

Department of Obstetrics & Gynecology

Residency Education Program

2018- 2019 OB/GYN RESIDENCY EDUCATION MANUAL

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Department Directory

Department of Obstetrics and Gynecology

Residency Education Program

On behalf of the administration, faculty and staff of MSM, we you to the Department of Obstetrics and Gynecology. Our program offers a dynamic and comprehensive graduate medical education program with an emphasis on the individual professional growth of each resident.

The Department of Obstetrics and Gynecology was established September 1991. The Residency Program began July of 1993 and received accreditation from the Accreditation Council on Graduate Medical Education in January 1998. Our mission is closely aligned with the mission of MSM. We are committed to supporting the interface of women’s health and primary care with an emphasis on working in the community and with the undeserved. We emphasize quality patient care along with pursuit of scholarly activity and meaningful research.

We have a diverse and dedicated faculty with demonstrated excellence in teaching. The close interaction between faculty and resident is a major strength of our program.

We are very encouraged by your decision to join our program and will ensure that you receive a fulfilling learning experience.

**Roland P. Matthews, MD**

Chairperson and Professor

**Franklyn H. Geary, Jr., MD**

Professor, Residency Training Program Director

**Kiwita Phillips, MD**

Assistant Professor, Assistant Residency Program Director



Mission Statement

Morehouse School of Medicine (MSM) exists to:

* improve the health and well being of individuals and communities
* increase the diversity of the health professional and scientific workforce
* address primary healthcare needs through programs in education, research, and service

With emphasis on people of color and the underserved urban and rural populations in Georgia, the nation, and the world.

Resident Eligibility

The MSM Obstetrics and Gynecology Residency Program will select from eligible applicants based on their preparedness and ability to benefit from our program. Aptitude, academic credentials, the ability to communicate effectively, personal characteristics such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty, shall be considered in the selection process.

The following are the institution’s **Technical Standards and Essential Functions for Appointment and Promotion information:**

1. **Introduction**

Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills and behaviors necessary for the practice of medicine and throughout a professional career. Those abilities that Residents must possess to practice safely are reflected in the technical standards that follow. These technical standards/essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty.

Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.

Residents in Graduate Medical Education programs must be able to meet these minimum standards, with or without reasonable accommodation (*see* Section III).

**II. Standards**

A. Observation

Observation requires the functional use of vision, hearing and somatic sensations. Residents must be able to observe demonstrations and participate in procedures as required. Residents must be able to observe a patient accurately and completely, at a distance as well as closely. They must be able to obtain a medical history directly from a patient, while observing the patient’s medical condition.

B. Communication

Communication includes: speech, language, reading, writing and computer literacy. Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information, as well as perceive non-verbal communications.

C. Motor

Residents must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers. Residents must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.

D. Intellectual - Conceptual, Integrative and Quantitative Abilities

Residents must be able to measure, calculate, reason, analyze, integrate and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians. In addition, Residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

E. Behavioral and Social Attributes

Residents must possess the psychological ability required for the full utilization of their intellectual abilities, for the exercise of good judgment, for the prompt completion of all responsibilities inherent to diagnosis and care of patients, and for the development of mature, sensitive, and effective relationships with patients, colleagues and other health care providers. Residents must be able to tolerate physically and mentally taxing workloads and function effectively under stress. They must be able to adapt to a changing environment, display flexibility and learn to function in the face of uncertainties inherent in the clinical problems of patients. Residents must also be able work effectively and collaboratively as a team member. As a component of their education and training, Residents must demonstrate ethical behavior consistent with professional values and standards.

**III. Reasonable Accommodation**

MSM will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation. A reasonable accommodation is designed to assist an employee or applicant in the performance of the essential functions of his or her job or MSM’s application requirements.

Accommodations are made on a case-by-case basis. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in each situation. Complete information is found on the MSM Human Resources Office of Disability Services webpage at-

<http://www.msm.edu/Administration/HumanResources/disabilityservices/indx.php>.

In most cases, it is an employee’s or applicant’s responsibility to begin the accommodation process by making MSM aware of his or her need for a reasonable accommodation. Please see full MSM Accommodation of Disabilities Policy for information on how to request a reasonable accommodation. *\*It is important to note that the MSM enrollment of non-eligible Residents may be cause for withdrawal of residency program accreditation*.

Title IX Compliance

The residency education environment shall be free of undue harassment, confrontation, and coercion because of one’s gender, cultural and religious beliefs, other individual traits, and status or standing.

Therefore, in compliance with the Title IX of the Education Amendments of 1972, Morehouse School of Medicine (MSM) does not discriminate on the basis of sex in its education programs and activities, and is required under Title IX and the implementing regulations not to discriminate in such a manner. The prohibited sex discrimination covers sexual misconduct including, but not limited to, sexual harassment and sexual violence, and extends to employment in and admission to such programs and activities.

Also in compliance with federal law, including Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (and ADAAA amendments), it is the policy of MSM that discrimination against any person or group of persons on the basis of race, color, national origin, religion, gender, sexual orientation, marital status, ancestry, genetic information, age, disability, veteran or military status, or any other legally protected characteristic is specifically prohibited.

MSM also prohibits retaliation against members of the MSM community who raise concerns about or report incidents of discrimination based on legally protected characteristics. The following persons have been designated to handle inquiries about and reports made under **MSM’s Sex/Gender Nondiscrimination and Sexual Harassment policy**.

Marla Thompson, Title IX Coordinator, Direct Dial (404) 752-1871,

Fax (404) 752-1639 Email: [mthompson@msm.edu](mailto:mthompson@msm.edu)

Irma Stewart, Deputy Title IX Coordinator, Direct Dial: (404) 752-1606

Email: [istewart@msm.edu](mailto:istewart@msm.edu)

Morehouse School of Medicine, 720 Westview Drive, SW Harris Building,

Atlanta, GA 30310

Resident Eligibility

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) “Institutional Requirements” of the “Essentials of Accredited Residencies in Graduate Medical Education.”

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

* Graduates of medical schools in the United States accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA); graduates of Canadian medical schools approved by the Licentiate of the Medical Council of Canada (LMCC)
* Graduates of medical schools outside the United States and Canada who have a current and valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction in their current ACGME specialty/subspecialty program
* United States citizen graduates from medical schools outside the United States and Canada who have successfully completed the licensure examination (USMLE Step 3) in a United States jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of Graduate Medical Education
* Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in the paragraph above
* Those who have completed the fifth pathway, a period of supervised clinical training for students who obtained their premedical education in the United States, received medical undergraduate abroad, and passed Step 1 of the United States Medical Licensing Examination
  + After these students successfully complete a year of clinical training sponsored by an LCME-accredited United States medical school and pass USMLE Step 2 components, they become eligible for an ACGME-accredited residency as an international medical graduate.
  + The Fifth Pathway program is not supported by the American Medical Association after December 2009.
* Applicants who have passed United States Medical Licensing Examination (USMLE) Steps 1 and 2—Clinical Knowledge (CK) and Clinical Skills (CS), or have a full, unrestricted license to practice medicine issued by a United States State licensing jurisdiction.

