With more than 4 million live births a year, the United States has one of the highest birth rates amongst industrialized countries; it also has a disproportionately high prematurity rate.

To make matters worse, there has been a steep rise in births between 37 0/7 and 38 6/7 weeks gestation, a group now referred to as “early term” (Figure 1). As the number of early term infants has grown, so has the awareness of their unique set of problems, such as delayed neonatal transition, wet lung syndrome, hypothermia, hypoglycemia and hyperbilirubinemia. There has been a clear shift in the distribution of births away from term and post-term towards earlier gestational ages with the average gestational age dropping by nearly one week (Figure 2). While the reasons for this shift are multifactorial, higher rates of induced deliveries, cesarean births, and efforts to reduce stillbirths may have contributed to the rise.

A study by the National Institutes of Health(NIH)-sponsored Maternal Fetal Network revealed that a good one-third of all “term” elective repeat cesarean sections occur at < 39 weeks with a consequent rise in neonatal complications (Figure 3). Early term babies now account for a significant proportion of NICU admissions in the United States, adding strain to the overburdened system of healthcare delivery, particularly in community hospitals and rural areas. These admissions range from short stays for problems such as transient tachypnea of the newborn (TTNB),

to more complicated/extended NICU stays for problems such as persistent pulmonary hypertension of the newborn (PPHN).

In addition to the expense of the initial hospitalization, cost of caring for an early term baby can also be compounded by the increased incidence of hospital re-admissions and long-term care issues related to persistent problems. More importantly, there may be a lasting impact with neurodevelopmental delays extending into early school-age. Since a significant proportion of brain growth occurs during the last six weeks of gestation, early term babies are vulnerable to neuronal injury and disruption of normal brain development. While more longitudinal studies are needed, preliminary studies show that early term infants are more likely to have a diagnosis of developmental delay within the first 3 years of life, require special needs preschool resources, and have more problems with school readiness. Given the shortcomings clinicians face in accurately estimating gestational age, elective inductions and cesarean sections may have increased the burden of early births. In an attempt to minimize the occurrence of iatrogenic prematurity in light of the increasing frequency of elective cesarean sections (commonly performed between 37 and 40 weeks

Continued on page 6
President’s Column

A Review of Our Society’s Events

by the time you receive this newsletter, my presidential year will be half over. I wanted to review the activities that have transpired in the first six months of my tenure, and the activities that are just ahead.

1. After assuming the role of president of the Society following the annual scientific meeting at the Cloister in August, 2012, I have been extensively preoccupied putting together a panel of speakers to function as “physicians and the public” and to continue the excellent tradition for our Annual Meeting, August 22-25, 2013 at the Reynolds Plantation, Ritz Carlton at Lake Oconee. The registration brochure should arrive in your mail within the next few weeks.

2. The Georgia OB/Gyn Society, the Georgia Chapter of the American Academy of Pediatrics (GA AAP), and the Network of Georgia Neonatologists (NGN) had a joint meeting in November at the Galleria conference center in Atlanta about HB 954 (the Fetal Pain Bill) and the impact on obstetrics, pediatrics and neonatology. The intense day allowed the three groups of physicians to contemplate the necessary practice pattern changes to comply with the law. Thanks to immediate Past President Dr. David Byck for his leadership of this conference. Fortunately, the ACLU was successful in getting an injunction placed by the Supreme Court in Fulton County so this law did not go into effect on January 1, 2013. The Society will continue to follow the progress of this bill as it goes through the court system.

3. The Society continues to be active with the Patient-Centered Physician Coalition of Georgia (PC2) which includes the Georgia OB/Gyn Society, the Georgia Chapter of the American Academy of Pediatrics, the Georgia Academy of Family Practice, the Georgia Chapter of the American College of Physicians, and the Georgia Osteopathic Medical Association. The annual Legislative Day at the Capitol on February 7, 2013. Thanks to Past President Dr. Willis Lanier for establishing a tradition of involvement with our specialty and this group.

4. The Society sponsored the bi-annual CPT Coding conference in December to keep members updated on new 2013 coding changes. This conference will also be held on May 3, 2013 at the Macon Marriott Hotel.

