

RESIDENTS' MANUAL

**DEPARTMENT OF
OBSTETRICS and GYNECOLOGY**

**UNIVERSITY HOSPITALS CASE MEDICAL
CENTER**

MACDONALD WOMEN'S HOSPITAL

2009-2010

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I. EDUCATIONAL OBJECTIVES OF THE PROGRAM

Congratulations on your selection to the Ob/Gyn Residency Program at MacDonald Women's Hospital, University Hospitals Case Medical Center. We promise you a superior education and the opportunity to make some life long friends. From you we want your best efforts and your hardest work.

Our department fully embraces the mission statement of the University Hospitals Case Medical Center: **To Heal, To Teach and To Discover**. By the end of your residency you will begin to understand what it means to practice as a physician. You will have vastly increased your knowledge base, understanding that it is always incomplete and that medicine requires life-long learning. You will have struggled with your own research project and learned to appreciate just how imperfect our best science remains. You will have learned what the practice of evidence-based medicine means and that "see one, do one, teach one" is a time-honored but outdated phrase. You will understand that healing doesn't always mean curing and that sometimes the healing goes from patient to physician rather than the other way around. It's going to be a great ride for all those willing to give their best.

Our residency program will provide you with a high quality, structured, progressive educational experience in all aspects of the practice of Obstetrics and Gynecology. We strive to achieve all objectives found in the Core Curriculum in Obstetrics and Gynecology published by the Council on Resident Education. (Your own personal copy awaits you. Read it. It's very simply what you need to know.) When you finish, it is expected that each of you will be an active candidate for the Boards and then Board-certified, ready to take off in whatever career path has taken hold of your imagination.

Detail Educational Objectives of the Program Include:

- Provide structured training in obstetrics and gynecology that produces graduates who can independently practice and provide excellent ambulatory, procedural and inpatient health care to women.
- Provide training in obstetrics and gynecology that lays the foundation for graduates to have successful careers in general ob/gyn or its subspecialties, whether academic or private.
- Provide a structured curriculum and effective evaluation/feedback process that allows ob/gyn residents to achieve and demonstrate proficiency in the core competencies of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
- Train residents to effectively utilize the medical literature to optimize the care of their patients and produce graduates who practice life long learning.
- Provide the opportunity for residents to participate in meaningful research relevant to women's health and to disseminate their findings at national/regional meeting and in published form. To produce a substantial proportion of graduate who will continue to perform research after completing residency.
- To provide a curriculum and training environment that results in graduates who maintain a high standard of professionalism and ethics in their practice, including adherence to core principles of informed consent, disclosure of medical errors, documentation, and medical record completion.
- To provide a curriculum and outstanding faculty role models that result in graduates with strong teaching skills, who have a commitment to use these skills to educate their patients, other health professionals and society.

- To provide a curriculum, training environment and professional role models that result in graduate with a strong commitment to the psychosocial needs of their patients and women in society, particularly in the areas of cultural competence, family planning, cancer detection, substance abuse, domestic violence, sexually transmitted infections, sexual preferences, and underserved populations

II. RESIDENCY PROGRAM OFFICE

The program director, the executive chief resident, and the program coordinator are primarily responsible for supervision of the housestaff.

Dr. Cossler e-mails residents on a regular basis. Ignorance of these e-mails is never an acceptable excuse. The hospital expects that you will use Outlook: first name.lastname@uhhospitals.org. We will not forward e-mail to a personal e-mail address. All information from the GME office is also via Outlook.

For the academic year 2009-2010:

Program Director	Dr. Nancy J. Cossler	844-1692 office
Assistant Program Director	Dr. Susan Lasch	32963 Pager
Executive Chief Resident	Dr. Rebecca Flyckt	31377 Pager
Program Coordinator	Mrs. JoAnn Laurent	844-8551 office

All scheduling, evaluations and other personnel management issues are handled through the residency office. The people listed above are your advocates. Feel free to contact them if any problems or questions arise.

Furthermore, the Program Director and the Chair believe firmly in an open door policy. You are encouraged to discuss with one, or both of them, all issues of concern or importance, personal as well as professional.

III. CODE OF PROFESSIONAL ETHICS

Obstetrician-gynecologists, as members of the medical profession, have ethical responsibilities not only to patients, but also to society, to other health professionals, and to themselves. The following Code of Conduct has been adopted by the American College of Obstetricians and Gynecologists (ACOG Code of Professional Ethics. Vol 102, No 3, September 2003).

Our department strives to fully live up to its precepts.

A. Patient-Physician Relationship

- 1. The patient-physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments.**
2. The obstetrician-gynecologist should serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.
3. The patient-physician relationship has an ethical basis and is built on confidentiality, trust, and honesty. If no patient-physician relationship exists, a physician may refuse to provide care, except in emergencies. Once the patient-physician relationship exists, the obstetrician-gynecologist must adhere to all applicable legal or contractual constraints in dissolving the patient-physician relationship.
4. Sexual misconduct on the part of the obstetrician-gynecologist is an abuse of professional power and a violation of patient trust. Sexual contact or a romantic relationship between a physician and a current patient is always unethical.
5. The obstetrician-gynecologist has an obligation to obtain the informed consent of each patient. In obtaining informed consent for any course of medical or surgical treatment, the obstetrician-gynecologist must present to the patient, or to the person legally responsible for the patient, pertinent medical facts and recommendations consistent with good medical practice. Such information should be presented in reasonably understandable terms and include alternative modes of treatment and the objectives, risks, benefits, possible complications, and anticipated results of such treatment.
6. It is unethical to prescribe, provide, or seek compensation for therapies that are of no benefit to the patient.
7. The obstetrician-gynecologist must respect the rights and privacy of patients, colleagues, and others and safeguard patient information and confidences within the limits of the law. If during the process of providing information for consent it is known that results of a particular test or other information must be given to governmental authorities or other third parties, that must be explained to the patient.
8. The obstetrician-gynecologist must not discriminate against patients based on race, color, national origin, religion, or any other basis that would constitute illegal discrimination.

B. Physician Conduct and Practice

1. The obstetrician-gynecologist should recognize the boundaries of his or her particular competencies and expertise and must provide only those services and use only those techniques for which he or she is qualified by education, training, and experience.
2. The obstetrician-gynecologist should participate in continuing medical education activities to maintain current scientific and professional knowledge relevant to the medical services he or she renders. The obstetrician-gynecologist should provide medical care involving new therapies or techniques only after undertaking appropriate training and study.
3. In emerging areas of medical treatment where recognized medical guidelines do not exist, the obstetrician-gynecologist should exercise careful judgment and take appropriate precautions to protect patient welfare.
4. The obstetrician-gynecologist must not publicize or represent himself or herself in any untruthful, misleading, or deceptive manner to patients, colleagues, other health care professionals, or the public.

5. The obstetrician-gynecologist who has reason to believe that he or she is infected with the human immunodeficiency virus (HIV) or other serious infectious agents that might be communicated to patients should voluntarily be tested for the protection of his or her patients. In making decisions about patient-care activities, a physician infected with such an agent should adhere to the fundamental professional obligation to avoid harm to patients.
6. The obstetrician-gynecologist should not practice medicine while impaired by alcohol, drugs, or physical or mental disability. The obstetrician-gynecologist who experiences substance abuse problems or who is physically or emotionally impaired should seek appropriate assistance to address these problems and must limit his or her practice until the impairment no longer affects the quality of patient care.

C. Conflicts of Interest

1. Potential conflicts of interest are inherent in the practice of medicine. Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions. If there is an actual or potential conflict of interest that could be reasonably construed to affect significantly the patient's care, the physician must disclose the conflict to the patient.
2. Commercial promotions of medical products and services may generate bias unrelated to product merit, creating or appearing to create inappropriate undue influence. The obstetrician-gynecologist should be aware of this potential conflict of interest and offer medical advice that is as accurate, balanced, complete, and devoid of bias as possible.
3. The obstetrician-gynecologist should prescribe drugs, devices, and other treatments solely on the basis of medical considerations and patient needs, regardless of any direct or indirect interests in or benefit from a pharmaceutical firm or other supplier.
4. When the obstetrician-gynecologist receives anything of substantial value, including royalties, from companies in the health care industry, such as a manufacturer of pharmaceuticals and medical devices, this fact should be disclosed to patients and colleagues when material.
5. Financial and administrative constraints may create disincentives to treatment otherwise recommended by the obstetrician-gynecologist. Any pertinent constraints should be disclosed to the patient.

D. Professional Relations

1. The obstetrician-gynecologist's relationships with other physicians, nurses, and health care professionals should reflect fairness, honesty, and integrity, sharing a mutual respect and concern for the patient.
2. The obstetrician-gynecologist should consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients.

E. Societal Responsibilities

1. The obstetrician-gynecologist should support and participate in those health care programs, practices, and activities that contribute positively, in a meaningful and cost-effective way, to the welfare of individual patients, the health care system, or the public good.
2. The obstetrician-gynecologist should respect all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. The professional competence and conduct of obstetrician-gynecologists are best examined by professional associations, hospital peer-review committees, and state medical and licensing boards. These groups deserve the full participation and cooperation of the obstetrician gynecologist.
3. The obstetrician-gynecologist should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician-gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior.
4. The obstetrician-gynecologist must not knowingly offer testimony that is false. The obstetrician-gynecologist must testify only on matters about which he or she has knowledge and experience. The obstetrician-gynecologist must not knowingly misrepresent his or her credentials.
5. The obstetrician-gynecologist testifying as an expert witness must have knowledge and experience about the range of the standard of care and the available scientific evidence for the condition in question during the relevant time and must respond accurately to questions about the range of the standard of care and the available scientific evidence.
6. Before offering testimony, the obstetrician-gynecologist must thoroughly review the medical facts of the case and all available relevant information.
7. The obstetrician-gynecologist serving as an expert witness must accept neither disproportionate compensation nor compensation that is contingent upon the outcome of the litigation.

IV. Contract Between Resident Physicians and Their Teachers

Residency is an integral component of the formal education of physicians. In order to practice medicine independently, physicians must receive a medical degree and complete a supervised period of residency training in a specialty area. To meet their educational goals, resident physicians must participate actively in the care of patients and must assume progressively more responsibility for that care as they advance through their training. In supervising resident education, faculty must ensure that trainees acquire the knowledge and special skills of their respective disciplines while adhering to the highest standards of quality and safety in the delivery of patient care services. In addition, faculty are charged with nurturing those values and behaviors that strengthen the doctor-patient relationship and that sustain the profession of medicine as an ethical enterprise.

Core Tenets of Residency Education

Excellence in Medical Education

Institutional sponsors of residency programs and program faculty must be committed to maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a resident's educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to their patients always take priority over purely educational considerations.

Highest Quality Patient Care and Safety

Preparing future physicians to meet patients' expectations for optimal care requires that they learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing resident education is the provision of high quality, safe patient care. By allowing resident physicians to participate in the care of their patients, faculty accept an obligation to ensure high quality medical care in all learning environments.

Respect for Residents' Well-Being

Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, residents must be allowed sufficient opportunities to meet personal and family obligations, to pursue recreational activities, and to obtain adequate rest.

Commitments of Faculty

1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
2. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
3. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
4. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
5. We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
6. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
7. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
8. We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
9. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
10. We will nurture and support residents in their role as teachers of other residents and of medical students.

Commitments of Residents

1. We acknowledge our fundamental obligation as physicians—to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
7. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
8. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
9. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
10. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

This compact serves both as a pledge and as a reminder to resident physicians and their teachers that their conduct in fulfilling their obligations to one another is the medium through which the profession perpetuates its standards and inculcates its ethical values.

For more information about the Compact, go to www.aamc.org/residentcompact

V. ACGME COMPETENCIES

We are required by the ACGME to help you obtain competence to the level expected of a new practitioner in the six areas listed below. These competencies are the backbone of all that our residency strives to teach.

Patient Care

Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and end of life care.

- Gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records and diagnostic/therapeutic procedures.
- Make informed recommendations about preventive, diagnostic and therapeutic options and interventions that are based on clinical judgment, scientific evidence, and patient preference.
- Develop, negotiate and implement effective patient management plans and integration of patient care.
- Perform competently the diagnostic and therapeutic procedures considered essential to the practice of Obstetrics and Gynecology.
- Inform patient and family of end of life concerns, issues and rights. Work with ancillary services to help with these issues.

Medical Knowledge

Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

- Apply an open-minded and analytical approach to acquiring new knowledge.
- Access and critically evaluate current medical information and scientific evidence.
- Develop clinically applicable knowledge of the basic and clinical sciences that underlie the practice of Obstetrics and Gynecology.
- Apply this knowledge to clinical problem solving, clinical decision-making, and critical thinking in patient care.

Practice-Based Learning and Improvement

Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes and processes of care.
- Analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient practice.
- Develop and maintain a willingness to learn from errors and use errors to improve the system or processes of care.
- Use information technology or other available methodologies to access and manage information, support patient care decisions and enhance both patient and physician education.

Interpersonal and Communication Skills

Residents are expected to demonstrate interpersonal communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

- Provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, their families and colleagues.
- Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.
- Interact with consultants in a respectful, appropriate manner.
- Maintain comprehensive, timely, and legible medical records.
- Work effectively as a member of the ward team and the clinic form.

Professionalism

Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession and society.

- Demonstrate respect, compassion, integrity, and altruism in relationships with patients' families, and colleagues.
- Demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors and disabilities of patients and professional colleagues.
- Adhere to principle of confidentiality, scientific/academic integrity, and informed consent.
- Recognize and identify deficiencies in peer performance.
- Remain professional in appearance and behavior in the performance of all duties.
- Participate fully in all educational conferences provided as well as committed, ongoing self-study and reflection.

Systems-Based Practice

Residents are expected to demonstrate both understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

- Understand, access, and utilize the resources, providers and systems necessary to provide optimal care.
- Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient.
- Apply evidence-based, cost-conscious strategies to prevention, diagnosis and disease management.
- Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care.

The faculty of the Department of Obstetrics and Gynecology is dedicated to providing the education and leadership necessary to aid the house staff in achieving these competency goals.

The residents' obligation is to develop a personal program of learning that will foster continued professional growth with guidance from the teaching staff. In addition, they should participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students.

VI. CHAIN OF COMMAND

“Men who are occupied in the restoration of health to other men, by the joint exertion of skill and humanity, are above all the Great of the Earth. They even partake of divinity, since to preserve and renew is almost as noble as to create.”

VOLTAIRE, “Physicians,” Philosophical Dictionary (1764)

Since Voltaire’s declaration, women have joined the human race and physicians have been knocked off the pedestal of divinity. Still, the pressure to constantly strive for perfection is a very real trap awaiting you on day one of your residency. What’s more, you’ll find yourself pursuing this unobtainable goal in the midst of long hours, complicated patients, not enough sleep and a burgeoning volume of stuff you’re expected to know.

Work hard, don’t whine; but know that you are a resident IN TRAINING. You don’t know everything and you can’t know everything (nor do we). The best among us understand that completely.

This residency is built upon a progression of graduated responsibility from junior residents to senior residents to attending staff. At no time are you (or your chief for that matter) in this alone. It is the responsibility of all junior residents to communicate fully with their seniors in all aspects of patient care. The seniors have the same responsibility with their chiefs and the chiefs with the attendings. Faculty schedules are structured to provide all residents with continuous supervision and consultation.

All consults to any of our services are, in reality, consults to the designated attending physician. At the discretion of the attending, these consults may first be seen by a junior resident and then by the chief, but all need to be seen by the Attending. All consults from the ER need to be discussed with the appropriate attending.

All faculty and residents are educated to be alert for and recognize fatigue and emotional conflict. The lines of communication to the program director and/or chair are open 24/7 to address (proactively if possible) any issues.

The responsibility of the Attending Faculty includes:

- See section IV, Contract between resident Physicians and Their Teachers
- Sets the tone for all clinical and academic endeavors in complete accordance with the ACOG Code for Professional Ethics (see section III).
- Oversees team function and overall patient care.
- Teaches residents and medical students.
- Accepts ultimate and total responsibility for the welfare of the patient.
- Communicates personally and fully with all colleagues, consult services and support staff regarding any major patient care issues.
- Understands and respects the concept that medicine today is practiced as a group effort and that within the standard of care more than one approach is often acceptable.
- Assures the attendance, in a timely fashion, of team members at all required conferences.

VII. PROFESSIONAL ATTIRE

Residents are required to be appropriately attired at all times, including weekends, nights and holidays. Appropriate attire never includes jeans, tee shirts, shorts or any other informal wear.

Scrubs are appropriate attire only when the resident is working in L&D, scheduled to be in the Gyn OR, the night of call or daytime post call.

Lab coats are to be worn in-patient care areas, and should be clean. You must have your University Hospital ID badge on, at all times, above the waist.

VIII. RESIDENT RESEARCH PROGRAM

Resident Research Committee:

Vivian E. von Gruenigen, MD, Chair

Helene Bernstein, PhD, MD

Neal S. Rote, PhD

Sam Mesiano, PhD

Kristine Zanotti, MD

Lynne Liu, Ph.D.

Noam Lazebnik, M.D.

Nancy Cossler, MD, ex officio

James Liu, MD, ex officio

Residency Research Component

Completion of a research project is a requirement for graduation from our residency program.

Expectations

The philosophical expectations of this project are guided by the requirements of the Accreditation Council for Graduate Medical Education (ACGME). They are to establish and maintain an environment of inquiry and scholarship, including discovery, dissemination, application, and mentoring.

The goals of our resident research experience are:

1. to gain an understanding that medical progress is based on basic and clinical innovation and discovery,
2. to develop critical thinking skills,
3. to develop, understand, and thoroughly discuss the basis for choices and decisions related to a resident's own research project,
4. to gain an appreciation for measures of quality in research endeavors, and
5. to gain an appreciation and understanding of how collaboration and teamwork are essential for successful research.

Acceptable research

The concept of research and innovation is broadly defined. Although the core of any definition is novelty, novelty must be accompanied by relevance and quality.

1. All residents must have a mentor. That mentor can be any full-time faculty member of the Department of Obstetrics and Gynecology. The resident may select co-mentors from inside or outside the department if the complementary expertise of two mentors would benefit the design and

- implementation of the research project.
2. The resident should have multiple options for choosing a research project. Research questions that originate from the resident should be encouraged, but not expected. If a resident has a good idea, it should be developed in collaboration with a mentor who has knowledge and experience related to the particular research question. Alternatively, a resident should be aware that many potential mentors have ongoing research programs that include very clinically-related questions from which the resident may choose. For many residents, participation in ongoing research programs should be strongly encouraged.
 3. The precise area of research investigation will be mutually determined by the mentor and resident, with the advice and consent of the Resident Research Committee.
 4. All forms of research are acceptable, if they fulfill the requirements of innovativeness, relevance, and quality.
 5. In an unusual situation, a resident may choose a project that complements that of another resident. In general, however, each resident will have a project that is unique and independent of other residents in the program.

Acceptable outcomes

The outcome of the research experience is presentation at a departmental Resident Research Forum, which is scheduled in the spring of the residents last year. This style of presentation should bring together all members of the faculty to support and praise the accomplishments of each resident. It adds to faculty/resident unity and demonstrates that research is, in fact, an important part of the Residency Program. The resident research experience should be an enjoyable and challenging portion of their training. The faculty will provide adequate ongoing reinforcement of the importance of research and adequate mentoring over the four-year program.

Expected Progress

During orientation of Ob/Gyn PGY I residents, the Chair of the Resident Research Committee will meet with them to clearly communicate expectations and responsibilities, goals, lists of acceptable mentors, and processes towards a successful research experience. This information will be supplemented throughout the first year.

The progress of each resident will be monitored by the Resident Research Committee. Each resident is responsible for submitting a written Research Progress Report yearly to the Committee. The Report must be submitted on or before the dates designated below and will become part of the resident's record. The Report will be critiqued by the Resident Research Committee. The responsibility of meeting these deadlines is entirely the resident's. This individualized support should help the residents stay on track throughout the duration of the project. Clearly, expectations of quality and completeness of the report will increase as the resident moves through the program.

Resident Research Obligations

1. The initial Research Progress Report, to be submitted in the Spring of the **PGY I**, will consist of a brief discussion of the general research/clinical interests of the resident and identification of a potential mentor. If the resident has not yet identified a mentor, it is the responsibility of the Resident Research Committee to recommend possible research mentors or general project areas that match the resident's interests. The Chair of the Resident Research Committee will function as resident's research mentor until an official mentor is chosen. **During the PGY1 year residents are required to complete research compliance training on the protection of human participants in research**, as offered by the CWRU Continued Research Education Credit (CREC) Program. Residents are required to complete the BASIC level of the CITI, on on-line educational program. For more information, access the following website: <http://ora.ra.cwru.edu/research/orc/crec/index.cfm>.
2. Each **PGYII** resident must make a 5 minute oral presentation at an informal Ob/Gyn Resident Research Meeting to be held in the Spring of the PGYII year. The presentation should include a brief discussion of the general subject of the proposed research, how it relates to Ob/Gyn, specific aims, study approach, and expected outcomes. A written version of this presentation and printed

copies of the PowerPoint presentation, slides, or overheads will be provided by the resident within 1 week after the presentation and will be entered in their file. The Resident Research Committee has the responsibility to approve the research project as presented or with specific modifications.

3. The **PGYIII** Progress Report will be submitted in the Spring of the PGYIII and consist of a detailed and clear description of research progress and problems that have occurred as of that time. The Resident Research Committee has the responsibility to judge the amount of progress and the quality of the research experience. As a result, the Committee may affirm the resident's research program or require major or minor changes in the program in order to address issues of quality or productivity.
4. The research project must be completed for final presentation at the Ob/Gyn Resident Research Forum in the spring of the resident's PGYIV year. Within a month after the Forum, each **PGYIV** resident must submit a written final report of the research. All PGYIV residents must present their research in a 10 minute presentation at an Ob/Gyn Resident Research Forum to be held in the Spring of each year. The presentations will be judged and monetary prizes awarded. The program may also include an invited outside speaker who is an accomplished researcher in Ob/Gyn and Women's Health, preferably a graduate from the program. **All PGYIV residents will submit an abstract to the Cleveland Ob/Gyn Society and make an oral presentation of their research at this meeting, held in May of each year.** It is the responsibility of the mentor to determine whether the research is of adequate quality to be submitted for presentation at a national meeting or for publication, although these will be highly encouraged.
5. Although all residents are required to present a research project to the OB/GYN Society by the conclusion of their chief year, any resident may present (with Research Committee approval and support) any year or every year. **All** residents are eligible to compete for the department's and the society's cash prizes.
6. **It is the responsibility of the resident to fulfill the research requirement of the Program.** The opportunities and goals are stated, and it is the resident's responsibility to confirm an understanding of those requirements and complete them within the mandated time.

Department Obligations

1. Time should be set aside for research preparation and presentations. These should relate to resident research topics provided by the resident, guest lecturers, our own faculty or others at University Hospital or Case.
2. The didactic portion of the Residency Program should include lectures/discussions/active learning of scientific reasoning, including hypothesis generation and testing, research ethics, IRB and IACUC processes, research funding, oral presentation skills, and other relevant aspects of the discipline.
3. It should be understood that the key to the success of a resident research program is reinforcement from the top-down. The members of the faculty must be knowledgeable of the goals and requirements of the research portion of the Residency Program and should be aware of the responsibility of supporting those requirements during interactions with the residents.
4. The Resident Journal Club should occasionally include publications from faculty in our department. Each resident should also be strongly encouraged to present publications related to clinical aspects of their research project.
5. Reprints of publications from faculty in our department should be made available to each resident.
6. All members of the faculty should be notified of ongoing resident research projects and be strongly encouraged to inquire informally with each resident about their progress.
7. Major changes in policy should be transitioned in order to allow each group of residents adequate time to adapt to any new expectations or requirements.

Department Scholarly Activities

1. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included within each program. Both faculty and residents must participate actively in scholarly activity. Scholarship is defined as one of the following:
 - a) The scholarship of discovery, as evidenced by peer-reviewed funding or publication of original research in peer-reviewed journals.
 - b) The scholarship of dissemination, as evidenced by review articles or chapters in textbooks.
 - c) The scholarship of application, as evidenced by the publication or presentation at local, regional, or national professional and scientific society meetings, for example, case reports or clinical series.
 - d) Active participation of the teaching staff in clinical discussions, rounds, journal club, and research conferences in a manner that promotes a spirit of inquiry and scholarship; offering of guidance and technical support, e.g., research design, statistical analysis, for residents involved in research; and provision of support for resident participation as appropriate in scholarly activities.
2. Adequate resources for scholarly activities for faculty and residents must be available, e.g., sufficient laboratory space, equipment, computer services for data analysis, and statistical consultation services.

Resident Scholarly Activities

It should be noted that most of the above description is directed towards defining faculty scholarship, within which the residents can participate. The ACGME within its Program Requirements for Residency Education in Obstetrics and Gynecology, Section V, Educational Program, states the following:

Research

The quality of the educational experience within a department of obstetrics and gynecology is enhanced by an active research environment. Programs should involve residents in research projects.

Scholarly Environment

Documentation of scholarly activity on the part of the program and the faculty must be submitted at the time of program review. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the teaching staff. While not all members of a teaching staff must be investigators, the staff as a whole must demonstrate broad, ongoing involvement in scholarly activity. This activity should include the following: Again, it should be noted that the description of "Scholarly Environment" relates primarily to faculty scholarly activities in which residents can participate. Thus, the ACGME appears to want faculty involved in scholarly activity, which is broadly defined, and wants programs to "involve" residents in research projects.

1. Active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship (Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.)
2. Participation in journal clubs and research conferences
3. Participation in regional or national professional societies
4. Presentation and/or publication of studies
5. Participation in research, particularly in projects that are funded following peer review and/or result in publication or presentations at regional and national scientific meetings
6. Offering of guidance and technical support (e.g., research design, statistical analysis) for residents involved in research
7. Provision of support for resident participation in scholarly activities."
8. How is "involved" defined? It is left up to the specific program to determine that definition. From a small sampling of Web sites of Ob/Gyn Residency Programs, the implementation of "involvement" differs somewhat among programs, although common aspects exist. The most commonly observed characteristics of Ob/Gyn Residency Programs are: a mandated presentation at a departmental research day, the desired goal of acceptance for presentation at a national meeting or for publication, and the lack of a quality assessment process or a precise definition of acceptable resident

performance. Therefore, all the programs agree that each resident must do a research project that will be at least presented to the faculty. Unlike most other components of the residency program, however, there are neither clear guidelines to help the resident in this process nor a continuing assessment plan to confirm progress or establish a minimum level of quality.

Evaluation of Resident Research Project, Cleveland Ob/Gyn Society

You will have seven minutes to present your research topic, with two minutes for questions. Your project will be judged in the following categories:

- Originality
- Scientific Merit
- Knowledge of Pertinent Literature
- Organization and Analysis of Data
- Quality of Presentation
- Applicability to clinical Practice

You have much to live up to: we often win multiple prizes but, at the very least, one of our residents has won first place in the society competition for the last three years running. Good luck; make us proud!

IX. RESIDENT CONFERENCE SUPPORT

The department supports attendance at regional or national conferences of significance. These conferences promote personal life-long learning and professional advancement. Further, involvement in our professional societies is important to the advancement of our specialty. We provide 5 extra days of time away for meeting attendance to each **chief** resident.

We also encourage participation of any interested resident in the Junior Fellows organization within the American College of OB/GYN. Help with expenses for their conferences are available through the residency office.

Additionally, the department will fund up to \$ 2,000 in conference expense for any resident who is invited to present their research at a national or regional meeting. For PGY1 through PGY 3, travel and presentation time will NOT be counted as vacation time. PGY 4 residents have allotted conference time.

Department funds, like all else, are subject to budgetary constraints. Availability in any given year is predicated by the number of residents who apply. Apply early. The funds are not limitless.

Please note: You must apply for a trip ticket if the department is paying your expenses. JoAnn can assist you in filling out the travel form. You will not be issued a trip ticket until you confirm coverage for any missed calls.

X. FRIDAY EDUCATION CONFERENCES

The faculty provide the residents with five hours of protected educational time every Friday morning. L&D, the GYN floors, OR and the ED are covered by faculty and midwives. These attendings hold the OB and Gyn beepers and manage all patient issues during this protected time. **We understand that residency is first, and foremost, an educational endeavor.** Since we dedicate ourselves to completely protecting your educational time, we expect the same dedication from you in conference attendance and participation. Towards this end, it is expected that all patient rounds will be completed prior to the start of Friday's Grand Rounds 0730. There will be 30 minutes of patient care time between the finish of Grand Rounds and the start of the first resident conference at 0900. Your presence and participation, unless specifically excused by the Program Director, is expected at all conferences.

FRIDAY LECTURE SERIES

TIME	1 st Friday	2 nd Friday	3 rd Friday	4 th Friday
0730	Quality and Patient Safety	Grand Rounds	Grand Rounds	Grand Rounds
0900	Life Long Learning	Problem Based Learning	Adolescent GYN	Behavioral Medicine
1000	SBP- Resident Meeting	Professor Rounds	UroGynecology/TBA	Journal Club
1100		OB	REI	Oncology
1200	OB	Ethics	Fetal Board	Neonatology

Tumor Board: Friday: 0830 – 0930. Oncology team only.

TBA: variable topics as designated by the program director, for example:

- Family Medicine/OB/GYN joint conference
- Business of Medicine
- Coding
- Systems Based Practice
- Government and Medicine
- Primary Care

XI. VACATION/LEAVE POLICY

The department's vacation/leave policy is based on compliance with the rules of ABOG as well as the GME office of UHCMC.

No vacation will be granted the week of Thanksgiving, the last two weeks of December and the last two weeks of June, without exceptional circumstances. Chiefs cannot take vacation days in July except for fellowship interviews.

