Georgia Obstetrical and Gynecological Society, Inc.

OBGyn News

PROMOTING EXCELLENCE IN WOMEN'S HEALTHCARE in GEORGIA

DECEMBER 2020 • VOLUME 14, NUMBER 6

Landmark Decision Concerning Georgia's Emergency Care Statute

Paul Weathington

Founding Partner and Senior Partner of the Medical Malpractice Defense Practice at Weathington, LLC.

WEATHINGTON's appellate practice team won a landmark decision before the Georgia Court of Appeals on Friday, October 23, 2020, concerning the application of Georgia's emergency medical care statute, O.C.G.A. 51-1-29.5, to medical emergencies occurring in the obstetrical unit. Generally, a plaintiff only has to show that a provider was negligent in their care and treatment, but under this decision, plaintiffs will now have to show by clear and convincing evidence that providers rendering emergency care and treatment in the obstetrical unit exhibited care that was absent of even slight diligence, almost equivalent to providing no care at all. This is a steep burden for plaintiffs.

In that case, the underlying medical malpractice action was filed against a Certified Registered Nurse Midwife and an OBGYN group, alleging that the Midwife was negligent in her delivery of a baby after a shoulder dystocia was encountered. The Plaintiffs attempted to argue that the Midwife used excessive traction in her attempts to free the shoulder which allegedly resulted in brachial plexus injury. As the case progressed, the provider Defendants moved for summary judgment, arguing that under the emergency medical care statute, the Plaintiffs must prove gross negligence by clear and convincing evidence because the shoulder dystocia was a medical emergency occurring in the obstetrical unit. The trial judge disagreed, finding that the emergency medical care statute only applied to emergency medical care provided in obstetrical units following treatment in the emergency department, and also finding that because shoulder dystocias are commonly encountered by obstetricians and the dystocia in this case was resolved in 40 seconds, it was a jury question as to whether this dystocia was a medical emergency.

The provider Defendants appealed this decision to the Georgia Court of Appeals and argued that the Plaintiffs' and trial court's interpretation of the emergency medical care statute was wrong as the plain language clearly stated that the gross negligence standard was to be applied to emergent treatment in the obstetrical unit, the emergency room, and in surgical suits following evaluation in the emergency department. The Defendants also argued that the statute does not require a catastrophic or rare injury, but instead covers any emergency treatment when the failure to treat could lead to serious injury or death.

The Court of Appeals agreed on both points, finding that the statute unequivocally applied to emergency care rendered in the obstetrical unit without the need to present first to the emergency room, and the frequency or ease of resolving a particular condition did not necessary preclude it from being an emergent medical condition as a matter of law; thus, Defendants were entitled to the heightened standard of gross negligence. Following this decision, the key factor when evaluating whether a case in the obstetrical unit will be afforded this heightened standard is whether or not the care is considered "emergency medical care."

In Georgia, emergency medical care is focused on the symptoms of the patient, not the actual underlying condition, or even what the provider thinks is the underlying condition. The legal definition of emergency medical care is: *"bona fide emergency services provided after the onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."* Thus, the key

Continued on page 3

Important Dates

February 25, 2021
Legislative Day

May 12, 2021
Golf Tournament

August 19-22, 2021
GOGS Annual Educational Meeting

in this issue

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Landmark Decision Concerning Georgia's Emergency Care Statute (*Continued from page 1*)

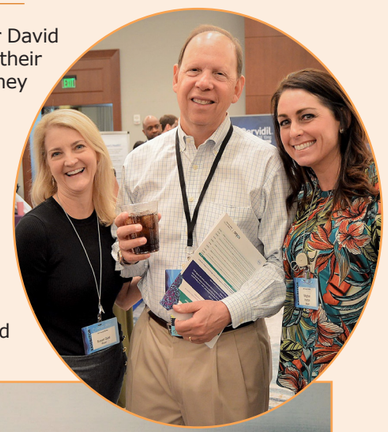
factor is whether the patient is showing severe symptoms that reasonably indicate severe injury or death could result without immediate medical treatment or a clear condition that will result in severe injury if not for immediate medical intervention.