Selectees cannot begin MSM residency programs prior to passage of the Step 2 Clinical Knowledge and Skills (CS) examinations. This expectation must be met by the time of the MSM-GME Incoming Resident orientation.

Each resident in our programs must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at Morehouse School of Medicine.

Resident Screening and Selection Criteria

Morehouse School of Medicine participates in the National Resident Matching Program (NRMP). All MSM Post Graduate Year One (PGY-I) Resident positions shall be made available for application by all students graduating from United States and Canadian accredited medical schools as determined by the NRMP. Other applicants eligible to enter the “match,” including International Medical School Graduates (IMGs), may also apply.

All applicants to the MSM residency programs shall do so through the Electronic Residency Application Service (ERAS). This service shall be used to screen needed information on all applicants. All applicants shall request that three (3) letters of professional or academic references current as of at least 18 months, be sent to the residency program administration.

The following are required for admission to the Obstetrics and Gynecology Program:

* Deans Letter
* Medical School Transcript
* Written Personal Statement
* Three letters of recommendation (at least two of these should be from members of the Department of Obstetrics and Gynecology of your school, affiliate hospital or elective course, and current within the last 18 months)
* United States Medical License Examination (USMLE) Passing Scores for Step I and II (CS and CK)
* Educational Commission for Foreign Medical Graduates (ECFMG) Valid Certification (if applicable)

For those applying on Visa Status, we only accept J-I Visa.

*The successful applicant will have a passing score on USMLE, Step I and II. There is no minimum score for consideration, but note that the 4 year average scores were 224 for USMLE Step I and 241 for Step II. Step II Clinical Skills and Clinical Knowledge must be completed before the applicant will be placed on the rank list. A chair’s letter is expected.*

The Obstetrics and Gynecology (OB/GYN) Residency Training Selection Committee reviews applications for four (4) categorical PGY 1 positions and selects the most qualified candidates via the NRMP Match. Applications for the OB/GYN Residency Program are accepted from September through January of each academic year.

Resident Appointment

Available resident positions are dependent upon the current authorized number approved by the ACGME, the space available in the postgraduate year; and funding and faculty resources available to support the training of residents according to the specialty specific program requirements identified by the ACGME.

Morehouse School of Medicine Resident appointments shall be for a maximum of 12 months from July to June, year to year. At MSM, a “Resident Appointment” is defined as a non-faculty position granted to an individual based upon his or her academic credentials and the meeting of other eligibility criteria as stated in MSM and residency program policies and standards. This position is also that of a “physician in training.”

Foreign Medical School Graduates must have a current dated or (stamped) “Indefinite” certificate from the Educational Commission for Foreign Medical Graduates (ECFMG). The program administrator shall screen for signatures, seals, notarization, and other official stamps as being original

All applicants must have passed United States Medical Licensing Examination (USMLE) Steps 1 and 2 – Clinical Knowledge (CK) and Clinical Skills (CS), or have a full, unrestricted license to practice medicine issued by a United States State licensing jurisdiction. Selectees cannot begin MSM residency programs prior to passage of the Step 2 Clinical Skills (CS) examination. This expectation must be met by the MSM-GME Incoming Resident orientation.

Morehouse School of Medicine (MSM) supports the Association of American Medical Colleges (AAMC) recommendation that Foreign Exchange Visitors - J-1 Visa is the appropriate visa for the pursuit of graduate medical education by non-immigrants. Residents in this category shall strictly follow the ECFMG sponsorship requirements for the visa.

Resident appointments are for a maximum of 12 months (July to June). Residents may enter the program at other times during a post-graduate year, but must complete all requirements according to the objectives and structure of the program. MSM Residency programs have no provisions for “shared” or “part-time” positions.

**Please refer to the GME Eligibility, Selection, and Appointment policies available in the GME Office and website**

Orientation

The orientation for new interns is held one to two weeks prior to beginning the PGY-1 training year. During the orientation, residents receive an introduction into the administrative and academic environments of the Obstetrics & Gynecology Residency Program, The Department of Obstetrics & Gynecology, Morehouse School of Medicine and the affiliate training sites of the program; to include Grady Memorial Hospital, WellStar Atlanta Medical Center (Main and South Campuses), Dekalb Medical Center, and the Atlanta VA Medical Center. The orientation process includes completion of the new-hire process, review of faculty, rotation and call schedules, conferences, advisors, evaluation procedures and vacations. Participating affiliate house-staff orientations include review of the medical staff policy and procedures, medical records, social services, security and parking, medical library, admissions, infection control, OSHA, coding and billing systems and general overview of the health care delivery system.

Immediately following the NRMP Match results, interns begin receiving information in preparation for orientation including the following:

* Resident Agreement
* Professional Liability Coverage
* Essentials of Residency Training Programs
* Due Process and Grievance Procedures
* Program Goals and Objectives
* Work Schedules, with policies and procedures
* Leave processing procedures

The following records will be retained in the permanent file of each resident:

1. Application and supplemental materials
2. Credentials, including degree, transcripts, and curriculum vitae
3. Examination scores
4. Evaluation summaries
5. Rotation assignments
6. Record of cases treated by the residents (ACGME case log)
7. Transfer records, performance evaluations
8. Due Process and grievance proceedings

Program Goals and Objectives

The program goals and objectives listed below provide the relevant ACGME competency listed in brackets before the specific goal.

It is expected that each resident progressing/completing the program should develop the following knowledge and skills in each of the six ACGME competency areas:

I.) Patient Care

A. Patient Safety

Residents and attending physicians should be aware of the critical need to ensure the patient's safety while she is treated by physicians-in-training. Respect for safety demands that training programs establish clear lines of authority, adopt stringent requirements for graded levels of supervision, delegate responsibility in accordance with the resident's skill and level of experience, and create a work environment that reduces resident stress and fatigue. Programs should evaluate residents on a regular basis to ensure that they are acquiring appropriate cognitive knowledge and technical skills. Individual residents should:

1. Make clear, legible entries in the patient's medical record, including prescription orders.

B. Specialty-Specific Competency

The specialty-specific competencies required of the obstetrician-gynecologist are summarized as follows in the form of performance-based learning objectives.

1. Perform a complete and accurate medical history and physical examination.

2. Make an informed diagnosis.

3. Make evidence-based treatment decisions.

4. Prescribe medications in a rational, thoughtful, and safe manner.

5. Safely and correctly perform the diagnostic and surgical procedures unique to the discipline of obstetrics and gynecology.

