The Obstetrical Society of Philadelphia

To embrace our legacy, foster collegiality, and share expertise to improve the health of women in Philadelphia and beyond

Newsletter

JANUARY 2018

VOL. 45, NO. 1

President's Message

"The only thing that is constant is change."

- HERACLITUS OF EPHESUS, PRE-SOCRATIC GREEK PHILOSOPHER, 535 BC – 475 BC

Happy New Year and welcome to 2018, the Sesquicentennial Year of the Obstetrical Society of Philadelphia. We began our celebration year with an insightful and stimulating presentation by Hal Lawrence, III, MD, FACOG, Executive Vice President and Chief Executive Officer of The American College of Obstetricians and Gynecologists. His presentation provided a very interesting history lesson in the development of the College, and our specialty. He also challenged us with a look to the future. Dr. Lawrence recently surveyed a number of leaders in our specialty and concluded that we can expect continued evolution of technology, demand for changes in the way we educate our residents, and recognition of continued change in the demographics of our specialty. At the conclusion of his presentation, a spirited discussion ensued about these topics. While no definite conclusions were reached, I was impressed with the discussion and how it reflected the core of what our Society does as we strive to respond to the challenges of our time and anticipate the needs of our patients.

Relative to the changes in the demographics of our specialty, a review of the *Notes of the Obstetrical Society of Philadelphia in the Present Century*, authored in 1943 by Lewis C. Scheffy, MD, finds that our Society was challenged from it's very beginnings to address issues of the time. On November 6, 1879, Dr. Emily H. Cleveland, who was then Professor of Obstetrics and Diseases of Women and Children at the Women's Medical College, sought admission to the Obstetrical Society. A long standing prohibition on the admission of women was challenged, with her name being used as a test case. Dr. Sheffey reports that "controversy raged about admission of women to the Society" and the decision was made to deny Dr. Cleveland's admission, and so it was until April 7, 1892, when seven women were finally voted membership in our Society. Examination of contemporary statistics finds that 38% of our active Society members are women, and that number will surely continue to increase.

A publication in the *Journal of Medical Education* in December 2017 by Frank A. Chervenak, MD, et al, addressed the issue of gender diversity in our specialty and provides further insights to significantly changing demographics. He reports that 47% of medical students in the United States are women as of the 2015 – 16 academic year. ACOG fellowship has shown similar changes, with 18.6% of female fellows in 1994 increasing to 48.9% in 2015. The paper further reports that currently 85% of OB/GYN residents are women. While other specialties have experienced similar demographic shifts, Obstetrics and Gynecology continues to be the leader in this significant change.

During his presentation, Dr. Lawrence discussed data indicating differences in male and female members of our specialty in terms of their patterns of practice. I see these differences not as a negative, but rather as an opportunity to redefine our specialty and ultimately be more responsive to the needs of our practitioners regardless of their gender. In order to do so, we must approach our deliberations without preconceived notions or historical bias. In the pursuit of answers, let us not fall victim to a similar myopic focus that led to the exclusion of women from our Society for so many years, but rather let us embrace our diversity and the wonderful opportunities it provides.

I will conclude with the words of a 20th-century Nobel laureate:

Come gather 'round people
Wherever you roam
And admit that the waters
Around you have grown
And accept it that soon
You'll be drenched to the bone
If your time to you
Is worth savin'
Then you better start swimmin'
Or you'll sink like a stone
For the times they are a-changin'.

– BOB DYLAN 1964

A. George Neubert, M.D.
President

Upcoming Lecture

Thursday, February 8, 2018, 6:00 PM

"Providing Care for Transgender and Gender Nonconforming Individuals"

We hope that you will be able to join us for our February meeting when A panel of experts will discuss how obstetricians and gynecologists can fill the gaps in care faced by transgender and gender non-binary patients. Participants will learn about best practices in providing obstetrics and gynecologic care for this patient population.

PANELISTS:

LIN FAN WANG, MD, THE MAZZONI CENTER

LIBBY PARKER, MA, MSS, LSW; EINSTEIN MEDICAL CENTER; PHILADELPHIA, PENNSYLVANIA

SCOTT RICHARD, MD; THOMAS JEFFERSON UNIVERSITY

JAKE COOK, PHILLY FIGHT

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Embrace Our Legacy

The following excerpt was selected from "Harris on Early Puberty" from Decemeber 1, 1870:

Harris on Early Puberty.

