



The Obstetrical Society of Philadelphia

To foster collegiality, share expertise, and improve the health of women by promoting equity, compassionate and evidence-based care, education, advocacy, and scholarly endeavors in women's health

SEPTEMBER 2026

Newsletter

VOL. 52, NO. 2

President's Message



Learn Best Practices To Improve Success Of ECV

NICOLE M. SALVA, MD

President: Obstetrical Society of Philadelphia

Fall is in the air! While I'm thankful for the return of pumpkin spice lattes, cooler (but not cold) temperatures, and life structure, I'm most excited for the return of the Ob Society events!

I thank all our fellowship directors and participants for a successful first meeting to discuss the fellowship application processes. Despite having practiced for 14 years, I learned quite a bit about the fellowship match process! Check out my article in the newsletter about Fellowship Match: Dos and Don'ts.

Our October event features Dr. Amr Madkour from GW Faculty Associates talking about the art of ECV. Admittedly, when I performed ECVs, I frequently thought of the practice as a theatrical performance. It was performed to make us and our patients feel better about cesarean sections for malpresentation. But, when it worked, with no impact on the fetal heart tracing, which was approximately half the time at best (for me), man did it feel good to be

the hero! When it worked, but my patient had a cesarean section anyway for other causes, I often had internal philosophical debates about the utility of our interventions. When I read Katee Kemether's piece on ECV, I couldn't wait to share it. She managed to capture the emotion of caring for birthing people through the art of medical practice, like ECV. I look forward to

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our forum to learn best practices to improve success of ECV from Dr. Madkour, and I personally can't wait to ask him all the questions that ran through my mind about patient selection and technique for success.

Make sure to check out our members only portion of the website. We have a growing body of events, job list-

ings, and resources for ourselves and our patients.

Please make sure to contact Teri or I with anything you need this year!

Looking forward to seeing everyone in October!

Upcoming Lecture

Tipping Point: The Art and Science of the ECV



Amr Madkour, MD

GW Medical Faculty Associates

Thursday, October 8, 2026

[See page 3 for details.](#)

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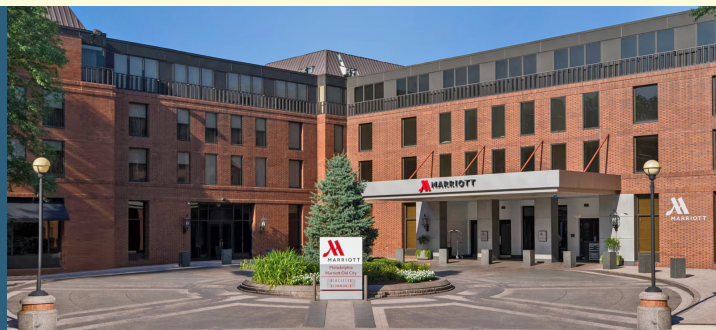
2026-27 Meeting Schedule



Thursday, October 8, 2026	Tipping Point: The Art and Science of the ECV Amr Madkour, MD – GW Medical Faculty Associates
Thursday, November 12, 2026	Breast Cancer Risk Reduction for the OBGYN Susan Domchek, MD – Rena Bassar Center for BRCA
Thursday, December 3, 2026	Joint PARES/OB Society Meeting Zev Williams, MD, PhD – Columbia University Fertility Center
Monday, January 11, 2027	High Yield CREOG Review (Virtual Meeting)
Thursday, January 14, 2027	Critical Access and Rural Health Care Camille Clare, MD, MPH – President ACOG
Thursday, March 11, 2027	Your Stress Has a Type: Why Your Colleague's Coping Strategy Might Not Work for You Ali Novitsky, MD – Founder, The Fit Collective
Thursday, April 8, 2027*	Research Symposium to pick S. Leon Israel Winner
Friday, May 7, 2027	Resident Education Day at the Marriott Old City
Thursday, May 13, 2027	President's Night