For example, if during a delivery the provider encounters shoulder dystocia, even if that provider is able to safely deliver the baby in thirty seconds with simple maneuvers and no apparent injury to the baby, this would be considered emergency medical care. The law is focused on the likely outcome if no immediate care is provided and the presentation of the condition through severe symptoms. Under this example, the baby would unequivocally suffer a hypoxic brain injury if the shoulder is not freed and the baby is not delivered in a matter of minutes. Similarly, cases of uterine rupture are unequivocally medical emergencies that require cesarean delivery in a matter of minutes to prevent brain injury. One final example would be a fetal strip case, whether there is Category III fetal heart race tracing. This is another medical emergency that requires an immediate C-Section.

One important note is that this statute will not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or care that is unrelated to the original medical emergency. So, moving forward, close attention needs to be paid to the criticisms of the plaintiff. If the criticisms are that the providers were negligent and caused an emergent condition such as the Category III fetal heart rate tracings or uterine rupture, this will likely not be afforded the gross negligence standard. But if the care criticized is the reaction to those emergent conditions, i.e. failure to timely ensure C-Section delivery, this care will be adjudicated under the heightened gross negligence standard.

Dr. David B. Byck

May 14, 1960 - November 19, 2020



Dr. David B. Byck, President, Georgia OBGyn Society (2011-2012) passed away Thursday, November 19, 2020 at his home in Savannah, GA. He is survived by his wife of 34 years, Dr. Peggy Lee Byck; three daughters, Amanda Jones (Powell), Jessica Hensley (Trent), & Elle Byck; grandsons, Clark Jones & David Hensley; granddaughter, Harper Hensley; mother, Ellen R. Byck; brother, Edwin Byck (Melinda); sister, Nancy Burton; along with several nephews.

Dr. Byck was born in Savannah on May 14, 1960. He graduated from the Savannah Country Day School in 1978 and then attended the University of North Carolina at Chapel Hill the home of his beloved Tarheels. David attended medical school in Augusta, GA at the Medical College of Georgia. It was here David met Peggy, and they married in 1986. After David and Peggy completed their medical residencies, they moved to Savannah and began practicing medicine at Memorial Health University Medical Center. Dr. Byck would practice here for over 30 years and establish his legacy as an advocate for women's reproductive rights and medical education.

ACOG Georgia Section Report

By: Ruth Cline, MD, *ACOG Georgia Section Chair, GOGS Board Member*

I would like to introduce myself as the new Georgia Section ACOG Chair effective October 11th, 2020. Your Georgia Section has been in good hands under the leadership of Dr David Byck who completed his five years of service at the ACOG District IV meeting that took place virtually October 10th and 11th, 2020. The first day included the District Advisory Council meeting, town hall informational meeting and virtual cocktail hour.

The second day featured medical student and resident research presentations as well as the final speaker as the Dr. Donald F. Richardson Lecture by Dr. Tamika Auguste who reviewed our specialty and its history of racial bias. She motivated the audience to move forward with embracing the concept of anti-racism. The second day closed with an innovative Mentorship Mingle program that allowed interaction in organized chat sessions. This program may provide a template for future virtual small group and more personal meeting interaction sessions.

While most physicians are weary of the zoom format, it is hopeful that physicians will be able to gather in person for education and fellowship in time the District IV annual clinical meeting that is scheduled for October 14th, 2021 in Norfolk, Virginia.

Your Georgia physician colleagues are highly engaged in ACOG leadership. The current elected leaders serving in District IV and the Georgia Section include: Dr. Sandra Reed-District IV Chair, Dr. Adrienne Zertuche-District IV Young Physician Chair, Dr. Michael Lindsay-District IV Maternal Mortality Chair, Dr. Victoria Green-District IV Disparities Committee Vice Chair, Dr. Ruth Cline-Georgia Section Chair, Dr. Cathy Bonk-Georgia Section Vice Chair, Dr. Susan Mobley Green-Georgia Section Young Physician Chair, Dr. Louise Wannamaker-Georgia Section Junior Fellow Chair, and Dr. Ralph Rogers-Georgia Section Junior Fellow Vice Chair.