No more than one person from any rotation team can be off in a given week and generally no more than two total residents per week unless special permission is granted. During a given rotation, only one week of vacation is allowed.

Vacation is permitted for 1st and 2nd year residents and the family medicine rotator while on the night float rotation. However, only one resident can be absent from the night float team at any given time.

You are personally responsible for trading any weekend call around your vacation (defined as Friday, Saturday or Sunday). This preserves everyone's control of their weekends off for the entire year. Call missed during your vacation week (Monday through Thursday) will be assigned to an available resident. However, **coverage for jeopardy calls missed while on vacation must be arranged in advance by the resident taking vacation.** Calls for residents who take vacation while on night float will not need to be covered. The call schedule will be published by the 25th of the preceding month. Onco residents will not generally be asked to take extra call coverage.

For this system of civilized call to work, you **MUST** request your vacation in WRITING by e-mail to the Executive Chief Resident and the Program Coordinator at least SIX WEEKS before the date. This is because the weekly schedule (ATC) will be made six weeks ahead of time to accommodate the WHC schedule. Residents will be assigned to cover clinic sessions of vacationing residents as needed. **Vacation requests not made at least six weeks in advance will be denied unless special circumstances exist.**

Please note: if you are requesting a vacation while on the Oncology Service, it must also be approved by Dr. Waggoner's office in addition to the Executive Chief and the Program Coordinator.

Many of you, for one good reason or another, have asked to be excused from Friday conferences **post call** because you've needed to(fill in the blank). Friday mornings are as crucial to your development as any day spent taking care of patients, therefore: you may request two Free Fridays. If the Program Director thinks the reason is acceptable, it will be approved. However, you can only request two free Fridays per academic year. Any request over two, if granted, will be counted as a vacation day.

If you choose to use your elective/research time to do an away rotation, the proposal first requires the Program Director's approval. You will be responsible for trading your weekend calls (defined above) during that away time. Call during the week will be assigned as above. The same rule will apply to any FMLA unless it occurs as an emergency.

Since you are in control of your weekends, vacation will be tallied as "days" rather than "weeks".

Fifteen days of vacation can be taken during the PGY1 and PGY2 years. PGY3 residents receive 20 days of vacation and PGY4 residents receive 25 days of vacation, which can also be used for fellowship or job interviews and conferences. If you present at a conference or attend a conference during the PGY3 or PGY4 years, those days will be deducted from the total time off allotment. In sum, PGY 1-2, 15 days, PGY 3, 20 days and PGY 4, 25 days.

That exam is always the last Monday of June. The chief resident will be expected to perform all duties, including call, until the end of the schedule.

Again, because you are in control of your weekends, you may take a vacation longer than 5 days at a time, provided there is room on the vacation schedule. For those of you who have asked if it is possible to take two weeks together, the answer is yes. However, a vacation longer than one week must straddle two rotations, as only one vacation week is permitted per rotation.

Maternity leave will be granted up to 6 weeks. Paternity leave for up to 2 weeks is also available. Please remember that, regardless of the cause of any time off from the program, the rules of the American Board of Ob/Gyn state:

“Leaves of absence and vacation may be granted to residents at the discretion of the program director in accordance with local policy. If, within the four years of graduate medical education, the total of such leaves and vacation, for any reason, (e.g., vacation, sick leave, maternity or paternity leave, or personal leave) exceeds eight (8) weeks in any of the first three years of graduate training, or six (6) weeks during the fourth graduate year, or a total of twenty (20) weeks over the four years of residency, the required four years of graduate medical education must be extended for the duration of time the individual was absent in excess of these guidelines.

XII. WORK HOURS

This department strives at all times to be in full compliance with the Accreditation Council for Graduate Medical Education’s (ACGME) duty hour standards. You are required to sign a duty hours affidavit once per month, which is then submitted to the hospital GME office, attesting that you specifically were in compliance the prior month. Any violations you note on the duty hours affidavit are immediately relayed to the Program Director to be resolved. It cannot be stressed strongly enough that we can’t fix problems if we are not aware they exist.

Please remember, the rules state that the longest duration of any scheduled work shift that includes NEW patient care is 24 hours. However, that 24 hour shift may be extended by 6 additional hour for completion of patient care in transfer to the new team, education and outpatient clinic. Some, unfortunately, have interpreted the 24 hour rule as: I put in my 24 hours, morning report is finished and I am out the door with my beeper off. THIS IS NOT APPROPRIATE. After morning report on your respective services, you are expected to complete whatever care needs to happen for your patients (order tests, write scripts, circs, etc). On L&D it might mean returning to the board because there is a crunch of scheduled surgeries and L&D needs covered. In GYN it might mean returning to complete floor work while the new team goes to the OR. It is also a perfect time to complete your professional obligations in medical records. It is expected that all residents have their beepers turned on until noon post call unless you are specifically dismissed by an attending or chief resident.

The ACGME work week rules are as follows:

- Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over 4 weeks.
- Residents must be given one day out of 7 free from all clinical and educational responsibilities, averaged over 4 weeks.
- Residents cannot be scheduled for in-house call more than once every three nights, averaged over 4 weeks.
- Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities.
- Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.
- In-house moonlighting counts toward the weekly limit. In addition, program directors must ensure that external and internal moonlighting does not interfere with the resident’s achievement of the program’s educational goals and objectives.

XIII. RESIDENT ROUNDING RESPONSIBILITIES

The Chief Resident (CR) is to function as the attending physician for all service patients.

- All service patients admitted to Mac 4 or 6 are to be seen and evaluated by the CR before they are discussed with the faculty attending.
- These patients require a CR note which reviews the HPI, acknowledges or amends the written H&P, and discusses in detail the assessment and plan
- Service patients admitted to L&D for delivery need a CR note as above.
(for uncomplicated patients, this may be a brief note.)
- All patients admitted for a surgical procedure require a brief CR Pre Op note.

PGY 1 through PGY 3 responsibilities:

- You are responsible for following up on all patients on whom you have rounded.
- If the CR has already written a note on your patient, it is still your responsibility to write your own note.
- If you are on the OB, MFM, or Benign Gyn service, you are expected to be at the hospital by **0600**. All Gyn service patients are to be seen prior to 0630 rounds whether you have a 0700 OR case or not. On the MFM team, it is expected that all new Mac 6 admissions will be seen and added to the printed signout prior to Board Rounds.
- Oncology resident call and post partum patients if possible.

Rounding on Post-partum patients

Post partum patients will be seen on Mac 3 and Mac 5 by the OB1, the OB2 and the family medicine fellow (who will help on all days except Mondays). They should arrive by at least 6:00am to perform these rounds, however, they may need to arrive earlier to complete rounds by 7:00am. Post partum patients on Mac 6 will be seen by the night float team either before or after board signout. Complicated post partums will be seen by the OB chief resident and should be placed on the printed signout so that they can be seen by the chief before 7:00am.

Rounding on Post-operative patients

- If a senior and junior resident both scrub on a case but the majority of the surgery is done by the senior resident, it is the SENIOR resident's responsibility to round on the patient and write daily progress notes. The junior resident should also see the patient and write notes as appropriate but the bulk of the care and management of the patient are to be provided by the Surgeon (the senior resident).
- If a senior and junior resident both scrub on a case but the senior is acting as the Attending and the junior as the Surgeon (and doing the majority of the case), it is the JUNIOR resident's responsibility to round on the patient and write daily progress notes (acting as Surgeon). That patient should also be seen by the senior resident and notes written as appropriate (just as I would do if the patient were mine and a resident did the case). In this case, the senior resident is in the role of the Attending. If you want to assume the role of the Attending, then you must act like the Attending.

Rounding for the Night Float (NF) team

Since there will be a full NF team, the NF team will be responsible for circumcisions as well as post partum rounding on Mac 6. Circumcisions will take place at 7:30am with the gynecology attending of the week. If desired, the night float team can perform circumcisions overnight, as long as they are supervised by the attending on call

If any patient is critical, or labs are pending, the NF team will put the patient in RECS and make sure to communicate all information/pending labs or consults to the day OB team.

Oncology Rounding

The oncology residents will take call on alternating weekends. The weekend call will consist of Friday night and Sunday 8am-7pm "beeper call". The onco resident on call Friday is expected to function as part of the on call team and be responsible for rounding with the attending on Saturday morning. Sunday mornings, the resident is required to round with the attending (at a time set by the resident and attending), but should be **no earlier than 6am**.

In house call (8am-7pm) is encouraged, but not mandatory as long as all rounding duties, lab follow up, and consults are completed. Also, duties that are outside of oncology service (i.e. covering L&D, ER consults) are not expected unless they involve an oncology patient. However, the onco resident **must be available within 20minutes to be at the hospital for any emergencies or admissions**. Until 7pm, the resident will be paged by the RN regarding any issues with oncology patients. He or she will be responsible for any orders to add/corrections/calls.

Signout will need to be at 7pm promptly and should consist of an updated RECS signout in person or over the phone to the on-call team. The on-call team should then take all calls from the floor/ED regarding onco patients.

The oncology pager (**#38384**) will be carried by the nurse practitioner, R3, or R2 on the oncology service. When the R2 or R3 is on call or on beeper call, they will also hold the onco beeper. This beeper is used for RN calls on onco patients, onco consults, replies from radiology, etc. It should be split equally by the team and should be held by the person who is most available (or covering the floor) for that day. It is NOT to be the R2's responsibility only.

At 5pm, the team is to sign out the beeper to the late call resident (R3 or R2) Mondays-Thursday or the on call team on Fridays. He or she is to retrieve the pager the next morning upon arrival. On the Saturdays, the beeper should be held by the resident covering for gyn (either OB2 or GYN3) and will be picked up by the onco resident Sunday by 8am. The beeper is to be kept by the onco resident on beeper call Sunday and then needs to be handed off to the night float R3 (for the first half of the year) covering Sunday at 7pm.

The RN's on MAC 4 are to use this pager **#38384** for onco patients instead of the resident's personal pagers. Onco residents, please tag this pager for radiology requests or for notes on patients on floors other than MAC 4 (i.e. Telemetry or SICU). Fellows should also be aware of this number to contact the resident covering the service overnight.

XIV. WEEKEND ROUNDING

All weekend call is protected and scheduled one year in advance. Weekend trades (Friday, Saturday or Sunday) are made only resident to resident. Please remember, if you trade call with someone, you are also trading for their rounding responsibilities. The chart below shows call responsibilities.

Weekend Rounding Schedule: **First ½ of Year (6.29.09-12.27.09)**

Saturday (weeks 1/3)

OB 4: Private Antepartum
MFM 3: Staff Antepartum
REI 2: Postpartum
Gyn 1: Gyn
Gyn 3: Postpartum
Onc 2: Oncology
FMF: Postpartum

Sunday (weeks 2/4)

ER4: Gyn
NF 3: Postpartum
NF 1: Postpartum
Onc 2: Oncology
OB 4: Private Antepartum
MFM 3: Staff Antepartum
REI 2: Postpartum
Gyn 1: Postpartum

Saturday (weeks 2/4)

Gyn 4: Private Antepartum
UG 3: Gyn
Gyn 2: Postpartum
MFM 1: Staff Antepartum
Onc 3: Oncology
OB 2: Postpartum
OB 1: Postpartum

Sunday (weeks 1/3)

NF 4: Private Antepartum
NF 2: Postpartum
US 1: Postpartum
Onc 3: Oncology
Gyn 4: Staff Antepartum
UG 3: Gyn
Gyn 2: Postpartum
MFM 1: Postpartum

Weekend Rounding Schedule: **Second ½ of Year (12.28.08-6.27.10)**

Saturday (weeks 1/3)

OB 4: Private Antepartum
MFM 3: Staff Antepartum
REI 2: Postpartum
Gyn 1: Gyn
Gyn 3: Postpartum
Onc 2: Oncology
FMF: Postpartum

Sunday (weeks 2/4)

UG4: Gyn
NF 3: Postpartum
NF 1: Postpartum
Onc 2: Oncology
OB 4: Private Antepartum
MFM 3: Staff Antepartum
REI 2: Postpartum
Gyn 1: Postpartum

Saturday (weeks 2/4)

Gyn 4: Private Antepartum
ER 3: Gyn
Gyn 2: Postpartum
MFM 1: Staff Antepartum
Onc 3: Oncology
OB 2: Postpartum
OB 1: Postpartum

Sunday (weeks 1/3)

NF 4: Private Antepartum
NF 2: Postpartum
Anes 1: Postpartum
Onc 3: Oncology
Gyn 4: Staff Antepartum
UG 3: Gyn
Gyn 2: Postpartum
MFM 1: Postpartum

On Call Team: Purple
Post Call Team: Red

XV. CONTINUITY OF CARE CLINIC

Most residents will have one Continuity of Care (COC) clinic session per week, with the exception of night float and elective residents. These sessions will include OB and Gyn patients allowing you the opportunity to see as many of your own patients in follow-up as possible. The sessions include patients requesting an Annual Physical Exam (APE). The APE is not simply a “breast and pelvic exam” as it has commonly been thought of in the past. The APE is a comprehensive evaluation for screening, prevention, diagnosis and initial management of all common health issues that affect all women. The COC clinics are all supervised by Faculty from the Generalist Division with broad expertise in Primary Care for Women.

Outpatient care and clinic protocols are reviewed at our monthly **Problem Based Learning (PBL) sessions**. A topic is chosen, e.g. Treatment of Uncomplicated Cystitis in Non-Pregnant Women. A team of residents review the presentation, epidemiology and pathophysiology of the topic. From their research they present an evidence-based protocol for treatment/care of the condition. Current compliance with the protocol is assessed by reviewing 10 to 20 WHC charts. Three to six months later, the WHC charts will be reassessed for improvement/compliance with the adopted protocol.

Admitting patients and scheduling surgery from the WHC can be complex. Here are some helpful hints:

H&P's/Consents

- Lois is in charge of sending the H&P/Consent to PAT. She will also fax them directly to Humphrey.
- Kathy/Nora maintain the Tubal Ligation consents in a file at the OR scheduling desk. When patients are scheduled for a TL, the patient's consent is pulled out of the file and posted on the board by their computer.
- Lois keeps a photocopy record of all Tubal Ligation consents in her office. That means it is our responsibility to make sure Lois has a copy.
- Lois has agreed to keep a copy of preop charts in the ASU box for the chiefs and interns to photocopy and review, but these should not be removed from the WHC.

Tracking the surgeries

- Each week, Kathy/Nora update a schedule of the OR cases for the next week. It is the Gyn intern's responsibility to go to the WHC on Friday and look in the ASU box for the charts of women having surgery the next week. The Gyn intern will then photocopy the H&Ps from the chart for the upcoming week so the Gyn team can review the cases.

Intern responsibilities

- Interns on the gyn service are expected to know which cases are staff cases each OR day. If there is no consent/H&P in the OR, interns can go to the WHC to photocopy the consent/H&P from the WHC chart in the ASU box.
- To facilitate this, Lois will pull the charts for patients with scheduled OR cases that week and place them in the ASU box located in clinic.

Chief responsibilities

- Chiefs are expected to know the staff cases each OR day and have reviewed their H&P. The chief resident (if the OR schedule permits) is also expected to staff the resident cases with a junior resident. Attendings should understand that chiefs may not be present for all staff cases if they are scrubbed on a major in another room and no other senior is available.
- To facilitate this, Lois will pull charts for patients with scheduled OR cases that week and place them in the ASU box located in clinic.

PreOp Testing

- There is an ambulatory surgery sheet in the WHC. It should be completed for each patient that is preoped and include a preop appointment. The sheet will note planned surgery, the attending, the equipment needed, the preferred date of surgery, any pre-op labs or testing needed. It should be affixed to the resident's H&P/Consent.
- Residents should be aware of what is required for pre-op testing/labs and should make note of tests/labs that they want to order on patients prior to surgery. This should be documented in the H&P.

Post-op follow-up

- All patients should be instructed to make a post-op appointment when they are notified of their surgery.
- If possible, post-op appointments should be scheduled at the time that the surgery date and time are assigned.

Gyn resident responsibilities re: pathology

- On gyn Friday morning rounds the Gyn team (in a tumor board-esque manner) will review the pathology from the previous week's surgery. Each resident who has operated on a staff case will present the patient in a very brief way: the surgery, the pathology, and the plan for follow-up (i.e.: if the patient has an appointment). In addition, any pathology specimens obtained from performing In-house consults should be reviewed and discussed by the resident who performed the procedure.
- The ASU folder can be used to track surgeries from the prior week.

Special Devices

- When scheduling a patient for any procedure that requires special devices (i.e.: Mirena IUD) there is a form that Lois now has which is a "Special Product Request Form". The product you need should be stated clearly on your Planned Procedure so that Lois can pre-order it.

Gynecology Rounds Education Schedule 2009-2010

First ½ of Year (6/29-12/27)

Week	Monday	Tuesday	Wednesday	Thursday	Friday
1	Surgical instruments and technique (orienting to the OR)	The preop evaluation: counseling & consent	Antibiotic prophylaxis for gyn procedures	OPEN	The GYN pager...how to respond?
2	Menorrhagia: diagnosis & workup	Medical and surgical treatment of menorrhagia	Hysteroscopy techniques and complications	OPEN	Pathology Review
3	Ectopic Pregnancy: diagnosis & workup	Medical & surgical treatment of ectopic pregnancy	Laparoscopy: background, setup, and complications	OPEN	Pathology Review
4	Abortions: definitions and workup	Abortions: medical and surgical treatment	Abortions: termination of pregnancy	OPEN	Pathology Review
5	PID & TOA: background	PID & TOA: workup	PID & TOA: treatment options	OPEN	Pathology Review

Gynecology Rounds Education Schedule 2009-2010

Second ½ of Year (12/28-6/27)

Week	Monday	Tuesday	Wednesday	Thursday	Friday
1	The Hysterectomy	Vaginal Hyst	Laparoscopic Hyst	OPEN	Pathology Review
1	Birth Control, back to the basics: Why does it work?	OCPs and Depo: which one and why?	The IUD, Essure, & Implanon	Tubal ligation: evidence based approach	Pathology Review
2	Menopause-Women's Health Initiative review	Menopause-Diagnosis	Menopause-Treatment	OPEN	Pathology Review
3	The adnexal mass: diagnosis and workup in children/teens	The adnexal mass: diagnosis and workup in adults	The adnexal mass: management	OPEN	Pathology Review
4	Abnormal pap smears: background	Abnormal pap smears: management	Cryo/LEEP/cone indications and procedures	OPEN	Pathology Review
5	Hysterectomy: background and indications	Comparison of types of hysterectomy	Complications of hysterectomy	OPEN	Pathology Review

Obstetrics Rotation - Rounds Education Schedule

First rotation (6/29 – 12/27)

	Monday	Tuesday	Wed.	Thursday	Friday	
Week	1	Normal labor	HROB	FHR evaluation	Journal review	-
	2	Techniques for vaginal delivery	HROB	Techniques for cesarean section with evidence-based review	Journal review	-
	3	Management of abnormal labor	HROB	Induction of labor	Journal review	-
	4	SROM & chorioamnionitis	HROB	GBS prophylaxis	Journal review	-
	5	Obstetric emergencies: shoulder dystocia	HROB	Obstetric emergencies: postpartum hemorrhage	Journal review	-

Obstetrics Rotation - Rounds Education Schedule

Second rotation (12/28 – 6/27)

	Monday	Tuesday	Wed.	Thursday	Friday	
Week	1	PTL and tocolysis	HROB	Antenatal corticosteroids: evidence based practice	Journal review	-
	2	Pre-eclampsia: definitions and workup	HROB	Pre-eclampsia: management	Journal review	-
	3	Trauma and abruption: presentation and workup	HROB	Management of placental abruption	Journal review	-
	4	Operative vaginal delivery: vacuum	HROB	Operative vaginal delivery: forceps	Journal review	-
	5	Management of the patient with diabetes during labor and delivery	HROB	Management of acute asthma exacerbations on labor and delivery	Journal review	-

XVI. CHAPERONE POLICY

Pursuant to Chapter 4731-26 of the Ohio Administrative Code, it is the policy of MacDonald Women's Hospital to have a chaperone present during **any** intimate examination performed by a physician or physician's assistant. An intimate exam is defined as examination of the pelvic area (genitals or rectum), and/or breast. If a patient requests a chaperone leave the room, this request should be documented in the patient chart, the patient should sign that documentation. Otherwise, when a chaperone is present, no documentation is necessary as this is a universal policy.

A chaperone can be the parent of a minor, a spouse or relative accompanying a patient, an office employee (non-clinical), or a clinical employee (nurse, PA, etc). If not a family member it is preferable, but not imperative, that the individual be of the same sex as the patient. Also, if a non-clinical employee does not wish to be a chaperone (receptionist, etc), they should not be compelled to perform this duty unless it is part of their job description.

XVII. FAMILY MEDICINE OBSTETRIC FELLOW

The Fellowship is open to physicians who have completed a residency in Family Medicine or who are certified by the American Board of Family Medicine.

The goals of the Fellowship are to acquire advanced skills in OB management, including surgical skills in primary and repeat Cesarean section and operative vaginal delivery. Generally the graduate fellows plan subsequent practice of Family Medicine with OB in rural situations or continued practice and teaching of the skills acquired in academic Family Medicine departments. Family Medicine physicians provide advanced obstetrical care to many rural communities in this country and require a source of excellent training.

The Fellow spends 70% of the time with the OB/Gyn department and 30% with Family Medicine. Nine months are spent on L&D, with 4 weeks vacation and an option of two months of elective experience. Some Fellows elect to take electives longitudinally to augment their time spent on L&D.

The Fellow will be with the Family Medicine department every other Monday and every Thursday, with the remainder of the time spent on Labor & Delivery.

The Fellows are expected to attend weekly Women's Health conferences in the department of Family Medicine every Thursday morning from 7:30-8:30.

On Labor & Delivery, they begin at an intern level and progress to a more advanced senior level on recommendation of the supervising chief residents and faculty supervisor, Dr. Ashby. It is intended that they function as an integral part of the Ob/Gyn housestaff team, but focusing on OB, though they may choose elective experiences in Gyn (e.g. colposcopy at the Women's Health Center).

Most Fellows progress at about three months into the Fellowship and perform over 100 primary and repeat sections over the course of the year, as well as other procedures.

The Fellows are to be formally evaluated by the supervising chiefs, Dr. Ashby and Cossler at 3 and 6 months into the Fellowship, and subsequently as needed to ensure that they are progressing appropriately. Dr. Cadesky will attend these sessions and will also arrange for periodic evaluation of their work in Family Medicine.

XVIII. FAMILY MEDICINE RESIDENT ROTATORS

Family Medicine residents spend a total of six weeks with the obstetric team at University Hospital. During this time spent rotating with the obstetrical team, the family medicine rotator will be considered an integral part of the team. They will be given responsibilities commensurate with their level of training with the anticipation of increasing responsibilities as they gain knowledge and skill. Their goals, while rotating with the inpatient obstetrical team, include learning the management of normal pregnancy and delivery as well as post partum care. They also need experience in recognizing and managing complications and emergencies in pregnancy, labor and delivery and postpartum.

As with other junior residents, all patients seen in triage must be discussed with the senior OB resident before any final management plan is determined. In general, this resident will follow a similar schedule to the night float team. The distribution of responsibility for obstetric patients is made by the OB chief.

Although the focus for this experience is labor delivery, triage and ante- and postpartum management, Family Medicine residents must also acquire surgical skills. As of the PGY2 year, they will be scrubbing on Cesarean deliveries as a second assistant for their continuity patients. Some residents will want to go on to acquire advanced obstetrical skills during fellowship training. As such, Family Medicine rotators are encouraged to second assist on cesarean sections, tubal ligations, as well as D&Cs done on Labor and Delivery. Supervised experience in the technique of circumcision should also be offered, except in the case of the occasional resident who conscientiously objects to performing the procedure.

XIX. MANAGEMENT OF FAMILY MEDICINE OB PATIENTS ON L&D

There are times when the OB Attending is also covering for the FM attending on L&D. When a FM patient, from their continuity clinic, is in labor, the FM resident will manage the labor and perform the delivery (consulting when needed) just as before.

However, if there is no FM Attending present and the OB attending is covering, then the FM resident will keep the senior OB resident on L&D informed as to the patient's progress. At delivery, the OB chief will attend the delivery (as well as the OB attending) for teaching purposes and help if necessary. It is very important that the FM resident manage and deliver all of their patients whenever possible and that we not confuse these patients with our WHC patients.

XX. COLLABORATIVE AGREEMENT ON L&D: OB/GYN Nursing AND ANESTHESIA

Of all the individual measures of patient satisfaction, the most important correlate of overall satisfaction is the extent to which the patient agrees with this statement: “The staff worked together to care for you”.

Labor and Delivery is a dynamic unit staffed by three integral services (Anesthesia, Nursing & Obstetrics). As a team we must be capable of caring for a broad range of patients and problems. Although L&D is commonly populated by normal laboring women, it is also an Intensive Care Unit for the Obstetric patient. This reality clearly requires the medical expertise of all three services, **and** the ability to function in harmony with clear communication facilitated by our support staff.

Chain of Command:

The responsibility for guiding the care of the obstetric patient belongs to the Attending physician. Obviously, since University Hospitals is a teaching institution, the Attending OB will often step back and care will be directed by the chief resident acting as an attending. But in all cases, the Attending is ultimately responsible for all decisions made.

Respect:

All of us want to be valued for our skills and treated as professionals. Please make every effort to address your colleagues by name rather than position (e.g. anesthesia, nurse). Help each other accomplish this: Wear your ID badge and position it so it is easy for others to see. In the same fashion, patients deserve to be addressed by their names, not by inappropriate terms of endearment (honey, sweetie).

Crowding at the Back Desk:

For the most part, Ob, Anesthesia as well as Nursing are on the L&D floor during their working hours. We need to be there. The Board is often busy. Emergencies are frequent and obviously unannounced. Unfortunately, L&D was not designed to accommodate a bevy of eager caregivers. Our presence can lead to severe crowding and noise at the hub of L&D, the back desk. With this in mind, please be cognizant of our need to appear to all our patients and families as the professionals that we are.

Communications:

L&D is a chaotic place. We need to communicate with each other directly, whenever possible. There are boards on the back desk that list the on duty Ob and Anesthesia teams as well as the nurse in charge, in triage and assigned to each patient. Each service is responsible for keeping these boards up to date.

IV Starts:

We must constantly keep our eyes on the prize: when there are problems with IV starts, or any other patient issues, the only goal is to take excellent care of the patient. The patient's needs cannot get lost in a turf battle. The nursing staff on L&D is skilled at IV starts. If an experienced L&D nurse cannot start an IV she may directly request help from the anesthesia team: AA, CRNA, or resident. (An inexperienced L&D nurse is expected to consult an experienced nurse or the charge nurse if she is experiencing difficulty).

Off L&D, on Mac 3-6, if nursing cannot place an IV, the charge nurse should be notified. The charge nurse should contact the L&D charge nurse. Depending upon staff availability, an L&D nurse can assist with difficult IV starts on the floors. If nursing is unable to start the IV, the Ob resident must personally evaluate the patient and, if appropriate, make an effort at blood draw or IV placement prior to consulting the anesthesia team.

Involvement of Anesthesia Services in Patient Care Outside of the OR/Pain Relief:

The concept of L&D as the Obstetric Intensive Care Unit derives from obstetric emergencies as postpartum hemorrhage or HELLP syndrome. Patients with such problems may require the expertise and close teamwork of Ob, Nursing and Anesthesia for fluid resuscitation and stabilization. If frequent blood draws are anticipated, we encourage consideration of arterial line placement by the Anesthesia team. Furthermore, training for the nurses on arterial line, management, and discontinuation will be provided. Should any nurse need assistance or guidance, the anesthesia staff will be available for questions.

**1/2007
Joint Committee,
OB, Anesthesia and Nursing**

XXI. Collaborative Agreement: Triage/Evaluation of Obstetric patients in the ED

The following are general guidelines for triage, evaluation and/or admission of the OB patient developed by consensus of Emergency Medicine and Obstetrics and Gynecology. They do not preclude individual judgment in emergency cases or unique presentations.

All Obstetric patients with EGA \geq 20 weeks will be triaged on L&D with these few exceptions:

- Maternal trauma with primary injury to head, chest, or extremities or a penetrating wound to the abdomen that does not include the uterus.
- An unstable patient with cardiovascular or respiratory compromise.
- Obstetric consult is not required for minor injury that, in the judgment of the ED physician, does not affect the pregnancy.
- If the ED physician wishes an obstetric consult, the patient's primary OB should be contacted. If the patient's care is provided by the WHC, a non-system provider or has had no prenatal care, the OB chief pager should be contacted (33719).

All patients with a known viable pregnancy, of any EGA, that require hospitalization, should generally be admitted to MacDonald 6 under either OB/GYN or Family Medicine as primary providers. All other services required will be consultations.

Exceptions to this general rule:

- patient requires admission to MICU/SICU
- patient with primary orthopedic injury

UHCMC Radiology services agree that L&D (the Obstetric Emergency department) will receive the same stat level of service as the ED.

The ED staff has been directed to please call 45925 instead of the triage line to give live verbal report of any incoming patient/babies that are in need of transfer from ED/Peds ED to MacDonald L&D. They have been directed to ask for the CHARGE RN to give report. The charge RN can then decide if the patient is a candidate for admission or triage after report has been given.

*Approved by the Committee Quality Patient Safety -MacDonald Women's Hospital on 5/21/08
Revised 5/27/08*

XXII. RESIDENT EVALUATION

The Program Director meets semiannually with each resident for a formal evaluation. This includes discussion of written feedback from faculty, peers, professional staff, medical students and patients regarding your knowledge, skills and growth as a physician. You will have the opportunity to formally voice your own assessment of your progress. A summary statement of the meeting will be included in your file, with your signature acknowledging the contents.