II.) Medical Knowledge

A. Terminology and classification of disease

The classification of disease requires use of a common language. The physician must become familiar with the CPT (Current Procedural Terminology) and ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) coding systems.

1. Describe the current standard terms and definitions used in obstetrics and gynecology.

2. Describe the classification and staging of obstetric and gynecologic diseases and conditions, according to both procedural and diagnostic codes.

B. Specialty-Specific Competency

Resident education programs in all fields of medicine now are being challenged to develop innovative methods for confirming that trainees acquire both the requisite cognitive knowledge and technical skills appropriate for their discipline and the important personal attributes that will enable them to function effectively in a competitive, stressful, highly technical, and rapidly changing environment. The goal of the residency training process is to produce a technically and intellectually competent physician who acts in a professional and ethical manner and consistently manifests compassion, sensitivity, and integrity. The specialty-specific competencies required of the obstetrician-gynecologist are summarized as follows in the form of performance-based learning objectives.

1. Demonstrate a sound understanding of the basic science background of reproductive medicine and apply this knowledge to the clinical care of patients.

2. Demonstrate the ability to use the scientific method and the deductive-reasoning process.

III.) Practice-based Learning and Improvement

A. Information management

Physicians are required to process increasingly greater amounts of complex information presented in many different forms. Physicians must be able to collect, report, and interpret statistical data. They also must be able to evaluate the medical literature in a systematic manner and to identify the best evidence-based guidelines and adapt these guidelines to the management of their patients.

1. Use computer-based word programs, the Internet, processing programs, statistical packages, data management.
2. Consult, as appropriate, with other professionals who have unique skills in information management (e.g. business managers, accountants, librarians, statisticians, and epidemiologists).
3. Use appropriate information resources to identify evidence-based literature, evaluate the quality of the data, and apply results to specific patient care issues.
4. Describe the relative scientific value of meta-analyses, systematic reviews, cohort studies, randomized controlled trials, and case reports.
5. Analyze critically and interpret correctly statistical data presented in journal articles.
6. Describe the classification system and mechanism for reporting and analyzing perinatal and maternal morbidity and mortality.
7. Scan the current literature systematically and organize it in an easily retrievable way for future reference.

B. Continuing Medical Education

The ultimate goal of CME is improvement in health care outcomes. Continuing medical education may take place through individual learning activities (e.g., programmed texts, videotapes, CD-ROM, DVD, the Internet, and audiotapes) or through programs developed by CME providers (e.g., postgraduate courses). An ongoing commitment to CME should enhance a physician's professional competence and improve the effectiveness and efficiency of the health care organization of which he or she is a part.

By the end of residency training, physicians should assume primary control for identification of their learning needs and selection of learning modalities. They must acquire attitudes and habits that will help them identify deficiencies in their performance and implement the necessary educational activities to correct those weaknesses.

1. Develop a lifelong pattern of independent self-assessment.
2. Develop systematic strategies to improve the efficiency and quality of care for women in one's practice.
3. Identify medical education programs that are appropriately accredited by the Accreditation Council for Continuing Medical Education.
4. Develop a system to track patient outcomes in order to adjust therapies should the resident's chosen approach fall below acceptable standards.

C. Effective Learning and Work Behaviors

Residents should develop behaviors that foster an attitude of receptiveness to acquiring and imparting information. Such skills are essential to successful learning as well as to patient care and practice management. Examples of such attributes include the following:

1. Develop a lifelong commitment to medical education.
2. Maintain receptiveness to instruction.
3. Maintain a high level of intellectual honesty.
4. Maintain civility, sensitivity, and humility in interacting with instructors, coworkers, and patients.
5. Develop and maintain habits of punctuality and efficiency.
6. Complete medical records and patient care assessments in a timely manner.
7. Maintain a consistently good work ethic (i.e., positive attitude, high level of initiative).

D. Patient Safety

Residents and attending physicians should be aware of the critical need to ensure the patient's safety while she is treated by physicians-in-training. Respect for safety demands that training programs establish clear lines of authority, adopt stringent requirements for graded levels of supervision, delegate responsibility in accordance with the resident's skill and level of experience, and create a work environment that reduces resident stress and fatigue. Programs should evaluate residents on a regular basis to ensure that they are acquiring appropriate cognitive knowledge and technical skills. Individual residents should:

1. Demonstrate a consistent willingness to discuss errors in management with the affected patient.

2. Participate consistently in organized peer review activities and use the outcomes of such reviews to improve their practice patterns.

E. Familiarity with the health care delivery system

The health care delivery system in the United States has become increasingly complex. Physicians must understand the social, legal, financial, and ethical system within which they now must practice. Physicians also must understand the mechanisms used to assess the quality and cost of the health care they provide and the procedures used to determine reimbursement for medical care.

1. Describe the process of quality assessment and improvement, including the role of clinical indicators, criteria sets, and utilization review.

F. Terminology and classification of disease

The classification of disease requires use of a common language. The physician must become familiar with the CPT (Current Procedural Terminology) and ICD-10-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) coding systems.

1. Describe the concepts of evidence-based medicine and outcomes analysis as they relate to treatment guidelines and reimbursement.

G. Specialty-Specific Competency

Resident education programs in all fields of medicine now are being challenged to develop innovative methods for confirming that trainees acquire both the requisite cognitive knowledge and technical skills appropriate for their discipline and the important personal attributes that will enable them to function effectively in a competitive, stressful, highly technical, and rapidly changing environment. The goal of the residency training process is to produce a technically and intellectually competent physician who acts in a professional and ethical manner and consistently manifests compassion, sensitivity, and integrity. The specialty-specific competencies required of the obstetrician-gynecologist are summarized as follows in the form of performance-based learning objectives.

1. Communicate effectively with other health care professionals.
2. Communicate with patients and their families in easily understood and culture-sensitive language.
3. Work effectively as both a member of a professional group and as a group leader.
4. Demonstrate the ability to serve as a consultant to other physicians and health care professionals.
5. Consistently demonstrate sensitivity to patients from different cultures.
6. Maintain comprehensive, timely, and legible medical records.

IV.) Interpersonal Communication

A. Communication skills

Communication with patients, their families, and fellow health care professionals is an integral part of the physician's responsibilities. Resident physicians have the additional responsibility of teaching medical students and fellow residents.

1. Communicate effectively with patients in language that is appropriate to their age and educational, cultural, and socioeconomic background.
2. Foster a trusting and cooperative physician-patient relationship by means of effective communication and interpersonal skills and patient education techniques.
3. Communicate effectively in a cooperative and professional manner with fellow health care providers.
4. Provide instruction and constructive feedback to medical students and other residents.

B. Cultural Diversity

The cultural and ethnic background of patients in the United States is more diverse than ever before. Physicians must understand and appreciate the various values, family structures, and meaning of life events to effectively care for women and families of different cultural backgrounds.

