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

DECEMBER 2017 VOL. 44, NO. 3

President's Message

"Of all the forms of inequity, injustice in health care is the most shocking and inhumane."

- MARTIN LUTHER KING, JR., NATIONAL CONVENTION OF THE MEDICAL COMMITTEE FOR HUMAN RIGHTS, CHICAGO, 1966

The Joint Commission began an April 2016 Quick Safety publication on Implicit Bias in Healthcare with this quote. The Joint Commission advisory goes on to state *"There is extensive evidence and research that finds that unconscious bias can lead to different treatment of patients by race, gender, weight, age, language, income and insurance status."* While the natural inclination is to deny that this could possibly be so, further reflection on the evidence leads us to question what could motivate such inequity.

Our November Society meeting took up the important issue of implicit bias. Arthur Breese, Director of Diversity and Inclusion at Geisinger Health System, provided us with a thought-provoking evening that served to expand our understanding of implicit bias and provided important insights into this phenomenon. The Joint Commission provides the following definition of implicit bias, *"Implicit (subconscious) bias refers to the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control".*

Implicit bias is therefore something that operates under our radar and without our awareness. In many ways it reflects a defense mechanism by which we can quickly make sense of a barrage of information and categorize it in a way that is consistent with our understanding and experience. While implicit bias cannot be completely eliminated, it can be tempered by development of cultural competency. Cultural competency requires personal introspection in which one explores their own cultural values with specific attention to discovering assumptions and biases that influence our decision-making. An acceptance of the fact that there is more than one point of view and different ways to do things is fundamental in developing respect for individuals whose perspectives and actions are different than our own.

The Joint Commission provides several suggestions for actions to combat implicit bias:

- Have an understanding of the cultures from which your patients come
- Avoid stereotyping your patients; individuate them
- Understand and respect the magnitude of unconscious bias
- Recognize situations that magnify stereotyping and bias

Mr. Breese also provides the following suggestions for mitigating bias:

- Recognize and accept that you have bias
- Develop the capacity to use a flashlight on yourself
- Practice constructive uncertainty
- Explore awkwardness and discomfort
- Engage with people you consider "others" and expose yourself to positive role models from that group
- Seek feedback

Mr. Breese also discussed a tool to aid in development of cultural competency. Project Implicit is a joint undertaking by Harvard University, University of Virginia, and University of Washington. I took his suggestion and visited the website and completed a number of the Implicit Association Tests (IAT) presented there. I must confess that it is been an interesting exercise in self-discovery enabling me to explore my own implicit bias that I would have firmly denied could possibly exist. I invite you to do the same. I hope you find the experience as enlightening as I have.

In summary, let us commit to meeting the challenge set before us by Dr. King as his words continue to echo across the decades. Our patients and our society deserve nothing less.

A. George Neubert, M.D.
President

Upcoming Lecture

Joint OB/PARES Meeting

Thursday, January 11, 2018, 6:00 PM

Hal C. Lawrence, III, MD
Executive Vice President and CEO, ACOG

"ACOG, Yesterday, Today and Tomorrow"

We hope that you will be able to join us for our January meeting when we welcome Hal C. Lawrence III, MD, Executive Vice President/ CEO of The American College of Obstetricians and Gynecologists. Dr. Lawrence will be discussing the history of ACOG, current challenges and future directions. We look forward to welcoming you as we officially begin our sesquicentennial celebration.

IN THIS Issue

Embrace Our Legacy

The following excerpt was selected from "Transactions of the Philadelphia Obstetrical Society" from September 6, 1894 to September 5, 1895:

REPORT OF AN OPERATION PERFORMED FOR ECTOPIC PREGNANCY DURING THE TENTH MONTH.

BY A. H. HALBERSTADT, M. D., POTTSVILLE, PA.