EARLY PUBERTY.

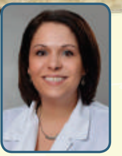
By ROBERT P. HARRIS, M.D., Phila., Pa.

(Read before the Philadelphia Obstetrical Society, Dec. 1st, 1870.)

MY attention has been recently directed toward the subject of early puberty, in consequence of having been consulted by a lady in regard to her daughter, who commenced to menstruate last month (October), at the age of nine years and five months, the flow continuing five days. This girl has a youthful face, and a mind in correspondence with her years, but is in all other respects far advanced towards womanhood, being five feet one inch high, having well developed mammæ, rounded limbs, a moderately ulll pelvis, hair upon her pubis, and weighing ninety pounds. She has been reared in a quiet country place, educated at home, and kept free from all excitement. A sister of twelve, who is two and a half inches taller, and four pounds heavier, has as yet no sign of approaching puberty.

In contrast with this case, I present two others, each representing different types of precocious menstruation, in which the epoch anticipates the other characteristic marks of puberty. The *first* is that of a large, over-grown plethoric girl, such as are very apt to menstruate at an early age, particularly in cities, whose menses appeared for the first time two months ago, at the age of eleven years and nine months, at which time she measured five feet one inch and a half in height, and weighed one hundred and six pounds. The attack was of a menorrhagic character, and due no doubt to the effect of the long hot summer, acting upon a plethoric habit. With all this size and weight, there is nothing womanly in the girl's configuration; her mammæ are undeveloped, her pelvis but slightly enlarged, and the measure of her chest and waist nearly the same. The parents of both these mentioned cases are of only medium height.

The *second* is that of a little girl who came under my notice, just two years and a half ago, at the age of twelve years and six months, at which time her menses made their first appearance. She was then four feet eight inches high, of very narrow frame, and weighed seventy-two pounds. Her parents are both below medium height, that of the mother being five feet. At fifteen, which she has just reached, she measures the same in height as her mother, weighs ninety-five pounds, and is only now presenting in her figure the marks of womanhood. She is mentally quite precocious, has been educated at home, enjoys excellent health, and is strong and active, from much attention having been paid to her physical training.



COMMENTARY BY LUISA GALDI DO, ASSISTANT PROFESSOR OF OB/GYN AT DREXEL UNIVERSITY COLLEGE OF MEDICINE

We've come a long way since isolated case reports of "early" puberty. Today precocious puberty is identified by the onset of secondary sex characteristics before the age of 8 in girls and 9 in boys. The decision to treat with "puberty blockers" depends on several factors: child's age, the rate of pubertal progression (sexual maturation), height velocity, and the estimated adult height as determined from the rate of bone age advancement. The goals of therapy are clear: to preserve normal adult height and to prevent psychological stress associated with early pubertal development.[1]

Modern medicine is addressing perhaps an even more complex developmental problem – natural puberty in the transgender, or gender nonconforming, child. For transgender youth, development of secondary sex characteristics and other pubescent changes can be destructive to their psychological and overall well-being. Pediatric endocrinologists have been using "puberty blockers" to treat precious puberty for decades, but only in the last 10 years have they started suppressing puberty for transgender children. The Endocrinology Society recommends "treating transsexual adolescents (Tanner stage 2) by suppressing puberty with GnRH analogues until age 16 years old, after which cross-sex hormones may be given."[2] These guidelines are supported by the Pediatric Endocrine Society and the World Professional Association for Transgender Health.

Studies show that childhood gender dysphoria will resolve before or in early puberty, and for this reason, the treatment is still controversial. But for transgender children whose feelings persist and intensify through adolescence, the onset of secondary sex characteristics often leads to body aversion and severe emotional distress. Blocking puberty allows for more time to explore gender nonconformity and prevents development of nonreversible secondary sex characteristics, facilitating transition. Interestingly, studies evaluating puberty suppression therapy included children who were at least 12 years old.[3] So, early puberty—precocious or not—adds an unfamiliar variable that will continue to be studied through isolated care reports, just as it was for our distant colleagues.

1 "Treatment of Precocious Puberty - UpToDate," January 10, 2018. https://www.uptodate.com/contents/treatment-of-precocious-puberty#H23809000.