**Indicates dinner meetings that are gratis – no cost for members in good standing!*

NEW VENUE
The Marriott Old City
One Dock Street, Philadelphia





**Tipping Point:
The Art and Science of the ECV**

Thursday, October 8, 2026

6:00 PM Cocktails and buffet

7:00 PM Program



AMR MADKOUR, MD
GW Medical Faculty Associates

— LOCATION —

**The Marriott Olde City
One Dock Street, Philadelphia**

— REGISTRATION —

\$75.00 Members • \$125.00 Non-Members

<https://obphila.org/events/>

RSVP BY THURSDAY, OCTOBER 1, 2026

An Op-Ed From The Sidelines



This morning I was moved to tears watching a reporter interview Tierra Walker's aunt about the recently filed lawsuit brought by Tierra's family. Lawyers for Tierra's family filed the lawsuit Tuesday in Bexar County District Court accusing Texas Attorney General Ken Paxton, the University of Texas Health Science Center at San Antonio, several of her doctors and others of "deliberate indifference, discrimination, and medical mistreatment [that] ultimately caused her horrific and tragic death" in 2024.

To say I was overwhelmed with emotions is an understatement. I experienced so many *feelings* at once...

Sorrow for her family's pain.

Outrage for the indifference and lack of basic humanity shown to Tierra.

Relief that my own daughter-in-law had access to miscarriage management after suffering five pregnancy losses. She was spared a possible fate like Tierra's.

Pride that my day job allows me to feel empowered to honor human dignity.

Gratitude that I work with Obstetrical Society members – "Every day I get to watch good people do great things."

Obligated to do whatever is within my ability to improve the current situation and work for change.

To that end, supporting and highlighting organizations that provide resources for women seeking medical care seems the most practical thing I can do.

- The Brigid Alliance – <https://brigidalliance.org>
- The Women's Center – <https://thewomenscenters.com>

I encourage all the Society's members who feel the same obligation to share these resources and support the care they provide to women in need.

Teri Wiseley

OB Society Executive Secretary



Membership Has Its Privileges...

*Have you received your password
for the Members Only area yet?*

Emeritus and current members are entitled to access the Members Only area of the website. Check out the latest job postings, mentorship, volunteer opportunities, sponsored dinners, professional resources and more!

Watching the procedure, I was immediately reminded of the phrase, “Medicine is not just a science; it is an art.”



KATHARYN KEMETHER
Sidney Kimmel Medical College, Class of 2027

I recently witnessed my first external cephalic version (ECV) as an inpatient sub-intern on Labor and Delivery. Our patient was a 33-year-old primigravida at just under 40 weeks who presented for her scheduled induction of labor. Her baby had been cephalic on prior scans, and she arrived expecting a vaginal delivery. On admission, however, ultrasound revealed something unexpected: her baby was breech, with her bottom firmly settled into her mother's pelvis.

The finding came as a surprise to the couple and the L&D team. Because she was at term, had no contraindications to the procedure, and strongly desired a vaginal delivery over cesarean delivery, she was offered an ECV.

Current ACOG clinical guidelines support offering ECV at or near term to appropriate patients with breech presentation.¹ Waiting until term reduces concern for complications related to preterm delivery, while performing the procedure in a setting with immediate access to fetal monitoring and cesarean delivery allows the team to respond to the rare serious complication.² Tocolysis may also be used to relax the uterus and improve the likelihood of a successful version.³

For our patient and her baby girl, whose head rested near her mother's heart, body facing maternal left, and bottom remained wedged in the pelvis, the team decided that a counterclockwise forward roll offered the best chance of success. Our patient received tocolysis and had already received an epidural. She was counseled that she might still experience significant discomfort and that we could stop or take breaks at any point.

Like so many patients I have met on Labor and Delivery, her primary concern was not her own discomfort, but her baby. She told us she could tolerate the pain as long as her daughter remained safe. After discussing the expected success rate, the uncommon but important risks, and the possibility that cesarean delivery could still be necessary, she agreed to proceed.

The mechanics of a forward roll sound deceptively simple when described in a textbook. One hand works to elevate the fetal breech out of the pelvis while the other applies pressure to the fetal head, encouraging the baby to roll in the desired direction. I had seen the maneuver demonstrated on models and illustrated in diagrams during medical school, but nothing quite prepared me for seeing it performed on a patient.