I was called to see Mrs. G. on December 27, 1894, who was supposed to be in normal labor at the full time. The pains had been in progress for about twenty-four hours, and her physician had been unable to reach the child *per vaginam*. I found an abdominal pregnancy. The patient had borne five previous children, the youngest being three years of age. During the early portion of this pregnancy it was thought by a medical attendant that she had a fibroid tumor in the right half of the pelvis, the existence of pregnancy not being recognized until quickening occurred. When I saw her the pains were so intense that I advised morphine hypodermically, in half-grain doses, until relief from pain should be obtained. On the following day I found her without pain, cheerful, and willing that anything should be done to save her life. The fœtal heart could not then be heard and the mother thought the child had died that day. For two days afterward she appeared to be very well, and the nights were spent very comfortably under the influence of three eighths of a grain of morphine. On the third day she was so well that I discontinued my visits until a change in her condition should occur. If worse, I proposed to at once remove the child.

The following day I was summoned and found the woman in collapse, pulse 150, extremities cold, vomiting dark blood. I immediately proceeded to operate with the belief that I would thus give the woman the only chance of escaping death. After etherization, an incision about six inches long was made from the umbilicus downward through the linea alba.

On cutting through the peritonæum, the fœtal surface of the placenta appeared through the membranes. On gentle manipulation, my finger passed into the cyst and liquor amnii escaped. I now init, about one gallon of dark blood that was contained within the cyst cavity. I then tore the membrane and extracted a well-formed and fully developed female child of about ten pounds weight.

The degenerate placenta was already detached to one half of its extent and bled freely at first, though the hæmorrhage was easily controlled by flushing the cavity with hot water. As the placenta hung loosely, I tore off the half, and under the influence of water as hot as my hand would bear but little blood escaped. The placenta had attachments extending from the right iliac crest to the linea alba and into the right half of the pelvis. Iodoform gauze was packed in the cavity and the womb closed around it.

Injections of whisky were given by the hypodermic syringe with no effect. She died without coming from under the influence of the ether. Death was due to the hæmorrhage prior to the operation, for the amount was not great during the removal of the child and placenta. The ether no doubt had its depressing influence also. No postmortem examination was made.

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

Is that really possible??? Yes!

Modern medicine is fixated on the future: implementing new processes, safer standards, better technologies, groundbreaking treatments. This approach is certainly not a bad thing. But, reflecting on past experiences offers unique insight into medical successes and failures and, even more, the magnificent potential of the human body that is limited (rightfully so) by today's standard of care. No text book or modern-day physician will tell you that a fetus might exist out of utero in the abdomen for 10 months. But, Dr. Halberstadt did in 1894.

Similarly, our professional organizations, like the Obstetrical Society of Philadelphia and ACOG, thrive today and anticipate the future because their leader learn from and improve upon the past.

I know I'll never see an ectopic pregnancy at term because no one would let that happen today. And that is definitely OK with me. But, now I know it is possible. And it just makes me think…

"Cultural Competence and Unconscious Bias"

Speaker: Arthur W. Breese, MS
Geisinger Health System

PHOTOS FROM OUR NOVEMBER 9, 2017 MEETING

SPEAKER, ARTHUR W. BREESE, M.S. SIGNS THE BOOK

Foster Collegiality

Foster Collegiality

Tower Health: A New Direction for Health Care in South Eastern PA

MARK B. WOODLAND, MS, MD, FACOG
CHAIR OBGYN, CLINICAL PROFESSOR OBGYN
READING HOSPITAL

Trying not to repeat the Allegheny Health mess of the 1990's, Reading Health System has completed the acquisition of five subsidiary hospitals and their associated assets from Community Health Systems. The Tower Health System will include Reading Hospital in West Reading; Brandywine Hospital in Coatesville; Chestnut Hill Hospital in Philadelphia; Jennersville Regional Hospital in West Grove; Phoenixville Hospital in Phoenixville; and Pottstown Memorial Medical Center in Pottstown. It effectively moves the 5 CHS hospitals from a for profit agency to a not for profit ownership in a joint endeavor with UPMC Health Plan.

Tower Health also will include Reading Hospital Rehabilitation at Wyomissing; Reading Hospital School of Health Sciences; and a connected network of 2,000 physicians, specialists and providers across 65 locations. All Tower Health facilities will participate in the payer-provider partnership, Tower Health/UPMC Health Plan. The acquisition was initiated when Reading Health executed an asset purchase agreement on May 25, 2017 and completed on October 1st, 2017. As Tower Health, our 11,000 team members will work together as a dynamic, nationally recognized healthcare provider/payer system to offer leading-edge, compassionate healthcare and wellness services to a population of 2.5 million people. The new name, Tower Health, reflects our collective strength, innovative spirit and bold commitment to taking healthcare to new heights.