All residents take the CREOG In-Training Examination in January of each year. The purpose of the exam is to help guide you (and us) in planning your educational needs. This test is only one part of your evaluation but it is important. Your performance on this exam is predictive of your ability to pass the written ABOG exam. Residents who score below the 25th percentile (vs. their year, PGY1 and 2; vs. overall PGY3 and 4) will be required to meet with their mentor and plan a self-study program to improve their performance the following year.

Mock oral exams are given once per year in the spring. This exam is 30 minutes in length and faculty will be paired as examinees. They are instructed not to give you any verbal or visual feedback, mimicking your oral board exam. In exactly the same manner that you will submit cases for your orals, you will submit 5 cases in each category: office practice, obstetrics and gynecology. These typed case lists will be due to the Program Coordinator the Friday BEFORE the oral exam. You will be examined on the cases you submit, just as you would for the ABOG oral exam. This is your opportunity to demonstrate your ability to think through clinical scenarios on your feet and to practice for the “real” oral boards.

You will also have an opportunity to formally and anonymously evaluate the faculty and the program rotations. You will receive these forms twice a year. They are typed by the Program Coordinator and distributed at six month blocks. No one will see your handwritten form except the Program Coordinator. What goes around comes around. We are interested in how we are doing, how we are teaching, and what we can do to improve. Honest.

(See examples of evaluation forms in Appendix A)

XXIII. EDUCATIONAL GOALS AND OBJECTIVES BY MAJOR ROTATION

Although residency is built on a progression of graduated responsibility, each resident's duty is never his or hers alone. We work as a team to provide excellent patient care. Nonetheless, resident responsibilities are loosely divided by service and resident level. Each resident has a basic set of jobs to attend to on a daily basis. This does not mean that senior residents should not help junior residents or vice versa so that the total amount of work is more equally balanced. We work together in all circumstances to foster a positive team spirit (yes this means that the OB chief may need to help with L&D triage, or the senior resident may need to do circumcisions). In addition to clinical responsibilities listed below, residents are expected to attend all educational conferences. Regardless of your assigned service, you must be available at minimum 7am to 5pm daily to help your colleagues. Specific resident service responsibilities are discussed under each rotation.

The following section outlines the department's educational goals and teaching objectives for the major rotations. We have attempted to be comprehensive and straightforward. We have also tried to reflect the expectations of the CREOG Educational Manual eighth edition. This manual is available online on the CREOG website.

Most rotations are described with general goals, by PGY level, in this section with detailed educational expectations found in the appendix. They will be referenced as such. Other rotations include complete detailed objectives within the body of this section.

In some sections you will find a list (marked by an arrow) preceding the educational objectives. These represent a general list of tasks, by PGY level, to guide in team function. They are not meant to be either all-inclusive or rigid in their assignment of any particular task or responsibility.

In any case, it is the **patient who is at the center of our circle!** The care of the patient is the reason we have all studied medicine. The patient is why we seek To Heal, To Teach and To Discover. It is the patient, and the patient's needs, that are pre-imminent in all that we do. And that fact takes precedence over anything else within this manual.

A. OBSTETRICS

(For detail of objectives, see Appendix B)

Weekly Obstetrics

OB1	Monday	Tuesday	Wednesday	Thursday	Friday
AM wk 1,3	WHC	L&D	L&D	L&D	Educ
PM wk 1,3	L&D	L&D	L&D	L&D	L&D
AM wk 2,4	WHC	L&D	L&D	L&D	Educ
PM wk 2,4	L&D	L&D	L&D	L&D	L&D

OB2	Monday	Tuesday	Wednesday	Thursday	Friday
AM	L&D	HR OB	WHC	L&D	Educ
PM	L&D	L&D	L&D	L&D	L&D

OB4	Monday	Tuesday	Wednesday	Thursday	Friday
AM	L&D	HR OB	L&D	L&D	Educ
PM	L&D	L&D	L&D	WHC	L&D

Board Rounds are held Monday through Friday starting promptly at 7 AM. Attendance is required by all members of the OB and MFM service and one member of the night call team (usually the night float) to review the current patients on the L&D board. Leading rounds will be the designated High Risk attending from the MFM service and the attending covering L&D during that day. Also present is the OB clinical nurse educator, the charge nurse from Mac 6 (antepartum floor) and the charge nurse from L&D. After all patients from L&D are discussed, the course of each antepartum patient on Mac 6 will be reviewed and treatment plans made or modified. All residents on the MFM team are expected to have seen, and written notes on, all new antepartum patients prior to Board rounds. These are teaching rounds as well as work rounds. For each patient on your list, you are expected to be conversant in the following:

1. all pertinent historical and physical details of each patient you present.
2. their assessment and plan organized by problem list.
3. the results of all current labs/radiologic studies.
4. if the patient is new, a DDX for the presenting complaint(s) and a proposed work up. The entire core library, including major textbooks like Williams, is available to you 24 hours a day from any computer in the hospital. If you don't know the answer, look it up.
5. if the patient is a follow-up, all notes from the intervening 24 hours and all results since you last saw the patient.

Evening patient handover (1705 weekdays) and weekends (0800 on Saturday and Sunday) occurs at the North desk on L&D. All patients on L&D, and complicated Antepartum, postpartum and post-op patients will be reviewed.

Circumcision Protocol

“Existing scientific evidence demonstrates potential medical benefit of newborn male circumcisions however, this data is not sufficient to recommend routine neonatal circumcision.”

Guidelines for Perinatal Care, 6th Ed

-American Academy of Pediatrics

-American College of Obstetricians and Gynecologists

Consent for circumcision: may be obtained on admission to L&D but it must be obtained by a resident or attending physician. CNMs may not obtain consent. The morning of the circ, someone from the circ team must confirm with the mom that consent was previously obtained and she agrees to proceed. This policy, for confirmation of consent, applies to MacDonald Women’s Hospital, not to babies at Rainbow. Rainbow babies still require written consent in the chart prior to circumcision.

Contraindications: Bleeding diathesis
Congenital abnormalities
Premature infants not ready for discharge.

Procedure:

- Infant must be at least 12 hours old and NPO for at least one hour.
- An H&P by pediatrics is required prior to circumcision.
-this H&P may be done at the time of delivery if pediatrics attends or at morning newborn rounds.
- Mon-Thur, the night call team is responsible for doing all eligible circs with the gyn attending.
Circs should start promptly at 0730
Eligible babies include all staff and CNM circs
Babies from Rainbow 4 and NICU will be placed on the MAC 5 circ list when ready.
Please do not postpone these until the day of discharge if at all possible.
- Friday circs (same team) at 0830
- Weekend circs are done by the on call team with the on call attending.

Analgesia:

Analgesia must be provided if circumcision is preformed. **Swaddling, sucrose by mouth, and acetaminophen** may reduce stress response but are **not sufficient** for operative pain and cannot be recommended as the sole method of analgesia.

GPC, 6th edition

- **Topical Lidocaine Cream**
- **Dorsal Penile Nerve Block**
- **Ring Block**

Dorsal Penile Nerve Block:

1 ml syringe, 27 or 30 gauge needle

0.8-1.0 mL 1% Lidocaine

without epinephrine

2 o'clock, 10 o'clock, base penis

Posteromedial direction

0.3-0.5 cm depth

tip freely mobile (loose connective tissue)

negative pressure, no blood

-In addition: sucrose-dipped pacifier (24% solution)

Crucial Steps:

1. Time out.
2. Use analgesia on all neonates. **Wait.**
3. Gomco shaft and base numbers match.
4. Insure that foreskin is not pulled too tightly or too loosely before it is excised.
5. V slit of foreskin is above the gomco base.
6. Leave clamp on 5 minutes. **Wait.**
7. Complete the circumcision procedure note.

Bleeding Complications:

1. Most will be avoided by leaving the gomco on for **5 minutes.**
2. Most cases will be resolved by applying pressure for 5 to 10 minutes. Look-at the clock.
3. Gelatin sponge (gelfoam) can be used if pressure alone does not suffice.
4. OPTIONS ACCEPTABLE ONLY WITH AN ATTENDING PRESENT:
 - dilute topical epinephrine solution
 - 6-0 chromic suture

Approved by CQPS-6/17/09

PGY1

- Labor and Delivery triage
 - Discuss each staff patient with OB chief prior to discharge or admit
 - Discuss each private patient with attending prior to discharge or admit
 - Document all discussions in the chart.
- Primary cesarean sections
- Full term staff spontaneous vaginal deliveries
- Call OB chief and attending IN TIME to supervise the delivery
- Admission H&P and consent on term, uncomplicated patients
- Answer pages from antepartum and postpartum floors
- Patient phone calls to Labor and Delivery
- Daily care of antepartum patients (seen before morning rounds)
- Daily care of postpartum patients (seen before morning rounds)
- Tubal ligation note
- Scrub on all post partum tubal ligations
- PGY-1 house officers are not certified to do ultrasound procedures independently until they have completed the formal ultrasound rotation. A resident who has not completed the ultrasound rotation may scan with the supervision of a more senior resident or an attending who will be responsible for the measurements, BBP and interpretation and documentation in the medical record.

PGY2

- Repeat, emergent, and anticipated challenging cesarean sections
- Daily care of antepartum patients (seen before morning rounds)
- Daily care of postpartum patients (seen before morning rounds)
- Admission H&P, consent, ultrasound, thorough evaluation of high risk patients, transfer patients, multi-fetal pregnancies
- Admission H&P on scheduled cesarean section patients you will be operating on
- Supervise directly or perform all 3rd/4th degree repairs
- Clinical rounds and written notes (roughly every 2 hours as feasible) on all patients on L&D
- Vacuum and forceps assisted deliveries (call attending and OB chief)
- Vaginal deliveries of preterm patients, multiple gestations, breech extraction, etc. (call attending and OB chief)
- Knowledge and discussion of all staff patients with OB chief
- Help OB intern with ALL above responsibilities as listed (this includes triage)
- Teaching and supervision of medical students as feasible
- Scrub on all cerclage placements

PGY3

- Repeat, emergent, and anticipated challenging cesarean sections
- Daily care of antepartum patients (seen before morning rounds)
- Daily care of postpartum patients (seen before morning rounds)
- Admission H&P, consent, ultrasound, thorough evaluation of high risk patients, transfer patients, multi-fetal pregnancies
- Admission H&P on scheduled cesarean section patients you will be operating on
- Supervise directly or perform all 3rd/4th degree repairs
- Clinical rounds and written notes (roughly every 2 hours as feasible) on all patients on L&D
- Vacuum and forceps assisted deliveries (call attending and OB chief)
- Vaginal deliveries of preterm patients, multiple gestations, breech extraction, etc. (call attending and OB chief)
- Knowledge and discussion of all staff patients with OB chief
- Help OB intern with ALL above responsibilities as listed (this includes triage)
- Teaching and supervision of medical students as feasible
- Scrub on all cerclage placements

PGY4

- Organize and run daily morning rounds
- Help OB intern and OB senior with all responsibilities as listed above
- Confirm staff patients appropriate for post partum tubal ligation prior to OR
- Round on all staff antepartum patients with MFM attending of the month
- Supervise and teach medical students
- Scrub on all staff cesarean sections
- Supervise all staff deliveries
- Directly supervise management of staff patients on L&D
- Staff consults to GYN beeper when cross covering (see chief coverage section)
- Participate in weekly High Risk Clinic (see patients if needed)
- Communicate with MFM attending on all consults/admissions
- Make certain clinic midwife circls are collected from L&D board and done
- Redistribute antepartum patients if necessary to ensure they are fairly divided among residents and that a senior resident is following the more complicated patients.
- Full term unattended private spontaneous vaginal deliveries
- Prepare case conferences as requested for Friday Educational Series

MFM Rotation

The MFM service will consist of an MFM1, an MFM3, and the high risk attending. The MFM rotation will function separately from the OB day team, but each team should be aware of patients on the other service.

Rounding: The MFM1 and MFM3 will arrive on Mac 6 at 6:00am to see and write notes on new admissions. The MFM3 will decide which patients are appropriate for the MFM1. New MFM patients must be added to recs prior to board signout on Mac 2 at 7:00am. Copies of the updated recs should be printed for the MFM team as well as the OB day team. At board signout, the MFM team will hear about labor and delivery patients (because they will be joining the L&D team later in the day) and the OB team (including the chief) will hear about the MFM patients on Mac 6. New patients will be presented in detail and ongoing patients will be summarized with a one-liner.

- MFM3 leads the service and decides which patients are appropriate for the MFM1 to follow.
- MFM3 needs to know about the patients the MFM1 is following.
- MFM3 will supervise the MFM1 in handling calls from the Mac 6 RNs
- OB4 is still the “captain of the ship,” functioning as a junior attending on labor and delivery

Walk rounds: After labor and delivery board signout, the MFM team will go to Mac 6 with the high risk attending to make team rounds on the MFM service (all staff and MFM patients).

- Team notes will be written on ongoing MFM patients. The MFM1 and MFM3 are **not** expected to have seen or written notes on ongoing MFM patients prior to these walk rounds.
- Private patients can be seen after walk rounds (e.g. for a Stephenson or Wieczorek private patient) because the MFM attending does not need to round on these patients. The private attending should then be contacted regarding management of these patients.
- After walk rounds, the MFM1 and MFM3 will place orders, discharge and dictate patients, schedule tests, and read NSTs.
- Residents are expected to go to help the OB day team on labor and delivery once their work is complete on Mac 6.
- At 4pm the MFM1 and MFM3 will meet on Mac6 to make sure labs and test results for the day are recorded in the chart and that recs is updated for PM signout.

Consults:

- The labor and delivery day team can consult the MFM service about high risk patients on labor and delivery.
- A labor and delivery H&P will still be done by the OB day team.
- The MFM service will function as CONSULTANTS and, as with any consultant recommendation, the OB4 and L&D attending may or may not follow the recommendations of the consulting team.
- If a consult is called, the MFM1 and MFM3 will see the patient, write a consult note, and staff the consult with the MFM attending.
- If consulted, the MFM service will round on the patient on labor and delivery like any consultant service.
- At the end of the day, the OB4 is still the “captain of the ship” and will make final decisions about their staff patients.
- Consults to the gyn beeper that are <20 weeks will still be seen initially by a gyn resident and then discussed and possibly transferred to the OB/MFM service if appropriate. Our policy is that a pregnant patient requiring hospitalization at any gestational age be admitted to our care, with other services functioning as consultants (please refer to the OB/ED policy).

Pager: Effective immediately, there will be an MFM pager (**38652**) that will be carried by the MFM1. Pages received by the MFM1 should be run by the MFM3. There will still be an OB1 pager, carried by the OB intern.

A1. MFM Rotation

Weekly MFM Schedule

MFM3	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Mac 6	HR OB	Mac 6	Mac 6	Educ
PM	Mac 6	Mac 6	WHC	L&D	Mac 6

MFM1	Monday	Tuesday	Wednesday	Thursday	Friday
AM wk 1,3	Mac 6	HR OB	Mac 6	Mac 6	Educ
PM wk 1,3	WHC	L&D	L&D	L&D	L&D
AM wk 2,4	Mac 6	HR OB	Mac 6	Mac 6	Educ
PM wk 2,4	WHC	L&D	L&D	L&D	L&D

B. ULTRASOUND/ANESTHESIA

(see Educational detail, Appendix C)

Weekly Rotation

US/A 1	Monday	Tuesday	Wednesday	Thursday	Friday
AM	US (2,4) Post-call (1,3)	US	US	WHC	Educ
PM	US (2,4) Post-call (1,3)	US	Pre-term	WHC	US Post-call (2,4)

INTRODUCTION TO ULTRASOUND

The program goal is to provide the residents with a graduated program incorporating elements of didactic sessions, text and primary reference material and experiential training that results in the ability to perform accurate basic obstetric and gynecologic scans of both normal and abnormal patient findings. This training is intended to serve as a foundation for performance of ultrasound in the clinical or research practice setting, but assumes that the resident will make use of available resources for continued skill and intellectual development. The resident is expected to develop and maintain a portfolio to document the performance of at least 100 gynecology scans, 200 obstetric scans, 50 early pregnancy scans, 50 BPP/AFI, 50 cervical measurements, 25(successful) amniocentesis and 25 anomaly studies by the end of the 4th year. They are also expected to present, with increasing levels of contributions, cases, review of the ultrasound findings and literature discussions at fetal board and gynecology rounds. Attendance at one or more journal clubs on Ultrasound topics is expected during the course of the 4 years.

INTRODUCTION TO ANESTHESIA SERVICES

This experience is supervised by Dr. Dave Wallace, co-program director for resident education in the department of anesthesia. This experience is designed to give each resident practical experience with difficult IV starts and basic knowledge of the indications, mechanics and complications of epidural general and spinal anesthesia. The resident will also spend time in the PACU learning optimal pain management in the immediate post-op period. Finally the rotation strengthens professional and collegial relations between two services whose close interaction is crucial for optimal patient experience in our specialty.

C. BENIGN GYNECOLOGY

(for details of Objectives, see Appendix F)

(also see REI, section E)

Weekly Benign Gyn

G1	Monday	Tuesday	Wednesday	Thursday	Friday
AM	OR	OR	WHC	OR	Educ
PM	OR	OR	WHC	OR	OR

G2	Monday	Tuesday	Wednesday	Thursday	Friday
AM	OR	OR	OR	OR	Educ
PM	WHC	OR	OR	OR	Post-call (1,3) OR (2,4)

G3	Monday	Tuesday	Wednesday	Thursday	Friday
AM	WHC	OR	OR	OR	Educ
PM	OR	OR	OR	OR	Post-call (2,4) OR (1,3)

G4	Monday	Tuesday	Wednesday	Thursday	Friday
AM	OR	OR	OR	OR	Educ
PM	OR	OR	OR	WHC	Post-call (1,3) OR (2,4)

Benign Gyn teaching rounds are held daily, Monday through Friday, at 0630 with all Gyn team members and the designated attending. This team is responsible for the care of all gyn staff patients, ED and floor consults and follow up of Beta Book patients. You are expected to have seen and written notes on all gyn staff patients prior to morning rounds. Like OB Board rounds, this is a forum for teaching as well as patient management.

The Beta Book is our Department's method of tracking patients with first trimester bleeding and for whom we are attempting to rule out the possibility of an ectopic pregnancy. The Beta Book is found on the S-drive in the Mac House folder and labeled Beta Book.

All patients with the possible diagnosis of ectopic pregnancy should be entered into this file for follow up. When you open the Beta Book you will find a form that has a place for the patient's pertinent info such as name, medical record number, date seen, initial exam, labs, etc. Please make sure that if you enter info into the file you identify yourself. Any patient placed in the Beta Book must be discussed with a chief resident at the time of entry. Rarely, other patients such as possible spontaneous abortions and molar pregnancies might be followed in the Beta Book.

The ultimate responsibility for the follow up of patients in the Beta Book is the gyn chief resident. A second or third year resident from the gyn service (assigned by the chief) will discuss every outstanding patient with the chief and make appropriate decisions concerning their care and follow up.

GYN RESIDENT RESPONSIBILITIES RE: PATHOLOGY

On gyn Friday morning rounds the gyn team (in a tumor board-esque manner) will review the pathology from the previous week's surgery. Each resident who has operated on a staff case will present the patient in a very brief way: the surgery, the pathology, and the plan for follow-up (i.e.: if the patient has an appointment). In addition, any pathology specimens obtained from performing In-house consults should be reviewed and discussed by the resident who performed the procedure.

PGYI

- Assist on all minor surgical gyn cases and some majors as needed
- Daily care of post op and inpatients (seen before morning rounds/surgery)
- Preop H&P and consent on all patients you will be operating on
- Rotate with other residents to carry GYN beeper and see consults
- See p. 50 (section XXVII) for responsibilities at Preterm

PGYII

- Daily care of post op and inpatients (seen before morning rounds/surgery)
- Pre-op H&P and consent on all patients you will be operating on
- Rotate with other residents to carry GYN beeper and see consults
- Assist on laparoscopy, major abdominal cases, some vaginal cases
- Pre-op WHC patients for minor procedures and schedule surgery

PGYIII

- Daily care of post op and inpatients (seen before morning rounds/surgery)
- Pre-op H&P and consent on all patients you will be operating on
- Rotate with other residents to carry GYN beeper and see consults
- Assist on laparoscopy, major abdominal cases, some vaginal cases
- Pre-op WHC patients for minor procedures and schedule surgery

PGYIV

- Assign resident coverage of scheduled cases daily
- Assist on difficult cases, vaginal cases
- Cover consults to GYN beeper
- Prepare weekly topics for morning rounds
- Pre-op and post-op patients in clinic during weekly scheduled session (Friday PM)
- Communicate with GYN attending of the week on all consults/admissions
- Review and make sure appropriate follow up is occurring for all Beta and Gyn book patients

In the fourth year, the resident will assume a leadership role on the service. They will refine their management of the above learning objectives and address any weaknesses. They will be expected to teach the junior residents and medical students as a mechanism of review and solidification of this knowledge base.

D. ONCOLOGY

(For detail of Objectives, See Appendix D)

Weekly Oncology Rotation

Onco 2	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Onco	Onco	Onco	Onco	Educ
PM	Onco	Onco	WHC	Onco	Onco

Onco 3	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Onco	Onco	Onco	Onco	Educ
PM	Onco	Onco	Onco	Onco	WHC

PGY2

- H&P for scheduled OR cases / inpatient admissions
- Assist in OR on all cases
- Daily morning pre-rounds on inpatients
- Daily team rounds with attending
- Equal share of weekend/holiday rounds with ONCO attending
- Review tumor board patients, know staging and treatment in advance

PGY3

- Daily morning pre-rounds on inpatients
- Assist in evaluation and admission of chemotherapy, inpatients
- Daily team rounds with attending
- Primary assistant in OR on all cases
- Prepare cases for weekly tumor board conference
- Supervise PGY2 in managing inpatients
- Equal share of weekend/holiday rounds with ONCO attending
- Communicate with ONCO attending on all admissions, inpatient complications

The onco residents will take call on alternating weekends. The weekend call will consist of Friday night and Sunday 8am to 7pm "beeper call".

GUIDELINES FOR PREPARATION OF GYN ONCOLOGY TUMOR BOARD

The third year on the Gyn Onc service is responsible for preparing the case descriptions for the Friday Gyn Onc tumor board.

If the third year is rotating off the service, he or she is still responsible for preparing the tumor board for cases done during the Third year's last week on service, even though the Third year will not present to present these cases at the tumor board.

With rare exception, **the deadline for cases to be added to tumor board case list is the Friday before tumor board.** Exceptions to this rule will be considered on a case by case basis.

It is assumed the Third year will budget time accordingly to get the case descriptions completed by the deadline. Sufficient time to prepare the case descriptions is available to the Third year on the Friday, Saturday, Sunday and Monday prior to tumor board.

The case list for the tumor board is to be provided to the Divisional secretary by the end of the day on Monday before tumor board. If Monday is a holiday, the case will be given to the secretary before noon on Tuesday. This includes cases for pathology review, review of outside slides, and therapy discussion.

The completed case descriptions will be provided to the Divisional secretary by the end of the day on the Tuesday before tumor board.

The Third year will get the list of cases for tumor board from the list in the Gyn Oncology Coordinator's office, as well as from personal communication from the Gyn Oncology attendings. All known new cases of gynecologic malignancy are to be presented. If the Third year is aware of a gynecology malignancy that is not on the coordinator's list, it should be added to the coordinator office list and put on the tumor board. This situation often occurs when biopsies or surgeries are performed by other faculty or residents on patients who have not yet been seen by one of the gynecologic oncology attendings.

The Third year does not need to contact the pathology office about the tumor board list. The Third year can check to see if a final pathology result is available prior to submitting the case list to the Divisional secretary. If a result is benign, the case may be removed or not added to the list, provided the Attending for this case is aware that the Resident thinks the case may not need to be presented. The Attending often will wish a case discussed even if the pathology is benign. Assume that a case will be presented if the final pathology report is not completed by the time the tumor board list is prepared.

For Outside Slide cases, the Third year should confirm with the Coordinators office that the slides have been received and submitted to pathology for review. Keep these cases on the tumor board list even if a final pathology report is not available by the time the list is submitted.

Charts for the tumor board patients are to be kept in the Third years' area or the Coordinator's office, unless the patient is being seen in clinic that day. By the end of the day on Thursday before tumor board, the Third year should check to make sure all the charts are ready to be brought to tumor board the following morning.

On Fridays, both residents are expected to attend Grand Rounds. Following this they will attend Tumor Board. As soon as Tumor Board is completed, they will both attend the remaining resident education sessions scheduled on Mac 7. They will not be available during this time to take floor calls or see patients on the onco service. Coverage during protected resident education time will be provided by the oncology faculty and fellow.

**** This on-line training needs to be completed before you will be permitted to assist on robotic cases.

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- View and upload clinical images and \bar{t} videos
- Comment on images and videos posted by colleagues
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- Start your own private discussion group
- Easily create and maintain your own da Vinci surgery blog
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How To Get Started

Just go to www.daVinciSurgeryCommunity.com and sign up for a free membership. It only takes a minute to create your member profile and get access.

If at any time you have questions about the community, just email us at community@intusurg.com, and we'll be happy to help.

How to Access Training Materials

Open Customer Resources Folder



Open Training Materials Folder



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Discuss



Learn



Share



Contact

We look forward to seeing you online!

E. REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY

(for detailed educational objectives, see Appendix E)

- Daily clinic sessions with REI attending (/UH Westlake /Landerbrook)
- Vaginal probe ultrasound at MacDonald Imaging & with REI attending
- Attend egg retrieval and embryo transfer sessions in IVF lab
- Attend daily chart reviews
- Perform hysterosalpingograms in radiology weekly with Drs. Hurd & Liu
- Pre-op H&P on patients you will be operating on
- Operate with REI attending on all scheduled OR cases
- Bring purple clinic charts to OR for all scheduled cases
- Weekly clinical topic discussion session with Dr. Hurd & Fellow
- Weekly Resident Research discussion session with Dr. Hurd & Fellow

Reproductive Endocrinology and Infertility requires a thorough knowledge of conditions that involve the normal and abnormal physiology of human reproduction. As our understanding this field expands, strong connections have arisen between genetic disorders and abnormalities in reproduction, which will be emphasized in our curriculum. Although residents in Obstetrics and Gynecology are not expected to master the actual assisted reproductive techniques, knowledge of the scientific basis for the procedure including ovulation induction, surgical techniques, gamete development and embryology, and embryo implantation are imperative.

Therefore, this rotation is designed to expose the resident in obstetrics and gynecology to the basic and clinical science knowledge behind the hypothalamic pituitary ovarian and testicular axis, endocrinological derangements that would lead to disease, human normal and abnormal development, and reproductive development and assisted reproductive technology. Special emphasis will be placed on diagnosis and treatment of infertility, polycystic ovary syndrome, recurrent pregnancy loss, and abnormal uterine bleeding.

The REI experience is composed of two 5-6 week rotations during the PGY-2 year. The resident will work with 3 REI faculty members and the first year REI Fellow daily as they diagnosis, evaluation and treatment private patients in the Reproductive Endocrinology and Infertility Clinic. In addition, they will manage service patients with the Fellow who are referred to the Fellow/Resident clinic for REI problems. Residents participate in operative cases and ART procedures throughout the week. REI faculty members supervise all clinical REI activities in the office, operating room, clinic, and ward, and are available for consultation 24-hours per day, 7 days per week.

There will be multiple didactic sessions during the rotation. A weekly conference staffed by Dr. Hurd where cases are discussed and currently literature is evaluated. A second weekly conference will focus on identifying and developing an OB/GYN research project required for every resident. Monthly, a REI lecture is given during the Friday morning Resident core curriculum which covers the most important REI topics, using a major REI textbook as a basic reference.

F. Female Pelvic Medicine and Reconstructive Surgery

(for detailed educational objectives, see Appendix G)

Weekly UroGynecology Rotation

(First half of year 6/29-12/27/09)

UG 3	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Westlake (am)	OR	Mac 1200	OR	Educ
PM	WHC	OR	Mac 1200	OR	Post-call

(Second half of year 12/28-6/27/10)

UG 4	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Westlake (1,3) Post-call (2,4)	OR	Mac 1200	OR	Educ
PM	WHC (1,3) Post-call (2,4)	OR	WHC (2,4) Mac 1200 (1,3)	OR	Landerbrook (2,4) OR (1,3)

- Pre-operative review of charts and preparation of H&P for scheduled cases for the following week
- All H&Ps for upcoming week to be formally reviewed with the attending the week prior to surgery
- Pre-operative preparation for OR cases, including review of relevant anatomy and the planned procedure
- Assist in all FPMRS OR cases scheduled on Tuesdays
- Complete AM rounds on all admitted FPMRS patients
- Attend Wednesday AM and PM office hours (UHC clinic)
- Assist in all urodynamic testing and cystoscopies procedures performed in Wed AM clinic
- Participate in Wednesday PM clinic session with FPMRS attending
- Weekly chapter review with FPMRS attending

Disorders of the pelvic floor affect up to 1 in every 3 women in the United States. An understanding of the etiology, evaluation and treatment of these disorders is essential for physicians caring for female patients. No matter what area or specialty of Obstetrics and Gynecology residents may enter, a thorough understanding of pelvic floor anatomy and disorders is essential to their education.

This rotation will seek to give residents the basic skills and knowledge to evaluate and treatment a variety of pelvic floor disorders. Basic pelvic anatomy will be reviewed in detail. Residents will become familiar with the evaluation and treatments of incontinence and pelvic organ prolapse. In addition, residents will have the opportunity to obtain the basic surgical skills to perform in-office/intra-operative cystoscopy, transvaginal and transabdominal vaginal suspensions and basic urinary incontinence procedures.