1. Describe the significance of conception and birth in different cultures, religions, and ethnic groups.
2. Describe the significance of marriage in different cultures, religions, and ethnic groups.
3. Describe the significance of death in different cultures, religions, and ethnic groups.
4. Provide compassionate, competent medical care to women from diverse cultural and ethnic backgrounds.

C. Specialty-Specific Competency

Resident education programs in all fields of medicine now are being challenged to develop innovative methods for confirming that trainees acquire both the requisite cognitive knowledge and technical skills appropriate for their discipline and the important personal attributes that will enable them to function effectively in a competitive, stressful, highly technical, and rapidly changing environment. The goal of the residency training process is to produce a technically and intellectually competent physician who acts in a professional and ethical manner and consistently manifests compassion, sensitivity, and integrity. The specialty-specific competencies required of the obstetrician-gynecologist are summarized as follows in the form of performance-based learning objectives.

1. Describe the clinical and economic significance of outcomes research.
2. Describe methods for analyzing practice-based outcomes research.
3. Describe a systematic plan for reviewing practice patterns and insuring continuous improvement in patient care.
4. Demonstrate the ability to use information technology to improve the practitioner's fund of knowledge and technical skills and, ultimately, provide better care to patients.

V.) Professionalism

A. Ethics

The physician specializing in obstetrics and gynecology must balance compassion, sensitivity, and pragmatism in interacting with patients and their families and fellow health care providers. The obstetrician-gynecologist must develop a lifelong commitment to continuing medical education (CME) and the highest ethical standards.

1. Demonstrate a high degree of personal responsibility to patients by being available for consultation, protecting the patient's confidentiality, and maintaining respect for the patient's physical and emotional comfort.

2. Describe basic ethical concepts such as:

a. Autonomy

b. Beneficence

c. Justice

d. Nonmaleficence

e. Positive rights

f. Negative rights

3. Apply ethical concepts appropriately and consistently to the day-to-day practice of medicine in situations, such as:

a. Obtaining informed consent

b. Assisting patients in developing advance directives and durable power of attorney

c. Balancing the interests of the individual patient, the more global patient population, and managed care organizations

B. Stress management

The practice of obstetrics and gynecology is an inherently stressful profession. Significant stress experienced by a resident can arise from career-related factors, such as concerns about professional liability, negligence, or potential litigation; the handling of complex clinical problems without close supportive supervision; the management and counseling of angry, demanding, or hostile patients; and financial pressures. Personal problems-such as lack of understanding from family concerning the demands and responsibilities of clinical practice, lack of time with spouse and family, childcare responsibilities, time pressures, and sleep deprivation add to stress and predispose to depression. Residents must develop strategies to recognize and manage unacceptably high stress levels and signs of depression. These strategies should be adaptive, healthy, and effective for the individual.

1. Describe the value of preventive stress-reduction activities, such as:

a. Regular exercise program

b. Regular program of recreation and diversion with family members and friends

c. Personal leave

2. Identify the warning signs of excessive stress within one's self and in others, such as:

a. Excessive fatigue

b. Poor concentration

c. Sleep disturbance

d. Mood disturbance

e. Withdrawal from relationships with family members and friends

f. Increased irritability

g. Poor appetite

h. Carelessness

i. Drug use

j. Self-destructive behavior

3. Recognize the need for professional counseling for oneself, family members, and fellow residents when stress causes dysfunction.

4. Intervene promptly when family members or peers exhibit evidence of excessive stress. Intervention usually will take the form of a referral for professional counseling.

C. Patient Safety

Residents and attending physicians should be aware of the critical need to ensure the patient's safety while she is treated by physicians-in-training. Respect for safety demands that training programs establish clear lines of authority, adopt stringent requirements for graded levels of supervision, delegate responsibility in accordance with the resident's skill and level of experience, and create a work environment that reduces resident stress and fatigue. Programs should evaluate residents on a regular basis to ensure that they are acquiring appropriate cognitive knowledge and technical skills. Individual residents should:

1. Acknowledge that patient safety is always the first concern of the physician (primum non nocere).
2. Demonstrate the ability to supervise more junior residents until those physicians have convincingly demonstrated competence in performing a given assignment or procedure.
3. Demonstrate a consistent willingness to acknowledge when stress or fatigue has compromised decision making or technical proficiency.
4. Demonstrate a willingness to seek remediation when deficits in cognitive knowledge or technical skill may have compromised patient care.

D. Familiarity with the health care delivery system

The health care delivery system in the United States has become increasingly complex. Physicians must understand the social, legal, financial, and ethical system within which they now must practice. Physicians also must understand the mechanisms used to assess the quality and cost of the health care they provide and the procedures used to determine reimbursement for medical care.

1. Describe the procedure for, and the professional significance of, maintaining general medical licensure, board certification, recertification, credentialing, hospital staff membership and privileges, and liability insurance.
2. Describe the concept of risk management.
3. Interact in a cooperative, professional manner with risk-management officials.
4. Describe the principal legal basis of the physician-patient relationship, i.e., contract law.
5. Describe the concept of standard of care as it applies to physicians and other health care professionals.
6. Describe the physician's legal relationship to other health care professionals, such as

a. Office staff

b. Nurses

c. Nurse practitioners

d. Nurse midwives

e. Physician assistants

7. Demonstrate the basic business skills needed to participate in a medical practice:

a. Explain the planning, budgeting, and controlling functions of health care organizations, including medical practices and hospitals.

b. Describe the concepts of partnership and incorporation.

c. Analyze and interpret basic financial statements.

d. Describe the concept of buying into a practice.

8. Describe the leadership skills needed in successful management of a modern health care organization.

E. Risk Management and Professional Liability

Regrettably, the threat of a malpractice claim is an ever-present concern confronting the clinician, particularly one engaged in a surgical specialty. Current estimates indicate that at least 70% of all obstetrician-gynecologists will be sued at some point in their career. Such suits can be markedly disruptive to the physician's personal and professional life. Accordingly, residents-in-training must become aware of the clinical events that most commonly precipitate malpractice claims and develop strategies to minimize the risk of such claims. They also must understand the sequence of events associated with a malpractice suit and adopt coping mechanisms to lessen the impact of such a suit on their practices and their families.