January 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."

Hal C. Lawrence, III, MD
Executive Vice President and CEO, ACOG

Joint OB/PARES Meeting

Topic:	**ACOG, Yesterday, Today and Tomorrow**
Date:	Thursday, January 11, 2018
Location:	***Philadelphia County Medical Society Building, 2100 Spring Garden Street***
Time:	6:00 PM Cocktails, 6:30 PM Dinner and Program

PLEASE NOTE THE NEW LOCATION!

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 2nd.

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

Call For Papers – S. Leon Israel Award

THE S. LEON ISRAEL AWARD WAS ESTABLISHED TO RECOGNIZE EXCELLENCE IN RESEARCH IN THE DISCIPLINE OF OBSTETRICS AND GYNECOLOGY.

The award is open to all current obstetrics and gynecology residents in programs associated with the Obstetrical Society of Philadelphia. **Original research manuscripts not published prior to April 1, 2018 will be accepted for review.**

The resident must be the first author, but not necessarily the only author of the paper. It is expected that the resident will have primary responsibility for the literature review, implementation of the study and final drafting of the discussion section. Review articles will not be accepted. Papers should be written in a scientific format to include title, authors, institution, abstract, introduction, materials and methods, results, and discussion and should conform to the instructions for the American Journal of Obstetrics and Gynecology.

Two copies should be submitted. One copy should have all institution and author information removed. The award and stipend ($500.00) will be conferred at the Annual Resident Day Bowl and Symposium on Friday, May 4, 2018. The author of the winning paper will be asked to present a brief summary of his/her work at the Resident Day Symposium and at President's Night, Thursday, May 10, 2018.

Manuscripts must be received no later than April 1, 2018 to allow adequate time for review. Any manuscripts received after April 1, 2018 will be ineligible for consideration.

Manuscripts should be submitted to:
Teri Wiseley, CMM, Executive Secretary via email to
obphila@yahoo.com

Gyn/Onc Past Present and Future

JOEL S. NOUMOFF, M.D.
CROZER KEYSTONE HEALTH SYSTEM

I concur with Neils Bohr the renowned Danish physicist when he stated, "I hate making projections, especially about the future." Despite this, I have accepted the challenge of predicting what changes we may expect in the field of gynecologic oncology.

Perhaps, it is wise, before looking ahead however, to first look to the past to understand where we have been, where we are now and where we are going.

It is over 40 years since the American Board of Obstetrics and Gynecology recognized that women with gynecologic malignancies have special needs; such that it was necessary to train physicians not just in the area of radical surgery, but also in the specialties of radiation and medical oncology, so that all aspects of treatment could be integrated to achieve individualized treatment and hence achieve best outcomes.

Indeed, gynecologic oncology in its earliest stages focused on the physician's skills and knowledge of radical surgical procedures along with use of radiotherapy and chemotherapy. With time, and better understanding of the natural history of the diseases treated, it became clear that radical surgery is not always necessary and that in fact the surgical procedure should be tailored to the patient's specific disease and its presentation. At times, the disease is best treated with alternative therapeutic modalities or with multimodality therapy. Treatment has thus advanced to managing the patient's individually, including the realization that therapy must include improved outcomes while decreasing morbidity with the ultimate goal of long term improvement in quality of life. Perhaps one such example is the increasing use of minimally invasive surgical procedures. Advances in radiotheraputic techniques have allowed for fewer complications without diminishing effectiveness. Now for example, targeted therapy facilitates management of tumors in locations heretofore not amenable to treatment. Current advances in chemotherapy have identified new agents more active for the diseases treated and different methods of administration such as intraperitoneal chemotherapy, dose dense regimens, etc. Specific agents are identified for specific tumors rather than using generalized regimens for all. The use of agents that are not necessarily cytotoxic, such as hormonal therapy, immunotherapy and antiangiogenic agents have increased our armamentarium, as h ave biologic response modifiers that allow for maintenance of blood counts so that chemotherapy is not interrupted. We must also not omit mention of the advances in diagnostic modalities such as ultrasound, CT, MRI, PET scan, etc., which provide better definition of disease prior to treatment, during treatment and make post therapy surveillance possible.