2 Hembree, Wylie C., Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, III Meyer Walter J., Norman P. Spack, Vin Tangpricha, and Victor M. Montori. "Endocrine Treatment of Transsexual Persons:An Endocrine Society Clinical Practice Guideline." *The Journal of Clinical Endocrinology & Metabolism* 94, no. 9 (September 1, 2009): 3132–54. https://doi.org/10.1210/jc.2009-0345.

3 "World Professional Association for Transgender Health Standards of Care." WPATH, World Professional Association for Transgender Health, Inc., Feb. 2001, www.wpath.org/publications_standards.cfm.

PHOTOS FROM OUR JOINT OB/PARES MEETING MEETING

"ACOG, Yesterday, Today and Tomorrow"

Speaker: Hal C. Lawrence, III, MD

American College of Obstetricians and Gynecologists

JANUARY 11, 2018

HAL C. LAWRENCE, III, MD SIGNS THE BOOK

Foster Collegiality

Foster Collegiality

Foster Collegiality

Foster Collegiality

February Meeting

The Obstetrical Society of Philadelphia

OUR MISSION: "TO EMBRACE OUR LEGACY, FOSTER COLLEGIALITY, AND SHARE EXPERTISE TO IMPROVE THE HEALTH OF WOMEN IN PHILADELPHIA AND BEYOND."

A panel of experts will discuss how obstetricians and gynecologists can fill the gaps in care faced by transgender and gender non-binary patients. Participants will learn about best practices in providing obstetrics and gynecologic care for this patient population.

PANELISTS:

LIN FAN WANG, MD, THE MAZZONI CENTER
LIBBY PARKER, MA, MSS, LSW; EINSTEIN MEDICAL CENTER; PHILADELPHIA, PENNSYLVANIA
SCOTT RICHARD, MD; THOMAS JEFFERSON UNIVERSITY
JAKE COOK, PHILLY FIGHT

Topic:	**Providing Obstetrics and Gynecologic Care forTransgender and Gender Non-Binary Individuals**
Date:	Thursday, February 8, 2018
Location:	***Philadelphia County Medical Society Building, 2100 Spring Garden Street***
Time:	6:00 PM Cocktails, 6:30 PM Dinner and Program

Free parking available in the lot next to the PCMS Building.

Payment by check or online at www.obphila.org
We cannot accept payments at the door.

Members - $60.00 Non-members $70.00
RSVP's are due no later than Tuesday, January 30th.

Please make your check payable to The Obstetrical Society of Philadelphia
308 Rolling Creek Road, Swarthmore, PA 19081.

Fund Raising for the OB Society

To My Colleagues and Friends,

The Obstetrical Society of Philadelphia was established in June 1868 when a group of 9 obstetricians met to begin a discussion of women's health.

Our Society is the third oldest Obstetrical Society in the United States.

As of 2018 our Society will be 150 years old.

Throughout our existence we have been committed to education, sharing of knowledge, and promotion of women's health.

Our mission statement exemplifies our goals:

"TO EMBRACE OUR LEGACY, FOSTER COLLEGIALITY, AND SHARE OUR EXPERTISE TO IMPROVE THE HEALTH OF WOMEN IN PHILADELPHIA AND BEYOND"

We've worked very hard over the last 150 years to provide quality education to the attending physicians, residents, and medical students of the Tri-State Area- Pennsylvania, New Jersey, and Delaware.

Going forward, we want to make sure that the Obstetrical Society of Philadelphia continues to exist in its present form not only for another 150 years but for as long as we have obstetrician/gynecologists caring for women of all ages.

In order to accomplish this goal, we are asking our current members and emeritus members to consider a donation to the Society to a special fund that we have established for the 150th celebration. All of the money donated to this fund will be maintained and invested to ensure the future existence of the Society and used to continue to support the quality programs that we have provided for the last 150 years. Consider a named donation in Honor or Memory of a loved one, colleague, or special event.

We also welcome your ideas and suggestions for maintaining the existence of the Society. Please contact us with your thoughts. We look forward to hearing from you and thank you for your continued commitment and dedication to the Obstetrical Society.

Thank you very much.

The Council of the Obstetrical Society of Philadelphia

Advertising Opportunity

Obstetrical Society of Philadelphia
150th Celebration- Commemorative Book
Request for an Ad

PLEASE FILL OUT THIS FORM AND SUBMIT WITH YOUR AD AND OR PHOTOGRAPH.