1. Describe the rationale for malpractice insurance.

2. Describe the major types of insurance providers, for example:

a. Commercial insurance companies

b. Underwriting associations such as the state, medical society, or physician group

c. Self-insured trust

3. Describe the major types of professional liability insurance, such as:

a. Occurrence policy

b. Claims made policy

c. “Tail” coverage policy

4. List the agencies to which malpractice claims may be reported:

a. National Practitioner Data Bank

b. State licensing board

c. Federation of State Medical Boards

5. Describe the most common reasons for malpractice claims, for example:

a. Inadequate rapport or communication with the patient or the patient's family

b. Failure to diagnose a specific disorder

c. Delay in diagnosis of a specific disorder

d. Failure to obtain timely consultation

e. Failure to obtain informed consent

f. Negligent performance of a procedure

g. Negligent treatment with drugs

h. Poor documentation of medical care

6. List the legal basis for most malpractice cases:

a. Breach of contract

b. Tort: intentional or negligent

7. Explain the following medical-legal concepts:

a. Applicable standard of care

b. Breach of the standard of care

c. Proximate cause of injury

8. Describe a systematic plan for minimizing the risk of malpractice claims in clinical practice:

a. Maintain a life-long commitment to learning and professional development.

b. Provide thorough documentation of all patient encounters.

c. Communicate effectively with patients and their families.

d. Ensure that all members of the office staff are well-trained in both technical and communication skills.

e. Ensure that office procedures are in place that facilitates:

(1) Timely review of all laboratory and radiographic test results and consultation reports

(2) Communication of these test results to the patient

9. Describe the steps in the processing of a malpractice claim:

a. Request for medical records

b. Notice of intent to file a claim

c. Filing of the claim

d. Naming of expert witnesses for the plaintiff and the defense

e. Submission of affidavits by the expert witnesses

f. Obtaining of depositions from expert witnesses

g. Mediation/settlement conference

h. Trial

i. Verdict

j. Appeal

10. Describe sources of support and advice for a physician and his or her family when a malpractice suit is in process:

a. Attorney

b. Insurance provider

c. Accountant

d. Financial adviser

e. Colleagues

F. Specialty-Specific Competency

Resident education programs in all fields of medicine now are being challenged to develop innovative methods for confirming that trainees acquire both the requisite cognitive knowledge and technical skills appropriate for their discipline and the important personal attributes that will enable them to function effectively in a competitive, stressful, highly technical, and rapidly changing environment. The goal of the residency training process is to produce a technically and intellectually competent physician who acts in a professional and ethical manner and consistently manifests compassion, sensitivity, and integrity. The specialty-specific competencies required of the obstetrician-gynecologist are summarized as follows in the form of performance-based learning objectives.

Please refer to the *GME Professionalism policy* regarding specific Resident Code of Conduct, Dress Code and Social Media Guidelines.

VI.) Systems-Based Practice

A. Patient Safety

Residents and attending physicians should be aware of the critical need to ensure the patient's safety while she is treated by physicians-in-training. Respect for safety demands that training programs establish clear lines of authority, adopt stringent requirements for graded levels of supervision, delegate responsibility in accordance with the resident's skill and level of experience, and create a work environment that reduces resident stress and fatigue. Programs should evaluate residents on a regular basis to ensure that they are acquiring appropriate cognitive knowledge and technical skills. Individual residents should:

1. Demonstrate a consistent willingness to seek consultation when confronted by unfamiliar clinical situations.
2. Develop a personal system for preventing oversights in review of laboratory studies.
3. Demonstrate an ability to cooperate with other specialists (e.g., pharmacists, nurses, risk managers) to correct system problems and improve patient care.

B. Familiarity with the health care delivery system

The health care delivery system in the United States has become increasingly complex. Physicians must understand the social, legal, financial, and ethical system within which they now must practice. Physicians also must understand the mechanisms used to assess the quality and cost of the health care they provide and the procedures used to determine reimbursement for medical care.

1. Describe the common methods of health care financing, such as:

a. Self-payment

b. Preferred provider organization

c. Health maintenance organization

d. Prepaid health care plan

e. Private health insurance

f. Managed care organization

2. Describe the major effects these payment plans may impose on the practitioner, such as:

a. Limitations on resources

b. Limitations on referrals for specialty care

c. Mandatory screening systems

d. Mandatory second opinions for medical and surgical treatments

3. Define the terms used in health care management systems, such as:

a. Utilization

b. Capitation

c. Risk sharing

4. Describe various concepts and methods of distributing income to physicians in a medical group practice, including:

a. Base salary

b. Productivity bonuses or incentives

c. Use of other factors to determine compensation, such as:

(1) Call schedule

(2) Patient satisfaction

(3) Seniority

(4) Administrative duties

(5) Quality assurance activities

5. Describe the legal and regulatory issues associated with:

a. Integrating multiple medical practices or other health care organizations or both

b. Contracting with managed care organizations

C. Terminology and classification of disease

The classification of disease requires use of a common language. The physician must become familiar with the CPT (Current Procedural Terminology) and ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) coding systems.

1. Apply current procedural and diagnostic codes to reimbursement mechanisms.

D. Specialty-Specific Competency

Resident education programs in all fields of medicine now are being challenged to develop innovative methods for confirming that trainees acquire both the requisite cognitive knowledge and technical skills appropriate for their discipline and the important personal attributes that will enable them to function effectively in a competitive, stressful, highly technical, and rapidly changing environment. The goal of the residency training process is to produce a technically and intellectually competent physician who acts in a professional and ethical manner and consistently manifests compassion, sensitivity, and integrity. The specialty-specific competencies required of the obstetrician-gynecologist are summarized as follows in the form of performance-based learning objectives.

1. Describe the responsibility of the individual physician to the patient, the practice, and the overall health care system.
2. Describe the concepts of limitation of resources and rationing of care.
3. Describe the concepts of cost-containment and cost-effectiveness.
4. Describe methods for ensuring that the practitioner and the practice group use scarce resources in a sound, thoughtful, and cost-effective manner.

Progression/Graduation Criteria

Additionally in order for a resident to be eligible for graduation, he/she must satisfactorily complete the following:

This list is not comprehensive but serves as baseline with minimal requirements for resident advancement/progression/graduation.

1. Core Competencies (see overall program goals and objectives)

2. Monthly rotation, annual program and peer evaluations

3. Biannual milestones assessments (as assigned by the CCC)

4. Journal club w/evaluation

5. 80% didactics attended

6. Daily attendance

7. Medical Records

8. Statistics – Complete ACGME Resident Case Log Entry, meet required minimum numbers

9. 2nd year case report

10. PGY-3 Research project with presentation at Annual Resident Research Day

11. PGY 4 Grand Rounds Presentation

12. Satisfactory completion of PGY4 Mock Oral Examination

While the CREOG exam score is not a criterion for promotion, it is an expectation that all residents score at least 200 (national mean) on the exam. For those residents who do not perform at this level, additional means of preparation may be instituted, such as tutorials, additional reading assignments, etc.

Upon successful completion of all the above criteria, the training director will certify same by final evaluation and inserting a formal statement into the resident’s residency folder indicating that the resident has successfully met the school’s requirements for graduation. A certificate will be issued to resident.

Training Environment

Major objectives of the MSM residency training programs are to provide for education, patient care, and scholarly activities. Residency training programs shall provide clinical and other programs designed to assure that the program shall provide the resident with the specialty “special requirements” and the program goals and objectives prior to the start of the Post Graduate Year (PGY). The program will ensure that residents have the rotation goals and objectives and schedules before the start of each rotation.