Though my comments so far have addressed changes in therapy, at least equally important is the fact that the definition of treatment has expanded to include addressing the quality of life during and post treatment. With time, this issue will become ever more vital. Focusing on survivorship including quality of life, sexuality, preservation of fertility and dealing with the effects of therapy are now part of and will continue to grow as a gynecologic oncologist's concerns.

As we look to the future, still paramount will be the treatment of disease made possible by advances in surgery, radiation and medical oncology. That said, we must now also focus on screening and prevention. Identifying those patients at risk, whether based on lifestyle or those with genetic predisposition, must be considered part of the management of our patients. The Cancer Genome Atlas has and will continue to improve insight to the etiology and classification of disease. We will be better able, based on molecular genetic studies to tailor treatment both in a preventive and adjuvant setting as well as to direct appropriate therapy. We will be able to identify those patients not just at risk for developing disease but also those with disease who are at increased risk for progression so that they may be treated more aggressively. We will see better definition of markers to identify patients at risk before they develop disease. Vaccines to prevent and even treat disease will be possible. Treatment regimens that address the molecular genetic characteristics of a cancer are now in their "infancy," but will in the future, ultimately with gene therapy, be on the forefront of prevention and treatement. We must be cautioned that these advances in genetics will also raise new challenges for clinicians. Screening guidelines will be changed to assist with prevention. Counseling of patients and families will be ever more detailed than is now the case. The role of surgical and chemical prophylaxis will be better defined. With this increased information, one of our greatest challenges will be the need to assure our patient's confidentiality. As we focus on the "whole patient," we will address issues of palliative care, hospice care and ethics. We must realize that treating the cancer is only part of

treating the patient. In conclusion, I would be remiss if I did not mention that the members of the Obstetrical Society of Philadelphia have served as a microcosm of that which has exemplified the field of gynecologic oncology since its inception. Fellowship training was immediately available in Philadelphia. Members of our society after training realized the expertise acquired in fellowship could be brought to the community so that the same quality of care provided in the university setting could be provided to the patients in a more convenient geographic location. Many of the innovations in our field were and continue to be developed in this geographic area by members of our society. Our region and members of our society continue to represent the field of gynecologic oncology today and in the future and indeed, we can be proud that the patients we serve enjoy the most up to date treatment available.

Past, Present and Future of OBGYN Resident Education

MARK B. WOODLAND, MS, MD, FACOG
CHAIR OBGYN, CLINICAL PROFESSOR OBGYN
READING HOSPITAL

I consider the position of Chair of the Counsel on Resident Education in OBGYN (CREOG) the icing on my career cup cake. My privilege of being a Program Director for over 25 years in the Philadelphia area at Cooper Hospital University Medical Center, then Pennsylvania Hospital (with a little jaunt as CoProgram Director with Thomas Jefferson University in the mid 1990's), and finally for Drexel University College of Medicine, has been the highlight of my professional life. To think that I have had the privilege of participating in 100's of young physicians launch into Women's Health Care is somewhat overwhelming but I am thrilled to have participated in not only educational progress but also clinical indications.

In 1990, I was invited back to Pennsylvania hospital to perform the 1st laparoscopic assisted vaginal hysterectomy (LAVH) in Philadelphia. My mentor Dr. Stephen Corson had encouraged me to work with Dr. Harry Reich of Kingston, Pennsylvania. Dr. Reich, the first GYN surgeon in the world to perform LAVH in the late 80s not only encourage me but also enabled me to put my laparoscopic skills together with my vaginal surgical skills to perform the surgeries. Minimally invasive surgery, which began in the gynecologist hands in the early 1940s to facilitate sterilization on women, is certainly one of the biggest innovations in surgical practice as well as clinical education for our specialty during my professional career. I remember when we 1st started doing laparoscopy for ectopic pregnancies and then for more advanced surgeries like myomectomy, ovarian cystectomy and finally hysterectomy that there were gynecologic surgeons who questioned whether this was a procedure looking for a reason rather one of the reasons being treated by a procedure. Obviously, those kept exam have been proven wrong and minimally invasive surgery has become not only a mainstay but a way of providing care for women.