G. Weekly Elective/Research Rotation

ER 3	Monday	Tuesday	Wednesday	Thursday	Friday
AM	E/R	L&D (am)	E/R	E/R	Educ
PM	E/R	E/R	E/R	E/R	E/R

ER 4	Monday	Tuesday	Wednesday	Thursday	Friday
AM	E/R (1,3)	L&D (am)	E/R	E/R	Educ
PM	Post-call (2,4)	E/R	E/R	E/R	E/R

These rotations are designed to allow a more individualized approach to resident education. Examples of past rotations include:

- Chagrin Breast Center
- Medical Spanish
- Adolescent gynecology
- Ultrasound
- Bench research
- Away rotation to enhance fellowship applications

You must meet with the Program Director prior to your elective research rotation and present a detailed written outline of your anticipated rotation. Your proposal requires the approval of the Program Director. If you are interested in the away rotation, it also must be approved by Dr. Shuck (DIO UHCMC) in the GME office and Dr. Levitan (Chief Medical Officer). Away rotations are strictly limited to four weeks and require you to trade any assigned weekend call.

XXIV. MEDICAL STUDENTS

University Hospitals is the major teaching affiliate of Case Western Reserve University. CWRU medical students rotate on OB/GYN year round. As a resident, you will play a critical role in their education. Occasionally, you may be the mentor who turns them on to Ob/Gyn as a career choice. Take this responsibility seriously. Teach the students about our field and encourage them to participate in all aspects of patient care.

- Medical students may write H&Ps, progress notes, delivery notes, etc. on patients; however, these notes are for their own education only. **THEY DO NOT REPLACE RESIDENT NOTES.** Regardless of anything written by a medical student a complete H&P, progress note, delivery note, etc. must be written in the chart by a resident.
- Residents may not co-sign medical student notes.
- Medical students may interview triage patients on L&D; however, a resident must complete the written and/or computerized medical record.
- Medical students may not conduct a gynecologic exam without a resident present.
- Medical students may not do deliveries without a resident gowned and gloved with them
- Medical students must be freed from all clinical responsibilities to attend scheduled conferences and preceptor assignments.
- Medical students should not be asked to call consults to other services.
- The Chief Resident/senior on each service assigned a medical student should clearly review with them expectations and goals of their participation in that service.
- Give students feedback at EVERY opportunity.

XXV. RESIDENT RESPONSIBILITY: ACGME DATA AND MEDICAL RECORDS

The ACGME requires all residency programs to provide a minimum number of Ambulatory Care, Obstetrical and Gynecologic cases in order to continue accreditation. This record keeping is not really about you; it is about our program. **DO NOT WASTE ONE SECOND OF YOUR ENERGY THINKING ABOUT ITS COMPLETE IRRELEVANCE TO YOUR BUSY SCHEDULE. JUST RECORD THE DATA. PERIOD. NO EXCUSES.**

When reporting surgical procedures, the RRC recognizes two categories of involvement; one is the Surgeon and the other is the Surgical Assistant. These definitions are fairly straightforward. The surgeon on the case is the resident that works up the patient, writes the orders, discusses the care with the attending physician and performs more than 50% of the surgical procedure. In addition, it is the resident who performs the bulk of the postoperative care under faculty supervision. The surgical assistant then, is the resident who serves as first assistant at the surgery and performs less than 50% of the surgical procedure.

IT IS ENTIRELY YOUR RESPONSIBILITY TO KEEP YOUR DATABASE UP TO DATE AND ACCURATE. Insufficient numbers can threaten our accreditation status. Insufficient numbers that are inaccurate will also cause the Program Director to threaten your livelihood!

Timely completion of all medical records in addition to the ACGME data base, is your professional responsibility. When you graduate and apply for hospital privileges, it is almost universally asked of the Program Director whether you had any issues with medical record completion as a resident. Please remember the Program Director will not hesitate to answer this question with complete honesty. The answer may affect whether you are granted or denied hospital privileges. Here are the guidelines:

- All written medical records must be complete, accurate and legible.
- If you do not document a patient encounter (e.g. called to see a patient for a fever work-up) then it did not happen.
- Medical student notes are NOT a part of the medical record. No matter how well done they are, they have no legal standing. You cannot countersign any medical student note to replace your own. You must document the chart as if the medical student's note was not written.
- All operative dictations must be done within 24 hours of the procedure. The attending should make clear at the end of the case who is responsible for the dictation. If you are not certain, ask. (see Format, Appendix I).
- All discharge dictations must be done within 24 hours of discharge (see Format, Appendix I). If you write the discharge note, you do the dictation.
- The best way to deal with medical records is to stop by once per week. If you do so, you will never be delinquent. If you will be away from the hospital (vacation, FMLA, away rotation), notify medical records and the time away will not be counted against you.

XXVII. DEPARTMENT POLICY ON PREGNANCY TERMINATION

MacDonald Women's Hospital supports the ethical principle of respect for autonomy as applicable not only to patients and their families, but also to practitioners. In keeping with that principle, no practitioner is required to perform an abortion if this is in opposition to his or her moral convictions. However, the participation by physicians in the ongoing care of abortion patients is an integral part of our commitment to patient care. While allowing for differences in viewpoints on abortion, our Hospital is committed to providing access to abortions for those who need the safety of our hospital for the elective/medical termination of their pregnancies.

A physician is not required either to initiate or to continue an abortion, but all caregivers are obligated to address patient needs that arise in the course of, or following the procedure.

Patients should be offered counseling from Social Work or the Division of Behavioral Medicine on their request and recommended if any of the following conditions are present:

- Extreme ambivalence
- Very young or older patient
- Prior infertility, fetal or pregnancy loss
- Partner or parent (if a minor) who differ from patient in request
- Rape/incest
- Incompetent patient

The ultrasound/anesthesia intern spends every Wednesday afternoon at Preterm. Preterm is Ohio's largest provider of outpatient abortion services. Residents actively participate in patient counseling, vaginal probe US for dating and 1st trimester termination options (medical and surgical).

The rotation is supervised by Dr. David Burkons, Preterm's Medical Director and a longtime enthusiastic educator.

XXVIII. GRIEVANCE PROCEDURE

GRIEVANCE PROCEDURE FOR CORRECTIVE ACTIONS OTHER THAN TERMINATION

1. For specific policies regarding appeal rights and procedures for termination refer to the UHHS/University Hospitals of Cleveland Residents & Fellows Manual.
2. If a resident has a grievance related to her/his training program or has been subject to any Corrective Action other than termination, the resident should first attempt to resolve the matter informally by consulting with the following people in the sequence as written: Chief Resident on Service, Executive Chief Resident, Program Director, and/or Division Chief/Chairman.

If the resident is unable to resolve the matter informally or wishes to grieve a Corrective Action other than termination, she/he should present her/his grievance in writing to the Director of GME (DIO) within 10 (ten) working days of the date the matter arose or recommendation for Corrective Action other than termination was made. If the grievance remains unresolved at the DIO level, the resident may appeal to the Chief Medical Officer and/or the Senior Vice President of Human Resources.

3. Although these formal policies are there for you, both the Program Director and the Department Chair reiterate their belief in an open door policy. In addition, the Program Director and the Chair fully appreciate just how difficult any residency can be. They encourage, by either self-report or in a collegial fashion, an open discussion of resident stress or dissatisfaction. Finally, there are two psychologists on faculty, whose officers are readily available and whose door is always open to help our residents if asked.

XXIX. UNIVERSITY HOSPITALS – CASE WESTERN RESERVE AFFILIATION

1. How do I get my Case Western Reserve Identification card?

Go to Access Services on the lower level of the Crawford building on the corner of Euclid Avenue and Martin Luther King Blvd. between the hours of 8:30 am and 5:00 pm on Monday, Wednesday, Thursday and Friday or Tuesday from 8:30 am – 6:00 pm. You must bring a government issued photo id such as valid driver's license, state id, or passport. If you lose your Case ID you will be charged \$15 for a new ID. If you have questions, you can call access services at 369-CARD.

2. What if I already have a Case Western Reserve Identification Card?

You must bring your old ID and return it to Access Service to get a new ID. If you lost your old ID you will be charged \$15 for the new ID. (So all you Case grads who kept your Med Student ID bring that ID with you or you will be charged \$15).

3. How do I get a Case e-mail account?

In order to access e-mail you need to first get a Case Network User ID and password. Your Network user ID is your key to accessing various centralized services that are and will be made available via the Case Network. Your user ID will be formed by the first initial followed by an x and your last initial all in lower case letters. So, if your name is Joe Resident, your user id is jxr. Your e-mail address is first name.lastname@case.edu or your network ID@case.edu. Either address will work.

Connect to the Internet, and use a World Wide Web browser such as Explorer or Netscape, go to the User ID Registration Page at:

<http://its-services.cwru.edu/middleware/NetworkTools/userReg.html>

Choose “start the registration.” Read the instructions provided and complete the online form, using your first name, x and last (family name). Note that in most cases, your Case id number is the same as your nine digit Social Security Number. Your password must be at least 8 characters, must contain at least one capital letter, and should NOT be based on a dictionary word. Press continue to apply. If successful, you will see a flag and “Success!” and will be provided with your Case Network ID. Once activated, please allow 24 hours for it to be fully active.

Note: If you receive an error, “The information does not match the database”, please contact Will Rebello, Manager of the GME office at x43887.

4. How do I access my e-mail?

You can access your e-mail through Webmail and/or at home using e-mail software. Webmail can be used on any computer with internet access at the address of the website, <http://mail.case.edu/> or <http://mail.cwru.edu> . If you have a e-mail software at home (i.e. Outlook, Outlook Express, Eudora, etc...) then you can set up your computer to receive e-mail by going to the Account setup menu for your software and filling in the following information:

POP3:pop3.case.edu

SMTP: smtp.case.edu

If you need more assistance, consult the IT services Help Desk page at <http://help.case.edu/email/check/view>

5. What is VPN and what do I use it for?

VPN stands for virtual private networking and it creates a connection between your internet service provider (ISP) and the Case intranet. This allows you to use services that are restricted for use on the Case campus, such as online journals and other library services. Once you have VPN access (see below) you just have to connect to the internet using your ISP and then launch VPN and then you can use these services as if you were sitting in a terminal in the library.

6. How do I get Case VPN access?

Once your Case account is active (see question #3), you can then proceed to set up the VPN access.

Connect to the Internet, using a World Wide Web browser such as Explorer or Netscape and go to the following page:

<http://help.case.edu/connect/vpn/>

Under tools, choose the option “Setting up VPN for Windows”, this will guide you thru setting up the VPN connection. The website also has several other sites to help you with the process. (VPN is also available for Macintosh, Linus and Solaris)

7. What is my title at Case Western Reserve?

Affiliate privileges and your title is Resident. Your library record is defined as a staff record. In general, each library at Case will have information.

8. When do these privileges start and when do they expire?

These privileges start from whenever you receive your ‘Welcome to Case letter’ and expire upon graduation from residency or fellowship. When the new interns arrive in July, their privileges will start with intern orientation.

9. What about discounts on tuition and computer software?

Currently, housestaff will not get any tuition discounts – only Case faculty are eligible for tuition discounts. Similarly, housestaff are not eligible to download institution licensed software from the Case website.

10. What are the hours of the Veale Center (Gymnasium)?

Mon-Fri 7:30 – 10:30PM; Sat 10:30AM-4:00PM; Sun 1:00PM-10:00PM during the regular semesters. During the summer semester, the hours are 8:00AM-8:00PM.

11. What facilities are available at the Veale Center?

There are racquetball, squash, and basketball courts. A weight room with both machines and free weights. A cardio room with treadmills, elliptical machines and exercise bikes. A swimming pool with open swim on weekdays from 7:30AM-9:00AM; 11:00AM-2:00PM; 4:00PM-6:00PM and the weekend from 2:00PM-4:00PM. Classes are not open to residents at this time.

12. What if my spouse wants to exercise at the Veale Center?

\$135 is the fee each academic year for your spouse to get a card that will grant her/him privileges at the Veale Recreation Center. Classes are not open to resident's spouses.

13. Do I get a discount at the bookstore?

At this time, housestaff do not get a discount at the University Book Store.

14. What privileges do I have at Case libraries?

You will have the same borrowing privileges that Case staff do at the Case libraries. The Case ID card you will receive is used as your library card so be sure to bring it with you if you want to borrow material from the library. Most material can be borrowed for 4 weeks and they may be renewed once for an additional 4 weeks. If you need the material longer you must return to the library with the material to have it checked in and back out to you if there are no holds on the item. The various libraries have different policies regarding printing, etc. so you will need to check with the library for that information.

Health Center Library: <http://www.case.edu/chsl/hc.htm>

Allen Memorial Medical Library: <http://www.case.edu/chsl/allen/htm>

Kelvin Smith Library: <http://library.case.edu/ksl/index.html>

MSASS (Mandel School of Applied Social Sciences) Harris Library: <http://msass.cwru.edu/library/>

Law Library: http://www.law.case.edu/tech_library/index.asp

Kulas Music Library: <http://library.case.edu/kal/kulas/>

Astronomy Library: <http://library.case.edu/ksl/astronomy/>

All patrons using the electronic resources available to them must abide by the acceptable use policy for that resource. These resources are purchased or leased with a license agreement and we must all follow the terms of that license for continued access.

The Cleveland Health Science Library (comprised of the Health Center Library and the Allen Memorial Medical Library) has a wealth of information that you can use to locate useful resources. This website is one that I would recommend you keep in your bookmarks or favorites list: <http://www.case.edu/chsl/homepage.htm>

Some specific pages that are excellent starting points include:

<http://www.case.edu/chsl/catalogs.htm>

electronic journals: <http://www.case.edu/chsl/ejournal.htm>

electronic books: <http://www.case.edu/chsl/ebook.htm>

Once you have a record in the EuclidPLUS system you will be able to borrow materials from the Case libraries as well as through the OhioLINK system. You may begin this process either from the EuclidPLUS catalog (<http://catalog.case.edu/>) or from the OhioLINK catalog (<http://olc1.ohiolink.edu/search/>). If you want to borrow an item that is not available in any of the Case libraries, you may select REQUEST THIS ITEM to have the item be sent here. When the system asks which institution you are affiliated with you must select CWRU. When you enter your ssn in the form (this is a secure page and the information is secured, so you do not need to be concerned at entering this) be sure to enter the dashes in it (123-45-6789) or the system will be unable to match you up with a valid record in the Euclid PLUS system and it will not allow you to borrow the material. You may select any of the Case branches as the location where you will pick up the item when it is delivered. You will receive an email from the system informing you that the item you requested is available for you. An additional feature available through Ohio LINK is the ability to request material and have it sent to another school within the state. This can be especially helpful when you are traveling within Ohio. You will need to work with a library staff member to get the request entered in the system.

XXX. CURRENT RESIDENTS

<u>NAME</u>	<u>MEDICAL SCHOOL</u>
PGY4	
Bedaiwy, Mohamed	Assuit School of Medicine
Ehrenberg, Stacey	Medical University of Ohio
*Flyckt, Rebecca	Stanford University
Sandadi, Samith	University of Miami
PGY3	
Escobedo, Joel	University of Michigan
Lazo, Marcela	University of Miami
Loomis, Kristina	University of Cincinnati
Quirino, Wendy	University of Miami
Velotta, Jennifer	Medical University of Ohio
PGY2	
Billow, Megan	Ohio University
Prinz, Deborah	University of Toledo
Deter, Stephanie	University of Texas, San Antonio
Rodewald, Katherine	University of Toledo
Ye, Peggy	Case Western Reserve University
PGY1	
James, Becky	Texas A&M
Miketa, Allison	University of Toledo
Petitt, Amy	University of Cincinnati
Wiley, Lena	Wright State University
Yeater, Alene	University of Toledo

*Executive Chief Resident

XXXI. FACULTY

FULLTIME

General Gynecology and Obstetrics

Karen Ashby, MD
Corinne Bazella, M.D.
Nancy Cossler, MD
Angelina Gangestad, MD
Marjorie Greenfield, MD
Susan Lasch, MD
Tia Melton, MD
Lisa Perriera, MD
Jay Pinkerton, MD
Martin Wieczorek, MD

Maternal-Fetal Medicine

Helene Bernstein, M.D.
Jane Corteville, M.D.
Michael Gyves, MD (covers L&D only)
Nancy Judge, MD
Noam Lazebnik, MD
Carol Lindsay, M.D.
George Van Buren, MD

Reproductive Endocrinology

William Hurd, M.D.
James Liu, MD
Stacy Weil, MD

Gynecological Oncology

Robert Debernardo, MD
Vivian von Gruenigen, MD
Steven Waggoner, MD
Kristine Zanotti, MD

Female Pelvic Medicine & Reconstruction

Sangeeta Mahajan, MD

Behavioral Medicine

Jeffrey Janata, PhD
Sheryl Kingsberg, PhD

Research

Neal Rote, PhD
Sam Mesiano, PhD

PART-TIME

Sandra Bellin, MD
David Burkons, MD
Mark Chapman, MD
Laura David, MD

Judith Evans, MD
Reza Ghayuri, MD
Mary Francis Haerr, MD
Karen Jaffe, MD
Thomas Janicki, MD
Steven Klein, MD
Deborah Gerson-Levitan, MD
Kathleen Neal, M.D.
Mitchell Reider, MD
Daniel Rzepka, MD
Sherilyn Sage, MD
Joseph Shawi, MD
Maurice Soremekun, MD
Marc Snelson, MD
Janette Stephenson, MD
Sandhia Varyani, MD
David Vexler, MD
Margie Wenz, MD

Revised 7/21/09

XXXII APPENDIX A

UNIVERSITY MACDONALD WOMEN'S HOSPITAL
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Resident Evaluation of Department Rotation

Resident Name: _____ PGY LEVEL: _____

Rotation: _____

Rotation Dates: _____ Evaluation Date: _____

Please evaluate your rotation using the following scale:

1 = Poor/Non Existent 2 = Fair 3 = Satisfactory 4 = Very Good 5 = Outstanding

Adequate clinical load to meet goals and objectives	
Adequate amount of teaching on this rotation	
Quality of teaching	
Relationship of teaching to goals and objectives	
Faculty believed that my education is important	
Faculty respectful and courteous	
Relief from clinical responsibilities to attend relevant teaching sessions	
Allowed responsibility to exercise judgment commensurate with level	
Given helpful/constructive criticism	
Overall quality of rotation	
Overall quality of teaching	

Additional Comments: Please provide comments positive or negative

EVALUATION OF A JUNIOR RESIDENT BY A SENIOR RESIDENT

Resident: _____

Evaluation Period: _____

EXPECTATIONS

PLEASE MARK THE NUMBER WHICH MOST CLEARLY REFLECTS YOUR ASSESSMENT OF THE JUNIOR RESIDENT'S SKILL LEVEL IN EACH OF THE FOLLOWING AREAS:	BELOW EXPECTATIONS 1	AT EXPECTATIONS 2	ABOVE EXPECTATIONS 3	UNABLE TO COMMENT
The Junior Resident.....				
▪ Successfully completes an assigned task				
▪ Is efficient in triage or on the floor				
▪ Presents patients well				
▪ Takes initiative				
▪ Constructs an appropriate differential diagnosis				
▪ Communicates effectively				
▪ Works well with colleagues (nurses, students and other residents)				
▪ Accepts constructive criticism				
▪ Takes time to teach medical students				

COMMENTS:

SIGNED: _____

PRINTED NAME: _____

EVALUATION OF A SENIOR RESIDENT BY A JUNIOR RESIDENT

Resident:

Evaluation Period:

Rotation:

EXPECTATIONS

PLEASE MARK THE NUMBER WHICH MOST CLEARLY REFLECTS YOUR ASSESSMENT OF THE SENIOR RESIDENT'S SKILL LEVEL IN EACH OF THE FOLLOWING AREAS:	BELOW EXPECTATIONS 1	AT EXPECTATIONS 2	ABOVE EXPECTATIONS 3	UNABLE TO COMMENT
The Senior Resident.....				
▪ Is available to provide clinical support and advice				
▪ Is willing to roll up his/her sleeves and help				
▪ Demonstrates leadership				
▪ Provides me with constructive feedback				
▪ Refers to the literature in teaching rounds				
▪ Is effective in leading teaching rounds				
▪ Is an effective communicator				

COMMENTS:

SIGNED: _____

PRINTED NAME: _____

EVALUATION OF ATTENDING PHYSICIAN

Attending Physician: _____

Evaluator PGY Level _____

Month/Year: _____

For each of the following criteria, please rate (x) the attending physician for the time period noted.

	Marginal	Satisfactory	Very Good	Excellent	N/A
Availability					
• Was usually prompt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Spent enough time on rounds, was unhurried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					

	Marginal	Satisfactory	Very Good	Excellent	N/A
Teaching					
• Asked questions in non-threatening way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Emphasized problem-solving (thought processes Leading to decisions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Integrated social/ethical aspects of medicine cost Containment, pain control, patient management, Humanism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Stimulated team members to read, research and Review pertinent topics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					

	Marginal	Satisfactory	Very Good	Excellent	N/A
Professionalism and Humanistic Patient Care					
• Displayed sensitive, caring, respectful attitude Towards patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Showed respect for physicians in other specialties/ Subspecialties and health care professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Served as a role model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Recognized own limitations; was appropriately Self critical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					

	Marginal	Satisfactory	Very Good	Excellent	N/A
Fund of Fund of Knowledge/Continuing Scholarship					
• Demonstrated broad knowledge of medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was up-to-date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Discussed Evidence-based medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					

	Marginal	Satisfactory	Very Good	Excellent	N/A
Organization					
• Provided useful feedback including constructive Criticism to team members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					

Suggestions for improvement in this faculty member's performance: _____

RESIDENT SURGICAL EVALUATION

Resident: _____ Procedure: _____ Date: _____ Attending: _____

Please circle the number corresponding to the resident's performance in each category, IRRESPECTIVE OF TRAINING LEVEL. (Please comment liberally on any score. Comments REQUIRED for score of 1)

Indication/Pre-op work up:

N/A	1-----2-----3-----4-----5		
	Not familiar w/ patient or indication for procedure	Met patient, aware of indication, complication And differential diagnosis	Complete knowledge of patient, procedure, differential diagnosis, risks, benefits & alternatives of surgery

Knowledge of Specific Procedure:

N/A	1-----2-----3-----4-----5		
	Deficient knowledge. Needed specific instruction at most steps	Knew all important steps of operation	Demonstrated familiarity with all aspects of operation

Anatomy:

N/A	1-----2-----3-----4-----5		
	Not familiar w/ basic structures	Can identify most structures	Able to identify all visible structures and develop plan to identify or protect structures not readily visible

Respect for tissue:

N/A	1-----2-----3-----4-----5		
	Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments	Careful handling of tissue but occasionally caused inadvertent damage	Consistently handled tissues appropriately with minimal damage

Time and Motion/Flow of Operation:

N/A	1-----2-----3-----4-----5		
	Many unnecessary moves. Frequently stopped operating and seemed unsure of next move	Efficient time/motion but some unnecessary. Demonstrated some forward planning w/ reasonable progression of procedure	Clear economy of movement and maximum efficiency. Obviously planned course of operation w/ effortless flow from one move to the next

Instrument Handling/Knowledge of Instrument:

N/A	1-----2-----3-----4-----5		
	Repeatedly makes tentative or awkward moves with instruments by inappropriate use of instruments. Frequently asked for wrong instrument or used inappropriate instrument.	Competent use of instruments but occasionally appeared still or awkward. Knew names of most instruments and used appropriate instrument.	Fluid moves with instruments no awkwardness. Obviously familiar with the instruments and their names

Use of Assistants:

N/A	1-----2-----3-----4-----5		
	Consistently placed assistants Poorly or failed to use assistants	Appropriate use of assistants most of the time	Strategically used assistants to the best advantage at all

My-Evals Faculty Evaluation of Resident

Core Competencies

Interpersonal and Communication Skills

Does not established even minimally effective therapeutic relationships with patients and families: does not demonstrate ability to build relationships through listening, narrative or nonverbal skills; does not provide education or counseling to patients, families, or colleagues.

Establishes a highly effective therapeutic relationship with patient and families; demonstrates excellent relationship building through listening, narrative and nonverbal skills; excellent education and counseling of patients, families, and colleagues; always “interpersonally” engaged.

Medical Knowledge

Limited knowledge of basic and clinical sciences; minimal interest in learning; does not understand complex relations, mechanisms of disease.

Exceptional knowledge of basic and clinical sciences; highly resourceful development of knowledge

Patient Care

Clinical Skills:

Incomplete/inadequate medical interviews and physician exams; incomplete treatment plans; fails to analyze clinical data/scientific evidence and patient preference when making medical decision; poor judgment.

Supurb, accurate, comprehensive, medical interviews and physical exams; complete/appropriate treatment plans based on synthesis of clinical data, available scientific evidence and patient preference; good judgment

Surgical Skills:

Tentative, lacks confidence; inappropriately overestimates surgical ability; clumsy; requires constant supervision/direction; cannot manage post-operative complications.

Appropriately confident and self-assured; few wasted steps; needs limited supervision/direction; adapts appropriately to intra-operative conditions; capable of managing post-operative complications.

Practice-Based Learning and Improvement

Fails to perform self-evaluation; lacks insight, initiative; resists or ignores feedback; fails to use information technology to enhance patient care or pursue self-improvement.

Constantly evaluates own performance, incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self-improvement

Professionalism

Lacks respect, compassion, integrity, honesty; disregards need for self-assessment; fails to acknowledge errors; does not consider needs of patients, families, colleagues; does not display responsible behavior.

Always demonstrates respect, compassion, integrity, honesty; teaches/role models responsible behavior; total commitment to self-assessment; willingly acknowledges errors; always considers needs of patients, families, colleagues.

System-Based Practices

Unable to access/mobilize outside resources; actively resists efforts to improve systems of care; does not use systematic approaches to reduce error and improve patient care.

Effectively accesses/utilizes outside resources; effectively uses systematic approaches to reduce errors and improve patient care; enthusiastically assists in developing systems improvement.

Secondary Competencies**Chart Audits/Medical Record Review**

Handwriting is not legible and pager number is not included.

Handwriting is always legible with signature and pager number included.

Evaluation Scale

Performance not appropriate for level (remediate) 1	Performance below average for level (feedback) 2	Performance appropriate for level of training 3	Performance above expected for level of training 4
Performance exceptional, in top 5-10% of class 5	No Interaction		

Resident Self Assessment and Reflection

Evaluation Period

Name: _____

PGY: _____

Identify 3 of your strengths:

Identify 3 deficiencies/limits in your knowledge or expertise:

Identify 3 Learning and Improvement Goals:
(State activities you will pursue to achieve your goals:)

Summary of Graduates' Comments Regarding the
OB/GYN Residency Training Program

1. Didactic activities were:

_____ Excellent _____ Good _____ Poor

2. Didactic activities would be improved by:

3. One-on-one mentoring and support for learning and professional growth was:

_____ Excellent _____ Good _____ Poor

Comments:

4. Resident Support from faculty would be improved by:

5. Educational goals were clear and I knew when I had attained them:

_____ Very true _____ True _____ Not true at all

6. Clinical experience and opportunity to acquire skills in general obstetrics was:

_____ Too much _____ Just Right _____ Too little

7. Clinical experience and opportunity to acquire skills in general surgical gynecology was:

_____ Too much _____ Just Right _____ Too little

8. Clinical experience and opportunity to acquire skills in general office gynecology was:

_____ Too much _____ Just Right _____ Too little

Comments:

9. Clinical experience and opportunity to acquire skills in high risk obstetrics was:

_____ Too much _____ Just Right _____ Too little

10. Clinical experience and opportunity to acquire skills in Reproductive
Endocrinology was:

_____ Too much _____ Just Right _____ Too little

11. Clinical experience and opportunity to acquire skills in gynecologic oncology was:

_____ Too much _____ Just Right _____ Too little

12. Clinical experience and opportunity to acquire skills in practice management was:

_____ Too much _____ Just Right _____ Too little

13. The three things I would have like to have done differently during my residency are:

14. Additional comments are welcome:

UNIVERSITY MACDONALD WOMEN'S HOSPITAL
OB-GYN MEDICAL STUDENT CLERKSHIP
FACULTY AND RESIDENT EVALUATION FORM

FACULTY/RESIDENT:

DATE:

INDICATE YOUR EVALUATION BY PLACING A NUMERICAL RATING IN THE BOX NEXT TO EACH CATEGORY

POOR 1 _____ 5 OUTSTANDING
N/O – NOT OBSERVED

COMMENTS ARE INVALUABLE. WE REALLY APPRECIATE THE FEEDBACK

1. LECTURE SKILLS: ORGANIZATION / CLARITY
i.e. Content is appropriate for students' level of knowledge; Communicates what is expected to be learned;
Provides an appropriate mixture of didactic presentation and discussion
COMMENTS: _____

2. GROUP INSTRUCTIONAL SKILLS (Rounds)
i.e. Encourages active participation; Demonstrates respect for and interest in students; Questions in a non-
threatening manner; Establishes rapport
COMMENTS: _____

3. KNOWLEDGE
i.e. Discusses current developments in OB-GYN; Demonstrates broad base of medical knowledge;
Shares knowledge that is both scholarly and pragmatic; Discusses divergent points of view
COMMENTS: _____

4. ENTHUSIASM / STIMULATION
i.e. Stimulates desire for learning; Is enthusiastic, appears to enjoy teaching; Stimulates interest in OB-GYN;
Has interesting style of teaching
COMMENTS: _____

5. CLINICAL SUPERVISION
i.e. Identifies strengths and weaknesses objectively; Allows an appropriate degree of autonomy;
Is empathetic toward students and their professional development; Corrects students' performance constructively
COMMENTS: _____

6. CLINICAL COMPETENCE
i.e. Uses good judgment in solving clinical problems; Objectively defines and synthesizes patient problems;
Works effectively with the health care team; Establishes rapport with patients
COMMENTS: _____

7. MODELING PROFESSIONAL CHARACTERISTICS
i.e. Initiates honest and open communication; Provides a role model for clinical practice; Takes responsibility;
Shows respect for others; Exhibits patience with self and others
COMMENTS: _____

8. COMMENT ON AMOUNT OF CONTACT WITH THIS PERSON (Total hours): _____ hours

ADDITIONAL COMMENTS - PLEASE USE BACK OF SHEET

RETURN CONFIDENTIALLY TO: CINDY MUELLER, CLERKSHIP COORDINATOR

STUDENT SEMINAR SERIES EVALUATION FORM

Presenter: _____

Topic: _____

UNIVERSITY MacDONALD WOMEN'S HOSPITAL OB-GYN CLERKSHIP

DATE: _____

INSTRUCTIONS:

INDICATE YOUR EVALUATION BY PLACING A NUMERICAL RATING IN THE BOX NEXT TO EACH CATEGORY.