Faculty members involved in residency training shall be qualified to supervise and instruct residents and must be able to devote sufficient time to their assigned responsibilities.

Faculty supervision, professional criticism, the evaluation of professional work, and didactic instruction to supplement clinical practical experiences will be provided within the curriculum of the program. All program faculty shall be given their educational responsibilities in writing.

The resident should ideally participate in the care of a diverse patient population. Some clinical skills sought are: the taking of patient histories, conducting physical examinations, recording the proper findings on charts to make a tentative diagnosis, and gaining the ability to recommend treatment in a problem–oriented fashion. Program content shall also address ethical, socioeconomic and medical-legal issues to support clinical training. Patients should not be subjected to any unnecessary diagnostic procedures.

The training of physicians requires the provision of inpatient and ambulatory settings where they may practice their specialty within guidelines at all assigned facilities. The program shall assign the resident night rotation and weekend duties (when applicable) providing relief from “call” built into the schedule consistent with the “special requirements” of the specialty. In-patient training sites shall make on-call facilities (including sleeping rooms and secured storage areas) available.

The program shall make available to the resident an evaluation of his or her performance on each rotation in the residency program. The evaluation should be available in New Innovations. The program should encourage the resident to discuss his or her training evaluations with supervisors and advisors. The residency program director, assistant program director, or designee shall discuss the resident’s overall progress toward achieving the educational objectives of the training program at least semi-annually.

Residents shall be progressively responsible for the supervision and teaching of medical students and other residents on their assigned service. Residents are also expected to evaluate the clinical and didactic aspects of the training program.

Residents shall be made aware of the current accreditation status of the training program, to include all provisos, and/or any anticipated change in the training requirements.

RESIDENT, FACULTY, AND PROGRAM EVALUATION

**Evaluation of Resident Performance**

***Residents are evaluated on a daily, weekly, monthly, and semiannual basis. The semiannual evaluation is a summative evaluation of the preceding 6 months and is inclusive of feedback received from patients, faculty, the hospital staff and other residents. The assignments of milestones are made by a group of faculty from different sites and of variable positions and NOT the opinion of one individual faculty member.***

**Program Evaluation Committee**

**POLICY**

Each ACGME-accredited residency/fellowship program will establish a Program Evaluation Committee to participate in the development of the program’s curriculum and related learning activities, to annually evaluate the program to assess the effectiveness of that curriculum, and to identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

**RESPONSIBILITIES:** (per ACGME Common Program Requirements, V.C.1 and V.C.2.)

The Program Evaluation Committee (PEC) serves as a committee to plan, develop, implement, and evaluate educational activities of the program, including:

• resident performance

• faculty development

• graduate performance, including performance of program graduates on the certifying examination

• program quality ¬ review and make recommendations for revision of competency-based curriculum goals and objectives

* address areas of non-compliance with ACGME standards
* review the program annually using evaluations of faculty, residents, and others.

Both core faculty responsible for resident education and residents must have the opportunity to evaluate the program confidentially. To assure confidentiality of such evaluations, the responses will be collected over a sufficient period of time so that the collated information contains responses from several residents and cannot be linked to specific respondents. The evaluation could include planning/organization, support/delivery, and quality. The residency program expects residents to complete an evaluation of rotations-specific assignments or learning experiences as part of a targeted improvement plan. The residents’ confidential evaluation of the teaching faculty may also be used as part of this evaluation.

The Program Evaluation Committee (PEC) is responsible for reviewing these confidential evaluations along with the other information collected to improve the program in a systematic and structured fashion with a written plan of action. The PEC will use the results of residents’ and faculty assessments of the program together with other program evaluation results to do the following:

* assess and document progress on the previous year’s action plan(s)
* develop and submit a written Annual Program Evaluation (APE) documenting the formal, systematic evaluation of the curriculum, including 2-5 areas targeted for improvement with action plans

**Composition**

The Program Director, serving as the committee’s chair, appoints the Program Evaluation Committee (PEC). The committee is comprised of the Program Director, the Assistant Program Director, the Program Manager, at least 2 faculty members, and at least one resident.

**Responsibilities**

The PEC will actively participate actively in the following:

• Planning, developing, implementing, and evaluating all significant activities of the residency program

• Reviewing and making recommendations for revision of competency-based curriculum goals and objectives

• Addressing areas of non-compliance with ACGME standards

• Reviewing the program annually, using evaluations of faculty, residents, patients, and housestaff

The residency program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE). The annual program evaluation will be conducted in the spring of each year, unless scheduled for other programmatic reasons. Approximately two months prior to the review date, the Program Director will:

• Facilitate the Program Evaluation Committees’ process to establish and announce the date of the review meeting

• Identify an administrative coordinator to assist with organizing the data collection, review process, and report development

• Solicit written confidential evaluations from the entire faculty and resident body for consideration in the review (if not done previously for the academic year under review)

At the time of the initial meeting, the PEC will consider:

• Achievement of action plan improvement initiatives identified during the last annual program evaluation

• Achievement of correction of citations and concerns from last ACGME program survey

• Residency program goals and objectives

• Faculty members’ confidential written evaluation of the program

• The residents’ annual confidential written evaluation of the program and faculty

• Resident performance and outcome assessment, as evidenced by:

* + 1. Aggregate data from general competency assessments
    2. In-training examination performance
    3. Case/procedure logs
    4. Productivity in scholarly activity projects

• Graduate performance, including performance on certification examination and scholarly activity successes

• Faculty development/education needs and effectiveness of faculty development activities during the past year.

Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities and to make recommendations. Written minutes will be taken of all meetings. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in one or more of these areas:

• Resident performance

• Faculty development

• Graduate performance

• Program quality

• Continued progress on the previous year’s action plan

The plan will delineate how performance improvement initiatives will be measured and monitored. The final report and action plan will be reviewed and approved by the program’s teaching faculty, and documented in faculty meeting minutes. A report will be provided to the GMEC, and discussed at a full meeting of the GMEC.

2018-19 Membership

Franklyn H. Geary, MD (Residency Training Director)

Kiwita Phillips, MD (Assistant Residency Program Director)

Roland P. Matthews, MD (Department Chair)

Doris Wilbourn (Program Manager)

Hedwige Saint Louis, MD (Assistant Professor, Clerkship Director)

Zandra Teamor (Clerkship Coordinator)

Ann Wiskind, MD (Associate Professor)

Frederick Bright, MD (Associate Professor)

Heather Skanes-Devold, MD (Administrative Chief Resident)

Ginger Baker, (Second Year Resident Representative)

**Clinical Competency Committee**

**Policy**

Per ACGME Common Program Requirements (V.A.1.), the following outlines the responsibilities of the Clinical Competency Committee (CCC). The Residency Clinical Competency Committee (CCC) is expected to monitor resident performance in accordance with ACGME Common Program Requirements and the Morehouse School of Medicine (MSM) Graduate Medical Education (GME) policies and procedures regarding promotion and dismissal. The purpose of the CCC is to review resident performance and to make recommendations to the Program Director for progression or advancement to the next PGY level.