Young physicians in training now not only choose residencies by their training in minimally invasive surgery, but can also take part in fellowship training sponsored by the AAGL.

There are many other aspects of training that have change during my time as a clinical OBGYN. While minimally invasive surgery is one of the highlights, certainly ultrasound, hysteroscopy, point of service biopsy, shortened length of stay, use of minimal anesthesia, promotion of inner professional educators, and facilitation of birth centers as well as minimally invasive birth centers are certainly areas that are not only current now but will be more for the future.

I also believe that the genetic health of the patient will be paramount in personalized computated algorithms to treat patients individually.

The future of gynecological surgery is exciting with rapid changes in minimally invasive surgery. These changes allow our patients to get the surgery they need with minimal pain and recovery time. Our task has been and will be how to introduce these changes safely, while staying at the leading edge of innovation.

Prenatal Screening For Genetic Disorders — Past, Present And Future

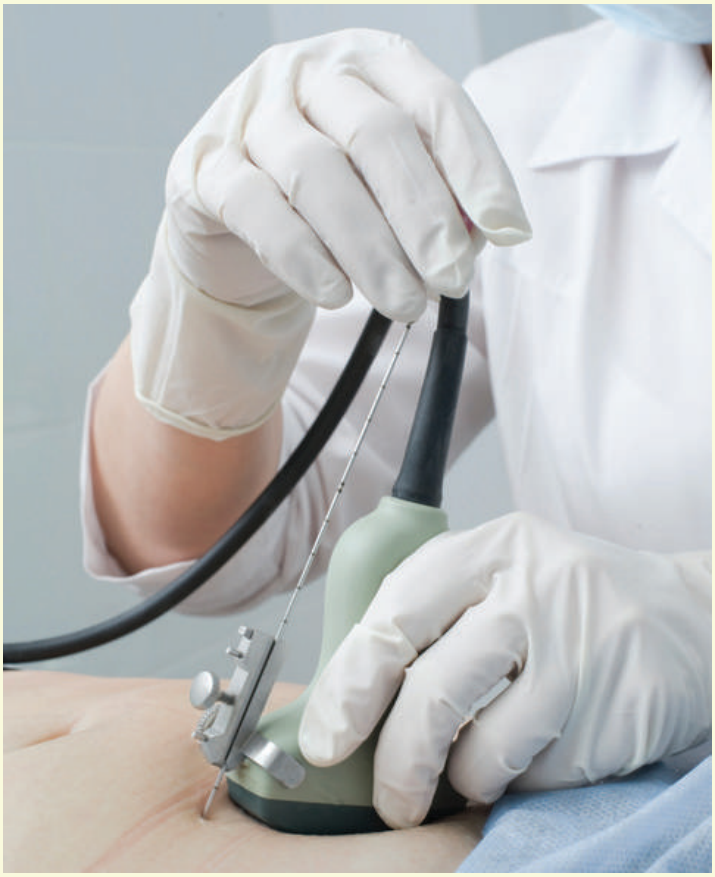
ARNOLD W. COHEN, MD
MATERNAL FETAL MEDICINE SPECIALIST
ALBERT EINSTEIN MEDICAL CENTER

Today prenatal screening for common aneuploidies is common place, but it wasn't always like that.

In the late 1960's it was noted that women over 35 had an increased risk of having a child with Down syndrome. It was known at that time that we all had 46 chromosomes (in the 1950's it was "known" that we had 48 chromosomes) and Down syndrome was due to an extra number 21 chromosome. It wasn't until the early 1970's that the technique of amniocentesis that was being used for isommunization due to Rh disease was used to get cells from the fetus to do a karyotype with banding that would allow us to diagnose Down syndrome in utero. Only women over 35 or those who had previously had a child with Down syndrome were eligible for this test. Amniocentesis was first done in blind fashion before we had the availability of ultrasound. When ultrasound became available in the late 1970's, we utilized ultrasound "guidance" to do the amniocentesis. Guidance, though, was sending the patient down to ultrasound where the ultrasonographer scanned the abdomen and marked an area on the abdomen where the fetus wasn't at that time. Often the fetus moved by the time the patient got back to our amniocentesis area. When we then inserted the needle where the radiologist had marked the belly it was obvious that the pocket of fluid that had been there was no longer present. There were many times after not getting fluid we then resorted to "palpation" to identify an area that seemed to be free of the fetus. There were also many times when we went through the placenta and got very bloody tapes. In fact, it was initially standard practice to draw serum alpha fetoprotein levels before and after the amniocentesis to determine if there was a fetal to maternal bleed secondary to the amniocentesis (Mike Mennuti, former chairman at Penn and president of our society published this.)