District IV is moving forward with its pre-covid commitment to pursue exploration of inequities in women's healthcare which has now been brought to the forefront with the pandemic and focus on social issues in our country. Dr. Wanda Nichols from North Carolina will be the Chair of this committee with Dr. Victoria Green as Vice Chair. Dr. Teresa Byrd will be representing the Georgia Section on this committee as well. Stay tuned for highlights of what will surely be thoughtful comments about this real and sensitive subject.

The ACOG State Legislative Round Table was held virtually on October 24, 2020. This forum allows all states in the country to review legislative priorities that are current or potential. The ACOG support teams can then provide support and tools for success on local and national initiatives.

The ACOG National meeting was held virtually on October 31, 2020 with Dr. Denise Jamieson, the current Department Chair of Emory University, giving a keynote lecture on global health threats-coronavirus and beyond.

The Georgia Section finances have been affected as expected with a decline in due's payments as well as investment productivity. Fortunately, the pandemic has also been associated with a decrease in travel expenditures: so there is stability. Please, don't forget to pay your Georgia Section dues!

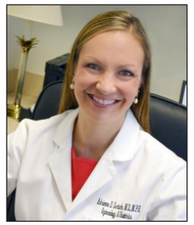
ACOG has extended the transition from in person to virtual meetings for all scheduled events through March 2021. The popular Congressional Leadership Conference (CLC) will be a virtual format February 21-23, 2021. Recent decisions have also been made to convert the ACOG Annual Clinical Meeting that was scheduled in April 2021 to a virtual format with details coming soon. Other meetings that are scheduled to put on your calendar but are subject to alterations pending the pandemic status are:

- The Georgia OB/GYN Society Annual Clinical Meeting August 19-22, 2021 at The Ritz Amelia Island
- ACOG District IV Annual Clinical Meeting October 7-10, 2021 in Norfolk, Virginia

It is an honor to serve and a challenge to communicate and stay in touch with the lack of social interactions that are no longer possible since the shutdown in March. I look forward to meeting with colleagues when we can ensure a safe and responsible environment. I am available and willing to assist any Georgia OB/GYN's with any ACOG relevant issues and will try to stay in communication by emails or phone until we can gather in person. Stay healthy and safe!

ACOG Elected Leaders District IV/Georgia Section

Sandra Reed, MD
Atlanta
District IV Chair



Adrienne Zertuche, MD
Atlanta
District IV Young Physician Chair

Michael Lindsay, MD
Atlanta
District IV Maternal Mortality Chair

Victoria Green, MD
Atlanta
District IV Disparities Committee Vice Chair

Ruth Cline, MD
Athens
Ga Section Chair

Cathy Bonk, MD
Decatur
Ga Section Vice Chair

Susan Mobley Greene, MD
Savannah
Ga Section Young Physician Chair

Louise Wannamaker, MD
Augusta
Ga Section Jr. Fellow Chair

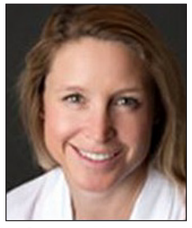
Ralph Rogers, MD
Savannah
Ga Section Jr. Fellow Vice Chair

Georgia OBGyn GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY, INC. 2020-2021 Georgia OBGyn Society Leadership

Cary Perry, MD
Athens
President Elect

Melissa Kottke, MD, MPH, MBA
Atlanta
President

Al Scott, MD
Decatur
Immediate Past President



Gretchen Koonz, MD
Atlanta
Secretary, Treasurer

Champa Woodham, MD
Macon
Member at Large

Tony Royek, MD
Savannah
Member at Large

GOGS Shares Commitment to End Racism

By: Victoria Green, MD, JD, MBA, MSHA, BS
ACOG District Four Disparity Committee Vice Chair, GOGS Board Member

George Floyd, Philando Castile, Eric Garner. Names that are forever etched on the canvas of America. The name of Ahmaud Arbery brings special somber meaning to those in Georgia. Names whose lives most of us know little about yet names whose deaths we have watched in horror.