**Composition**

The Clinical Competency Committee (CCC) is appointed by Program Evaluation Committee, and is comprised of the Assistant Program Director, core faculty, and designated staff members from The Morehouse School of Medicine and participating clinical affiliate sites.

**Responsibilities**

The Program Director has primary responsibility for monitoring the competence and professionalism of the Obstetrics and Gynecology residents for the purpose of recommending promotion and certification, and for initial counseling, probation or other remedial or adverse action. Residents will be evaluated on individual specialty requirements as well as program requirements. Committee members must maintain strict confidentiality about the proceedings of the committee.

The CCC will utilize data from program evaluation tools, (clinical performance evaluations by faculty, peers and other health care professionals, semi-annual evaluations, self-evaluations, direct observation, CREOG examination scores, etc.), that are currently used within the program, but are subject to change with the evolution of ACGME milestone requirements. The CCC will regard these evaluations that are completed by healthcare personnel and apply them to the milestone to mark the progress of each resident. The CCC will also serve as an early warning system if a resident fails to progress in the education program, and will assist in his or her early identification and move toward improvement and remediation.

**Procedure**

The OBGYN Residency CCC will have at least three (3) members with each member serving for 3 years. Each CCC member will participate actively in:

* Reviewing all resident evaluations semi annually
* Prepare and assure the reporting of Milestones evaluations of each resident semi annually to ACMGE
* Each CCC Member will be assigned at least two (2) resident(s) to preview. Each CCC Member will discuss in detail and determine the resident’s progress as outlined by the ACGME Milestones Requirements and Guidelines
* The CCC will make recommendations to the Program Director and the completed milestones for each resident will be reviewed by the Program Evaluation Committee for resident progress including promotion, remediation, or dismissal

**Meeting Frequency**

In order to meet the ACGME Milestone reporting deadlines of May and December, the OBGYN Residency CCC will meet twice per year. The meeting will be 2-3 hours each for a total of 2 days each year. The exact timing of the meeting may fluctuate depending on the ACGME Milestone Reporting schedule and faculty availability. In addition, the OBGYN Residency CCC will agree to meet, as necessary, to discuss any urgent issues regarding resident performance.

**Meeting Documentation**

The OBGYN Residency Program Manager will document each CCC meeting held. In addition, the CCC review and recommendation of each resident will be documented in the Residency Management Suite maintained by New Innovations.

The CCC can set thresholds for remediation, probation, and dismissal. The CCC will complete a "CCC Recommendation Form" for all residents who receive an adverse recommendation that will be sent to the PD and APD on each resident. The PD and APD will meet with each resident and communicate the recommendation and design an improvement plan that will be subsequently reported to the PEC committee.

**Recommendations**

Upon review of each resident's record, the CCC shall make the following recommendations to the PD and APD in accordance with MSM's "Residency Promotion Policy" and "Adverse Academic Decisions:

**Progression** -Resident is performing appropriately at current level of training with no need of remediation.

**Promotion** -Resident has demonstrated performance appropriate to move to the next level of training.

**Notice of Deficiency** -Resident has demonstrated challenges in a specific competency/area, but does not require remediation.

**Notice of Deficiency with Remediation**-Resident has demonstrated challenges in a specific competency/area and requires remediation.

**Immediate Suspension** -Serious misconduct or threat to colleagues, faculty, staff, or patients. Suspension time shall not to exceed 30 days in an academic year. Action remains in permanent record.

**Probation** -Resident has demonstrated challenges in a specific competency/area that are disruptive to the program. Probation time shall not to exceed 6 months in an academic year. Action remains in permanent record.

**Non-Promotion** -Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident's current level of training will be extended. Action remains in permanent record.

**Non-Renewal** -Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies. Resident's current level of training will not be extended.

Action remains in permanent record.

**Dismissal** -Resident will not be promoted to the next year of training due to repeated performance/academic deficiencies, the resident will be dismissed from the program. Action remains in permanent record.

**2018-19 Membership**

Associate Program Director Kiwita Phillips, MD

Residency Program Manager Doris Wilbourn

Generalist Hedwige Saint Louis, MD

VA Ann Wiskind, MD

Midwife Yvonne Hewitt, CNM

Affiliate Locations and Contacts

Grady Memorial Hospital, of the Grady Health System, is a full-service facility that contains 750 beds, 140 of which are designated for obstetrical patients; there are over 3000 deliveries annually. Grady Memorial Hospital also has a large outpatient department with over 64,000 obstetrical and gynecologic patients seen in the outpatient clinics. Grady Memorial Hospital (GMH) is the primary participating institution for the MSM Obstetrics and Gynecology Residency Training Program because it is a major teaching institution serving many years as a site for teaching and clinical supervision in the medical specialty areas as well as other health-related disciplines. This 2-county urban hospital facility located on twenty-seven acres accommodates over 730,000 patient visits per year. It has a large volume of ambulatory patient visits and admissions. General medical services and subspecialty divisions enables the Morehouse School of Medicine to have a high-quality OB/GYN Program. Ancillary services are available including phlebotomy teams, patient transport services, and skilled nursing staff that facilitate patient care thereby facilitating resident focus on more pressing issues of patient care. Because this facility provides primary and tertiary care for a broad array of patients with a variety of diseases and conditions, residents gain a well-rounded, in-depth training experience. Both the primary care and highly qualified subspecialty divisions provide close consultative support to our Program. This facility is shared with the Emory University School of Medicine (EUSM) Affiliated Residency Training Program. This relationship is collegial, cooperative, and participatory regarding the MSM service and educational activities at Grady Memorial Hospital. Morehouse School of Medicine and Emory University School of Medicine Departments of Obstetrics and Gynecology work collaboratively and share a number of patient care conferences.

Grady Memorial Hospital

80 Jesse Hill, Jr. Drive, S.E.

P.O. Box 26238

Atlanta, Georgia 30303

GME Office

Contact: Jenay Hicks, Morehouse School of Medicine GME Program Manager

Number: 404-752-1857

Address: 22 Piedmont Ave., Atlanta, GA 30303

WellStar-Atlanta Medical Center South (AMC-S) is a 365-bed community hospital that provides additional General Gynecology experience. The patient population consists mostly of insured patients that are both low-risk and high-risk. Community physicians on staff follow these “private” patients. There are “drop-in” or unassigned patients as well. There are a wide variety of gynecological patients with pathological conditions requiring medical and surgical treatment. OBG -2, OBG-3 and OBG-4 residents gain valuable experiences by managing these patients under supervision of attending physicians. Community hospital experiences afford residents the opportunity to work with board-certified obstetricians and gynecologists and hence learn various management styles. Residents began rotating through Atlanta Medical Center South (formerly South Fulton Medical Center) in January 1999. Dr. ~~\*\*\*~~ is the faculty coordinator at AMC South. Residents continue to take in-house call at Grady Memorial Hospital.