P. Ruth Cline, MD
GOGS President
Athens, Georgia

The legislative session of 2013 should be in mid-session by the time you receive this newsletter. As in past years, we can only hope to anticipate what challenges may come up. Currently, we are preparing to fight to protect Medicaid coverage for obstetric services in the state budget. Governor Deal’s budget cuts money to Medicare, justifying the cuts because Medicaid plans to deny payment to physicians and hospitals for non-medically necessary deliveries before 39 weeks.

The Society’s initiative to avoid neonatal morbidity associated with late preterm delivery has already been a quality focus for most obstetricians in the state over the past two years. It is debatable if the budget cut is a realistic saving since most physicians are already adhering to this ACOG practice recommendation.

Additionally, the budget contains a .74 percent reduction in fees for OB/Gyns, even though the OB/Gyn community has had no increase in fees in more than 10 years. Slashing the Medicaid budget for delivery services in our state will only compound the critical access issues for many women in rural Georgia. In December, another OB unit closed in Burke County, leaving that area without obstetrical services. We now have 40 counties without an obstetrician. We will keep the membership posted on these developments.

The Society is in the final weeks of preparation for its second annual joint conference with GA AAP at the Lenox Marriott on February 23, 2013. This conference has given the Society the opportunity to address public health issues that apply to the women and children in our state. The turn out was exceptional last year, and we anticipate a full lecture hall again this year. Thanks to Past President Dr. Cindy Mercer for moderating and organizing this important event.

In closing, remember the Society depends on its members, as well as our relationships with pharmaceutical and medical supply companies, to facilitate our educational events. Please remind your representatives to contact Beth Yoder at the Georgia OB/Gyn Society’s office at 770-904-0719 to be certain their companies are part of our Annual Meeting August 22-25th at the lovely Lake Oconee Ritz Carlton Lodge.

Editor’s Column

It Was Never about “Fetal Pain”: Watch for Code Word Politics

With an air of restraint, the only physician legislator in the Georgia Statehouse ended his speech at the GOGS Annual Meeting by merely stating that he is pro-life. Most of us already knew this, but had been expecting to hear a good bit more about why he and so many others felt compelled to vote for the Fetal Pain Bill, HB 954, a bill that was strongly opposed by GOGS. Perhaps we were looking for some heartfelt and earnest comments about how complex an issue it is and how difficult a decision it was for him. He might have expressed some regret about how problematic it will now be for obstetricians and their patients in high-risk and emotional situations. (Can a fellow doctor ground your empathy?) When prodded to explain how his being pro-life would make him vote so differently on that bill from most doctors in attendance, who are in no way against life, he declined to respond further.

As it turns out, the streamlined, one-word explanation was all that was needed. What was obvious, but left unsaid, was that fetal pain, the ostensible reason for the bill, had nothing to do with why the bill was introduced, why he voted for it and why Governor Deal signed it into law last spring. No one who voted for it cared to learn about when a fetus begins to feel pain. Neither were they bothered by the impossible constraints the bill put on obstetricians and patients in high-risk situations who never set out to terminate their pregnancies.

They voted for the bill because, as stated by our legislator, they are “pro-life,” but with a capital P, meaning the movement, the group that believes abortion should once again be illegal or severely restricted. You might ask, why not just introduce a bill banning abortion if that is the goal, and not write nuanced bills that threaten 10 years in jail for an obstetrician dealing with ruptured membranes at 20 weeks? Put it out there in plain language and let it be a direct challenge to Roe v. Wade, the oft stated ultimate intention of the Pro-life movement.

But plain language might reveal to people what they’re really voting for and that could be problematic for the cause. Today it’s “fetal pain.” Tomorrow it’s “personhood.” These are code words for bills that aim to not only challenge and overturn Roe v. Wade, but put major restrictions on many obstetric treatments and stem cell research.

Last summer when the personhood survey question was put on the Republican ballot in most Georgia counties, I voted yes. I did not understand what I was voting for. I read the nonbinding survey question and voted. It’s important that people understand the implications of their vote. The results and implications of that survey can be found at personhoodusa.com.

As a gynecologist and an advocate for women and families can make for complicated politics. Our professional involvement gives us a vantage point that is understood by few who are not similarly involved. We owe it to ourselves and our patients to remain vigilant to challenges to the fundamental rights, health and well-being of women.

