third of US hospitals. And only about half of those hospitals have protocols in place to routinely offer it to women with undocumented HIV status.

Ob-gyns are encouraged to develop departmental or hospital policies regarding rapid testing use. ♀

info

www.cdc.gov/hiv



Study shows HT may only postpone symptoms

A NEW STUDY OF DATA FROM the Women's Health Initiative shows the number of women on hormone therapy who saw menopause symptoms return once they stopped taking the drugs. The study was published in the July 13 issue of the *Journal of the American Medical Association*.

Doctors have long observed that hot flashes and night sweats returned to some women once they stopped hormone therapy, said Isaac Schiff, MD, chair of the ACOG Task Force on Hormone Therapy. However, this is the first study that quantified the actual number of women who became symptomatic after stopping hormone therapy, according to Dr. Schiff.

"This study shows that after WHI was halted, a significant proportion of these women had to go back on hormone therapy, even with all the adverse publicity, because of their severe symptoms," Dr. Schiff said. "As we indicated in the ACOG report on hormone therapy, HT does have a place for women with severe symptoms. After WHI, it was implied that women should try to tough out their symptoms, but for some women, these symptoms are very real and troublesome. Doctors should be offering treatment to patients who are symptomatic as long as the patient understands the benefits and risks, and together, they should decide whether hormone therapy should be prescribed."



JAMA findings

Researchers surveyed 8,405 WHI participants who were still taking hormone therapy pills or a placebo when the trial was stopped. Survey respondents reported a wide array of symptoms after discontinuing use of the pills. Respondents who had been taking the estrogen plus progestin pills had a higher prevalence of each symptom after stopping the hormone therapy compared with those who had been taking a placebo. The number of symptoms was also greater than those experienced by women who had been taking a placebo. Of those taking estrogen plus progestin pills, 37% reported no symptoms, while 60% of the placebo group said they didn't have any symptoms.

Thirty-six percent of women ages 55–59 who were on hormone therapy experienced hot flashes and night sweats after discontinuing use compared with 11% of women the same age who were taking a placebo. In addition, 28% of women ages 60–69 experienced hot flashes and night sweats compared with less than 7% of women their age who were on placebo. More women taking the estrogen plus progestin pills experienced other symptoms as well, including joint pain and stiffness, back and neck pain, tiredness, sleep problems, mood swings, and weight gain. ♀

info

<http://jama.ama-assn.org/content/vol294/issue2/index.dtl>



OCTOBER IS NATIONAL
BREAST CANCER
AWARENESS MONTH

Materials available to promote awareness month

A FREE GUIDE IS AVAILABLE online that provides information on how to promote National Breast Cancer Awareness Month in October and National Mammography Day on October 21.

Throughout October many mammography facilities will be offering special programs and extended hours.

The guide, available from the National Breast Cancer Awareness Month campaign, includes tips on how to get the word out about the importance of mammograms and early detection through physician offices and workplaces and throughout the community.

Some of the successful ideas include:

- ▶ Running a prerecorded telephone message about the importance of mammograms that patients listen to while on hold
- ▶ Scheduling a physician from your practice to speak to local media about breast cancer detection
- ▶ Combining local flu shot clinics with enrollment for mammography and clinical breast exams

The guide also includes a sample proclamation, a press release, and public service announcement scripts. ♀

info

www.nbcam.org/promote_nbcam.cfm

To find a local mammography facility accredited by the Food and Drug Administration: 800-4-CANCER

The National Breast and Cervical Cancer Early Detection Program of the Centers for Disease Control and Prevention provides screening for medically underserved women: 888-842-6355; www.cdc.gov/cancer/nbccedp/contacts.htm

Pause magazine helps women beat the heat



ACOG'S PAUSE MAGAZINE offers comforting tips to women suffering from hot flashes. The article "Beat the Heat" provides soothing strategies to keep hot flashes at bay, including exercising regularly, reducing stress, and keeping track of when and where hot flashes occur to pinpoint potential triggers.

Pause, formerly known as *Managing Menopause*, was revamped, redesigned, and renamed earlier this year. The next issue will be available later this fall. ACOG members can order copies of *Pause* to distribute to their patients by calling the ACOG Office of Communications at 800-673-8444, ext 2560.

ACOG educates residents about professional liability issues

IN MEDICAL SCHOOL, future ob-gyns take courses in gross anatomy, pharmacology, epidemiology, and neuroscience. However, one course they likely won't be offered is professional liability.

As medical students become residents, they may be unprepared if they are sued. Although residents work under supervision, they can still be hit with a lawsuit. In fact, almost 30% of ob-gyns responding to an ACOG survey on professional liability in 2003 had been sued for an incident that happened when they were a resident.

As residents become practicing ob-gyns, chances are good they will be sued during their career, making it crucial that they learn about professional liability.

"The Junior Fellow College Advisory Council has pushed for more education in professional liability because, although professional liability is known to have a great impact on recruitment and practice for many in ob-gyn, education on the issue has traditionally been lacking," said Immediate Past JFCAC Chair Leah A. Kaufman, MD.

Earlier this year ACOG developed *Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists*. The book includes a section on professional liability issues unique to residency.