Watching the procedure, I was immediately reminded of the phrase, “Medicine is not just a science; it is an art.”

An ECV requires an extraordinary amount of trust. There is something counterintuitive about watching a physician apply such deliberate pressure to a pregnant abdomen at term. For those in the room witnessing it for the first time, it is almost impossible not to tense up. After nine months spent protecting a pregnancy, suddenly we were intentionally trying to move this seemingly content baby from the position she had chosen.

...continued on the next page

The Art of the Version

It also requires strength, but not simply force. Hands must be positioned to generate enough traction to move a nearly full-term fetus while simultaneously minimizing discomfort for the patient. I watched as the physician took hold of the patient's abdomen, glistening with ultrasound gel, almost as a climber approaches a wall—looking for the right position, adjusting the angle, and calculating where pressure might produce movement. Each subtle shift of the baby dictated the physician's next move.

Perhaps most strikingly, the physician could not continuously see what they were doing. Ultrasound provided intermittent confirmation, but much of the procedure depended on touch: feeling where the baby was, recognizing movement, understanding resistance, and knowing when to push, when to adjust, and when to stop. The mental calculations occurred simultaneously with the physical demands of the maneuver. Watching them unfold in real time felt less like following an algorithm and more like watching a performance.

There are moments in medicine when a physical examination or maneuver can feel almost like magic, and the ECV is emblematic of this. It is a maneuver learned, practiced, taught, and passed from physician to physician, not dissimilar to a nursemaid's reduction or an Epley maneuver. Despite all of the technology surrounding a modern Labor and Delivery unit, the most essential instrument remains the clinician's hands.

In that way, the ECV felt like one of medicine's oldest exchanges between physician and patient: placing hands on the body, using touch to understand what cannot be completely seen, earning enough trust to intervene, and continuously adjusting based on what the patient, and in this case, her baby, gives back.

It was as beautiful to watch as it was fascinating. My first external cephalic version was not simply a lesson in obstetric technique; it was a masterclass in the art of medicine.

References

¹American College of Obstetricians and Gynecologists. *External Cephalic Version*. ACOG Practice Bulletin No. 221. *Obstet Gynecol*. 2020;135(5):e203-e212.

²Grootscholten K, Kok M, Oei SG, Mol BWJ, van der Post JA. *External cephalic version-related risks: a meta-analysis*. *Obstet Gynecol*. 2008;112(5):1143-1151. doi:10.1097/AOG.0b013e31818b4ade.

³Cluver C, Gyte GML, Sinclair M, Dowswell T, Hofmeyr GJ. *Interventions for helping to turn term breech babies to head first presentation when using external cephalic version*. *Cochrane Database Syst Rev*. 2015;(2):CD000184. doi:10.1002/14651858.CD000184.pub4.

Fellowship Information Night



On September 10th The Obstetrical Society hosted area residents for a Fellowship Information Night. Faculty from area fellowship programs were on hand to answer questions and share wisdom about planning for and applying to fellowship spots.



Drs. Tino Tran and Nicole Salva

Fellowship Information Night



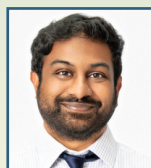
Fellowship Information Night



THANK YOU SPONSORS FOR YOUR SUPPORT



Artificial Intelligence in Obstetrics and Gynecology



NISHANTH SIDDURI, MD
Delaware Valley Community Health

We are entering a new age in medicine, one that is going to be powered by artificial intelligence, whether we like it or not. Artificial intelligence is going to be a game changer in our daily lives – there's no doubt about that. But how will it impact our jobs as obstetricians and gynecologists?

My experience with AI in medicine has been fairly limited thus far – I have used AI to help with writing office notes, generate patient handouts, and help organize presentations for residency education. For me, the uses so far have been limited to administrative tasks.

You can't go through a journal nowadays without reading something about how AI isn't just going to help us with the administrative aspects of medicine, but with the actual practice of medicine. So I've started to think about what this reality would look like.