Reference
1. Personhood USA website: http://www.personhoodusa.com/category/lobby/geo/
HIV Screening “Opt In” or “Opt Out”

Hugh D. Smith, MD, FACOG
Thomaston, GA

A patient was referred to me from the emergency department for follow up after a sexual assault. When I interviewed her, everything seemed to be in place for her recovery. However, she was uninsured and could not afford the $2300 for HIV prophylaxis. To help her find treatment, I called the local public health department, which referred her to our local district HIV clinic. This clinic was very helpful and would provide her with HIV medication and follow up. Even though I see patients with HIV, I do not treat them for their HIV condition. Therefore, I felt this patient would now receive the care she needed.

This encounter started me thinking about HIV screening for our non-pregnant patients. In a clinical opinion from 2008, the American College of Obstetrics and Gynecology (ACOG) recommended that women’s healthcare providers should screen all patients ages 18-63 for HIV. In 2006, the Centers for Disease Control (CDC) recommended HIV screening in all healthcare settings unless the patient declined or “opted out.” This recommendation did not require a separate medical consent, and prevention counseling was not required.

However, the State of Georgia requires “opt in” for HIV screening. This means when patients request screening, they must do a pre-screening interview and a separate verbal or written consent must be obtained. The Georgia law then requires a post-screening interview for all patients to discuss test results and to provide prevention counseling. I find these laws time consuming and limit my willingness to routinely screen for HIV.

The Georgia law, the ACOG clinical opinion and the CDC statement can be found on the internet (see provided websites below). The CDC statement is a little long, but it makes sense and is worth reading. “Opt out” screening is cost effective and helps diagnose patients with HIV who are unaware of their condition. I think it is time for the State of Georgia to change its screening laws to be the “opt out” type. It is good for patient care, and HIV is no longer a death sentence when diagnosed early. We as OBGyn care providers are already using “opt out” screening for our obstetrical patients. Isn’t time we do the same for our gynecological patients?


ACOG Clinical Opinion “Routine Human Immunodeficiency Virus Screening”: http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_Opinions/Screening

CDC Recommendations “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings”: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

Dr. Hugh Smith has more than 37 years of experience and specializes in gynecology with Upson Women’s Services in Thomaston.

HIV: Doctors Don’t Ask, Patients Don’t Tell

Ed Susman, Contributing Writer, MedPage Today
Published: October 20, 2012

Researchers reported on two studies at a poster session of IDWeek 2012, a joint meeting of the Infectious Disease Society of America (IDSA), the Society for Health and Epidemiology of America (SHEA), the HIV Medicine Association (HIVMA), and the Pediatric Infectious Diseases Society (PIDS). The studies exposed medical practitioners’ reluctance to ask patients to take the test as a major barrier to universal HIV testing, which is recommended by national, state, and local institutions.

A study by Marelle Yehuda, MD, an internal medicine resident at Lenox Hill Hospital, New York, and others reviewed records of 134 patients admitted during June 2011 and identified 87 who met criteria for HIV screening. Only eight of these patients were asked about HIV screening. Yehuda and colleagues surveyed medical residents to determine their knowledge of HIV screening criteria and their attitudes toward screening. The results showed that 81 percent were not familiar with the CDC recommendation that all patients should be screened for HIV infection nor the 2010 New York State legislative mandate that required patients be offered screening; 75 percent understood the difference between “opt in” and “opt out” testing; 43 percent believed written consent was necessary for rapid testing; and 38 percent did not know how to order the rapid HIV screening test. The residents provided three reasons for not pursuing HIV testing: They were too busy, thought the test not clinically relevant, or believed the patient was not at risk. These results led to the hospital implementing a series of interventions to improve the HIV screening rate, including educating residents, reminders on electronic medical records, and simplifying the test order form.

In another study at the University of Chicago, Sara Bares, MD, found that doctors did not ask patients to take the HIV test. A survey of 259 residents in a six-week period resulted in 162 responses (63 percent). Less than 32 percent of the residents in an outpatient clinic asked patients about HIV screening, 24 percent working with in-patients asked, and 16 percent in the emergency department asked. Many said that they did not ask because they thought that patients would refuse. Dr. Pitrak, MD, chief of infectious diseases at the University of Chicago and senior investigator in this study, commented that one reason physicians do not ask patients to be tested for HIV is that the physicians may not be able to properly counsel patients who test positive. Dr. Pitrak explained that at the University of Chicago, only infectious disease staff members follow up on positive test results. A coordinator finds the individuals who test positive to schedule their appointments.