1 _____ 5
POOR **OUTSTANDING**
 N/O = NOT OBSERVED

PLEASE PLACE THESE FORMS IN THE WIRE BASKET IN THE CONFERENCE ROOM OR CLASSROOM WHERE THE LECTURE IS BEING GIVEN

1. LECTURE SKILLS: ORGANIZATION/CLARITY

is appropriate for students' level of knowledge
 Communicates what is expected to be learned
 Provides an appropriate mixture of didactic presentation and discussion

2. GROUP INSTRUCTIONAL SKILLS

Encourages active participation
 Demonstrates respect for and interest in students
 Questions in a non-threatening manner
 Establishes rapport

3. KNOWLEDGE

i.e. Discusses current developments in OB/GYN
 Demonstrates broad base of medical knowledge
 Shares knowledge that is both scholarly and pragmatic
 Discusses divergent points of view

4. ENTHUSIASM/STIMULATION

i.e. Stimulates desire for learning
 Is enthusiastic, appears to enjoy teaching
 Stimulates interest in OB/GYN
 Has interesting style of teaching

5. COMMENTS (If you need more room, please use the back of this sheet)

	Content

**PLEASE COMPLETE THIS FORM
 AFTER EACH LECTURE
 THANK YOU!**

Dear Medical Student:

In order to acknowledge teaching excellence among the residents in our training program, we would very much appreciate it if you would take a few moments to indicate those residents who had a positive impact upon your education while on the OB/GYN rotation this year.

Please choose three residents, ranking them with numbers **1, 2, or 3** and return this survey along with your other evaluation materials.

Thank you for your time and attention,

Nancy J. Cossler, MD
Residency Director
Department of Ob/Gyn
University MacDonald Women's Hospital

My selection for Outstanding Resident Teacher during my OB/GYN Clerkship at MacDonald Women's Hospital:

#1 _____

#2 _____

#3 _____

Date(s) of Clerkship: _____

Do you have any suggestions for specific residents to help improve their teaching? (Please comment below)

PROFESSIONAL ASSOCIATE QUESTIONNAIRE

The Department of Ob/Gyn places a high value on interpersonal skills and humanistic health care. In order to assess these qualities in out housestaff we are asking you to complete this form for the resident physician named below. We are interested in your perception of their behavior during their last rotation regarding relationships with other professionals, patients, and family members.

Resident Name _____ Date _____

- Please indicate the clinical setting where you have interacted with the resident: Labor & Delivery _____ Inpatient Unit _____ Outpatient Area _____
- On average how many clinical observations did you have of the resident? <4 _____ 5-10 _____ 10-20 _____ >20 _____
- Professional role: Nurse _____ Resident _____ Attending _____ Medical Student _____ Other _____

		Unsatisfactory	Satisfactory	Excellent	Unable to assess
1. Communication	Communicates clearly; is willing to answer questions and provide explanations; willing to listen to patients and families	1 2 3	4 5 6	7 8 9	
	Consistently demonstrates willingness to listen to nursing and allied health staff	1 2 3	4 5 6	7 8 9	
2. Respectfulness	Treats others with respect; does not demean or make others feel inferior; provides equitable care to patients ; uses respectful language when discussing patients; uses respectful language when discussing patients; is sensitive to cultural needs of patients	1 2 3	4 5 6	7 8 9	
	Consistently courteous and receptive to nursing and allied health staff ; acknowledges and respects roles of other health care professionals	1 2 3	4 5 6	7 8 9	
3. Compassion	Is kind to patient and families; appreciates patients and families special needs and accepts inconvenience when necessary to meet the needs of the patient; consistently attentive to details of patient comfort	1 2 3	4 5 6	7 8 9	
4. Reliability	Completes and fulfills responsibilities; responds promptly when on call or when paged; assists and fills in for others when needed	1 2 3	4 5 6	7 8 9	
5. Honesty/Integrity	Knows limits of ability and asks for help when appropriate; is honest and trustworthy; does not falsify information; committed to excellence and self-learning	1 2 3	4 5 6	7 8 9	
6. Responsibility	Accepts responsibility (does not blame others or the system); committed to self-assessment; responds to feedback; committed to excellence and self-learning	1 2 3	4 5 6	7 8 9	
7. Advocate	An advocate for patient needs, effectively accesses and coordinates medical system resources to optimize patient care, seeks to find and correct system causes of medical error	1 2 3	4 5 6	7 8 9	

Please provide comments regarding resident's strength's and/or areas of needed improvement:

Adapted from

ABIM Questionnaire

Appendix B Obstetrics Detail Objectives

PGYI

It is expected that, at the conclusion of the first year of residency, the house officer will demonstrate competence in the following areas.

Basic Science (MK)

The resident will have a working knowledge and understanding of the basic sciences pertaining to the obstetric patient and the ability to apply the knowledge in the clinical setting. This includes:

- Genetics
- Embryology
- Anatomy
- Pharmacology
- Physiology
- Microbiology/Immunology

Antepartum Care of the Normal Obstetrical Patient (IC)

- A. The resident will be able to counsel patients regarding normal adaptations in pregnancy and the patient's role in her own care.
- B. The resident will be able to: **(MK,PC)**
- Apply appropriate prenatal screening tests
 - Recognize deviations from the normal antepartum course
 - Initiate appropriate diagnostic studies

Triage (PC)

- A. The resident will be able to triage the antepartum or postpartum patient who presents with routine complaints such as contractions, labor, rupture of membranes, pain, fever, vaginal discharge, bleeding, etc. This will include ordering appropriate diagnostic tests and initiating management.
- B. The resident will demonstrate knowledge of basic principles of abdominal ultrasound procedures.

Intrapartum Care (MK,PC)

- A. The resident will be able to manage the normal laboring patient. This will include:
- Cervical ripening and induction of labor
 - Use of analgesia
 - Recognition of labor dysfunction and appropriate intervention
- B. The resident will be able to utilize and correctly interpret fetal surveillance in labor, to include:
- Application of external and internal devices for monitoring FHR and contractions.
 - Interpretations of FHR patterns
 - Fetal pH assessment
 - Identify deviations from normal

Delivery (PC)

- A. The resident will be able to perform a controlled vaginal delivery to include:
- Midline episiotomy and repair
 - Repair of first and second degree perineal, vaginal and cervical lacerations
 - Management of immediate postpartum hemorrhage
- B. The resident will demonstrate the ability to perform a primary Cesarean section under supervision.

Postpartum Care (PC)

- A. The resident will demonstrate an understanding of the normal changes in the puerperium and the ability to recognize deviation from the norm.
- B. The resident will be able to diagnose and initiate treatment for postpartum febrile morbidity, including:
 - Breast engorgement
 - Mastitis
 - Urinary tract infection
 - Endometritis
 - Wound infection
 - Atelectasis
 - Pneumonia
 - Thrombophlebitis

Contraception (MK)

- A. The resident will be able to counsel patients regarding available options for reversible contraception and prescribe for the patient.
- B. The resident will be able to counsel patients regarding permanent contraception options and perform a postpartum tubal ligation.

Ultrasound (MK)

See Ultrasound Rotation Guidelines, Appendix D

I. Genetics

Understand the basic concepts of inheritance:

- Autosomal dominant inheritance
- Autosomal recessive inheritance
- X-linked recessive inheritance
- X-linked dominant inheritance
- Multifactorial inheritance
- Mitochondrial inheritance

Amplification

Understand the basic concept of:

- Chromosomal anomalies
- Monogenic disorders
- Methods of Prenatal Diagnosis

Noninvasive testing

- Ethnic related genetic disorders
- Maternal serum multiple marker screen
- Ultrasonography

Invasive testing

- Amniocentesis
- Chorionic villus sampling (CVS)
- Cordocentesis

Understand the concept of prenatal screening

- 1st trimester biochemical markers combined with ultrasound
- 2nd trimester biochemical markers combined with ultrasound

Risk Calculation

A priori risk

Likelihood ratio

Understand the roll of Preimplantation genetics

II. Embryology (MK)

Various placental types
Hemochorial - human
Endotheliochorial - dog, cat
Epitheliochorial - cow, pig, horse

III. Placental function (MK)

Metabolism
Transport
Endocrine
Placental Vs lung gas exchange
Fetal and placental acid-base balance
Normal fetal blood pH and gas values
Adult and fetal oxygen dissociation curve
Bohr effect
Haldane effect

IV. Anatomy (MK)

Describe the various types of bony pelvis and their features.
Describe the anatomy of the pelvic muscles.
Describe the vascular anatomy of the pelvis.
Describe the anatomic changes in the uterus and cervix during pregnancy and labor.
Describe the changes in the uterus and breast postpartum.

V. Pharmacology (MK)

Describe changes in serum levels of drugs and the way in which drug levels and efficacy are affected by pregnancy.
Describe the factors, which affect drug transfer to the fetus, i.e. size, ionization, lipid solubility, and binding.
Describe teratogenic effects of commonly used drugs:
Tetracycline
Quinolones
ACE inhibitors
Lithium
Anticonvulsants
Warfarin
Isotretinoin
Alcohol
Tobacco

VI. Physiology (MK)

Describe the effects of estrogen, progesterone and prostaglandin on maternal physiology
Describe hematologic changes in pregnancy and how they relate to changes in:
Cardiovascular function and physiology
Renal function
Describe changes in respiratory function in pregnancy
Describe changes in GI function in pregnancy
Describe changes in pregnancy in the skin and skeletal system
Describe neurologic manifestations of anatomic and physiologic adaptations in pregnancy.

VII. Microbiology/Immunology (MK)

Describe the immune response, both humoral and cellular.
Describe changes in host defenses and response to infection in pregnancy.
Describe mechanisms of fetal/neonatal infection and those factors which modify fetal/neonatal risk.

VIII. Antepartum Care (PC, MK)

Demonstrate the ability to advise a patient about anticipated weight gain, diet, exercise, risk avoidance and the nature of prenatal care

Demonstrate the ability to provide appropriate prenatal care to the low risk woman.

Order and interpret standard prenatal screening tests, to include initial prenatal lab tests, Quad check, diabetes screen, CF carrier screen (when indicated) and ultrasound as indicated.

Measure fundal height, do Leopold's maneuvers and document FHR.

Recognize deviations from the normal prenatal course with respect to weight gain, uterine size, blood pressure and urine dip.

Respond to #1 and #2 with appropriate testing, consultation and intervention.

IX. Triage (PC, MK)

Demonstrate the ability to evaluate those women who present to the labor/ delivery unit with a variety of complaints such as contractions, pain, fever, leaking fluid, vaginal discharge and bleeding.

Order appropriate diagnostic tests

Seek appropriate consultation

Initiate treatment, as needed.

Demonstrate the ability to evaluate the triage patient with a basic abdominal ultrasound exam, to include:

Fetal number

Presentation

Cardiac activity

Biometry/fetal weight

Placental location

Amniotic fluid index

Biophysical profile

X. Intrapartum Care (PC, MK)

The resident will demonstrate the ability to care for the normal, low risk laboring woman to include:

Assessment of the cervix for induction and determining when cervical ripening is appropriate.

Selection of an acceptable method of cervical ripening.

Assessment of cervical change in labor.

Recognition of the phases of Stage I, when labor progress deviates from the norm, and what interventions are appropriate.

The proper use of analgesia for labor and delivery.

Demonstrate competent fetal surveillance during labor, to include

Application of monitoring devices for FHR and uterine activity and knowing when each is appropriate or indicated.

Correct interpretation of FHR patterns, normal and abnormal, and the significance of the abnormal patterns.

Knowing when it is appropriate to use additional means of fetal surveillance, i.e. scalp pH, fetal O₂ saturation, BPP, and how to interpret them.

XI. Delivery (PC, MK)

The resident will demonstrate the ability to perform a controlled vaginal delivery to include:

Identification of fetal position

Performing and repairing a midline episiotomy

Repair of first and second-degree perineal lacerations, identifying the layers to be

repaired.

Inspection of the cervix after delivery and repair of cervical lacerations.

Knowledge of those factors, which predispose to postpartum hemorrhage.

Control of immediate postpartum hemorrhage by first evaluating the cause and then using bimanual manage and ecbolics.

Recognize those patients for whom more aggressive treatment is needed and knowing what options are available, i.e., curettage, packing/tamponade, hysterectomy, uterine artery ligation, hypogastric artery ligation.

The resident will demonstrate the ability to perform a primary Cesarean section under supervision. This will include:

Knowing the indications for primary cesarean.

Knowing risks, benefits and alternatives.

Being able to describe various abdominal incisions with their respective advantages and disadvantages.

Knowing how to avoid injury to uterine vessels.

Recognition of immediate complications and knowing how to deal with them.

XII. Postpartum Care (PC)

The resident will:

Describe changes in the breasts, uterus and lochia in the postpartum period.

Demonstrate an exam of a woman within three days of delivery

Demonstrate an exam of a woman at her postpartum visit and describe the purpose of that exam.

The resident will demonstrate the ability to:

Examine the patient with postpartum fever, assessing possible causes to include:

Breast engorgement

Mastitis

Urinary tract infection

Endometritis

Wound infection

Atelectasis

Pneumonia

Thrombophlebitis

Order appropriate diagnostic tests.

Obtain appropriate consultation and initiate treatment.

XIII. Contraception (MK)

The resident will be able to counsel patients regarding options for reversible contraception, including:

Oral contraceptives

Injectables

Patch

Vaginal ring

Barrier methods

IUD

Spermicides

The resident will prescribe appropriately.

The resident will be able to counsel patients regarding sterilization.

The resident will demonstrate the ability to perform a postpartum tubal ligation.

PGY2

In addition to the competencies expected at the conclusion of PGY1, it is expected that at the completion of the second year the resident will demonstrate competence in the following areas.

Preconception Care (IC)

The resident will be able to provide preconception counseling and general genetic counseling for the woman/couple at risk.

Antepartum Care (PC)

A. The resident will be able to recognize, diagnose and manage the antepartum patient with a variety of problems posing moderate risk, such as infectious diseases, cardiopulmonary, endocrine, gastrointestinal, hematologic, neurologic, psychiatric and urinary disorders, substance abuse and IUGR. This should include:

- A knowledge of risks to mother and fetus
- Use of appropriate diagnostic tests
- Appropriate antepartum fetal surveillance options
- Timing of delivery

B. The resident will be able to diagnose and provide management options for complications arising during pregnancy to include:

- Fetal death
- Preterm premature rupture of membranes
- Preterm labor
- Preeclampsia

C. The resident will be able to diagnose and manage early (first trimester) fetal loss.

Intrapartum Care (PC)

A. The resident will be able to perform emergency cesarean sections and repeat cesarean sections under supervision.

B. The resident will be able to manage immediate postpartum hemorrhage to include manual removal of placenta and postpartum curettage.

Ultrasound

See Ultrasound Rotation Guidelines, Section XIIIb.

I. Preconception Care (PC)

Demonstrate the ability to obtain a medical, family and obstetrical history and identify those factors which pose risks to a woman and/or her offspring

Counsel a woman regarding risks to her with pregnancy

Counsel a woman regarding risks posed to her fetus/baby by her genetic/family history, medical conditions, age and/or past obstetrical history

Counsel a woman regarding lifestyle and its implications for her pregnancy.

II. Antepartum Care (PC)

Perform a history and physical on a prenatal patient to identify risk factors

Institute appropriate planning and intervention to deal with those risks

Demonstrate the ability to recognize maternal-fetal risks and complications as they arise during prenatal care

Demonstrate appropriate use of diagnostic tests and interventions to manage those risks and complications to include:

Use of consultants

Imaging studies

Prescribing for medical complications

NST, BPP, Doppler studies

Monitoring of maternal physiology and endocrine status

Amniocentesis

Tests of fetal maturity

Choosing the correct time for delivery

Diagnose and manage early pregnancy, loss, including blighted ovum, missed abortion, incomplete and complete abortion. The resident will demonstrate appropriate use of:

Serum HCG

Serum progesterone

Ultrasound studies

Suction curettage – with and without ultrasound guidance

Diagnosis and manage third trimester fetal demise. The resident will demonstrate:

Knowledge of risks to the gravida

How to monitor the pregnant woman for complications

Knowledge of options for pregnancy termination

Diagnose and manage preterm premature rupture of membranes (PPROM), to include knowledge of:

Techniques for diagnosing PPRM

Risks and benefits of conservative management

Appropriate use of antibiotics

Role of antenatal steroids

Maternal/fetal surveillance

Appropriate timing of delivery

Diagnose and manage preterm labor:

Define preterm labor

Present options for tocolysis

Describe risks/benefits of tocolysis

Know the role of antenatal steroids

Counsel a patient with preterm labor regarding risks/benefits of interventions

List contraindications for arresting preterm labor

Diagnose and manage preeclampsia:

Define preeclampsia, severe preeclampsia, superimposed preeclampsia, HELLP syndrome and eclampsia

Know when delivery is indicated for the patient with the above diagnoses

Know the risks for the woman in labor with preeclampsia and how to manage them

Know the risks of treatment for preeclampsia and how to manage those risks

Know the appropriate management of the postpartum patient with preeclampsia

Know the role of antihypertensive agents, diuretics and corticosteroids in managing a preeclamptic patient

III. Intrapartum Care (PC)

Cesarean section

Emergency – The resident will demonstrate the ability to perform a safe, rapid cesarean section as a coordinated effort with the anesthesia team.

Repeat cesarean – The resident will demonstrate the ability to perform a safe cesarean in a patient with scarring in the abdominal wall and within the peritoneal cavity from prior surgery.

Breech – The resident will demonstrate the ability to deliver a breech efficiently and safely by cesarean

Twins – The resident will demonstrate an understanding of the indications for cesarean delivery of twins and the ability to safely deliver the second twin at cesarean.

Postpartum hemorrhage, the resident will:

Know when it is appropriate to manually remove a placenta with or without maternal hemorrhage

Demonstrate competent manual removal of a placenta at cesarean and vaginal delivery

Know the risk of manual removal of the placenta
Know the management of placenta accreta
The resident will demonstrate competent postpartum curettage
The resident will know how to manage uterine inversion
The resident will demonstrate competent repair of third and fourth degree perineal lacerations

PGY3

In addition to the competencies expected at the conclusion of PGY 1 and 2, it is expected that at the completion of the third year the resident will demonstrate competence in the following areas.

Antepartum Care (PC)

A. The resident will be able to recognize, diagnose and manage the antepartum patient with problems posing serious risks to mother and/or fetus, including but not limited to alloimmune thrombocytopenia, autoimmune diseases, isoimmunization, multiple gestation, and third trimester bleeding. This should include:

- A knowledge of risks to mother and fetus
- Use of appropriate diagnostic tests
- Appropriate antepartum fetal surveillance
- Timing of delivery

B. The resident will be able to manage second trimester loss. This will include:

- Appropriate evaluation and counseling of couples with recurrent second trimester loss
- Performing a McDonald cerclage
- Evacuation of the uterus with second trimester fetal demise
- Performing amniocentesis under supervision.

C. The resident will be able to diagnosis and manage serious complications arising during pregnancy; including co-managing pregnant patients with medical or surgical emergencies.

Intrapartum Care (PC)

- The resident will know the indications for classical cesarean section and will be able to perform a classical cesarean section.
- The resident will be proficient in low forceps deliveries and vacuum extraction.
- The resident will be proficient in delivery of a breech second twin
- The resident will be able to assess the newborn and perform neonatal resuscitation.

Postpartum Care (PC)

The resident will be able to diagnosis and manage serious postpartum complications such as:

- Seizures
- Prolonged febrile illness
- Wound infection/dehiscence
- Late postpartum hemorrhage

I. Antepartum Care (MK)

Management of serious high risk conditions

Alloimmune Thrombocytopenia
Describe the Pathophysiology
Cite risks to fetus
Describe the presentation of the condition
Describe methods of fetal assessment
Describe management/treatment

Isoimmune Thrombocytopenia

- Describe the pathophysiology
- Cite risks to fetus
- Describe methods of fetal assessment
- Describe management/treatment

Autoimmune Diseases

- Describe the risks to the patient and to her fetus
- Describe methods of maternal and fetal surveillance
- Describe treatment options

Hemolytic Disease of the Newborn

- Describe the pathophysiology and risks to the fetus
- Describe the tests/procedures for assessing the severity of fetal disease
- Describe treatment/management
- Describe prophylaxis and its mechanism

Multiple Gestation

- Cite the frequency of multiple gestation and the effect of ART
- Describe maternal and fetal risks with multiple gestation
- Describe the technique for diagnosing dichorionic vs monochorionic twins
- Describe the appropriate monitoring/surveillance of the antepartum course for twins and triplets
- Define discordance and describe appropriate diagnostic studies and interventions for various causes of discordance
- Cite the appropriate mode of delivery for various twin presentations and for triplets

Third Trimester Bleeding

- Cite the various causes of third trimester bleeding
- Describe predisposing factors
- Describe the techniques for evaluating the patient with third trimester bleeding
- Review the options of expectant management vs prompt delivery and when each is appropriate

Second trimester loss

- Demonstrate the ability to counsel a couple with recurrent second trimester loss regarding:
 - possible causes
 - diagnostic testing
 - methods of evacuating the uterus
 - treatment options in the next pregnancy
- Correctly perform a scheduled McDonald cerclage
- Demonstrate the ability to evacuate the uterus with second trimester fetal demise using:
 - D&E
 - Prostaglandin
- Perform second trimester amniocentesis with supervision

Manage serious complications

- Demonstrate the ability to manage serious medical complications arising during pregnancy, such as congestive heart failure, pulmonary embolus and diabetic keto-acidosis
- Demonstrate the ability to manage surgical complications during pregnancy such as ovarian cyst with torsion, appendicitis, serious trauma, utilizing appropriate fetal surveillance and maternal positioning during surgery

Utilize appropriate consultants for emergencies

II. Intrapartum Care (PC)

Classical cesarean section

- Cite the indications for a classical cesarean section
- Correctly perform a classical cesarean section
- Describe risks for subsequent pregnancies

Forceps and Vacuum

- Define mid, low and outlet forceps/vacuum delivery
- Describe indications for and risks of operative vaginal delivery
- Cite the requirements for safe application of forceps or vacuum
- Describe the criteria for determining the proper application of forceps
- Describe the principle of axis traction and how it is applied
- Demonstrate the correct performance of a low forceps and a low vacuum delivery

Breech Twin

- Cite the contraindications for vaginal delivery of a breech second twin
- Describe the risks associated with delivery of a breech second twin
- Describe the complications which may arise during breech delivery and how to prevent or manage them
- Demonstrate a competent breech delivery

Newborn

- Demonstrate assessment of a normal newborn
- Perform resuscitation of a depressed newborn, to include ventilation with bag and mask and intubation.

III. Postpartum Care (PC)

Manage serious postpartum complications:

Seizures

- Order appropriate diagnostic studies
- Diagnose the etiology of the seizures, with necessary consultation
- Institute appropriate therapy

Prolonged febrile illness

- Consider the applicable differential diagnosis – abscess, wound infection, pneumonia, endometritis, septic pelvic thrombophlebitis, drug fever, etc.
- Order appropriate diagnostic studies
- Provide appropriate therapy

Wound infection/dehiscence

- Demonstrate appropriate management of a superficial wound infection, including drainage, debridement and continuing wound care
- Demonstrate diagnosis and repair of a wound dehiscence

Late postpartum hemorrhage (PPH)

- Cite the causes of late PPH
- Describe the appropriate diagnostic workup for a woman with late PPH
- Describe alternatives for management of late PPH and the risks/benefits of each
- Demonstrate safe evacuation of a uterus with late PPH

In addition to the competencies expected at the conclusion of PGY1, 2 and 3, it is expected that at the completion of the fourth year the resident will demonstrate competence in the following areas:

Antepartum Care (PC)

- Prenatal diagnosis and fetal therapy. The resident will understand the principles regarding CVS, cordocentesis, intrauterine transfusion and other procedures for fetal therapy and will know the indications for those procedures, and when appropriate MFM consultation should be instituted.
- Operative procedures. The resident will know the indications for and demonstrate proficiency in:
 - Shirodkar cerclage
 - External cephalic version
 - Cesarean hysterectomy.

Postpartum Care (P)

- The resident will know the indications for and demonstrate proficiency in
 - Uterine artery ligation
 - Uterine packing/tamponade
- The resident will know the indications for and understand the principles of:
 - Postpartum hysterectomy
 - Hypogastric artery ligation

I. Antepartum Care (PC)

Prenatal diagnosis and fetal therapy

Chorionic Villus Sampling (CVS)

Describe the role of CVS in prenatal diagnosis, how it is performed and it's advantages/disadvantages

Cite the risks of CVS

Cite the appropriate gestational age for CVS

Cordocentesis

Describe the role of cordocentesis in prenatal diagnosis and treatment and how it is performed

Describe the risks of cordocentesis

Intrauterine transfusion

Cite indications for intrauterine transfusion

Describe the techniques used for intrauterine transfusion and the risks of the procedures

Fetal therapy – Medical

Describe appropriate therapy for fetal arrhythmias, heart block, anemia, hypothyroidism

Fetal therapy – Surgical

Describe the use of laser to treat twin-twin transfusion and when it is indicated

Describe the techniques used for fetal surgical management of congenital cystic adenomatoid malformation, diaphragmatic hernia, hydronephrosis, teratoma, meningomyelocele

Cite indicators for and against surgery

II. MFM Consultation (PC)

Describe those conditions for which maternal-fetal medicine consultation should be obtained.

II. Operative procedures (PC)

Shirodkar cerclage

- Describe indications for Shirodkar cerclage vs McDonald cerclage
- Cite risks associated with Shirodkar cerclage
- Cite alternatives to a Shirodkar cerclage
- Demonstrate the correct placement of a Shirodkar cerclage

External cephalic version

- Cite the indications for and contraindications to external cephalic version
- Cite risks, benefits and alternatives
- Define the appropriate gestational age for external cephalic version
- Describe those conditions which improve or decrease the success rate of version
- Demonstrate proper technique for external cephalic version

Cesarean hysterectomy

- Cite appropriate indications for cesarean hysterectomy
- Describe risks and benefits
- Describe concerns related to removal of the cervix, and how to deal with them
- Demonstrate a properly and safely executed cesarean hysterectomy

III. Postpartum Care (PC, MK)

Postpartum hemorrhage

- Uterine artery ligation
- Describe indications for uterine artery ligation
- Cite risks, benefits and alternative of uterine artery ligation
- Cite risks for future pregnancies
- Demonstrate the correct performance of uterine artery ligation
- Uterine packing/Tamponade
- Describe indications for uterine packing or tamponade
- Cite risks, benefits and alternatives
- Describe patient assessment post procedure
- Describe measures to be taken if packing or tamponade fails
- Demonstrate proper uterine packing or balloon tamponade

Postpartum hysterectomy

- Cite indications for postpartum hysterectomy
- Cite risks, benefits and alternatives of postpartum hysterectomy
- Describe concerns related to removal of the cervix and how to deal with them

Hypogastric Artery Ligation

- Cite indications for hypogastric artery ligation
- Describe the rationale for hypogastric artery ligation
- Describe risks, benefits and alternatives
- Describe the techniques employed to avoid the vascular accidents/complications associated with hypogastric artery ligation
- Describe how to recognize ligation of the external or common iliac artery
- Cite the risk of hypogastric artery ligation for future pregnancy

Communicate effectively with patients, staff, consultants and colleagues. **(IC, SBP)**

Demonstrate ethical and professional behavior. **(P)**

Teach medical students and junior colleagues. **(IC, SBP, P)**

Identify areas for personal improvement in Female Pelvic Medicine and implement strategies to accomplish this. **(PBL)**

Identify areas for personal improvement in surgical skills and implement strategies to accomplish this. **(PBL)**

APPENDIX C ULTRASOUND

PGYI

I. Theory (MK)

Understanding of basic physics and instrumentation of ultrasound
Indications and guidelines for ordering and performing ultrasound
Elements of a basic obstetric and pelvic ultrasound examination
Normal pelvic anatomy
Normal maternal/fetal anatomy
Common obstetric pathology
Common gynecologic pathology
Assessment of fetal well-being
Assessment of gestational age and fetal growth, including uses and limitations
Limitations, risks and benefits of prenatal ultrasound
Ethical issues involved with ultrasound

II. Practice (PC)

Choosing appropriate approach, transducer and settings
Orientation to the maternal pelvis
Transabdominal
Transvaginal
Identify and measure in appropriate planes on GYN exam
Uterus and endometrium
Ovaries
Cervix
Identify and measure in appropriate planes on 1st Trimester exam
Uterus and ovaries
Gestational sac(s) with amnionicity/chorionicity
Crown-rump length
Cervix
Yolk sac
Cardiac activity and rate
Identify and measure in appropriate planes on 2nd Trimester exam
Presentation and laterality of fetus
Number and relationships of multiple gestation
Placental grade and site
Cervical state and length
Presence and rate of cardiac activity
Amniotic fluid index
Basic Biometry/Estimated Fetal Weight
BPD and HC
AC
Femur length
 Elements of Complete "Basic" Ultrasound Anatomy
 Cranium, midline structures, ventricles, cerebellum, nuchal thickness
 Orbits, nose/lips, face
 Long and transverse spine
 Cardiac axis, position, 4 chambers, rhythm and rate
 Umbilical cord insertion, gastric bubble and liver, normal situs
 Kidneys and urinary bladder
 Genitals

Enumeration of extremities
Placental cord insertion, 3 vessel cord

III. Teaching Techniques (PC)

Clinical Practice: In a step-wise fashion during the Imaging rotation, the resident is expected to first observe scans to acquire visual pattern recognition of criterion images for 1-2 days, correlating these views to ongoing reading.