These names and their stories have propelled social justice issues to the forefront of our daily lives. Social justice is a political and philosophical theory which asserts that everyone deserves equal economic, political and social rights and opportunities. Embodied in this concept is fair and equal treatment of all people in a society in which each individual matters, their rights are recognized and protected, and decisions are made in ways that are fair and honest.

Social justice in healthcare translates to the delivery of high quality care to all individuals to ensure that all individuals can maintain their highest level of health and wellness. Despite our best efforts, disparities exist in health and wellness where black women are 3 times more likely to die from pregnancy related complications. Hypertensive disorders of pregnancy disproportionately affect minority women and minority women have a higher risk of adverse outcomes including severe maternal morbidity.[1,2] Hispanic women are at increased risk of cervical cancer and Black women are more likely to die from breast cancer. Additionally, Native American and Black women are at increased risk of having a preterm delivery.[3]

Disparities persist not only across reproductive and gynecological health care but general and neonatal care as well. As compared to whites, African Americans are less likely to receive recommended breast cancer surgery, radiation and hormone therapy.[4] Black patients were less likely than white patients to receive potentially beneficial cardiac therapies, even after controlling for disease severity, comorbidities, insurance status and other potential confounders. Additionally disparities are reported in referral for diagnostic and interventional cardiac procedures, medications for secondary prevention of cardiac events and surgical procedures. Disparities persisted where individuals had access to a health care system without financial barriers.[5] Also lamentably, recent data suggests that when Black newborns are cared for by Black physicians, the mortality is halved as compared with white infants particularly in complicated cases.[6]

The Institute of Medicine's (IOM) 2002 report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care documented the pervasiveness of racial and ethnic disparities in the quality of medical care.[7] Drivers of these healthcare disparities exist at the provider, patient and system levels. Provider level factors include knowledge, attitudes and preferences which can impact patient outcomes. A patient level factor includes the quality of the relationship with the healthcare providers (or their perception of that relationship). System level factors can include structural racism. Each of these affect patient outcomes and providers can potentially impact each.

As providers we must focus on changing the culture of medicine by addressing racism and biases that contribute to health disparities. The American College of Obstetrics and Gynecology (ACOG) has released a joint statement with other professional organizations in the field of women's health to address racism. The statement lists examples of foundational advances rooted in racism and oppression including the surgical experimentation of James Marion Sims on enslaved black women without consent and without anesthesia, forced sterilization and experimentation with high-dose hormonal contraception without consent. It suggests that elimination of inequality in women's health care requires transformational change including collaboration, education, recognition, scholarship, inclusive excellence, rooting out racism in caring for patients and communities and policy and advocacy. These themes can be used to address inequities in organizations, practices, institutions, and individual care.

The Georgia Ob GYN Society supports the ACOG joint statement. Consider partnering with those presently engaged in racial and social justice. Learn of the history of oppression and mistreatment throughout the evolution of our field. Acknowledge racism and address systemic and institutional racism in scholarship, research and publications. Create an equitable and inclusive culture without your practices and work to achieve greater diversity and inclusion. Work to ensure health care is free from racism and bias, treating discrimination as a risk factor for poor health outcomes. Advocate for policies seeking to eliminate inequalities in health care and health outcomes.

Understanding disparities is critical as they likely contribute to inequality in health. There is growing emphasis on improved cultural competency by establishing improved, effective interpersonal and working relationships with patients in addition to recognizing the social and cultural influences that are important to them. Providers should acknowledge underlying preferences and the potential impact these preferences have on suggested therapeutic care and increased adverse outcomes. Providers can cultivate the mental habit of focusing on the things that make people individuals or mentally changing the race/ ethnicity of your patient, to see if you would do or recommend anything differently. Always ask permission when examining pts during the prenatal period and in labor. Never assume family structure of relationships such as "single mother" simply because she is not accompanied by her partner.

It is incumbent upon all of us to achieve inclusiveness in our own professional settings. Knowledge must turn into action. Support the ideology by designing strategic models of social justice in your practice.[8] Incorporate these strategies for promotion of social justice into your health care routines and clinical practice. There isn't a clear framework for what this looks like in practice, however as long one values social justice and remains committed to equity and inclusiveness, progress is possible.