Two things happened in the 1980's.

The first was the discovery by Irwin Merkatz that the risk of Down syndrome could be determined by using maternal blood analytes in a "Triple" screen. This allowed us to screen not only women who were over 35 but all pregnant women (more children were born with Down syndrome from women under 35 just because the number of women over 35 giving birth at that time was only a small percentage of the total pregnant population). The second phenomenon was advancement of ultrasonography so that the radiologists no longer needed to do the scan but it could be done by the obstetrician right before the needle was inserted. Subsequently we learned how to watch the needle going in and avoid the fetus. This was felt to make the procedure safer; and in fact the loss rate from amniocentesis was said to have gone from 1 in 200 to some say now 1 in 1600 using ultrasound guidance by experienced personnel.



Share Expertise

Amniocentesis and then CVS became the "gold standard" for diagnosing chromosomal number abnormalities and large rearrangements or deletions. Triple screen, followed by a Quad screen, and then followed by a Penta screen all continued to be used for the screening of "low risk" women until the early 2000's when the FASTER trial was published. This trial showed that an increased nuchal translucency between 10 wks. 6 days and 13 weeks 6 days along with analyte analysis would detect about 90-92% of all fetuses with Down syndrome as well as a 70-90% of fetuses of trisomy 18 and 13's with a 5% false positive rate. This allowed low risk women to be screened with a more sensitive test and lowered the need to do amniocenteses for a higher number of false positive tests with analyte testing alone. Amniocentesis was still the preferred diagnostic test for the high risk populations. Maternal Fetal Medicine sub-specialists became credentialed and did most of the First Trimester screening under the quality program developed by the Society for Maternal Fetal Medicine.

This approach to prenatal screening for trisomy 21, 18 and 13 (as well as cardiac abnormalities in the fetus) was considered a major step forward until the ability to analyze fetal (actually placental) DNA in the maternal serum became available through sophisticated multiplex screening of millions of DNA fragments. This Non-invasive prenatal testing (screening- NIPT or NIPS) became commercially available for at risk populations in 2012-13 and was found to have sensitivities of over 99% for Down syndrome and only slightly less sensitive for trisomy 18 and 13. The false positive rate was not 5% but was now less than 0.5%. This test was quickly adopted for "high risk" patients because of the high sensitivity as well as avoiding the risk of a fetal loss with amniocentesis, an invasive testing. Because of this test the number of amniocenteses, the gold standard in testing, has fallen precipitously so that now many units don't do more than a few a month.

Today the question is if we have a test that picks up over 99.5% of Down syndrome fetuses and almost as many trisomy 18 and 13 fetuses, is this test not being used for all patients, not just high risk patients.

The reason given by national organizations is the test has not been validated in enough low risk patients and since the prevalence of aneuploidy is lower in the low risk populations, the positive predictive value of the test is lower than reported in high risk populations. More recent studies do confirm that the false positive rate for this test in low risk populations remains unchanged at less than 0.5%. Therefore, even if NIPS has a lower positive predictive value (but still much better than First Trimester or Quad screening) the number of unnecessary amniocenteses will be markedly reduced. In fact, if this test were done on all patients the need for First trimester nuchal translucency testing would be eliminated and some feel that the barrier to adoption of NIPS at this time may be the possible loss of income to those doing the First Trimester screening and follow up amniocenteses. I would predict that within the next 3 years we will see the standard change.