After observation period, brief interval scans with limited objectives. Demonstrated ability to the sonographer or to the faculty member (prior to advancing to the next task) to acquire the appropriate image without assistance

- Demonstrate ability to orient to pelvic and fetal structures, fetal cardiac activity
- Locate placenta and fluid pockets
- Properly orient, acquire landmarks and measure BPD and HC (to within 2 mm and 20 mm of the sonographer's values)
- Abdominal circumference to within 20 mm, using gastric bubble and bifurcation of umbilical vein
- Femur length to within 2mm with appropriate orientation, shadowing
- Biophysical profile
- Renal and urinary structures
- CNS structures
- Basic Cardiac structures
- Umbilical cord
- As time permits, other features of normal anatomy
- Pelvic scans: Uterine and adnexal localization and measurement; imaging of the uterine cavity, endometrium and cul de sac

IV. Examination: (MK)

- Track performance on the CREOG ultrasound segment
- Pre- and post test on the lecture instruments
- Performance of unassisted Basic Ob and Pelvic scan to 60% of target elements, BPP with 100% concordance with sonographer/attending's score, AFI to within 15% of the sonographer standard and cervical assessment to within 0.3 cm of target, based on self-assessment of readiness to be evaluated. Performances are to be scored by at least one sonographer and two sonologists and on the basis of review of the resident portfolio.

PGYII

References as for Year One, with addition of readings in transvaginal gynecologic, oncology and Doppler studies, texts on genetic/anomaly topics. (MK)

Supervised scanning by attending or chief in the WHC of patients with first trimester pregnancy and gynecologic complaints (PC)

Familiarity with gestational trophoblastic disease, ovarian and uterine neoplastic processes, endometriosis and myomas, IUDs, polyps; scans of adnexal and uterine pathology with post-operative and pathology correlations for portfolio entry (MK)

Pre-reading interpretation of ER studies on the PACS system on ER/Gyn coverage with self-assessment of correct readings (PC)

Presentation of a case at Fetal Board with description of the ultrasound finding **(MK)**
Familiarity with pitfalls in ultrasound, including artifacts, bioeffects
Ability to complete OB studies to 75% of target; cervical length transvaginally and translabial approach

Examination: CREOG performance **(MK)**
Pre- and Post tests
Review of portfolio elements

PGYIII

As above, with addition of readings in infertility and continued investigation of text and primary material in MFM, Oncology, Genetics, Doppler and 3-D **(MK)**

Independent performance of L&D studies, completion of 80-90% of target elements in Ob study; Observation of Mac Imaging follicle studies repeated **(PC)**

Presentation at Fetal board/Gyn rounds, with reference to the literature as well as US descriptive discussion **(MK)**

Additional anatomic features: Uterine and ovarian vascular supply and torsion assessment. Umbilical, uterine and MCA Doppler studies; Arch and outflow cardiac views, CNS details, pulmonary, biliary, intestinal, distal extremity and digit, accretion and uterine contour abnormalities **(PC)**

Interpretation of ectopic studies with correlation to Hcg **(PC)**

Identification of common IVF ultrasound situations: Retrieval, transfers, Saline sonography, hyperstimulation, Follicle studies **(PC)**

Intra-operative guidance for version, twins, completion of D&C **(PC)**

Maturity amniocentesis 10-20**(PC)**

Measurements should correlate with formal studies, diagnosis should meet or exceed radiology report **(SBP)**

Can incorporate imaging correctly into management schemes **(SBP)**

PGY IV

Primary literature and critical review of articles; self-directed reading in topics of interest **(SBP, P)**

Teaches junior residents and supervise their scans in the clinic and on L&D **(P, MK)**

Evidence-based utilization of ultrasound and proficiency in interpretation of normal and abnormal findings; correlation with other imaging modalities, e.g. MRI and CT. **(SBP, MK)**

Completion of portfolio for certification of adequate scanning experience; 100% of target views on self-selected patient, 90% on random patient., able to complete the study in 20 minutes; gyn study in 15 minutes. **(P)**

Can describe the features of common genetic syndromes by ultrasound and has shadowed studies with at least 15 anomalies **(MK)**

Genetic Amniocentesis 5-10 **(PC)**

Demonstrates ability to accurately explain ultrasound findings for gyn, ob and genetics to the patient without attending assistance **(PC)**

Presents at Fetal board one case in its entirety, including management and pediatric aspects (15-20 minutes) OR presents an ultrasound-related research project **(SBP)**

Reading: Callen; Ultrasonography in Obstetrics and Gynecology
Fish: Physics and Instrumentation of Diagnostic Medical Ultrasound
Sanders: The Complete Fetal Anomalies
ATL: Basic Ultrasound Standards

<http://radiographics.rsnajnl.org/cgi/content/full/21/6/1409>

General Competency Based Skills in Ambulatory Gynecology

Communicate effectively with patients, staff, consultants and colleagues. **(IC, SBP)**

Understand and perform appropriate periodic health assessment tailored to patient's age and risk factor status **(MK, PC)**

Demonstrate ethical and professional behavior. **(P)**

Teach medical students and junior colleagues. **(IC, SBP, P)**

Identify areas for personal improvement in Ambulatory Gynecology and implement strategies to accomplish this. **(PBL)**

Specific Competency Based Skills

At the end of the rotation the PGY 2 will be able to discuss and/or perform the screening, evaluation and management strategies related to : **(PC, MK)**

- Pap smear guidelines, triage and management
- STD screening and risks
- Benign breast disease
- Bone health
- Depression/Stress
- Cardiovascular risks, HTV, dyslipidemia, obesity and exercise
- Immunizations
- Sexuality/Sexual functioning
- Skin exposure
- Peri-menopausal changes/hormone therapy

Resident Competency Checklist

The following OB Pre-Comp Checklist will be completed in order to aid the resident in gaining OB scanning experience, proper documentation of anatomy, confidence, and efficiency. This form should be used as a checklist to test the Resident's knowledge of fetal anatomy, maternal structures, fetal measurements and routine obstetrical protocols. This form should be completed by Resident preceptor prior to working individually and completing required competencies. Following completion, it is to be turned into Imaging preceptor.

Demo: Demonstrated to resident by RDMS
 Identified: Resident able to identify to RDMS
 Competent: Resident independently scan

Maternal Structures	Demo	Identified	Competent
Uterus			
Endometrium/Decidua			
Cervix			
Ovaries			
Adnexa			
Bladder			

Environment	Demo	Identified	Competent
Placenta			
Umbilical Cord			
PCI			
Amniotic Fluid w/AFI			
Position/Fetal Lie			

1st Trimester Scan	Demo	Identified	Competent
Embryo			
Yolk Sac			
M-Mode			
Amnion			
Chorion			

Measurements & Biometry	Demo	Identified	Competent

CRL			
BPD			
HC			
AC			
FL			
HL			
FHR			

Basic Fetal Anatomy	Demo	Identified	Component
Cranium			
Falx/Thalamus/CSP			
Face/Profile/Nose & Lips			
4 Chamber Heart			
Stomach			
Kidneys			
ACI			
Bladder			
Spine			
Extremities			

Fetal Well Being	Demo	Identified	Component
BPP			

RDMS Preceptor Signature _____ Date _____

Resident Signature _____ Date _____

APPENDIX D
Gynecologic Oncology: Detail Objectives

PGY 2

At the conclusion of the PGY 2 year, the resident should have developed competency in the following general objectives: **(MK)**

- Describe the gross anatomy of the pelvic organs and breast.
- Describe the vascular, lymphatic and nerve supply of each structure.
- Describe the histology of the gynecologic malignancies and pre-malignant conditions.
- Describe the epidemiology and clinical manifestations of the gynecologic and breast malignancies
- Understand HPV pathogenesis and its epidemiology
- Understand diagnostic modalities (and their limitations) used for the evaluation and management of known or suspected gynecologic malignancies and pre-malignant conditions.
- Be able to diagnose and manage common postoperative problems.
- Be able to diagnose and manage critically ill patients with the following problems: shock, heart failure, sepsis, adult respiratory distress syndrome, and renal failure.
- Understand the general principles of chemotherapy, mechanisms of action, risks and complications.
- Understand the general principles of radiation therapy, mechanisms of action, risks and complications.
- Understand the influence of co-morbid medical conditions on the surgical, chemotherapeutic and radiotherapeutic management of gynecologic malignancies.
- Describe the basic principles of palliative care and pain management and end of life issues.

Anatomy (MK)

Describe the gross and histologic anatomy of the pelvic organs and breast.

Describe the vascular, lymphatic, and nerve supply to each of the pelvic organs as well as understand avascular spaces relevant to dissection and exploration techniques .

Describe the anatomic relationship between the reproductive organs and other viscera, such as bladder, ureters, and bowel.

Describe the likely changes in the anatomic relationships of the pelvic and abdominal viscera created by surgical or radiation treatment for malignancy.

Cytology/Histology/Staging (MK)

Understand the Bethesda Classification System terminology and its diagnostic categories.

Describe the microscopic features relevant to diagnosis in each cytologic category.

Understand the diagnostic strategies recommended for each cytologic category.

Understand the WHO Classification System for endometrial hyperplasia.

Describe the cytologic and architectural features relevant to diagnosis in each diagnostic category.

Understand the therapeutic implications of each diagnostic category.

Understand the elements of the WHO scoring system for risk assessment in gestational trophoblastic neoplasia

Understand the broad prognostic and therapeutic implications for low- and high- risk GTN.

Understand the FIGO grading and staging system for the gynecologic malignancies.

Understand the cytologic and architectural features relevant to diagnosis in each diagnostic category.

Understand the broad prognostic and therapeutic implications of each staging category.

Diagnostics (MK)

Describe the epidemiology and clinical manifestations of the gynecologic and breast pre-cancers and cancers.

Describe and understand Gail Model for risk assessment for breast cancer.

Describe the current indications for referral to medical genetics for BrCa1 and BrCa2 counseling. Understand reasonable risk thresholds for pursuing genetic testing.

Perform focused history and physical examination in women with signs or symptoms of breast or gynecologic cancer.

Understand diagnostic modalities, their appropriate applications and their limitations used for the evaluation and management of known or suspected cervical and vulvar dysplasia and neoplasia, endometrial hyperplasia and carcinoma, adnexal masses and ovarian carcinoma and gestational trophoblastic neoplasia.

Office techniques

- pap smear

- colposcopy/cervical biopsy

- endometrial biopsy

- vulvar biopsy

- FNA

- office hysteroscopy

Laboratory studies

- Tumor markers

- Molecular and genetic studies

- Hormone receptor evaluation

Radiologic techniques

- Pelvic ultrasound/Doppler flow

- SIS

- CT scan

- MRI

- PET scan

- Angiography

- Mammography/breast ultrasound/core-needle biopsy/excisional biopsy

Surgical techniques

- EUA

- D&C/Hysteroscopy

- Conization

- Laparoscopy

- Proctoscopy

- Cystoscopy

Physiology (MK)

Describe the metabolic changes associated with malignancy of the pelvic organs or breast.

Describe the metabolic and physiologic changes that result from injury due to surgery, radiation and chemotherapy.

Understand the influence of co-morbid medical conditions on the surgical, chemotherapeutic and radiotherapeutic management of gynecologic malignancies.

Understand the concept of the therapeutic index.

Nutrition (MK)

Identify risk factors for malnutrition

Understand tests used to assess nutritional status

Understands formulas/nomograms used to assess caloric needs

Indications for enteral or parenteral nutritional support

Risks/benefits/complications of nutritional therapy

Total parenteral nutrition

Enteral nutrition

Preoperative preparation (MK)

Recognize patients with medical or disease-related problems that require special consideration prior to surgery.

Understand general strategies for medical optimization prior to surgery

Understand fluid, electrolyte and nutritional optimization prior to surgery

Understand strategies for anti-coagulation management in patients on chronic anti-coagulation or platelet inhibitors prior to surgery.

Understand indications and strategies for bowel preparation.

Understand indications for antibiotic, subacute bacterial endocarditis, DVT and steroid prophylaxis prior to surgery.

Postoperative care (MK)

Be able to diagnose and manage postoperative problems to include:

Febrile illness

Cellulitis/abscess

Urinary tract infection/pyelonephritis

Pneumonia

C difficile colitis

Thromboembolic events

DVT/PE

MI/Stroke

Wound complications

Infection

Separation

Dehiscence

GI complications

Nausea/vomiting

Ileus

Postoperative obstruction

Surgical injury

Bowel perforation or fistula

Ureteral transaction or fistula

Bladder injury or fistula

Critical Care (MK)

Shock

Explain the various causative factors associated with shock.

hypovolemic shock.

cardiogenic shock.

septic shock.

Understand and manage septic shock

Explain the pathophysiology of septic shock.

Understand in detail potential symptoms and clinical manifestations of septic shock.

Perform a focused physical examination.

Describe indications for and interpret results of the following diagnostic tests:

Microbiologic cultures

CBC with differential

Arterial blood gases

Liver function tests

Renal function tests

Coagulation profile

Central hemodynamic monitoring

Chest X-ray

Ultrasound, MRI or CT of the abdomen and pelvis

Describe the principles of management of septic shock including supportive care and antimicrobial therapy

Understand and manage cardiogenic shock

Describe the causes of cardiogenic shock. Be particularly familiar with causes seen most frequently in gynecologic cancer patients, including:

- myocardial infarction
- pulmonary embolus
- pericardial tamponade
- cardiomyopathy

Understand and interpret relevant diagnostic modalities and their applications including:

- Focused physical examination
- Central hemodynamic monitoring
- Echocardiogram
- Cardiac catheterization

Understand fluid management and pharmacologic treatment strategies for patients in cardiogenic shock

Understand and manage hypovolemic shock

Blood component therapy

Understand the composition, indications, risks of packed washed, frozen red cells, platelets, pooled and fresh frozen plasma, albumin, concentrated leukocytes, and cryoprecipitate.

Understand the risks of transfusions due to infections with the human immunodeficiency virus (HIV), hepatitis, and other agents.

Understand how to recognize and manage transfusion reactions.

Understand normal hemostasis and risk factors for abnormal clotting states

Renal failure

Understand physiology of normal renal function

Describe potential symptoms and clinical manifestations of renal failure

Highlight the problems in gynecologic cancers and their treatment that could lead to renal failure and describe a differential diagnosis of renal failure within each broad diagnostic category:

- Pre-renal
- Intrinsic Renal
- Post-renal

Describe diagnostic modalities and their applications for the evaluation of renal function, including:

- Urine dipstick
- Urine electrolytes
- Microscopic analysis
- FENA
- GFR calculation techniques
- Renal ultrasound/Doppler studies
- MRI and MR angiography
- Radionuclide scanning and its indications

Describe specific management strategies for patients with renal failure including:

- Fluid management
- Dietary management
- Hyperkalemia
- Metabolic acidosis
- Blood pressure

Understand techniques and their indications for the management of renal failure due to ureteral or bladder outlet obstruction.

Identify indications for dialysis

Pulmonary failure

Understand physiology of normal pulmonary functioning

Describe potential symptoms and clinical manifestations of pulmonary failure

Pulmonary embolism. Identify predisposing factors and pathophysiology of deep vein thrombosis and pulmonary embolus

Describe the usual signs and symptoms for DVT/PE

Perform a focused physical examination

Describe and interpret potentially relevant diagnostic tests:

- CBC

- Coagulation profile

- ABGs with alveolar-arterial oxygen gradient calculation

- D-dimer

- Hypercoagulable profile

- Venous duplex scanning

- V/Q scans

- Spiral CT scan

- Pulmonary angiography

Describe specific management strategies for patients with a diagnosis of DVT/PE

Anti-coagulation-acute and long-term

Indications for IVC filter placement

Pleural effusion. Understand the difference between transudative and exudative pleural effusions. Identify potential causes of each and explain pathophysiology.

Perform a focused physical examination

Describe and interpret potentially relevant diagnostic tests

- Chest X-ray

- Ultrasound

- Thoracentesis

- Thoracoscopy

Describe potential treatments for malignant pleural effusions

- Large volume thoracentesis

- Chemical pleurodesis

- Indwelling catheter placement

Adult respiratory distress syndrome. Identify causes and explain pathophysiology of ARDS

Describe the usual signs and symptoms associated with ARDS

Perform a focused physical examination

Describe and interpret relevant diagnostic tests:

- ABGs

- Pulse oximetry

- PFT's and ventilator pressure profiles

- Central hemodynamic monitoring

Understand general management strategies for the treatment of patients with ARDS

Disease and treatment specific goals (MK)

Cervical pre-cancer and neoplasia

Understand HPV molecular pathogenesis

Understand ACOG guidelines for cervical cancer screening

Understand new recommendations for incorporation of HPV testing into screening and follow-up strategies

Understand management recommendations/rationale for CIN-1/CIN-2 and CIN-3

Understand the spontaneous progression/regression rates of each over time

Understand factors influence progression of HPV-associated disease
Understand recurrence risks after LEEP
Understand management recommendations/rationale for AIS.
Understand the distinction between carcinoma in situ, microinvasive carcinoma and invasive cervical carcinoma.
Describe the pathologic issues
Describe the therapeutic implications

Microbiology and immunology (MK)

Describe the influence of immunosuppression in susceptibility to gynecologic malignancies.
Describe the alterations in host immune mechanisms that occur as a result of malignancies of the reproductive tract and breast.
Describe the immune changes that occur as a result of treatment of malignancies of the reproductive tract and breast.
Describe the immune aberrations that result from malnutrition and cachexia.
List the principal consequences of immunosuppression, either disease- or treatment-related (e.g., increased susceptibility to infection and poor wound healing).
Understand the management of the neutropenic patient.

Chemotherapy

Describe the general categories and mechanism of action of chemotherapeutic agents used in gynecologic malignancies.
Describe the indications for chemotherapy in the treatment of gynecologic neoplasms.

Radiation therapy (MK)

Describe the general principles of radiation therapy.
Describe the indications for radiation therapy in the treatment of gynecologic neoplasms.
Describe the rationale and applications for radiation sensitizing chemotherapy.
Describe the general mechanisms of action of:
 Intracavitary irradiation
 External-beam irradiation
 Interstitial irradiation
 Radioisotopes
 Palliative radiation therapy
Describe the factors that influence decisions regarding intervention, such as:
 Classification and FIGO staging of disease and histology
 Age of patient
 Underlying medical conditions
 Implications for future fertility
 Concomitant therapy with radiosensitizers or chemotherapy
 Previous abdominal procedures
 Maximal dose tolerance of selected organ systems
 Radiation therapy complications
Describe risk factors for radiation complications
Describe common radiation complications and general management strategies associated with the treatment of gynecologic malignancy
Describe general strategies for management
In consultation with a subspecialist, manage the complications of radiation therapy.

Terminal care (MK)

Describe the basic principles of palliative care.

Describe the most common quality of life impairing medical problems for each of the gynecologic malignancies at the end of life.

Refractory ascites

Refractory pleural effusions

Bowel obstruction

Pain

DVT

Cachexia

Fatigue

Describe the medical, radiation, and operative modalities for palliation of these symptoms in terminally ill patients.

Describe the basic principles of pain management and the various modalities used to address cancer-related pain.

Describe the concept of therapeutic index when considering interventions to improve patients' quality of life.

Describe the major psychosocial problems that affect quality of life at the end of life

Depression

Anxiety

Social Isolation

Describe the medical and social strategies for treating these psychosocial issues.

Describe the elements of and appropriate indications for a do-not-resuscitate (DNR) order.

Describe the medical, ethical, and legal implications of such an order.

PGY 2 Procedures (PC)

The following table lists additional procedures that are specific to gynecologic oncology and summarizes the level of technical proficiency that should be achieved by a graduating resident. The resident should either understand a procedure (including indications, contraindications, and principles) or be able to perform it independently. These distinctions are based on the premise that knowledge of a procedure is implicit in the ability to perform it.

PROCEDURE	UNDERSTAND	ASSIST	PERFORM
Colectomy (partial or total)	X		
Colostomy	X		
Fistula Repair			
Enterocutaneous	X		
Ureterovaginal	X		
Rectovaginal	X		
Vesicovaginal	X		
Hysterectomy			
Extrafascial			X
Radical		X	
Ureteral Identification			X
Lymph Node FNA			X
Lymph Node Biopsy/ Dissection			
Axillary	X		
Inguinal	X		
Para-aortic	X		
Pelvic	X		
Sentinal	X		

Paracentesis			X
Pelvic Exenteration	X		
Radiation Therapy			
Brachytherapy	X		
External Beam	X		
Interstitial	X		
Repair enterotomy		X	
Resection of Large and Small Bowel	X		
Staging Laparotomy			
Biopsy of peritoneal implants			X
Cytologic smear of diaphragm			X
Infracolic omentectomy			X
Suction Evacuation of Molar Pregnancy			X
Vaginal Reconstruction			
Gracilis flap	X		
Martius flap	X		
Skin graft	X		
Transverse rectus flap	X		
Venous access device placement			X
Vulvectomy, Partial Simple			X
Vulvectomy, Radical		X	
Wide Local Excision of Breast Mass		X	

PGY 3

At the conclusion of the PGY 3 year, the resident should have developed competency in the following objectives: **(MK)**

- Describe the major chemotherapeutic agents and indications for their use in gynecologic malignancy as well as understand strategies for prevention and management of adverse side effects
- Describe the pathogenesis, staging, pre-treatment evaluation, treatment strategies and stage/grade-related prognosis of endometrial carcinoma.
- Describe the pathogenesis, staging, pre-treatment evaluation, treatment strategies and stage/histology-related prognosis for cervical carcinoma.
- Describe the pathogenesis, staging, pre-treatment evaluation, treatment strategies and stage/histology-related prognosis for fallopian tube, primary peritoneal and ovarian carcinoma.
- Describe the pathogenesis, staging, pre-treatment evaluation, treatment strategies and stage/grade-related prognosis of carcinoma of the vulva.
- Describe the pathogenesis, staging, pre-treatment evaluation, treatment strategies and stage/grade-related prognosis of carcinoma of the vagina.
- Be able to diagnose, classify (low/high risk), perform appropriate pre-treatment evaluation and manage gestational trophoblastic disease.
- Understand genetic issues that influence risk for the development of the gynecologic malignancies.

At the conclusion of the PGY3 year, the resident is expected to have the competency and proficiency delineated in the goals/objectives of a PGY2 as well as the following:

Chemotherapy (MK)

Describe the likelihood of response of each common gynecologic malignancy to chemotherapeutic agents.

Describe the mechanisms of action and most appropriate indication for chemotherapeutic agents, such as:

- Alkylating agents
- Antimetabolites
- Vinca alkaloids
- Antibiotics
- Hormones
- Heavy metals

Describe the medications of most value in treatment of complications resulting from chemotherapy and irradiation, such as:

- Marrow suppression
- Nausea and vomiting
- Hemorrhagic cystitis
- Peripheral neuropathy
- Renal toxicity
- Cardiac toxicity

Radiation Therapy (MK)

Describe the general mechanisms of action of:

- Intracavitary irradiation
- External-beam irradiation
- Interstitial irradiation
- Radioisotopes

Describe the factors that influence decisions regarding intervention, such as:

- Classification and FIGO staging of disease and histology
- Age of patient
- Underlying medical conditions
- Implications for future fertility
- Concomitant therapy with radiosensitizers or chemotherapy
- Previous abdominal procedures

Radiation therapy complications

- Understand relative maximal dose tolerances of selected organ systems
- Describe risk factors for radiation complications

Describe common radiation complications and general management strategies associated with the treatment of gynecologic malignancy

Describe general strategies for management of radiation-related complications

Carcinoma of the endometrium (MK)

Describe the epidemiology and pathogenesis of invasive endometrial cancer.

Describe the typical clinical manifestations of invasive endometrial cancer.

Describe the FIGO staging of invasive endometrial cancer.

Describe the differential diagnosis of invasive endometrial cancer.

Describe the treatment of invasive endometrial cancer.

Describe the prognosis for invasive endometrial cancer.

With the assistance of a subspecialist, provide definitive treatment for a patient with endometrial carcinoma.

Understand the elements of complete surgical staging

Understand the indications for complete surgical staging

Understand the indications for adjuvant postoperative radiotherapy, chemotherapy or hormonal therapy.

Invasive cervical cancer (MK)

Describe the epidemiology and pathogenesis of invasive cervical cancer.

Describe the typical clinical manifestations of invasive cervical cancer.

Describe the FIGO staging of invasive cervical cancer.

Detail the therapeutic implications for each diagnostic category

Describe the stage-related prognosis for invasive cervical cancer.

Describe the elements of a radical hysterectomy

Describe the issues that surround patient selection for this treatment modality.

Describe the indications for adjuvant radiation therapy after radical hysterectomy.

Describe the technique of chemoradiation therapy for cervical carcinoma.

Describe the issues that surround patient selection for this treatment modality

Manage, in combination with a subspecialist, the common complications of surgical and radiation treatment for cervical cancer.

Describe the psychosocial concerns of patients who have invasive cervical cancer.

Describe the indications for referral to a specialist for treatment of psychosocial dysfunction.

Carcinoma of the fallopian tube (MK)

Describe the epidemiology and pathogenesis of fallopian tube cancer.

Describe the typical clinical manifestations of fallopian tube cancer.

Describe the histology, FIGO staging, and prognosis of fallopian tube tumors.

Perform appropriate tests to diagnose cancer of the fallopian tube.

Describe the treatment for fallopian tube cancer based on:

- Type

- Grade

- Stage

- Patient characteristics

Perform procedures to treat women with fallopian tube cancer in consultation with subspecialists when indicated.

Manage, in consultation with a subspecialist, the common complications resulting from treatment of fallopian tube cancer.

Provide psychosocial support and appropriately palliate woman dying of fallopian tube cancer.

Carcinoma of the ovary (MK)

Describe the epidemiology and pathogenesis of ovarian cancer.

Describe the inherited syndromes that increase a woman's likelihood of developing ovarian cancer.

Describe the screening protocols that may identify patients who have an inherited form of ovarian cancer.

Describe the typical clinical manifestations of ovarian cancer.

Describe the histology, staging, and prognosis for:

- Epithelial tumors

- Germ cell tumors

- Stromal tumors

- Sarcomas

- Metastatic tumors

- Tumors of low malignant potential

Interpret the following tests to diagnose ovarian cancer:

- Ultrasonography

- Serum tumor markers

- Cytology from paracentesis

- CT scan

Describe the treatment of ovarian cancer based on:

- Type
- Grade
- Stage
- Patient characteristics

With the assistance of a subspecialist, provide definitive treatment for a patient with ovarian cancer.

Describe the indications for secondary cytoreductive surgery.

Manage, in consultation with a subspecialist, the common complications resulting from treatment of ovarian cancer.

Provide psychosocial support and appropriate palliative therapy for woman dying of ovarian cancer.

Invasive carcinoma of the vagina (MK)

Describe the epidemiology and pathogenesis of invasive vaginal cancer.

Describe the typical clinical manifestations of invasive vaginal cancer.

Describe the FIGO staging of invasive vaginal cancer.

Describe the differential diagnosis of invasive vaginal cancer.

Describe the treatments for invasive vaginal cancer.

Describe the prognosis for invasive vaginal cancer.

With the assistance of a subspecialist, provide treatment for a patient with invasive cancer of the vagina.

Manage, in combination with a subspecialist, the common complications of surgical and radiation treatment for vaginal cancer, including vaginal necrosis, rectovaginal and vesicovaginal fistula.

Invasive vulvar carcinoma (MK)

Describe the epidemiology and pathogenesis of invasive vulvar lesions:

- Melanoma
- Squamous cell cancer
- Basal cell carcinoma
- Paget's disease
- Sarcoma
- Verrucous carcinoma

Describe the clinical manifestations of invasive vulvar malignancies.

Describe the staging of invasive vulvar cancers using the system adopted by the International Federation of Gynecology and Obstetrics (FIGO).

Describe the differential diagnosis of vulvar cancer.

Describe the treatments for invasive vulvar cancer.

Describe the prognosis for invasive vulvar malignancies.

With the assistance of a subspecialist, provide definitive treatment for a patient with an invasive vulvar malignancy.

Manage, in consultation with a subspecialist, the common complications of surgical and radiation treatment for invasive vulvar cancer.

Describe the impact of treatment of vulvar cancer on sexual dysfunction and appropriately refer the patient for specialized treatment if sexual dysfunction develops.

Malignant gestational trophoblastic disease(MK)

Describe the conditions that may precede malignant GTD.

Describe the histologic appearance of invasive mole versus choriocarcinoma versus placental site trophoblastic tumor.

Diagnose malignant GTD using a combination of physical examination, hCG, chest X-ray, CT

scan, and ultrasonography.