CPT Coding Seminar

May 3, 2013

Macon Marriott City Center

Presenting:
Steve Adams and Brian L. Tuttle of InGaHealthcare Solutions and
Dr. Denise Hines of GA-HITREC

Education & Outreach

Topics Will Include:
• 2013 OB/Gyn CPT & ICD-9 Coding and Reimbursement Update
• HIPAA Privacy and Security Implementation
• Phase II Meaningful Use Requirements
• OSHA for the Medical Practitioner

CEUs for Staff Personnel and CMEs for Physicians will be available.

Call the Society for additional details at 770.904.0719 or visit our website at www.georgiaobgyn.org

Plan now to attend
Winter Symposium 2013

Improving Collaborative Care for Patients

Georgia OB/Gyn Society and Georgia Chapter - AAP

Saturday, February 23, 2013
8:15 - 4:30 p.m.
Atlanta Marriott Buckhead Hotel, Atlanta, GA

See the www.georgiaobgyn.org website for registration and details.
gestation), fetal lung maturity testing was recommended before elective cesarean sections. Due to the risks and complications associated with amniocentesis, this is infrequently done, especially as recent studies show that even late preterm infants and some early term infants born by cesarean section before the onset of labor have respiratory distress, despite having mature surfactant profiles. This prompted the American College of Obstetrics and Gynecology (ACOG) in 2002 to recommend scheduling elective cesarean section at 39 weeks or later or waiting for the onset of spontaneous labor. Unfortunately, the convenience of scheduled elective cesarean section deliveries for both families and providers will continue to influence the timing of elective cesarean sections. The adoption of these guidelines has been slow, but has lately gained momentum thanks to a push from perinatal quality collaboratives. In a study from Utah, Oshiro et al. found that a concerted effort to reduce elective births at <39 weeks can have dramatic results (Figure 4). Authors reported no increase in fetal deaths during the study period. Similar efforts have begun in Georgia with impressive results.

Given their large numbers, the overall socio-economic impact of the late preterm births can be quite significant. Strategies are required that can reduce the preventable fraction of early term births, and work must continue to reduce morbidity in births where continuing the pregnancy is deemed harmful to the fetus or the mother.

SUGGESTED READING

Definition, Epidemiology, and Background:


References

2. Clark RH. The epidemiology of respiratory failure in neonates born at an estimated gestational age of 34 weeks or more. J Perinatol. 2001;21:251-257. DOI:10.1038/ (p)7211424. Published online 16 Dec. 2004

Dr. Lucky Jain is Professor and Executive Vice Chairman at Emory University School of Medicine and Medical Director of Emory Children’s Center in Atlanta, GA.
**John Moore Honored by SAAOG**

The South Atlantic Association of OBGYN (SAAOG) honored John Moore, MD, for his contributions as their president for the past year at their Annual Meeting in January. Dr. Moore was honored at a luncheon following his presidential address and at an evening dinner and dance on January 21.

**GOGS members serving as Officers for ACOG**

Sandra B. Reed, MD, of Thomson, was recently selected as ACOG District IV Treasurer and will serve until 2015. In addition, Ben H. Cheek, MD, of Columbus, was nominated in November as Secretary for ACOG by the Committee on Nominations. Dr. Cheek is one of four officer nominees who will appear on the slate and be voted on at ACOG’s Annual Business Meeting on May 6, 2013, during the Annual Clinical Meeting in New Orleans.

**Dr. Burke runs for Georgia State Senate Seat**

Dr. Dean Burke, an OBGYN from Bainbridge, is in a runoff election for the Georgia State Senate, District 11. On Feb. 5, he will be in a runoff for the Georgia Senate seat. Currently, there are no physicians in the Georgia Senate and only one physician in the Georgia House of Representatives. Dr. Burke has been a practicing OBGYN in Georgia since 1985. The District 11 seat was left vacant after the resignation of Sen. John Bullock.