PLEASE RETURN WITH YOUR CHECK BY FEBRUARY 19TH TO THE ADDRESS BELOW.

If you have any questions, please contact:

Theresa B. Wiseley, CMM
Executive Secretary
308 Rolling Creek Road
Swarthmore, PA 19081
obphila@yahoo.com
484-343-8199

or

Susan I. Kaufman, DO
skaufman17@comcast.net

Institution: ____

Contact Person: ____

Email: ____

Phone Number: ____

PLEASE CHECK APPROPRIATE BOX:

Ad size:

- ❑ Whole page $500
- ❑ Half page $250
- ❑ Quarter page $125
- ❑ Shout out – one line. . $50

❑ **Picture included**

Einstein Health Networks' Pride Program: Caring for LGBTQ+ Patients

LIBBY PARKER, MSS, LSW
PRIDE PROGRAM
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

In 2015, Dr. Michele Style, resident physician and co-founder of Einstein Health Network's Pride Clinic, treated a patient who presented with advanced-stage cervical cancer. The patient had health insurance and lived within walking distance of the hospital, however she had avoided preventative care, including routine Pap smears. During the course of her treatment, the woman disclosed that she identifies as a lesbian, and feared she would be unfairly judged and unwelcome in a hospital setting due to her sexual orientation. As such, she had avoided pursuing life-saving screenings which could have prevented the progress of her cancer. Unfortunately, her story reflects a much larger trend in healthcare access and outcomes for LGBTQ+ identified individuals.

According to national research, individuals who identify as lesbian, gay, bisexual, transgender, and queer are more likely to experience discrimination in health care settings. In a 2010 survey conducted by Lambda Legal, **70% of transgender respondents, and almost 56% of lesbian, gay, and bisexual research participants, reported experiencing at least one instance of discrimination while trying to access health services.**[1] In a similar analysis conducted by the National Center for Transgender Equality, in partnership with the National Gay and Lesbian Task Force, **19% of the trans identified respondents described having been outright denied healthcare due to their gender identity.** The same survey found that **28% of respondents reported being harassed and *2% experienced physical violence while seeking medical care*[2].**

Avoiding healthcare settings due to concerns regarding safety, comfort, and acceptance has left a large swath of our population without adequate care. *In the City of Philadelphia alone it is estimated that roughly 3.9% of the population[3], a little over 60,000 people, identify as LGBTQ+.* Yet despite the demand for LGBTQ+ competent services, resources are limited. As a result, individuals who identify as lesbian, gay, bisexual, transgender, and queer, are more likely to experience adverse health outcomes when compared to their cisgender[4], straight peers.

Because medical schools seldom require students to learn about the unique experiences of their lesbian, gay, bisexual, trans, and queer patients, medical providers are often without adequate tools for providing quality care. When Einstein Healthcare Network launched its LGBTQ+ health initiative and established the Pride Program, its founders recognized that training staff was essential.

The Pride Program's training introduces staff to four essential components of identity: **(1) Sex Assigned at Birth; (2) Gender Identity; (3) Gender Expression; and (4) Sexual Orientation.**

1. **Sex assigned** at birth refers to the classification of an individual as male, female, or intersex. Individuals are often assigned a sex by medical providers at the time of birth, as reflected on their birth certificate. It is important to remember that some people may have the sex on their birth certificate changed later in life, hence we say '*sex assigned at birth*' rather than 'sex'.

2. **Gender identity** refers to one's *individual, internal experience of their gender*. As such, we must be told how another person identifies before we know what their gender is. While our sex is most often assigned to us, **our gender identity is a matter of self-determination**. One's gender identity may or may not vary over time and is not inherently visible to others, as opposed to *gender expression*.

3. **Gender expression** is an *external* manifestation of gender communicated in a variety of ways, including, but not limited to: *one's name, pronouns, clothing, haircut/style, voice, or body characteristics*. Society most often identifies these "cues" as masculine and feminine, although what is considered masculine and feminine changes over time and varies by culture.

4. **Sexual orientation**, akin to gender identity, is an *internal* sense of physical, romantic and/or emotional attraction to another person. Our sexual orientation is also not necessarily visible to others nor is it inherently static.