Understand risk for false positive/“phantom hCG” test

Classify GTD into good prognosis (low risk) versus poor prognosis (high risk).

Describe the medical and surgical management of malignant GTD.

Provide, in consultation with subspecialist, medical and surgical treatment for a patient with malignant GTD.

Provide appropriate follow-up at the completion of treatment.

Counsel patients regarding risk of recurrence and prognosis for future pregnancies.

Carcinoma of the breast (MK)

Describe the staging of breast cancer and understand elements of prognostic significance including histologic type, hormone receptor status, relevant immunohistochemical characteristics and nodal/metastasis status.

Understand best candidates/clinical indications for lumpectomy versus mastectomy.

Describe indications and strategies for neoadjuvant and adjuvant therapy

Radiation

Hormonal

Chemotherapy

Manage side effects of therapy, including hormone withdraw symptoms.

Cancer genetics (MK)

Understand familial patterns in breast, endometrial, ovarian and colon cancer.

The cancer family syndromes: HNPCC and BRCA and site specific ovarian cancer

Describe the genetic defects associated with these cancer syndromes

Describe the clinical manifestations among affected women

Describe the pros/cons/indications/limitations of genetic testing among women suspected of genetic mutation associated with increased cancer risk.

Describe management options and screening strategies for women with known or suspected genetic mutations associated with increased cancer risk.

PGY 3 Procedures (PC)

The following table lists additional procedures that are specific to gynecologic oncology and summarizes the level of technical proficiency that should be achieved by a graduating resident. The resident should either understand a procedure (including indications, contraindications, and principles) or be able to perform it independently. These distinctions are based on the premise that knowledge of a procedure is implicit in the ability to perform it.

PROCEDURE	UNDERSTAND	ASSIST	PERFORM
Colectomy (partial or total)	X		
Colostomy	X		
Fistula Repair			
Enterocutaneous		X	
Ureterovaginal		X	
Rectovaginal		X	
Vesicovaginal		X	
Hysterectomy			
Extrafascial			X
Radical		X	

Ureteral identification			X
Lymph Node FNA			X
Lymph Node Biopsy/ Dissection			
Axillary		X	
Inguinal		X	
Para-aortic		X	
Pelvic		X	
Sentinal		X	
Paracentesis			X
Pelvic Exenteration	X		
Radiation Therapy			
Brachytherapy		X	
External Beam	X		
Interstitial	X		
Repair enterotomy			X
Resection of Large and Small Bowel		X	
Staging Laparotomy			
Biopsy of peritoneal implants			X
Cytologic smear of diaphragm			X
Infracolic omentectomy			X
Suction Evacuation of Molar Pregnancy			X
Vaginal Reconstruction			
Gracilis flap	X		
Martius flap		X	
Skin graft	X		
Transverse rectus flap	X		
Venous access devise placement			X
Vulvectomy, Partial Simple			X
Vulvectomy, Radical			X
Wide Local Excision of Breast Mass			X

General Competency in Gynecologic Oncology

Communicate effectively with patients, staff, consultants and colleagues. **(IC, SBP)**

Demonstrate ethical and professional behavior. **(P)**

Teach medical students and junior colleagues. **(IC, SBP, P)**

Identify areas for personal improvement in Female Pelvic Medicine and implement strategies to accomplish this. **(PBL)**

Identify areas for personal improvement in surgical skills and implement strategies to accomplish this. **(PBL)**

REI Detail Objectives

APPENDIX E REI Detail Objectives

At the conclusion of the PGY-2 year, each resident should have developed competency in the following objectives:

Genetics (MK)

The resident should be able to

- Understand the genetic basis for normal and abnormal Mullerian development.
- Classify the genetic causes of androgen excess.
- Discuss the genetic causes of recurrent pregnancy loss.
- Describe the hormonal and genetic causes from ambiguous genitalia.

Physiology (MK)

The residents should be able to describe

- Normal and abnormal physiology of the hypothalamic pituitary axis.
- Adrenal physiology and catecholamine synthesis.
- Normal and abnormal thyroid gland as it relates to human reproduction and 1st trimester of pregnancy.
- Regulation of normal tissue receptors.
- Normal bone formation and resorption.

Anatomy (MK)

The resident should be able to

- Interpret and perform studies to visualize the reproductive tract
- Interpret such images such as:
 - Hysterosalpingogram (HSG)
 - Pelvic ultrasound and saline infusion ultrasonography
 - CT scan and MRI
- Describe normal and abnormal reproductive tract anatomy as visualized both hysteroscopically and laparoscopically.
- Differentiate between normal and abnormal Mullerian development at the time of surgical procedures.

Pharmacology (MK)

The resident should understand

- The basis for the use of medications to induce and inhibit ovulation,
- Medications that inhibit the effects of prostaglandins
- The pharmacology of hormone therapy and selective estrogen receptor modulators
- The pharmacology of medications used to inhibit bone resorption and stimulate bone formation.

Pathology and Neoplasia (MK)

Residents, at the end of their rotation should be able

- Describe the histologic appearance of endometriosis
- Discuss the changes in the endometrium according to Noyes criteria
- Recognize changes that occur in the endometrium during the normal and abnormal menstrual cycle
- Describe the normal histologic appearance of the ovary describe
- Describe changes that occur in pathologic conditions such as PCOS and ovarian cysts.

Microbiology (MK)

The resident should be able to

- Describe the histologic alterations of the endometrium and fallopian tubes associated with infection, and how these could lead to infertility
- Understand the effects of hydrosalpinx on fertility and the options for treatment

Premature and Delayed Puberty (MK)

The resident should be able to

- Understand the physical causes of premature and delayed puberty
- Elicit a history and perform a physical examination
- Make appropriate referrals

Menstrual and Endocrine Disorders (MK)

The resident should be able to

- classify, evaluate and treat dysmenorrhea
- Perform selected tests to evaluate dysmenorrhea such as
 - Cervical cultures
 - Endometrial biopsy
 - Pelvic ultrasounds/saline infusions ultrasonography
 - Hysteroscopy/laparoscopy,
 - CT scan and MRI
- Describe the classification of amenorrhea that includes its major causes
- Elicit a pertinent history and physical examination
- Perform and interpret selected diagnostic and hormonal tests
- Describe the causes for galactorrhea and hyperprolactinemia
- Understand appropriate treatment, including side effects and complications

Premenstrual Syndrome (MK)

Residents should be able to

- Describe the diagnostic criteria for premenstrual syndrome
- List possible causes, pertinent history, evaluation, differential diagnosis; and PMS interventions such as
 - Psychosocial support
 - Counseling
 - Lifestyle changes
 - Medications.

Hirsutism and PCOS (MK)

Residents should be able to

- Describe the principal causes of hirsutism
- Obtain a pertinent medical history and hormonal evaluation
- Be aware of the different treatment choices for hirsutism
- Know indications for referral
- Know possible effects on reproduction.
- Describe the clinical features of PCOS
- List genetic and environmental factors that contribute to PCOS pathogenesis
- Elicit a pertinent PCOS history
- Perform an appropriate physical exam
- Select appropriate hormonal tests for PCOS
- Describe the 2004 Rotterdam criteria for the diagnosis of PCOS

Recurrent Pregnancy Loss (MK)

Residents should be able to

- List the most common causes of recurrent first and mid-trimester pregnancy loss
- Obtain a pertinent medical history, family history, and pedigree analysis, detection of underlying medical disorders, toxins and hereditary and acquired thrombophilias
- Do a targeted physical examination and be able to perform testing for such conditions
- Interpret and carry out diagnostic hormonal tests

Peri-Menopause and Menopause (MK)

Residents should be able to

- Management of climacteric period that includes the evaluation of typical symptoms associated with menopause
- Assessment for the risk of osteoporosis by history, examination and testing
- Manage peri-menopause and menopausal conditions that include using
 - Hormone therapy
 - Calcium and vitamin supplementation
 - Behavioral and lifestyle modifications
 - Dietary alterations and medications

Infertility and Assisted Reproductive Technologies (MK)

The resident should be able to

- Evaluate and classify causes of infertility
- Obtain a pertinent medical history and physical examination for infertility.
- Perform and interpret diagnostic tests
- Perform pelvic ultrasonography/saline infusion ultrasonography, and hysterosalpingogram
- Evaluate semen analysis results
- Diagnose and treat abnormal ovulation with
 - Insulin sensitizing drugs
 - Clomiphene citrate
 - Recombinant FSH.
- Perform select surgical procedures to correct conditions that cause infertility such
 - Lysis of adhesions
 - Resection of endometriosis in the peritoneum and ovary.
- Describe the indications for referring to a sub-specialist for gonadotropin therapy and assisted reproductive technologies (ART).
- Describe the indications for ART procedures such as in vitro fertilization, ICSI, gamete donation and preimplantation genetic diagnosis.
- Identify and manage complications associated with ART such as ovarian hyperstimulation syndrome, ovarian torsion, cyst formation, etc.

It is expected that end of the PGY-2 rotation the resident should be able to understand or perform procedures as shown in the table below: **(PC)**

Procedure	Understand	Understand And Perform
Ovulation Induction		
Clomiphene Citrate		X (20)
Recombinant FSH	X	
IUI		X (20)
IVF	X	
ICSI	X	
Gamete donation	X	
Preimplantation genetic diagnosis	X	
Hysterosalpingography		X (20)
Hysterosonography		X (20)
Incision of vaginal septum	X	
Operative laparoscopy		
Lysis of pelvic adhesions	X	
Cystectomy	X	
Endometriosis treatment	X	
Operative hysteroscopy		
Polyp or fibroid removal	X	
Uterine septum resection	X	
Lysis of intrauterine adhesions	X	
Microscopic tubal anastomosis	X	

Competency Based Skills in REI

Communicate effectively with patients, staff, consultants and colleagues. **(IC, SBP)**

Demonstrate ethical and professional behavior. **(P)**

Teach medical students and junior colleagues. **(IC, SBP, P)**

Identify areas for personal improvement in Female Pelvic Medicine and implement strategies to accomplish this. **(PBL)**

Identify areas for personal improvement in surgical skills and implement strategies to accomplish this. **(PBL)**

Presentation Topics for REI rotation (MK)

The Resident will choose a different topic each week from the following to discuss during clinics and at the 1 PM Thursday meeting with Dr. Hurd. They will be expected to have read the corresponding textbook chapter.

***The 5 topics with asterisks are required for every resident.**

1. Hypothalamic-pituitary-ovarian axis & control of the menstrual cycle
2. Physiology of female and male gametogenesis
3. Reproductive genetics
4. Normal fertilization and implantation
5. Pelvic anatomy
6. Histology and pathology of reproductive endocrine disorders
7. Statistics for the clinician scientist
8. Ethics of reproduction
9. Normal puberty and pubertal disorders
10. Congenital anomalies of the reproductive tract
11. Pediatric gynecology
12. Adolescent reproductive disorders
13. **Polycystic ovarian syndrome***
14. Amenorrhea
15. Galactorrhea
16. Hirsutism
17. Anovulation and ovulatory dysfunction
18. Premature ovarian failure
19. **Abnormal uterine bleeding***
20. Management of pituitary, thyroid and adrenal disorders
21. Premenstrual syndromes
22. **Menopause***
23. Osteoporosis
24. Hormonal contraception
25. Intrauterine devices
26. Surgical sterilization
27. Reproductive imaging
28. Preservation of fertility
29. Sexually transmitted disease associated with infertility
30. **Evaluation of female infertility***
31. Male infertility
32. Artificial insemination
33. Ovulation induction
34. ART: Assisted reproductive technology: clinical aspects
35. ART: Assisted reproductive technology-laboratory aspects.
36. **Recurrent pregnancy loss***
37. Hysteroscopy
38. Laparoscopy
39. Complications of laparoscopic and hysteroscopic surgery
40. Leiomyoma and myomectomy
41. Surgery for tubal disease (chronic PID, tubal reconstructive surgery including tubal reversal & tubal cannulation)
42. Ectopic pregnancy
43. Endometriosis
44. Techniques for surgery on the ovary
45. Techniques for management of Mullerian anomalies and ambiguous genitalia
46. Adhesion prevention
47. Surgery of the male reproductive system

APPENDIX F
BENIGN GYNECOLOGY: DETAIL OBJECTIVES

PGY1

Allergic drug reactions (MK, PC)

1. Describe the drugs most likely to produce allergic reactions in obstetric and gynecologic patients.
2. Describe the typical symptoms experienced by a patient with a drug reaction.
3. Describe the varying degrees of severity of a drug reaction.
4. Perform a focused physical examination to confirm the diagnosis of a drug reaction and assess the severity of the reaction.
5. Describe the differential diagnosis of a drug reaction, such as:
 - Septic shock
 - Hypovolemic shock
 - Cardiogenic shock
 - Pulmonary embolism
6. Treat a drug reaction in consultation with a specialist in critical care medicine

Genetics (MK)

1. Describe the inheritance of coagulation disorders.
2. Describe the genetic basis for repetitive reproductive loss.

Microbiology and immunology (MK)

1. Describe the microbiologic principles germane to the diagnosis and treatment of gynecologic infectious diseases.
2. Describe the epidemiologic principles involved in the spread of infectious diseases, including transmission and prevention of human immunodeficiency virus (HIV), in both patients and health care workers.

Pharmacology (MK)

1. Describe the pharmacology of medications used in treatment of common gynecologic disorders.
2. Describe the pharmacologic principles of drug therapy in prepubertal girls, women of reproductive age, and elderly patients

Sexually transmitted diseases (MK, PC)

1. Describe the most common causes of STDs, such as:
 - a. Chlamydia
 - b. Gonorrhea
 - c. Syphilis
 - d. Hepatitis B and hepatitis C
 - e. Human immunodeficiency virus (HIV)
 - f. Herpes simplex
 - g. Human papillomavirus
 - h. Chancroid
2. Elicit a pertinent history in a patient with a suspected STD.
3. Perform a focused physical examination to confirm the diagnosis and determine the specific cause of an STD.
4. Perform tests and/or interpret their results to confirm the diagnosis of an STD:
 - a. Aspiration of vesicle
 - b. Bacterial culture
 - c. Endocervical aspirate for Gram stain
 - d. Endocervical aspirate for nucleic acid probe
 - e. Endocervical culture
 - f. Endometrial biopsy

- g. Pap test
 - h. Scraping of an ulcer or chancre
 - i. Serologic assays
 - j. Tzanck smear
 - k. Viral culture
5. Treat STDs with appropriate antimicrobial agents.
 6. Describe the long-term follow-up for patients with an STD including assessment of the patient's sexual partner, discussion of preventive measures, and review of serious sequelae, such as:
 - a. Infertility
 - b. Ectopic pregnancy
 - c. Chronic pelvic pain

Spontaneous abortion (MK, PC)

1. Describe the principal causes of, or predisposing factors for, spontaneous first-trimester abortion.
2. Describe the usual symptoms and findings experienced by a patient with an early pregnancy loss.
3. Perform a focused physical examination to confirm the diagnosis of early spontaneous abortion.
4. Describe the differential diagnosis of early spontaneous abortion
5. Perform and/or interpret selected tests to confirm the diagnosis of early pregnancy loss:
 - a. Quantitative hCG
 - b. Endovaginal ultrasonography
 - c. Qualitative and quantitative serum hCG
 - d. Serum progesterone
 - e. Complete blood count
6. Treat a patient with an early incomplete spontaneous abortion.
7. Describe and treat the complications that may develop as a result of treatment of an incomplete spontaneous abortion, for example:
 - a. Genital tract infection
 - b. Uterine perforation
 - c. Retained products of conception
8. Describe the indications for anti-D immune globulin in patients experiencing an early spontaneous abortion.

Vaginal and vulvar infections (MK, PC)

1. Describe the principal infections that affect the vulva and vagina.
2. Elicit a pertinent history in a patient with a possible infection of the vulva or vagina.
3. Perform a focused physical examination in a patient with a suspected infection of the vulva or vagina.
4. Perform selected tests to confirm the diagnosis of vulvar or vaginal infection:
 - a. Determination of vaginal pH
 - b. Wet prep microscopy
 - c. Bacterial and viral culture
5. Interpret the results of diagnostic tests, such as:
 - a. Gram stain of suspicious lesion of the vulva or vagina
 - b. Bacterial and viral culture
 - c. Vulvar or vaginal biopsy
6. Treat vulvar and vaginal infections medically and surgically.
7. Describe the long-term follow-up that is necessary for a patient with a vulvar or vaginal infection, for example:
 - a. Assessing and treatment sexual partner(s)
 - b. Assessing the patient for other possible genital tract infections
 - c. Counseling the patient with respect to measures that prevent reinfection with sexually transmitted diseases (STDs)

PGY 2

Anatomy (MK)

1. Describe the anatomy of the anterior and posterior abdominal wall.
2. Describe the anatomic relationship between the reproductive organs and the nongynecologic abdominal viscera.
3. Describe the gross and histologic anatomy of the external genitalia, including arterial blood supply, venous and lymphatic drainage, and neurologic innervation.
4. Describe the gross and histologic anatomy of the pelvis and pelvic viscera, including arterial blood supply, venous and lymphatic drainage, and neurologic innervation.
5. Describe the gross and histologic anatomy of the breast, including arterial blood supply, venous and lymphatic drainage, and neurologic innervation.
6. Describe the anatomy of the central nervous system as it relates to menstrual function.

Abnormal uterine bleeding (MK, PC)

1. Describe the principal causes of abnormal uterine bleeding.
2. Elicit a pertinent history in a patient with abnormal uterine bleeding.
3. Perform a focused physical examination to determine the etiology of abnormal uterine bleeding.
4. Perform selected diagnostic tests to determine the cause of abnormal uterine bleeding, for example:
 - a. Endometrial biopsy
 - b. Endovaginal ultrasonography
 - c. Hysteroscopy
 - d. Laparoscopy
5. Interpret the results of other diagnostic tests, such as:
 - a. Serum human chorionic gonadotropin (hCG) titer and other endocrine assays
 - b. Microbiologic cultures
 - c. Complete blood count
 - d. Coagulation profile
 - e. Radiologic imaging studies
6. Treat abnormal uterine bleeding medically and surgically.
7. Describe the long-term follow-up that is necessary for a patient with abnormal uterine bleeding.

Ectopic pregnancy (MK, PC)

1. Describe the major factors that predispose to ectopic pregnancy.
2. Elicit a pertinent history in a patient with a suspected ectopic pregnancy.
3. Perform a focused physical examination to confirm the diagnosis of ectopic pregnancy or to identify other possible causes of the patient's symptoms.
4. Describe the differential diagnosis of ectopic pregnancy.
5. Perform tests to confirm the diagnosis of ectopic pregnancy, for example:
 - a. Endovaginal ultrasonography
 - b. Uterine curettage
 - c. Laparoscopy
6. Interpret the results of other diagnostic tests, such as:
 - a. Quantitative serum hCG titer
 - b. Serum progesterone
 - c. Complete blood count
7. Describe the indications and contraindications for, and complications of, medical management of an ectopic pregnancy.
8. Describe the indications for, and complications of, surgical management of an ectopic pregnancy.
9. Treat an affected patient medically and surgically.
10. Describe the indications for anti-D immune globulin in patients experiencing an ectopic pregnancy.
11. Describe the long-term follow-up that is indicated for a patient treated for an ectopic pregnancy.
12. Counsel patients about the recurrence risk for an ectopic pregnancy and prognosis for a normal intrauterine pregnancy.

Pathology and neoplasia (MK)

1. Describe the pathogenesis and epidemiology of the common nonmalignant neoplasms that affect the external and internal genitalia.
2. Describe the role of oncogenes in the pathogenesis of premalignant lesions of the external and internal genitalia.

Pelvic Masses (MK, PC)

1. Describe the major causes of pelvic masses.
2. Elicit a pertinent history suggestive of a pelvic mass, such as:
 - a. Weight loss or weight gain
 - b. Gastrointestinal symptoms
 - c. Menstrual abnormalities
3. Perform a focused physical examination to confirm the diagnosis of a pelvic mass.
4. Perform tests such as Endovaginal or abdominal ultrasonography to confirm the diagnosis of a pelvic mass.
5. Interpret the results of other tests to confirm the diagnosis of a pelvic mass, for example:
 - a. MRI or CT scan
 - b. Serum markers, such as CA 125, alpha-fetoprotein and human chorionic gonadotropin (hCG)
6. Treat benign pelvic masses medically and surgically, considering such factors as:
 - a. Patient age
 - b. General health
 - c. Patient preference
 - d. Desire for future childbearing
 - e. Symptom complex
7. Describe the appropriate follow-up for patients who have been treated for a benign pelvic mass.

Physiology (MK)

1. Describe the hemodynamic changes associated with blood loss.
2. Describe the changes that occur in the cardiopulmonary function of an anesthetized and postanesthetic patient.
3. Describe the physiology of thermoregulation in the anesthetized and postanesthetic patient.
4. Describe the physiologic changes in the urinary system related to maintenance of adequate urine output.

Preoperative care (MK, PC)

1. Conduct detailed preoperative assessment with consideration given to the needs of special patient groups such as:
 - a. Children and adolescents
 - b. The elderly
 - c. Patients requiring medically complicated care
2. Choose appropriate suture and surgical instruments as dictated by the procedure.
3. Choose pain control appropriate to the type of surgical procedure, age of patient, and degree of patient discomfort.

Postoperative care (PC)

1. Perform a physical examination and order appropriate tests to assess common postoperative complications such as:
 - a. Fever
 - b. Gastrointestinal ileus/obstruction
 - c. Infection
 - d. Fluid or electrolyte imbalances
 - e. Respiratory problems
 - f. Thromboembolism
2. Treat common postoperative complication

Toxic shock syndrome (MK, PC)

1. Describe the pathogenesis of toxic shock syndrome (TSS).
2. Describe the typical signs and symptoms of a patient with TSS, such as:
 - a. Myalgia
 - b. Rash
 - c. Fever
 - d. Hypotension
 - e. Tachycardia
3. Perform a focused physical examination to confirm the diagnosis of TSS, determine the etiology, and assess the severity of the patient's illness.
4. Interpret the results of diagnostic tests, such as:
 - a. Microbiologic cultures
 - b. Complete blood count and white cell differential
 - c. Liver function tests
 - d. Renal function tests
 - e. Coagulation profile
 - f. Chest X-ray
5. Treat patients with TSS in consultation with a specialist in critical care medicine.
6. Counsel affected patients about the risk of recurrence and the value of preventive measures.

Vulvar dystrophies and dermatoses (MK, PC)

1. Describe the principal causes of vulvar dystrophies and dermatoses, such as:
 - a. Squamous cell hyperplasia
 - b. Lichen sclerosus
 - c. Lichen planus
 - d. Atrophic dermatitis
2. Elicit a pertinent history in a patient with a suspected vulvar dystrophy or dermatosis.
3. Perform a focused physical examination in a patient with a suspected vulvar dystrophy or dermatosis.
4. Perform selected diagnostic tests to confirm the diagnosis of a vulvar dystrophy or dermatosis, for example:
 - a. Colposcopy
 - b. Staining with dyes to localize the affected area
 - c. Vulvar biopsy
5. Treat the common vulvar dystrophies and dermatoses medically and surgically.
6. Describe the long-term follow-up that is essential for a patient with a vulvar dystrophy or dermatosis, including assessment of the risk for malignant change.

General principles of aging (MK)

1. Describe the normal, mental, anatomic, and physiologic changes of aging.
2. Describe age-related changes in common laboratory values.
3. Describe the demographics of the aging population.
4. Describe the types of living arrangements that may be appropriate for the aging patient.

Geriatric functional assessment (MK, PC)

1. Assess the patient's socioeconomic status.
2. Assess the patient's cognitive function and affect, using surveys, such as:
 - a. The Folstein Mini-Mental Status Examination
 - b. The Short Portable Mental Status Questionnaire
- C. Beck's Depression Screen
3. Assess the patient's vision using an instrument such as the Snelling Vision Chart.
4. Assess the patient's hearing using the whisper test or a handheld audioscope.
5. Assess activities of daily living (ADL) using a survey such as the Katz ADL Scale.
6. Assess gait and balance.
7. Assess home safety.
8. Assess the patient's nutritional status and ability to cook her own meals.
9. On the basis of all of the above, assess the patient's capacity for independent living

10. Assess the impact of proposed gynecologic surgery on a patient's capacity for independent living.

Geriatric preventive health services (MK,PC)

1. Obtain a detailed history from a geriatric patient.
2. Perform a comprehensive physical examination of a geriatric patient.
3. Describe the appropriate interval for screening tests, such as:
 - A. Pap test
 - B. Urinalysis
 - C. Mammogram
 - D. Lipid profile
 - E. Fecal occult blood test
 - F. Sigmoidoscopy
 - G. Colonoscopy
4. Describe the indications for immunizations, such as:
 - a. Influenza vaccine
 - b. Pneumococcal vaccine
 - c. Tetanus/diphtheria toxoid

Pediatric and Adolescent Gynecology (MK)

1. Describe the anatomical changes of the genital tract, including the vulva, uterus and ovaries, related to different ages in the newborn, child, and adolescent, including:
 - a. Tanner Staging
 - b. Hormonal and growth effect
2. Describe the sex hormonal changes that occur anatomically and in the first two years of life and in childhood.

PGY 3

Benign disorders of the breast (MK, PC)

1. Describe the principal pathophysiologic conditions that affect the breast, such as:
 - a. Breast mass
 - b. Nipple discharge
 - c. Pain
 - d. Infection (mastitis)
 - e. Dermatologic abnormality
 - f. Asymmetry
 - g. Excessive size
 - h. Underdevelopment
2. Describe the typical clinical history of a patient with one of the aforementioned conditions.
3. Perform and/or interpret the results of tests to assess breast disorders:
 - a. Cyst aspiration
 - b. Collection of nipple discharge for cytologic examination and/or culture
 - c. Needle aspiration of an abscess
 - d. Skin biopsy
 - e. Needle or excisional biopsy-histology
 - f. Mammography
 - g. Ultrasonography

Critical care adult respiratory distress syndrome (MK, PC)

1. Describe the principal causes of adult respiratory distress syndrome (ARDS).
2. Describe the usual signs and symptoms manifested by a patient with ARDS.
3. Perform a focused physical examination to confirm the diagnosis of ARDS, determine the etiology of the disorder, and assess the severity of the condition.
4. Interpret the results of diagnostic tests, such as:
 - a. Chest X-ray

- b. Pulse oximetry
 - c. Arterial blood gases
 - d. Pulmonary function tests
 - e. Central hemodynamic monitoring
5. Treat a patient with ARDS in consultation with a specialist in critical care medicine.

Critical care hemodynamic monitoring (MK, PC)

Describe the conditions most likely to cause cardiovascular dysfunction in obstetric and gynecologic patients.

2. Perform a focused physical examination to detect hemodynamic derangements, such as:
- a. Hypotension or hypertension
 - b. Bradycardia or tachycardia
 - c. Apnea or tachypnea
 - d. Signs of poor tissue perfusion (e.g., oliguria, delayed capillary refill)
 - e. ARDS
 - f. Myocardial failure
 - g. Altered mental status
3. Describe the indications for central hemodynamic monitoring (right heart catheterization).
4. Interpret the results of central hemodynamic monitoring.
5. Describe and, in consultation with a critical care specialist, treat the complications of central hemodynamic monitoring.

Critical care cardiopulmonary resuscitation (MK, PC)

1. Describe the conditions that most commonly cause cardiopulmonary failure in obstetric and gynecologic patients.
2. Perform a rapid, focused physical examination to identify the patient who requires cardiopulmonary resuscitation and to determine the cause of the patient's decompensation.
3. Perform basic cardiac life support:
- a. Assess airway, breathing, and circulation.
 - b. Secure the airway.
 - c. Provide ventilation by mouth-to-mouth and bag-mask techniques.
 - d. Perform chest compressions.
4. In consultation with a specialist in critical care medicine, perform advanced cardiac life support:
- a. Intubate the patient.
 - b. Administer drugs, such as:
 - i. Lidocaine
 - ii. Atropine
 - iii. Epinephrine
 - iv. Sodium bicarbonate
 - c. Defibrillate
5. Describe the complications of basic and advanced cardiac life support.

Chronic pelvic pain (MK, PC)

1. Describe the principal causes of chronic pelvic pain (acyclic pain >6 months in duration).
2. Elicit a pertinent medical and sexual history to determine the most likely etiology of chronic pelvic pain, including those causes emanating from nonreproductive organs.
3. Perform a focused physical examination to determine the most likely etiology of chronic pelvic pain.
4. Perform and interpret the results of selected diagnostic tests to determine the cause of chronic pelvic pain, for example:
- a. Microbiologic cultures of the genitourinary tract
 - b. Hysteroscopy
 - c. Laparoscopy
 - d. Injection of anesthetic agent at a specific trigger point
 - e. Mental status examination
5. Treat medically and surgically patients with chronic pelvic pain.
6. Describe the indications for referral of a patient to a subspecialist or a specialist in a different field such as

psychiatry or pain management.

7. Describe the appropriate long-term follow-up for a patient with chronic pelvic pain.

Endometriosis (MK,PC)

1. Describe the theories of the pathogenesis of endometriosis.
2. Describe the typical history of a patient with endometriosis.
3. Perform a focused physical examination in a patient with suspected endometriosis and identify the principal abnormal clinical findings.
4. Perform selected tests to confirm the diagnosis of endometriosis, for example:
 - a. Endovaginal ultrasonography
 - b. Laparoscopy and biopsy of a suspicious
5. Perform selected tests to assess the fertility status of a patient with endometriosis (see Unit 5, Reproductive Endocrinology).
6. Describe the staging system for endometriosis according to the 1996 Revised American Society for Reproductive Medicine Classification of Endometriosis.
7. Treat endometriosis medically and surgically.
8. Describe the appropriate long-term follow-up in patients who have endometriosis.