1 Shahul S, Tung A, Minhaj M, et al. Racial disparities in comorbidities, complications, and maternal and fetal outcomes in women with preeclampsia/eclampsia. *Hypertens Pregnancy 2015*;34:506-15
2 Miranda M, Swamy G, Edwards S. et al. Disparities in maternal hypertension and pregnancy outcomes: evidence from North Carolina 1994-2003 Public Health Rep 2010:579-87
3 Jackson FM, Rashied-Henry K, Braveman P, et al. A prematurity collaborative birth equity consensus statement for mothers and babies. *OB GYN News* GOGS 14(4): September 2020
4 Hassett MJ, Schymura MJ, Chen K. et al. Variation in breast cancer care quality in New York and California based on race/ethnicity and Medicaid enrollment. *Cancer*. 2016 Feb b; 122(3):420-31
5 Dong L, Oludolapo AF, Garth G, et al. Racial/Ethnic disparities in quality of care for cardiovascular disease in ambulatory settings: A review. *Med Care Res Rev* 2018 Jun; 5(3):263-291
6 Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sciences* 117(35):21194-21200
7 Nelson AR, Smedley BD, Stith AY. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: *National Academies Press*. 2002
8 Chidi E, Cahill EP Protecting your birth: a guide for black mothers. How racism can impact your pre- and postnatal care- and advice for speaking to your OB GYN about it. Oct 22. 2020. *The New York Times*. https://nyti.ms/3jqy6tz

— JOINT STATEMENT —

Obstetrics and Gynecology: **Collective Action Addressing Racism**

As our nation confronts systemic racism and consequences of persistent inequities and disparate outcomes in health care, our organizations—which include the leading professional organizations in the fields of obstetrics and gynecology—are committed to changing the culture of medicine, eliminating racism and racial inequities that lead to disparate health outcomes, and promoting equity in women's health and health care. Our commitment to a better future requires an honest examination of the past and the present.

Recognizing that race is a social construct, not biologically based, is important to understanding that racism, not race, impacts health care, health, and health outcomes. Systemic and institutional racism are pervasive in our country and in our country's health care institutions, including the fields of obstetrics and gynecology.

Many examples of foundational advances in the specialty of obstetrics and gynecology are rooted in racism and oppression. For example, the mid-1800s surgical experimentation of James Marion Sims leading to successful treatment of vesicovaginal fistula was performed on enslaved Black women, including three women, Betsey, Lucy, and Anarcha, who underwent repetitive gynecologic procedures without consent.

Additionally, among many injustices, women of color have been subject to

sterilization and experimentation with high-dose hormonal contraception without consent.

It is beyond the scope of this document to describe all the injustices inextricably linked to the fields of obstetrics and gynecology or recognize all the contributions made both willingly and unwillingly by oppressed and marginalized persons. Our organizations commit to working with scholars, advocates, and activists with diverse expertise and experiences as part of an intentional, sustained, and team-based effort to more extensively acknowledge the wide range of injustices.

We recognize that history weighs upon on the present and the future. Racism in overt and covert forms persists in the delivery of health care. Black women are three times more likely to experience maternal mortality or severe maternal morbidity than white women. American Indian and Alaska Native women experience adverse maternal outcomes at a greater rate than white women. Black and Latinx populations experience higher rates of mortality from cervical cancer than white women. Unacceptable inequities in access to care and outcomes are not limited to these examples; inequities are found across our specialty including reproductive and gynecological health care. Differences in outcomes result from many factors, including racism and bias in access to and delivery of quality health care, and must be acknowledged and addressed.