We know the past. We are living the present. What will the future bring? Genetic testing will have the ability to do not just aneuploidy testing but testing for all other deletions from maternal serum and then analyze the entire genome. This would truly broaden our ability to detect fetal "abnormalities". The ethical questions though will be: Do we know what all the DNA alterations that we find really mean?, Do we really want to know about all possible genetic abnormalities?, What will we do with this information?, Will it alter prenatal care?, Will it result in more terminations for fetuses that may or may not have significant abnormalities? and, What do we do with all this information if abortions are limited in our country?. Only futurists can answer these questions. All I know is that we have come a long way since I started in Ob/Gyn and I am sure the journey is not over.

Pregnancy Means Job Loss for Some Women: What Medical Providers Can Do About It

MARGARET ZHANG
FELLOW AT THE WOMEN'S LAW PROJECT

Thirteen weeks into her pregnancy, a certified nursing assistant (CNA) at an assisted living facility gave her employer a doctor's note, which said she had a lifting restriction. Her employer said she was a "liability," placed her on medical leave, and—when she ran out of leave—fired her.

This story comes from a real case, which is still being decided in the courts. At the Women's Law Project, we believe what happened to this employee was illegal, but we know mistreatment of pregnant workers still happens in Pennsylvania. So we have resources dedicated to helping pregnant workers, and, along with the Pennsylvania Campaign for Women's Health, are supporting the Pennsylvania Pregnant Workers Fairness Act (House Bill 1583, sponsored by Representative Sheryl Delozier, of Cumberland County). This Act would explicitly grant Pennsylvania women the right to reasonable accommodations for pregnancy, childbirth, and related medical conditions.

As medical providers, you have an essential role to play in advocating for pregnant workers. Here's what you can do.

Write Narrowly Tailored Notes to Patients' Employers

As shown in the story above, ***a note from a medical provider can prompt an employer to mistreat a pregnant employee. But a narrowly tailored note can highlight how your patient can maintain a healthy pregnancy while continuing to do her job. Here's what we recommend:***

1. ***Start by connecting your patient to a legal services provider.*** The laws on pregnancy are complex. The Women's Law Project (215-928-5761, info@womenslawproject.org) can advise pregnant women in Pennsylvania and can also refer women outside of Pennsylvania to other legal services providers.
2. ***Discuss what accommodations would allow your patient to keep her job, while safeguarding her health and safety.*** Ask your patient what she is required to do on the job and what she is comfortable revealing to her employer. Try to find accommodations she thinks her employer would approve. For ideas, visit the Center for WorkLife Law's website (https://www.pregnantatwork.org/accommodation-ideas) or the Job Accommodation Network (https://askjan.org/media/atoz.htm).
3. ***Write a narrowly tailored note. It is not always necessary to disclose your patient's pregnancy or precise medical condition.*** To maximize your patient's chance of receiving the accommodations she needs, however, the Women's Law Project recommends that medical providers state at least: (1) the patient's precise limitations; (2) that she is able to work with a reasonable accommodation; (3) a suggested reasonable accommodation; and (4) the time period during which the accommodation will be needed, which you can extend later.[1]

Support the Pennsylvania Pregnant Workers Fairness Act

The Pennsylvania Pregnant Workers Fairness Act would make it clearer that women employed by most Pennsylvania employers have a legal right to pregnancy accommodations. In so doing, it would also help ensure that these women preserve the income needed to care for their growing families, as well as any employer-provided health insurance, while maintaining safe and healthy pregnancies.

Medical providers' views carry weight. Please call your Pennsylvania legislators and ask them to co-sponsor or support House Bill 1583.

Our thanks from the Women's Law Project for the work you already do each day to help your patients. Please contact us with any questions at 215-928-5761 or info@womenslawproject.org

Reference

1. See Chavi Eve Karkowsky & Liz Morris, Pregnant at Work—Time for Prenatal Care Providers to Act, AM. J. OBSTETRICS & GYNECOLOGY, Sept. 2016, at 306, 308 tbl.2; WORKLIFE LAW, Pennsylvania Guidelines: Drafting Work Accommodation Notes for Pregnant Patients, https://www.pregnantatwork.org/pennsylvania-work-note-guidelines (last visited Nov. 8, 2017).

2018 Meeting Schedule

Dinner Meetings

January 11, 2018 — ***Joint OB/PARES Meeting***
ACOG, Yesterday, Today and Tomorrow
Hal C. Lawrence, III, MD, ACOG

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*".

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