The JFCAC has alerted residency program directors to the publication and has requested that they expand education in residency on professional liability issues and inform residents about available resources, including emotional support, in the event of a lawsuit. At the request of the JFCAC, CREOG has agreed to include at least one presentation about teaching liability issues to residents at all future CREOG meetings.

Issues that are unique to residency

Lawsuits can arise from patients not knowing or misunderstanding a physician's status, according to *Professional Liability and Risk Management*. When residents are interacting with patients, they should make sure that patients know that their doctor is a resident. It's important for residents to remember at all times that only attending physicians have the authority to direct treatment and that attendings are liable for any procedures by a resident.

When residents receive a summons or complaint, they must act quickly—there is usually a set period of time during which physicians must respond. While practicing physicians need to immediately notify their insurance carrier, residents are covered under their residency program and need to notify their institution. It's helpful if residents find out before a lawsuit even occurs what their program's procedures are and who should be notified.

Seeking emotional support

Being sued can be frustrating, scary, and stress inducing. Attorneys may tell their clients to talk



to no one about the case. But that doesn't mean residents should not seek emotional support.

According to *Professional Liability and Risk Management*, "Avoiding any and all discussions about the case will be difficult and is probably unwise for your mental health. You probably will feel a strong need to talk about your emotions and the lawsuit's impact."

But who to talk to? Residency programs may not have any professional liability-related support services, and other physicians may be reluctant to talk with the physician being sued because they don't want to jeopardize that person's defense. Therefore, options include discussing the case with a spouse or close friend as long as the ob-gyn doesn't discuss the legal or clinical aspects of the case. Also, discussions with clergy-therapists and mental health professionals are usually protected from disclosure, but ob-gyns should doublecheck with their attorney first.

"We realized through conversations on the JFCAC that most programs tell residents essentially 'it happens to everyone; move on,' but the residents don't know where to turn to for support," Dr. Kaufman said. "We want Junior Fellows to know who they can turn to and that conversations with respect to stress and emotions that go along with a lawsuit need to be shared with spouses, family, and friends. Additionally, we want them to know that counseling may be a normal part of the process." ♀

info

Professional Liability and Risk Management: An Essential Guide for Obstetrician-Gynecologists: Order at <http://sales.acog.org>; 800-762-2264, ext 192
Coping with the Stress of Medical Professional Liability Litigation, Committee Opinion #309: available on the ACOG website, www.acog.org, under "Publications" and "Committee Opinions"

Essay about mentor due by November 15

SHOWCASE A POSITIVE relationship you had with an ob-gyn mentor in this year's Junior Fellow essay contest. Essays focusing on "How My Ob-Gyn Mentor Influenced Me" must be submitted online by November 15.

The contest is open to all Junior Fellows. Essays should be between 500 and 750 words and should not mention the specific names of any mentors.

One winner will be selected from each district and will receive \$500. A grand-prize winner will be selected from the district winners and receive an additional \$500 plus an expenses-paid trip to the 2006 Annual Clinical Meeting in Washington, DC. (The prize includes ACM Junior Fellow registration fee, coach airfare, and two to three days per diem for room and board.) ♀

info

Visit the Junior Fellow section under "Membership" on the ACOG website, www.acog.org
Christine Himes, 800-673-8444, ext 2561, or chimes@acog.org

2005 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

SEPTEMBER

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ACOG WEBCAST:

How to Survive an Audit
1-2:30 pm ET
800-673-8444, ext 2498

14-18

ACOG District I Annual Meeting

Quebec City, QC
800-673-8444, ext 2531

22-25

ACOG District VII Annual Meeting

San Antonio
800-673-8444, ext 2540

22-25

ACOG District VIII Annual Meeting

San Antonio
800-673-8444, ext 2540

25-29

15th World Congress on Ultrasound in Obstetrics & Gynecology

Vancouver, BC
www.isuog2005.com

27-30

Royal College of Obstetricians and Gynaecologists 6th International Scientific Meeting

Cairo, Egypt
pioneerevents@yahoo.com
www.rcog2005.com
(011) +202 4053575 or
+202 4046672

28-Oct 1

NAMS: North American Menopause Society

San Diego
www.menopause.org
440-442-7550

29-Oct 1

The American Gynecological and Obstetrical Society and the American Association of Obstetricians and Gynecologists Foundation

Victoria, BC
www.agosonline.org
800-673-8444, ext 1648

30-Oct 2

ACOG District V Annual Meeting

Toronto, ON
800-673-8444, ext 2540

30-Oct 2

ACOG District VI Annual Meeting—Fellows

St. Thomas, Virgin Islands
800-673-8444, ext 2540

OCTOBER

4

ACOG WEBCAST: Managing Adverse Outcomes

1-2:30 pm ET
800-673-8444, ext 2498

15-20

61st Annual Meeting of the American Society for Reproductive Medicine (in conjunction with the 51st Annual Meeting of the Canadian Fertility and Andrology Society)