**Bourke Medical Hospital in Waynesboro closes its Labor and Delivery program**

Bourke Medical Hospital in Waynesboro closed its Labor and Delivery program on December 22, 2012. Burke County Hospital Authority Chairman Gerald Murray said the move was prompted for two reasons: economics and because Dr. Mark Gresham would be closing his practice at the end of 2012, which would leave the hospital without an obstetrician. Murray said he is not totally “on board” with closing the labor and delivery unit, but the authority cannot borrow enough money to keep it open.

**ACOG’s 61st Annual Clinical Meeting**

ACOG’s 61st Annual Clinical Meeting will be held May 4-8, 2013 in New Orleans at the at the Ernest N. Morial Convention Center. Headquarters hotel is the Hilton New Orleans Riverside Hotel. For additional information on the Clinical Meeting, visit http://www.acog.org/~media/ACM/acmPreview.pdf.

**Great Start Georgia Launch**

On January 7th, Georgia’s First Lady Sandra Deal helped health officials launch Great Start Georgia (GSG), which represents the new Georgia Early Childhood System of Care (ECSOC). This new initiative is the first step in implementing comprehensive, community-based systems for expectant parents, children birth to age five, and their families. The Governor’s Office for Children and Families (GOCF) works with communities throughout the state to meet the program’s goals of ensuring children and families are educated, healthy, safe, and growing.

This new effort expands the Great Start Georgia program, which already provides home-visit services to needy families. Currently seven counties, including Muscogee, Glynn, Crisp, DeKalb, Houston, Clark and Whitley, have received federal funding from the GOCF to embed evidence-based home-visit programs into their local Great Start Georgia systems. These infrastructure changes allow communities to provide a welcome to every child, natural supports for expectant families and families of young children, basic parenting information and resources, and links to more intensive services when needed. It is believed that linking home visits to other community services promoting optimal early childhood health and development will serve families in a coordinated way, ensuring they are healthy, strong, and off to a Great Start.

“If you need help anywhere in this state, you can get help,” Deal said. “We want every mother to find out how to help her child grow up and develop properly. We want them to notice the milestones and be able to know when their child needs extra help.”

Each year in Georgia, about 35,000 newborns need additional medical help or developmental services. About 37,000 of them were identified as “at risk,” such as a premature birth or an unwed teenage mother, said Dr. Brenda Fitzgerald, Commissioner of the Department of Public Health. She said those families are particularly in need of support and care before and after the birth of a child.

“The through these programs,” Fitzgerald said, “we hope to ensure that every baby born in Georgia and their families are linked to crucial services.” GSG invites providers, community-based organizations, hospitals, and programs serving women and children to support this initiative and becoming a partner in its success. Please contact Carol Wilson at carolcwilson@gmail.com or 404-993-7714 if you have questions. For more information on Great Start Georgia and a list of community programs and services please visit their website, www.greatstartgeorgia.org.

**Questions About Medicare?**

Dr. Hugh Smith is a member of the Medicare Consumer Advocate Committee (CAC). The CAC is the method by which physicians can get information on Medicare audits and rule changes, as well as have input into Medicare procedures. If you have questions about Medicare or would like additional information or input, please contact Dr. Smith at hughdmd@urmc.edu or by phone at (706) 476-5000.

**Parent and children in the Great Start Georgia launch**

Parents and children participated in the Great Start Georgia launch.

**Great Start Georgia**

• Spring 2013 CPT Coding Seminar: GOGS is offering the 2013 CPT Coding Seminar on Friday, May 3, at the Marriott, featuring Steve Adams of MAG Mutual Healthcare Solutions, Inc. Contact the GOGS office at 770-904-0719 to register.

• GOGS Golf Tournament: Plan now to attend the GOGS Annual Golf Tournament, Wednesday, May 15, 2013 at Bear’s Best in Suwanee, GA. See our ad on page 3.

• 2013 GOGS 62nd Annual Meeting: The time is now to make your reservations for the Society’s Annual Meeting, Thursday, August 22-Sunday, August 25, at The Ritz-Carlton Lodge, Reynolds Plantation, Greensboro, GA. The GOGS room block is filling fast, so make your room reservations soon by calling 706-467-0600.

• HMHB Golf Tournament

Healthy Mothers Healthy Babies is sponsoring their First Annual Golf Tournament, Wednesday, April 24, 2013 at Cherokee Run Golf Club in Conyers. For additional information or to register, go to www.hmbhga.org.