Einstein Health Networks' Pride Program: Caring for LGBTQ+ Patients continued from page 10.

Share Expertise

While this language is particularly advantageous in working with LGBTQ+ identified individuals, it is important to recognize that ***all people were assigned a sex at birth, we all have an internal gender identity and external gender expression, in addition to our sexual orientation***.

Understanding these four broad categories helps us better communicate with all our patients regarding essential components of their identity. While there is a great deal of nuanced language specific to these broader categories (including language which is understood to be offensive and should therefore be avoided[5]), the Pride Program's training emphasizes the importance of self-determination. **By respecting the self-determination of our clients we recognize that, when discussing areas of identity, it is our job to listen, and remember *the patient is always the expert.*** *As care providers it is up to us to mirror the language used by our patients and not inset our own assumptions into our interactions.* We can take steps towards cultivating a more welcoming environment by using gender neutral language and avoiding language, policies, and practices which exclude our LGBTQ+ identified patients.

If you are interested in learning more about how to best serve your LGBTQ+ identified patients there are a plethora of trainings available to you, including those provided through the Pride Program. To learn more please contact our Program Manager, Libby Parker, MSS, LSW via email at ParkerLi@Einstein.Edu.

References

1. From When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010). Available at www.lambdalegal.org/health-care-report.
2. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey, J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, and M. Keisling, 2011 (Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force), accessed Feb. 4, 2011.
3. The Metro Areas With the Largest, and Smallest, Gay Populations, David Leonhardt, Claire Cain Miller, March 20th, 2015, The New York Times, accessed June 1st, 2017
4. Cisgender describes a gender identity in which a person almost always, if not exclusively, identifies as their sex assigned at birth.
5. If you are interested in learning more about terms to avoid, you utilize a variety of resources available online including GLAAD's publication, 'An Ally's Guide to Language', Available at: https://www.glaad.org/publications/talkingabout/terminology

The Medical Marijuana Notices

THE PENNSYLVANIA DEPARTMENT OF HEALTH IS IN THE PROCESS OF IMPLEMENTING THE STATE'S MEDICAL MARIJUANA PROGRAM, SIGNED INTO LAW ON APRIL 17, 2016. WHEN FULLY IMPLEMENTED IN EARLY SPRING OF 2018, THE MEDICAL MARIJUANA PROGRAM WILL PROVIDE ACCESS TO MEDICAL MARIJUANA FOR PATIENTS WITH A SERIOUS MEDICAL CONDITION.

Introduction to Medical Marijuana in Pennsylvania

The PCMS intro to medical marijuana program is informational only and seeks to provide physicians, resident/ fellows and medical students with additional information and resources to better understand the program.

Date: Thursday, February 15, 2018
Time: 6:30 PM – 8:00 PM
Place: The Philadelphia County Medical Society
Address: 2100 Spring Garden Street, Philadelphia 19130
Parking: Limited Free Outdoor Parking
Contact: (215) 563-5343 X 102

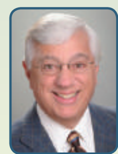
Medical Cannabis Training for Physicians for DOH Certification

The Chester, Delaware & Philadelphia County Medical Societies are partnering with the University of the Sciences and the Continuing Education Department of Delaware County Memorial Hospital to offer the required four-hour training program on medical cannabis – coursework that is approved by the state and required for physicians who wish to recommend cannabis for their patients.

Conference costs will be $275 for physicians, pharmacists, physician assistants and nurse practitioners who desire DOH certificate of completion and CME credits. ($75 for no certificate or CME).

Date: Saturday, March 24, 2018
Place: The Philadelphia County Medical Society
Address: 2100 Spring Garden Street, Philadelphia 19130
Parking: Limited Free Outdoor Parking
Contact: (215) 563-5343 X 102

REI: Past, Present and Future



VINCENT A. PELLEGRINI, M.D.
TOWER HEALTH MEDICAL GROUP

I have been asked to give my personal perspectives on the evolution of the subspecialty of REI, as I have experienced it over my 40 years of practice in Reading, PA. I am truly humbled to do so. I will restrict my comments to In Vitro Fertilization (IVF), as I feel the most dramatic REI advances have occurred in this area.