Montreal, QC
www.asrm.org
205-978-5000

20-24

Academy of Breastfeeding Medicine Annual Meeting

Denver
www.bfmed.org/meeting.html

28-30

ACOG District II Annual Meeting

New York City
518-786-1529

28-30

ACOG District III Annual Meeting

Los Cabos, Mexico
916-920-8100

28-30

ACOG District IV Annual Meeting

Los Cabos, Mexico
916-920-8100

28-30

ACOG District IX Annual Meeting

Los Cabos, Mexico
916-920-8100

30-Nov 2

ACOG Armed Forces District Annual Meeting

Seattle
800-673-8444, ext 2540

NOVEMBER

1

ACOG WEBCAST: Complications of Laparoscopic Surgery

1-2:30 pm ET
800-673-8444, ext 2498

4-8

American Medical Association Interim Meeting

Dallas
www.ama-assn.org
800-673-8444, ext 2515

9-12

Global Congress of Minimally Invasive Gynecology—34th Annual Meeting of the American Association of Gynecologic Laparoscopists

Chicago
www.aagl.org
562-946-8774

11

2nd Annual Advanced Practice Lectureship (in conjunction with the Amazing Newborns ... Prematurity and Beyond Conference)

Sponsored by the March of Dimes and the University of New Mexico Neonatology Outreach Program
Albuquerque, NM
www.neonatology-outreach.org
505-272-1322

ACOG COURSES

- 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"
- 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.

SEPTEMBER

6-8

Special Problems for the Advanced Gynecologic Surgeon

Laguna Niguel, CA

9-11

Screening in Ob-Gyn

Laguna Niguel, CA

16-18

CPT and Coding Workshop

Atlanta

23-25

CPT and Coding Workshop

Memphis, TN

OCTOBER

7-9

CPT and ICD-9-CM Coding Workshop

Las Vegas

NOVEMBER

11-13

Practice Management Update for the Obstetrician-Gynecologist

Coronado, CA

12-13

No Frills—Operative Hysterectomy

Chicago

18-20

CPT and Coding Workshop

Washington, DC

DECEMBER

1-3

Complications in Obstetrics

New York City

2-4

CPT and ICD-9-CM Coding Workshop

Sante Fe, NM

8-10

Pearls from Ob-Gyn

Chicago

USDA provides safety measures for listeriosis



BECAUSE PREGNANT WOMEN are at high risk for listeriosis, the US Department of Agriculture's Food Safety and Inspection Service has developed a free flier to inform pregnant women about how they can protect their baby and themselves from the disease.

The flier suggests many ways that women can keep their food safe and fight bacteria. It also outlines the food and drinks that are not safe to eat and lists the symptoms of listeriosis.

Protect Your Baby and Yourself from Listeriosis can be distributed to patients or displayed in reception areas. A Spanish version is also available. ♀

info

Fliers are available in packs of 100. Email fsis.outreach@usda.gov with your mailing address and the number of packs you would like.

Food safety questions? Call the USDA Meat and Poultry Hotline to speak to a food safety specialist: 888-MPHotline; 888-674-6854; TTY, 800-256-7072

CDC group B strep brochure for Hispanics



ANEW SPANISH-LANGUAGE BROCHURE on group B strep is available from the Centers for Disease Control and Prevention. The free brochure, *Protect Your Baby from Group B Strep*, specifically targets patients in Hispanic communities, educating them about perinatal group B strep testing, prevention, and treatment.

The brochure is a colorful and easy-to-read guide that can be distributed directly to patients or placed in reception areas. Group B strep is one of the leading infectious causes of morbidity and mortality in newborns. ACOG Committee Opinion #279 (December 2002) calls for culture-based screening for GBS at 35–37 weeks' gestation. ♀

info

www.cdc.gov/groupbstrep 404-639-2215

NASPAG postgraduate course offered during ASRM annual meeting

THIS YEAR'S ANNUAL Postgraduate Course of the North American Society for Pediatric and Adolescent Gynecology will focus on "Problem Solving in Pediatric and Adolescent Gynecology."

The course will be held in Montreal, Canada, on October 15 from 8:15 am to 5 pm in conjunction with the annual meeting of the American Society for Reproductive Medicine and the Canadian Fertility and Andrology Society.

Course faculty are Drs. Janice L. Bacon, Zeev Harel, Mary Anne Jamieson, and Frank Biro. Topics will include gynecologic emergencies, common vulvovaginal disorders in children and teens, what's normal during puberty, and an update on teen contraceptive use. ♀

info

naspag@asrm.org 205-978-5011

NIH accepting applications for loan repayment program

HEALTH PROFESSIONALS devoting the majority of their time to research can receive up to \$35,000 in educational debt reimbursement from the National Institutes of Health.

The NIH Loan Repayment Program repays physicians pursuing careers in clinical, pediatric, contraception and infertility, or health disparities research. Applicants must have a doctoral-level degree, devote 50% or more of their time to research funded by a nonprofit or government entity, and have educational loan debt that is 20% or more of their institutional base salary.

The new application cycle opened September 1, and applications are due in mid-December.

In fiscal year 2004, NIH repaid more than 1,400 health researchers across the country a total of nearly \$68 million. ♀

info

www.lrp.nih.gov



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Obstetricians and Gynecologists**

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