Eliminating inequities in women's health care requires transformational change. Our organizations are committed to making this change and pledge, individually and collectively, to undertake the following initial actions:

- **Collaboration:** Our organizations recognize that transformative work is being done within the profession and the broader public health community by committed advocates, activists, scholars, and leaders. We will collaboratively consult, support, and partner with those presently engaged and leading work to achieve racial justice, reproductive justice, and equity in women's health care.
- **Education:** We are committed to active listening and education in obstetrics and gynecology and in the broader women's health community about the profession's history and role in the oppression and mistreatment of Black enslaved women, Black women, and other women of color in the name of scientific advancement. Drawing upon the expertise of scholars, advocates, and activists, curricula will be developed and available to medical and health professional students, residents, faculty, practicing obstetricians, gynecologists, and all health care professionals.
- **Recognition:** We are committed to officially designating February 28 and March 1, the dates that bridge Black History and Women's History months, as days for formal acknowledgement of Betsey, Lucy, and Anarcha, the enslaved women operated on by Dr. J. Marion Sims, and other enslaved Black women who were subjected to abuse in the name of advancing science.
- **Scholarship, research, publication, guidance:** Racism continues to be prevalent in research, in its conduct as well as its scholarship and publication. We will promote the conduct of research, publications, presentations, and other types of programming that incorporate anti-racism and address systemic and institutional racism manifested through disparate outcomes. We will make intentional and concerted efforts to support research that ethically addresses the needs of Black and Indigenous populations and populations of color and to promote the work and scholarship of physicians, clinicians, and public health professionals of color. We are committed to a comprehensive review of scholarship, clinical documents, research, and publications guidelines produced or directed through our organizations to address racism, in particular ensuring that race is not treated as a biological factor.
- **Inclusive Excellence:** We will work to achieve greater diversity and inclusion in the leadership of our own organizations at all levels. We will adopt policies and procedures that facilitate these goals and create an equitable and inclusive organizational culture. Within the specialty of obstetrics and gynecology, we will support policies, procedures, and the development of professional cultures where people of color are supported and promoted.
- **Caring for patients and communities:** We will work to ensure that health care is free from racism and bias. We will recognize the impact that history, racism, and violence have on our patients and their communities. We will treat discrimination and racism as evidence-based risk factors for poor health outcomes and will teach and encourage clinicians to recognize this in caring for patients. We will lift up, support, and amplify the work that community-based organizations, advocates, and activists are doing to advance reproductive justice and equity in the delivery of health care.
- **Policy and advocacy:** We will collectively advocate for public policies that seek to eliminate racial and other inequities in the delivery of health care and in health outcomes, including policies addressing systemic and institutional inequities outside of health care that lead to poor health outcomes.

Our organizations recognize that these actions require sustained, intentional commitment. We also recognize that to embark on this work will require team-based approaches with measurable goals and accountability structures. We also recognize that while these initial actions are a starting point, more work will need to be done. Through active listening, discernment, and humility, we will—individually and collectively—expand upon these actions and objectives as we undertake a commitment to embrace anti-racism, learn and unlearn, change the culture of medicine, and eliminate racism and racial bias in the delivery of women's health care.

HEALTHY MOMS. STRONG BABIES.

2020 MARCH OF DIMES REPORT CARD

In the 2020 Report Card, we highlight the latest key indicators to describe and improve maternal and infant health in the United States (U.S.). Preterm birth and its complications are the second largest contributor to infant death in the U.S., and preterm birth rates have been increasing for five years. Prematurity grades are assigned by comparing the 2019 preterm birth grade to March of Dimes' goal of 8.1 percent by 2020.

Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state level health insurance policy and the availability of surveillance and research data affect the health and survival of both mom and baby. While we currently do not have enough to grade states or report on all maternal health indicators, we have highlighted measures with the best available data.