Pelvic support defects (MK, PC)

1. Describe the normal anatomic supports and dynamics of the vagina, rectum, bladder, urethra, and uterus.
2. Describe the principal etiologies of pelvic support defects.
3. Perform a pertinent history in a patient with a suspected pelvic support defect.
4. Perform a focused physical examination to identify a specific pelvic support defect, such as:
 - a. Cystocele
 - b. Urethrocele
 - c. Rectocele
 - d. Enterocele
 - e. Uterine descensus
 - f. Vaginal vault prolapse
5. Treat pelvic support defects medically and surgically.
6. Describe the appropriate follow-up for a patient who has been treated for a pelvic support defect.

Septic shock (PC, MK)

1. Describe the usual causes of septic shock in obstetric and gynecologic patients.
2. Describe the typical symptoms experienced by a patient with septic shock.
3. Perform a focused physical examination to confirm the diagnosis of septic shock, determine the etiology of the disorder, and assess the severity of the patient's illness.
4. Interpret the results of diagnostic tests, such as:
 - a. Microbiologic cultures
 - b. Complete blood count and white cell differential
 - c. Liver function tests
 - d. Renal function tests
 - e. Coagulation profile
 - f. Chest X-ray
 - g. MRI and CT scan of the abdomen and pelvis
 - h. Ultrasonography of the pelvis
 - i. Arterial blood gases
 - j. Central hemodynamic monitoring
5. Treat a patient with septic shock in consultation with a specialist in critical care medicine

Urogynecologic disorders (PC, MK)

1. Describe the major suspected causes of urogynecologic disorders, such as:
 - a. Obesity
 - b. Pulmonary disease
 - c. Multiparity

- d. Medications
 - e. Infection
2. Describe the typical symptoms experienced by a patient with an urogynecologic disorder.
 3. Perform a focused physical examination to determine the cause of an urogynecologic disorder.
 4. Perform selected tests to determine the cause of a urogynecologic disorder, for example:
 - a. Assessment for residual urine
 - b. Examination of the genitourinary organs during a Valsalva maneuver
 - c. Examination of urethral and vaginal supports
 - d. Assessment of perineal and levator ani muscle strength
 - e. Urinalysis
 - f. Focused neurologic assessment
 5. Interpret the results of other diagnostic tests, such as:
 - a. Cystourethroscopy
 - b. Urethral profilometry
 - c. Cystometrics
 - d. Uroflowmetry
 6. Treat urogynecologic disorders medically and surgically.
 7. Describe the appropriate long-term follow-up for a patient treated for an urogynecologic disorder.

Geriatric Surgical Care (PC, MK)

1. Describe the principal goal of surgery in the geriatric patient, i.e., a safe, effective operation that returns the patient to maximum functional capacity.
2. Describe complications of anesthesia that are unique to the elderly patient.
3. Describe the appropriate preoperative evaluation for a geriatric patient.
4. Describe intraoperative complications that typically occur with greater frequency in geriatric patients, such as:
 - a. Entrapment (pressure) neuropathies
 - b. Hypothermia
 - c. Fluid and electrolyte imbalances
 - d. Thromboembolism
5. Describe the unique considerations related to post operative care of the geriatric patient, such as:
 - a. Doses of analgesics
 - b. The need for early ambulation
 - c. Prophylaxis for Thromboembolism
 - d. Prevention of falls
 - e. The need for referral to an assisted-living facility

Geriatric Pharmacology, Pharmacokinetics, and Pharmacodynamics (PC, MK)

1. Describe changes in drug metabolism and excretion that occur as a result of aging.
2. List the most common reasons for adverse drug reactions in geriatric patients.
3. List the drugs that most commonly cause adverse reactions in geriatric patients, such as:
 - a. Psychotropic medications
 - b. Diuretics
 - c. Cardiovascular agents
4. Obtain an accurate history of drug use in geriatric patients, including nonprescription medications.

Geriatric Ethical and Legal Issues (SBP, IC)

1. Assess the geriatric patient's capacity for independent decision-making.
2. Describe the usual signs of elder abuse or neglect.
3. Counsel patients and family members about advance directives, living wills, power of attorney, 4. and surrogate decision-making.
4. Counsel patients and family members about the right of refusal of treatment.
5. Counsel patients and family members about the proper use of "do not resuscitate" (DNR) orders.
6. Describe appropriate indications for referral of a patient to hospice for end-of-life care.

Coding and reimbursement (SBP)

1. Describe the evaluation and management (E&M) codes that are most applicable to outpatient care of elderly women.
2. Describe the preventive medicine services that usually are reimbursable under the Medicare insurance program.
3. Describe the appropriate resident-attending interaction required for the care of an elderly patient insured under the Medicare program.

Pediatric and Adolescent Gynecology (MK,PC)

1. Describe the principal gynecologic disorders or conditions experienced by adolescent patients and the special implications for diagnosis and management of these complex diseases as they pertain to adolescents:
 - a. Normal and abnormal pubertal development
 - b. Normal psychosocial development
 - c. Primary amenorrhea
 - d. Breast mass
 - e. Menstrual irregularities
 - f. Dysmenorrhea
 - g. Vulvovaginitis
 - h. Sexuality
 - i. Contraceptive needs
 - j. Sexually transmitted diseases
 - k. Pregnancy
 - l. Sexual abuse
 - m. Ovarian diseases and masses
 - n. Endometriosis
 - o. Chronic pelvic pain
2. Elicit a pertinent medical and sexual history from an adolescent patient.
3. Perform a focused physical examination with proper technique and instrumentation to identify specific conditions in an adolescent patient with special attention to the appropriateness of sexual development.
4. Provide for the primary care needs of the adolescent, demonstrating knowledge of the following:
 - a. Psychologic health
 - b. Immunizations
 - c. Confidentiality issues
 - d. Facilitation of parent-child communication
 - e. Safety and prevention of morbidity and mortality
 - f. Substance abuse
 - g. Nutrition and dietary management
5. Perform and/or interpret selected tests to confirm the diagnosis of specific gynecologic disorders, such as:
 - a. Microbiologic tests
 - b. Endocrinologic assays
 - c. Ultrasonography and MRI
 - d. Laparoscopy
 - e. Examination under anesthesia
6. Interpret other diagnostic tests, such as:
 - a. Qualitative and quantitative hCG
 - b. MRI
7. Treat adolescent gynecologic disorders medically and surgically.
8. Describe the indications for referral to a subspecialist.
9. Counsel the patient and her family about the long-term prognosis of her condition and its effect on reproduction and general health.
10. Provide patient and parent education concerning the following:
 - a. Normal anatomic and psychosocial development
 - b. Personal hygiene
 - c. Menses

- d. Sexuality
 - e. Prevention of pregnancy and STDs, including emergency contraception
 - f. Psychosocial concerns, e.g., eating disorders, substance use, safety.
11. Evaluate and manage Prepubertal children with:
- a. Vaginal discharge
 - b. Vulvar lesions (labial agglutination, condyloma acuminata, psoriasis, lichen sclerosis, seborrheic dermatitis, hemangioma, molluscum contagiosum)
 - c. Periurethral lesions (urethral prolapse, periurethral cyst, urethral caruncle)
 - d. Sexual assault
12. Evaluate and manage or make appropriate referral for adolescent disorders:
- Developmental issues
- a. Body image disturbances, eating disorders
 - b. Substance abuse
 - c. Sexual/Physical violence

General Competency Based Skills in Benign GYN

Communicate effectively with patients, staff, consultants and colleagues. **(IC, SBP)**

Demonstrate ethical and professional behavior. **(P)**

Teach medical students and junior colleagues. **(IC, SBP, P)**

Identify areas for personal improvement in Female Pelvic Medicine and implement strategies to accomplish this. **(PBL)**

Identify areas for personal improvement in surgical skills and implement strategies to accomplish this. **(PBL)**

APPENDIX G FPMRS DETAIL OBJECTIVES

At the conclusion of the PGY4 year, the resident should have developed competency in the following objectives: **(PC, MK)**

1. Explain the normal anatomic supports of the vagina, rectum, bladder urethra and uterus (or vaginal cuff), including the bony pelvis, pelvic floor nerves and musculature, and connective tissue.
2. Describe the relationships between the pelvic floor organs with regards to function and support mechanisms
3. Understand the function of the lower urinary tract during bladder filling and emptying and the mechanisms involved in continence
4. Summarize the possible psychosocial, economic and physical burdens of disorders of the lower urinary and genital tracts
5. Describe the etiology of disorders of pelvic organ support, urinary incontinence and fecal incontinence
6. Identify the anatomic defects associated with the different disorders of pelvic support disorders
7. Explain the different types of incontinence
8. Understand the different potential abnormalities of the urethra, including diverticuli, urethral syndrome, and urethritis
9. Understand the valuation and possible treatments for painful bladder syndrome
10. Understand the different possible causes of voiding dysfunction and their characteristics
11. Understand the anatomic abnormalities, common causes, diagnostic evaluations and treatments of lower urinary and genital tract fistulas
12. Describe the symptoms associated with disorders of pelvic organ support, urinary incontinence and fecal incontinence
13. Obtain a pertinent history in patients with disorders of the pelvic floor
14. Perform a focused physical examination to identify and characterize specific pelvic floor defects, including:
 - a. Anterior vaginal wall defects
 - b. Urethral hypermobility
 - c. Posterior vaginal wall defects
 - d. Apical defects
15. Perform a focused physical examination on a patient with urinary or fecal incontinence, including:
 - a. Bladder/anterior vaginal wall support
 - b. Posterior vaginal wall support
 - c. Anal sphincter integrity
 - d. Neurologic status
16. Perform and understand the basic evaluation tools of:
 - a. Assessment of residual urine volume
 - b. Simple cystometry
 - c. Q-tip test
17. Describe the indication for and interpretation of the results for basic diagnostic tests, including:
 - a. Urinalysis
 - b. Urine culture
 - c. Cystourethroscopy
 - d. Multichannel cystometry
 - e. Urethral profilometry
 - f. Uroflowmetry
 - g. Radiologic studies
 - h. Electromyography
 - i. Assessment of anal sphincter integrity (i.e. anal ultrasound)
18. Treatment pelvic floor disorders both surgically and with non-surgical measures
19. understand the importance and indications of pelvic floor physical therapy
20. describe and understand the treatment algorithms of possible peri-operative complications associated

with the treatment of pelvic floor disorders

21. describe the appropriate follow-up of patients with pelvic floor disorders after treatment
22. summarize and counsel patients regarding the risks, benefits, and expected outcomes of surgical and non-surgical treatments for disorders of the pelvic floor
23. distinguish between the different types of urinary tract infection
24. understand the evaluation of hematuria in women
25. understand the risk factors and methods of evaluation for possible nephrolithiasis or intra-vesicle calculi
26. understand the diagnostic criteria associated with nephrolithiasis versus urinary tract infection
27. understand the treatment regimens for acute urinary tract infections and nephrolithiasis
28. understand the evaluation and treatment of patients with recurrent urinary tract infections

General Competency Based Skills IN FPMRS

Communicate effectively with patients, staff, consultants and colleagues. **(IC, SBP)**

Demonstrate ethical and professional behavior. **(P)**

Teach medical students and junior colleagues. **(IC, SBP, P)**

Identify areas for personal improvement in Female Pelvic Medicine and implement strategies to accomplish this. **(PBL)**

Identify areas for personal improvement in surgical skills and implement strategies to accomplish this. **(PBL)**

APPENDIX H

Operative and Discharge Dictations

Dictations: dial 258 and follow prompts. Press 1 for OR dictation and 7 for discharge.

OP dictations should be done immediately following the procedure and must be done within 24 hours. At the end of each procedure, make certain that each person on the operative team understands who is responsible for the dictation. Generally, the dictation will be done by a resident who is acting as surgeon or by the Attending.

OP dictation format needs to include:

- Pre op DX(s):
- Post op Dx(s):
- Procedures(s):
- Surgeon:
- Assist(s):
- Anesthesia:
- EBL:
- IV Fluids
- Complications:
- Findings:
- Narrative of procedure:

You must dictate the date of the procedure (and it must be correct) or the OR dictation will not count.

Discharge dictation format needs to include:

- Date admission:
- Date discharge:
- Admit Dx:
- Discharge Dx:
- Procedures performed/treatment rendered:
- Complications:
- Condition on discharge:
- Disposition on discharge:
- Discharge meds:

Discharge dictations are the responsibility of the resident who discharges the patient. All things being equal, they should be done at the time of discharge.

2009-2010 Call Schedule	Final
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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
CNM	NF1	NF1	NF1	NF1	CNM	Gyn1
US/A 1	NF2	NF2	NF2	Gyn2	FMF	REI2
NF2	NF3	NF3	NF3	NF3	Onco2	MFM3
NF4	NF4	NF4	NF4	Gyn4	Gyn3	OB4
Onco3 to 7					(FAC)	
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
CNM	NF1	NF1	NF1	US/A 1	CNM	MFM1
NF1	NF2	NF2	NF2	NF2	OB1	Gyn2
NF3	NF3	NF3	NF3	Gyn3	OB2	UG/ER3
ER/UG 4	NF4	NF4	NF4	NF4	Onco3	Gyn4
Onco2 to 7					(FAC)	
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
CNM	NF1	NF1	NF1	NF1	CNM	Gyn1
US/A1	NF2	NF2	NF2	Gyn2	FMF	REI2
NF2	NF3	NF3	NF3	NF3	Onco2	MFM3
NF4	NF4	NF4	NF4	Gyn4	Gyn3	OB4
Onco3 to 7					(FAC)	
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
CNM	NF1	NF1	NF1	US/A1	CNM	MFM1
NF1	NF2	NF2	NF2	NF2	OB1	Gyn2
NF3	NF3	NF3	NF3	Gyn3	OB2	UG/ER3
ER/UG4	NF4	NF4	NF4	NF4	Onco3	Gyn4
Onco2 to 7					(FAC)	

1st Years

FMF (Fri x 2)
 OB1 (Fri x 2)
 MFM1 (Sat x 2)
 Gyn1 (Sat x 2)
 US/A 1 (Thurs x 2, Sun x 2)
 NF1

2nd Years

OB2 (Fri x2)
 Gyn2 (Thurs x2, Sat x 2)
 Onco2 (Fri x 2, 1/2 Sun x 2)
 REI2 (Sat x 2)
 NF2

3rd Years

MFM3 (Sat x 2)
 Gyn3 (Thurs x 2, Fri x 2)
 Onco3 (Fri x 2, 1/2 Sun x 2)
 UG/ER3 (Sat x 2)
 NF3

4th Years

OB4 (Sat x 2)
 Gyn4 (Thurs x 2, Sat x 2)
 ER/UG4 (Sun x 2)
 NF4

MASTER RESIDENT DAY SCHEDULE

First Half of Year (6/29/09-12/27/09)

Weeks 1 & 3

	Monday	Tuesday	Wednesday	Thursday	Friday
WHC AM	OB1 Gyn 3	High Risk OB 4 MFM 3 OB 2 MFM1	OB2 Gyn 1	REI 2 US/A1	
WHC PM	MFM1 UG3 Gyn 2		MFM3 Onco 2 Gyn 1	Gyn 4 OB 4 US/A1	Onco 3 FMF
L&D	OB 2 OB 1 (pm) REI (am)	OB 1 FMF (am) OB 2 (pm)	OB 2 (pm) OB 1 FMF	OB 2 OB1 FMF	OB 2 (pm) OB 1 (pm)
OB Chief	OB4	ER/4 (am) OB 4 (pm)	OB4	OB 4 (am) MFM (pm)	OB 4 (pm)
GYN	Gyn 3 (pm) Gyn 2 (am) Gyn 1	Gyn 3 Gyn 2 Gyn 1	Gyn 3 Gyn 2	Gyn 3 (am) Gyn 2 Gyn 1	Gyn 1 (pm)
Gyn Chief	Gyn4	Gyn4	Gyn4	Gyn3 (pm) Gyn 4 (am)	Gyn 3 (pm)
REI	REI 2 (pm)	REI 2	REI 2	REI 2 (pm)	REI 2 (pm)
UG	Urogyn3 (am)	Urogyn3	Urogyn3	Urogyn3	Urogyn3 (pm)
Onco 2	Onco2	Onco2	Onco2 (am)	Onco2	Onco2 (pm)
Onco 3	Onco 3	Onco 3	Onco 3	Onco 3	
MFM	MFM3 MFM1 (am)	MFM3 (pm) MFM1 (pm)	MFM3 (am) MFM1	MFM3 (am) MFM1	MFM3 (pm) MFM 1 (pm)
US/A 1		US/A1	US/A1 (preterm pm)		US/A1
E/R	ER4	ER4 (pm)	ER4	ER4	ER4 (pm)
Jeopardy Call	Gyn3 MFM3 OB1	OB4 Gyn2 MFM1	Gyn4 OB2 FMF	Gyn1	
Vacation/Leave					
On Call					
Post Call					

MASTER RESIDENT DAY SCHEDULE

First Half of Year (6/29/09-12/27/09)

Weeks 2 & 4

	Monday	Tuesday	Wednesday	Thursday	Friday
WHC AM	OB1 Gyn 3	High Risk OB 4 MFM 3 OB 2 MFM1	OB2 Gyn 1	REI 2 US/A1	
WHC PM	MFM1 UG3 Gyn 2		MFM3 Onco 2 Gyn 1	Gyn 4 OB 4 US/A1	Onco 3 FMF
L&D	OB 2 OB 1 (pm) US/A 1 (am)	OB 1 FMF (am) OB 2 (pm)	OB 2 (pm) OB 1 FMF	OB 2 OB1 FMF	OB 2 (pm) OB 1 (pm)
OB Chief	OB4	ER/4 (am) OB 4 (pm)	OB4	OB 4 (am) MFM3 (pm)	OB 4 (pm)
GYN	Gyn 3 (pm) Gyn 2 (am) Gyn 1	Gyn 3 Gyn 2 Gyn 1	Gyn 3 Gyn 2	Gyn 3 (am) Gyn 2 Gyn 1	Gyn 2 (pm) Gyn 1 (pm)
Gyn Chief	Gyn4	Gyn4	Gyn4	Gyn3 (pm) Gyn 4 (am)	Gyn 4 (pm)
REI	REI 2	REI 2	REI 2	REI 2 (pm)	REI 2 (pm)
UG	Urogyn3 (am)	Urogyn3	Urogyn3	Urogyn3	Urogyn3 (pm)
Onco 2	Onco2	Onco2	Onco2 (am)	Onco2	Onco2 (pm)
Onco 3	Onco 3	Onco 3	Onco 3	Onco 3	
MFM	MFM3 MFM1 (am)	MFM3 (pm) MFM1 (pm)	MFM3 (am) MFM1	MFM3 (am) MFM1	MFM3 (pm) MFM 1 (pm)
US/A 1	US/A 1 (pm)	US/A1	US/A1 (preterm pm)		
E/R		ER4 (pm)	ER4	ER4	ER4 (pm)
Jeopardy Call	Gyn3 MFM3 OB1	OB4 Gyn2 MFM1	Gyn4 OB2 FMF	Gyn1	
Vacation/Leave					
On Call					
Post Call					

MASTER RESIDENT DAY SCHEDULE

Second Half of Year (12/28/09-6/27/10)

Weeks 1 & 3

	Monday	Tuesday	Wednesday	Thursday	Friday
WHC AM	OB1 Gyn 3	High Risk OB 4 MFM 3 OB 2 MFM1	OB2 Gyn 1	REI 2 US/A1	
WHC PM	MFM1 UG4 Gyn 2		MFM3 Onco 2 Gyn 1	Gyn 4 OB 4 US/A1	Onco 3 FMF
L&D	OB 2 REI 2 (am) OB 1 (pm)	OB 1 FMF (am) OB 2 (pm)	OB 2 (pm) OB 1 FMF	OB 2 OB1 FMF	OB 2 (pm) OB 1 (pm)
OB Chief	OB4	ER/3 (am) OB 4 (pm)	OB4	OB 4 (am) MFM3 (pm)	OB 4 (pm)
GYN	Gyn 3 (pm) Gyn 2 (am) Gyn 1	Gyn 3 Gyn 2 Gyn 1	Gyn 3 Gyn 2	Gyn 3 (am) Gyn 2 Gyn 1	Gyn 1 (pm)
Gyn Chief	Gyn4	Gyn4	Gyn4	Gyn 4 (am) Gyn3 (pm)	Gyn 3 (pm)
REI	REI 2 (pm)	REI 2	REI 2	REI 2 (pm)	REI 2 (pm)
UG	Urogyn4 (am)	Urogyn4	Urogyn4	Urogyn4	Urogyn4 (pm)
Onco 2	Onco2	Onco2	Onco2 (am)	Onco2	Onco2 (pm)
Onco 3	Onco 3	Onco 3	Onco 3	Onco 3	
MFM	MFM3 MFM1 (am)	MFM3 (pm) MFM1 (pm)	MFM3 (am) MFM1	MFM3 (am) MFM1	MFM3 (pm) MFM 1 (pm)
US/A 1		US/A1	US/A1 (preterm pm)		US/A 1 (pm)
E/R	ER3	ER3 (pm)	ER3	ER3	ER3 (pm)
Jeopardy Call	Gyn3 MFM3 OB1	OB4 Gyn2 MFM1	Gyn4 OB2 FMF	Gyn1	
Vacation/Leave					
On Call					
Post Call					

MASTER RESIDENT DAY SCHEDULE

Second Half of Year (12/28/09-6/27/10)

Weeks 2 & 4

	Monday	Tuesday	Wednesday	Thursday	Friday
WHC AM	OB1 Gyn 3	High Risk OB 4 MFM 3 OB 2 MFM1	OB2 Gyn 1	OB 4 REI 2 US/A1	
WHC PM	MFM1 Gyn 2		UG4 Onco 2 Gyn 1	Gyn 4 MFM3 US/A1	Onco 3 FMF
L&D	OB 2 OB 1 (pm) US/A 1 (am)	OB 1 FMF (am) OB 2 (pm)	OB 2 (pm) OB 1 FMF	OB 2 OB1 FMF	OB 2 (pm) OB 1 (pm)
OB Chief	OB4	ER/3 (am) OB 4 (pm)	OB4	OB 4 (pm) MFM3 (am)	OB 4 (pm)
GYN	Gyn 3 (pm) Gyn 2 (am) Gyn 1	Gyn 3 Gyn 2 Gyn 1	Gyn 3 Gyn 2	Gyn 3 (am) Gyn 2 Gyn 1	Gyn 2 (pm) Gyn 1 (pm)
Gyn Chief	Gyn4	Gyn4	Gyn4	Gyn 4 (am) Gyn3 (pm)	Gyn 4 (pm)
REI	REI 2	REI 2	REI 2	REI 2 (pm)	REI 2 (pm)
UG		Urogyn4	Urogyn4	Urogyn4	Urogyn4 (pm)
Onco 2	Onco2	Onco2	Onco2 (am)	Onco2	Onco2 (pm)
Onco 3	Onco 3	Onco 3	Onco 3	Onco 3	
MFM	MFM3 MFM1 (am)	MFM3 (pm) MFM1 (pm)	MFM3 MFM1	MFM1	MFM3 (pm) MFM 1 (pm)
US/A 1	US/A 1 (pm)	US/A1	US/A1 (preterm pm)	US/A 1	
E/R	ER3	ER3 (pm)	ER3	ER3	ER3 (pm)
Jeopardy Call	Gyn3 MFM3 OB1	OB4 Gyn2 MFM1	Gyn4 OB2 FMF	Gyn1	
Vacation/Leave					
On Call					
Post Call					

ROTATION SCHEDULE 2009-2010
Final 5/26/09

PGY-1
5/6 wks

RESIDENT	6/29-8/2	8/3-9/6	9/7-10/11	10/12-11/22	11/23-12/27	12/28-1/31	2/1-3/14	3/15-4/18	4/19-5/23	5/24-6/27
Petitt	OB1	NF1	US/A 1	MFM1	Gyn1	OB1	NF1	US/A 1	MFM1	Gyn1
Wiley	Gyn1	OB1	NF1	US/A 1	MFM1	Gyn1	OB1	NF1	US/A 1	MFM1
Miketa	MFM1	Gyn1	OB1	NF1	US/A 1	MFM1	Gyn1	OB1	NF1	US/A 1
James	US/A 1	MFM1	Gyn1	OB1	NF1	US/A 1	MFM1	Gyn1	OB1	NF1
Yeater	NF1	US/A 1	MFM1	Gyn1	OB1	NF1	US/A 1	MFM1	Gyn1	OB1

PGY-2
5/6 wks

RESIDENT	6/29-8/2	8/3-9/6	9/7-10/11	10/12-11/22	11/23-12/27	12/28-1/31	2/1-3/14	3/15-4/18	4/19-5/23	5/24-6/27
Ye	OB2	Gyn2	NF2	REI2	Onco2	Gyn2	NF2	REI2	Onco2	OB2
Rodewald	Onco2	OB2	Gyn2	NF2	REI2	OB2	Gyn2	NF2	REI2	Onco2
Billow	REI2	Onco2	OB2	Gyn2	NF2	Onco2	OB2	Gyn2	NF2	REI2
Prinz	NF2	REI2	Onco2	OB2	Gyn2	REI2	Onco2	OB2	Gyn2	NF2
Deter	Gyn2	NF2	REI2	Onco2	OB2	NF2	REI2	Onco2	OB2	Gyn2

PGY3
5/6 wks

RESIDENT	6/29-8/2	8/3-9/6	9/7-10/11	10/12-11/22	11/23-12/27	12/28-1/31	2/1-3/14	3/15-4/18	4/19-5/23	5/24-6/27
Escobedo	MFM3	NF3	UG3	Onco3	Gyn3	MFM3	NF3	ER3	Onco3	Gyn3
Loomis	Gyn3	MFM3	NF3	UG3	Onco3	Gyn3	MFM3	NF3	ER3	Onco3
Quirino	Onco3	Gyn3	MFM3	NF3	UG3	Onco3	Gyn3	MFM3	NF3	ER3
Lazo	UG3	Onco3	Gyn3	MFM3	NF3	ER3	Onco3	Gyn3	MFM3	NF3
Velotta	NF3	UG3	Onco3	Gyn3	MFM3	NF3	ER3	Onco3	Gyn3	MFM3

PGY4
6/7 wks

RESIDENT	6/29-8/9	8/10-9/27	9/28-11/8	11/9-12/27	12/28-2/14	2/15-3/28	3/29-5/09	5/10-6/20
Ehrenberg	OB4	NF	ER4	Gyn4	OB4	NF4	UG4	Gyn4
Bedaiwy	Gyn4	OB4	NF4	ER4	Gyn4	OB4	NF4	UG4
Sandadi	ER4	Gyn4	OB4	NF4	UG4	Gyn4	OB4	NF4
Flyckt	NF4	ER4	Gyn4	OB4	NF4	UG4	Gyn4	OB4

WHC Resident Schedule: First ½ of Year (6.29.09-12.27.09)

Wk 1/3	Mon	Tues	Wed	Thurs	Fri
AM	OB1 Gyn3	High Risk OB 4 MFM 3 OB 2 MFM 1	OB2 Gyn 1	REI 2 US/A 1	
PM	MFM 1 UG3 Gyn 2		MFM 3 Onco 2 Gyn 1	Gyn 4 OB 4 US/A 1	Onco 3 FMF

Wk 2/4	Mon	Tues	Wed	Thurs	Fri
AM	OB1 Gyn3	High Risk OB 4 MFM 3 OB 2 MFM 1	OB 2 Gyn 1	REI 2 US/A 1	
PM	MFM 1 UG 3 Gyn2		MFM 3 Onco 2 Gyn 1	Gyn 4 OB 4 US/A 1	Onco 3 FMF

WHC Resident Schedule: Second ½ of Year (12.28.09-6.27.10)

Wk 1/3	Mon	Tues	Wed	Thurs	Fri
AM	OB 1 Gyn 3	High Risk OB 4 MFM 3 OB 2 MFM 1	OB 2 Gyn 1	REI 2 US/A 1	
PM	MFM 1 UG 4 Gyn 2		MFM 3 Onco 2 Gyn 1	Gyn 4 OB 4 US/A 1	Onco 3 FMF

Wk 2/4	Mon	Tues	Wed	Thurs	Fri
AM	OB 1 Gyn 3	High Risk OB 4 MFM 3 OB 2 MFM 1	OB 2 Gyn 1	OB 4 REI 2 US/A 1	
PM	MFM 1 Gyn 2		UG 4 Onco 2 Gyn 1	Gyn 4 MFM 3 US/A 1	Onco 3 FMF

Name: _____
Date: _____

Intern Credentialing for C-section
Second Assist (Must be completed first)

Date	Label	Procedure	Comments	Attending

Second Assist (Must be completed first)

Date	Label	Procedure	Comments	Attending

Second Assist (Must be completed first)

Date	Label	Procedure	Comments	Attending

Second Assist (Must be completed first)

Date	Label	Procedure	Comments	Attending

Second Assist (Must be completed first)

Date	Label	Procedure	Comments	Attending

Name: _____

Date: _____

Intern Credentialing for C-section
First Assist (Surgeon must be FT/PT faculty member)

Date	Label	Procedure	Comments	Attending

First Assist (Surgeon must be FT/PT faculty member)

Date	Label	Procedure	Comments	Attending

First Assist (Surgeon must be FT/PT faculty member)

Date	Label	Procedure	Comments	Attending

First Assist (Surgeon must be FT/PT faculty member)

Date	Label	Procedure	Comments	Attending

First Assist (Surgeon must be FT/PT faculty member)

Date	Label	Procedure	Comments	Attending