**OBGyn Physician Wanted**

An established, busy 4-female OBGyn practice in Marietta is seeking to replace a 5th physician.

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Understanding HEDIS Measures
Adapted from an article by Dr. Alan Joffe

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.

HEDIS is the tool used by greater than 90% of all health care plans to measure the performance of care and service. The Georgia Division of Medicaid uses these performance scores to make improvements in its quality of care and service delivered to Georgia citizens by the care management organizations (CMO): Amerigroup, Peach State and WellCare. To better understand the HEDIS measure and what it means to you, we have listed common FAQ’s.

Why are HEDIS measures important?
HEDIS data is used by consumers to make an apple to apple comparison of health plan performance. In addition, HEDIS data is used in the Consumer Report/US News and World Report Health Plan rankings which are published each fall.

What HEDIS measures apply to OB/Gyns?
• Cervical Cancer Screenings
• Chlamydia Screenings
• Timeliness of Prenatal Care
• Postpartum Care
• Frequency of Ongoing Prenatal Care

What criteria do these measures use?
• The percent of women 21-64 years of age who received a Pap test(s) to screen for cervical cancer within the calendar year.
• The percent of sexually active females 16-24 years of age who received a Chlamydia screening within the calendar year.
• The percent of deliveries that received a prenatal care visit in the first trimester or within 42 days of plan enrollment.
• The percent of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
• The percent of deliveries that received greater than 81 percent of expected prenatal visits.

How can physicians help improve HEDIS efforts?
• The measured positive Chlamydia test rate statewide in family planning clinics is 11%. Physicians can flag all CMO patients in this group for screenings. Any female prescribed contraceptives or who has been pregnant will be considered eligible for this measure by most of the CMO’s. A standard office procedure of completing a STD panel, which specifically includes Chlamydia, might be an option.

• Physicians and their staff can encourage newly-diagnosed pregnant patients to register early and make timely appointments available to them. Through innovative CMO programs, members are contacted and encouraged to begin prenatal care as soon as possible and complete all recommended prenatal visits through their delivery. Members who complete their first prenatal visit, the expected number of antepartum visits and the postpartum visit can be rewarded by their plans. An example of a reward patients might receive is a financial reward card valued up to $45, whereby the patient would receive $15 on their card per trimester of care. The member can also earn up to $45 just for going to all their newborn’s recommended well-child check-ups up to 15 months.
• Remind your pregnant patients to keep their antenatal appointments. As a CMO member, non-emergency transportation services are available through their plans to assist them with free transportation. Members can find the list of participating vendors from the CMO plan. Remind patients to call at least 3 days prior to their appointment to schedule transportation.
• Remind your staff that the postpartum visit should be scheduled within 21 to 56 days after delivery. One way to do this might be to have a staff person call your members enrolled in the CMO plans 2-4 days after they deliver their baby (or they have been notified of the delivery) to assist them in scheduling the appointment within the time frame. This will alleviate a member calling in for an appointment and having no available appointments within the required time frame.
• To read more about the HEDIS measure log onto The National Committee for Quality Assurance (NCQA): www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx.
• To review Georgia Department of Community Health’s Validation of all performance measures for the reporting period calendar year 2011 for the Care Management Organizations (CMO’s, Amerigroup, Peach State, or WellCare) as well as members enrolled in fee-for-service Medicaid log onto: www.dch.ga.gov.

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OB/Gyn NEWS, February 2013

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62nd Annual Meeting
The Ritz-Carlton Lodge, Reynolds Plantation
Lake Oconee Trail, Greensboro, GA
Thursday, August 22 - Sunday, August 25, 2013

Faculty

Ronald A. Adams, MD
G. Wright Bates, MD
Linda D. Bradley, MD
Ruth Cline, MD
Brenda Fitzgerald, MD
Anna Bradshaw Fretwell, JD
Barbara S. Levy, MD
Brian Raybon, MD
Cyril O. Spann, MD
Zachary Stowe, MD
Sidney Summers Welch, JD, MPH
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For Room Reservations, 706-467-0060, Rate: $209 per Night
To Register for the Annual Meeting or for additional information, contact the Society Office
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