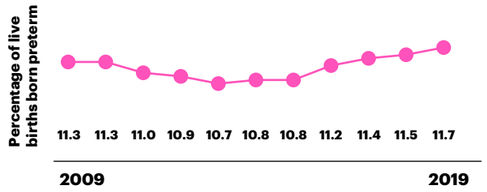
GEORGIA

PRETERM BIRTH GRADE

F

PRETERM BIRTH RATE

11.7%

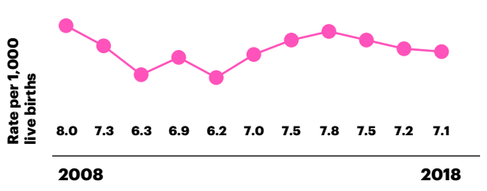


INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

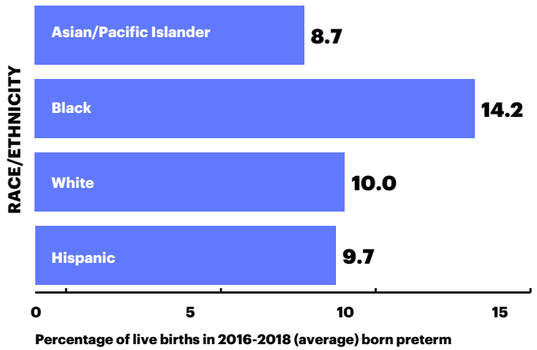
INFANT MORTALITY RATE

7.1



PRETERM BIRTH RATE BY RACE AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Georgia, the preterm birth rate among Black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.30

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATE BY CITY

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Atlanta	D-	11.4%	Better

MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

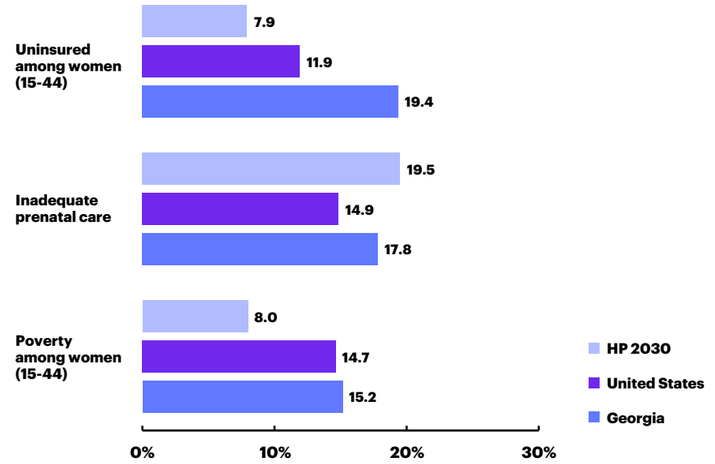
March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes. For more detail visit **Policy & Action.** For details on data sources and calculations, see Technical Notes. To learn how we are working to reduce preterm birth visit **www.marchofdimes.org.**

Scan for details

GEORGIA MATERNAL AND INFANT HEALTH

SELECTED SOCIAL DETERMINANTS OF HEALTH

Many structural, systemic and environmental factors influence the health of moms and babies, especially for Black, American Indian and Alaska Native people. When looking at factors such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. March of Dimes is collaborating with others to confront these drivers of health outcomes, while identifying solutions to achieve health equity for all.



THE AMERICAN ACADEMY OF PEDIATRICS

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Breastfeeding Friendly Physician Office Resources

American Academy of Pediatrics (AAP):

Booklet: Ten Steps to Support Parents' Choice to Breastfeed
www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Documents/tenstepsposter.pdf

Handout: How to Have a Breastfeeding Friendly Practice
www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Documents/Breastfeeding_FriendlyPractice.pdf

Centers for Disease Control and Prevention (CDC):

Article: CDC Call to Action to Support Breastfeeding
www.cdc.gov/breastfeeding/pdf/actionguides/Doctors_in_Action.pdf

Georgia Obstetrical and Gynecological Society, Inc.

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If you would like to send a letter to the editor, please send it to info@gaobgyn.org or mail it to the Society's office.

Georgia OBGyn

GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

70th Annual Educational Meeting

The Ritz Carlton at Amelia Island, Florida

August 19 - 22, 2021

Room rates start at $229 per night.
Book on-line: book.passkey.com/go/GAOBGYN2021
or call The Ritz Carlton for reservations at (888) 239-1217.
Ask for the GA OBGyn Annual Conference room block.

Rooms at The Ritz Carlton fill quickly. Be sure to reserve your room in advance!

DATES 2020 TO 2021 REMEMBER

CPT Coding Seminar
December 4, 2020
Virtual Webinar

Legislative Day
February 25, 2021
The Georgia Freight Depot, Atlanta

GaPQC Annual Meeting
Spring, 2021
Location TBA

GOGS Golf Tournament
May 12, 2021
Bear's Best, Suwanee

Annual Education Meeting
August 19-22, 2021
The Ritz Carlton at Amelia Island, Florida