When our private practice IVF program began in 1986 after two years of planning and education, a whole new world opened for our patients and myself. Clearly, I was in awe of this monumental development. Pregnancy was now a possibility for many whose dreams of parenthood were quite unlikely to be fulfilled a few years previously. IVF successes happened with non-repairable fallopian tubes! The role of microsurgical tubal reconstruction was truly challenged, never to reign king of REI services again. Our program began with a list of 20 very brave patients willing to embark on a special, new journey with us. Pregnancy rates were hoped to be 20% per IVF attempt. It took us six months to have our first success.

Our first few patients to step forward had their oocytes gathered laparoscopically. However, shortly thereafter as ultrasound developed, we were able to retrieve oocytes in the office. Under abdominal ultrasound guidance, a free-hand needle technique was used, advancing through the bladder transabdominally or by way of the urethra, and/or by puncturing the posterior culdesac of the vagina. Fortunately, I was very soon able to obtain a prototype vaginal ultrasound probe. Until a needle guide was developed for this probe, the plastic protective sleeves of NICU intracatheters were taped onto the probe and used to direct the retrieval needles into the stimulated ovaries.

Over the next 10 years, great progress was made in IVF. With the advent of Intracytoplasmic Sperm Injection (ICSI), pregnancy became possible even when no sperm were present in the ejaculate. Testicular biopsy sperm worked equally well to achieve conception. Refinements were made in stimulation and laboratory techniques. In the early years of IVF, it was routine to inseminate 6 oocytes and transfer all normally developed embryos into the uterus 2 days later. As success rates improved, the number of oocytes inseminated gradually decreased to 5, 4 and then 3. Embryo cryopreservation soon came onto the scene. This technique helped to control the number of fresh embryos transferred. This technique markedly influenced the occurrence of multiple pregnancies, a downside of IVF often seen in 20-30% of pregnancies. Single embryo transfer (SET) became common and is now very often utilized. Embryos are now transferred into the uterus on day 3 or day 5-6 of laboratory development.

Oocyte cryopreservation has more recently been refined. This has allowed an alternative means to minimize multiple pregnancies, especially for those patients uncomfortable with the ethics of residual, unneeded cryopreserved embryos. Now, just 2-3 oocytes can be inseminated and the remainder cryopreserved for later use, just like embryos. This technique has also fostered medical and elective fertility preservation.

Currently, IVF pregnancy rates are as high as 60-70% per attempt. To improve implantation rates even further, Preimplantation Genetic Screening (PGS) is now commonly used, especially for women over age 35. PGS allows for the identification of euploid embryos for uterine transfer.

It's hard for me to predict the next big development in IVF. What I do know is that this has been the most unbelievable adventure through my medical practice. I have been performing IVF long enough to subsequently have the privilege of being involved in the IVF cycle of one of our IVF babies, along with performing advanced ovulation induction for several other IVF babies from our program. I have recently attended the wedding of one of our very first IVF babies, of whom I am the godfather. I have also watched first hand another very early IVF baby move up the corporate ladder to become an executive. This has been such a rewarding path with a great legacy. I wish a similarly satisfying career to all the young members of the Obstetrical Society of Philadelphia.

2018 Meeting Schedule

Dinner Meetings

February 8, 2018 — ***Providing Care for Transgender and Gender Nonconforming Individuals***
Lin Fan Wang, MD, Mazzoni Center

March 8, 2018 — ***Providing Patient Centered Care***
Daniel Davis, PhD, Geisinger Health System

April 12, 2018 — ***Women's Reproductive Health – Historical Perspectives/Future Challenges***
Philip Darney, MD, MSC, University of California, San Francisco

THE VENUE FOR THE DINNER MEETINGS IS THE PHILADELPHIA COUNTY MEDICAL SOCIETY BUILDING, 2100 SPRING GARDEN STREET. THERE IS **FREE PARKING** IN THE LOT ADJACENT TO THE PCMS BUILDING.

Sesquicentennial Gala at the College of Physicians!

May 10, 2018 — ***150 Years of Contributions by Philadelphia Physicians to Women's Health***
Anthony Tizzano, MD, Cleveland Clinic Foundation

Resident Education Day

Friday, May 4, 2018 — Reading Hospital will host. Look for exciting changes, specifically to the Resident Bowl and the return of the Mock Trial, this time focusing on "*The Anatomy of a Deposition*".

Obstetrical Society Of Philadelphia
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