Imagine you're in the operating room. You get underway with a total laparoscopic hysterectomy on a patient with endometriosis and a history of several prior intra-abdominal surgeries. My biggest anxieties about a case like this would be regarding visualization of the ureters and bladder and trying to avoid iatrogenic injury to any of those structures. Imagine looking at monitor and an AI model plots out the likely course of the ureter in this patient, and tells you percentage chance that each bite you take with your bipolar electrosurgical device will result in an injury.

On Labor and Delivery, obstetricians typically have to juggle large amounts of data – from cervical exams to fetal heart rate monitoring – to interpret a patient's labor progress and determine the status of fetal wellbeing. AI may improve pattern recognition, predict deterioration earlier, and help identify patients at risk for postpartum hemorrhage or unplanned cesarean before the crisis arrives. It could also help us better navigate the gray area of category II fetal heart rate tracings and our decisions of when and when to not take someone back to the Operating Room for a Cesarean section.

While I am optimistic about the potential of AI in our field, I think we need to be cautious as well. Medicine is an art. If we become over-reliant on algorithms and automation, I fear we may lose the skills that make us good clinicians. I also worry that algorithms could worsen disparities in healthcare outcomes, especially in a time where there are serious concerns about differences in maternal and fetal outcomes depending on race, geography and socioeconomic status.

We need to be at the forefront of shaping the tools that AI will bring us, instead of merely receiving them. That means insisting on transparency about training data and performance across different population groups, ongoing monitoring after deployment, and clear human – or rather, physician - oversight. Used well, AI can restore the time and presence that drew many of us to this specialty. But it can also further disconnect us from our patients if we aren't careful.

Do's and Don'ts for Fellowship Application

I'd like to acknowledge our fellowship representatives who took the time out of their busy days to join us from PENN, Jefferson, St. Lukes, Cooper, and Virtua to give us the inside scoop on the fellowship match process. Below are the top ten highlights of our discussion.

1. **DO** treat all those you encounter along the way with respect and gratitude. Know people are watching and commenting on your behavior and professionalism
2. **DON'T** let your pets on your Zoom interview. Make sure you are somewhere quiet with a good connection. If it's at home, make sure your background is professional. Although people noted they appreciate some decor that says something about you as a person, you don't want your interviewers seeing your dirty laundry or dishes. You definitely don't want your pets, no matter how beloved, walking across your desk or barking in the background to say hello.
3. **DO** know why you want to subspecialize. Anecdotes or stories that illustrate your passion or interest are helpful. And, ideally have a vision of yourself in 10-15 years so you can discuss how your fellowship will impact your career trajectory
4. **DON'T** have different versions of yourself that are dependent on your interviewer. Be consistent with the narrative of yourself you present. When interviewers debrief at the end of an interview session, if they got differing or inconsistent responses to similar questions, it may be considered a red flag.
5. **DO** prepare to talk about any experience or research on your CV and application. If you have any research experiences prior to residency, those carry less weight than your residency research. It can harm your application, if you can't explain the projects on which you worked.
6. **DO** show "follow through" with your research. Although ideas and participation in research are nice, fellowship directors are looking for the ability to take an idea for research to completion. Aim to publish something as first author rather than just present posters or help others with their research. This will show your natural curiosity and a deeper interest that actually inspires research and innovation.
7. **DON'T** do an audition rotation unless you have a particular interest in a program and you are ready to shine. Remember, most programs are filling 1-2 spots. You **MUST** go to impress.
8. **DON'T** subscribe to P = MD mentality. Programs do assess your CREOGs, Step 2 and 3 scores. Scoring below the average will put you at a disadvantage. Programs want candidates who they know will pass their boards.
9. **DO** have compelling reasons for your interest in specific programs.
10. **DO** network! Even among your generalist attendings. This is a way to get additional mentorship for research, exam and interview prep, or life in general. If you are well liked, people will go the extra mile to introduce you to subspecialists that can help your fellowship application.

Obstetrical Society of Philadelphia

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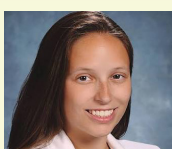
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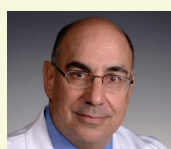
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