WellStar - Atlanta Medical Center South Campus

1170 Cleveland Avenue

Atlanta, GA 30344

GME Office:

Contact: Coyea ET Kizzie, MHA, CM, GME Director

Number: (404) 265-4585

WellStar- Atlanta Medical Center Main Campus (AMC)

The Atlanta Medical Center campus comprises a 460-bed acute care facility. OBG -2, OBG-3 and OBG-4 residents participate in an array of obstetric and gynecologic procedures with Program faculty, including routine obstetrical management, as well as laparoscopic and vaginal surgeries. Patients are mostly commercially insured. Obstetrical care is rendered to laboring patients under supervision of program faculty. Gynecologic patients are seen by residents immediately pre-operatively with history and physical exams done as necessary. Program residents continue their patient involvement with operative and post-operative care and management. Program faculty directly supervise residents on all cases. This educational experience includes patients with benign and malignant disease. Dr. Kiwita Phillips is the faculty coordinator at this location. There is no night call.

WellStar- Atlanta Medical Center Main Campus

303 Parkway Drive, NEAtlanta, GA 30312

GME Office:

Contact: Coyea ET Kizzie, MHA, CM, GME Director

Number: (404) 265-4585

Dekalb Medical Center (DMC)

Dekalb Medical Center is a 628-acute care bed facility with a large, thriving women’s center that provides complete obstetrical, gynecological, diagnostic and educational services. Patients are mostly commercially insured. OBG-2, OBG-3, and OBG-4 residents participate in both Obstetric and Gynecologic care with Program faculty. Patients are followed throughout their antepartum, intrapartum and postpartum courses with program faculty supervision. Gynecologic patients are seen immediately preoperatively by residents with history and physical exams done as necessary. Residents continue their patient involvement with operative and post-operative care and management. Dr. Cyril Spann is the faculty coordinator at this location. There is no night call.

Dekalb Medical Center

2701 North Decatur Road

Decatur, GA 30033

GME Office:

Contact: Joselyn McClain, GME and Credentialing Coordinator

Number: 404-466-1952

Address: 2701 N. Decatur Road, Rm. #2758, Decatur, GA 30033

**Atlanta VA Medical Center (VA)**

The Atlanta VA Medical Center covers over 130,000 enrolled Veterans living in 50 counties and 10 Congressional districts in northeast Georgia.  The Atlanta VA is comprised of a tertiary medical center with twelve additional sites of care.  These include VA Community-Based Outpatient Clinics (CBOCs) located in:  Austell (Cobb County); Blairsville (Union County); Decatur and Henderson Mill (DeKalb County); East Point and Fort McPherson (Fulton County); Lawrenceville (Gwinnett County); Newnan (Coweta County); Oakwood (Hall County); Stockbridge (Henry County); Trinka Davis Veterans Village (Carrollton County); and the Rome Outreach Clinic (Floyd County), Georgia.  In August 2012 the medical center opened the Trinka Davis Veterans Village as a multi-specialty CBOC and 27-bed Community Living Center (CLC).  This combined facility provides improved access to health care services to Veterans in Carroll, Haralson, Douglas and Paulding counties.  In May 2013, the Atlanta VA opened the Fort McPherson CBOC. Dr. Jennifer Goedken is the faculty coordinator. There is night call from home.

Atlanta VA Medical Center

1670 Clairmont Road

Decatur, GA 30033

**GME Office**

Contact: Ken Ratcliffe, GME and Credentialing Coordinator

Number: (404) 321-6111

Position Descriptions for Resident Physicians

Department of Obstetrics and Gynecology

Morehouse School of Medicine

Atlanta, Georgia

Introduction

The RRC-approved Obstetrics and Gynecology Residency-training program at Morehouse School of Medicine is under the direction of the Chair and the Program Director. The residency-training program currently utilizes the Grady Health System as its parent institution.

General Principles of the Training Program for Residents in Obstetrics and Gynecology at Morehouse School of Medicine:

1. The house staff physician (resident) meets the qualifications for resident eligibility outlined in the Essentials of Accreditation Council of Graduate Medical Education.
2. As the position of house staff physician involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal educational activities, the competence of the house staff physician is evaluated on a formal semi-annual basis as required by the Residency Review Committee (RRC). The program maintains a confidential record of the evaluation.
3. The position of house staff physician entails provision of care commensurate with the house staff physician's level of training and competence, under the general supervision of appropriately privileged attending teaching staff. This includes:
   * participation in safe, effective and compassionate patient care;
   * developing an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and how to apply cost containment measures in the provision of patient care;
   * participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students;
   * participation in institutional orientation and education programs and other activities involving the clinical staff;
   * participation in institutional committees and councils to which the house staff; physician is appointed or invited; and performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the house staff physician is assigned; including, state licensure requirements for physicians in training, where these exist
   * following the rules and guidelines as directed by the MSM OB/GYN department resident protocol.

Position Descriptions for Resident Physicians Specific to Level

1. PGY-l

Residents are introduced to the principles of Obstetrics and Gynecology. They are further exposed to related fields of Primary Care such as Internal Medicine and Family Medicine. PGY 1 residents also learn principles of Critical Care Medicine, Pediatrics and Emergency Medicine.

In general, direct supervision is required of all first year residents. During the 1st year, however, the resident is cleared on an individual basis to perform basic and minor procedures by the teaching faculty and senior residents. First year residents are authorized to perform a variety of procedures such as pelvic exams, insertion of intrauterine pressure catheters and fetal scalp electrodes, vaginal deliveries, episiotomy repair, selected cesarean deliveries and infant male circumcisions (guardian consent required). The nursing staff is encouraged to contact the senior resident, attending or Program Director with any questions concerning resident authorization. Procedures include but not limited to the following:

OBSTETRICS

* Spontaneous vaginal delivery
* Episiotomy and repair, repair of all lacerations
* Low forceps and vacuum deliveries with attending summoned
* Amniocentesis
* Postpartum tubal ligation
* Medical management of second trimester termination with supervision

GYNECOLOGY

* D & C, suction curettage, cervical conization/LEEP
* Tubal ligation (open, laparoscopic, postpartum)
* Diagnostic laparoscopy and hysteroscopy
* Cesarean section with the attending summoned
* Emergency laparotomy with the attending summoned

2. PGY-2

Residents have continued training in Obstetrics and Gynecology, with introduction to the areas of Gynecologic Oncology and Advanced Laparoscopy.

Residents perform but are not limited to the following: vaginal deliveries, low forceps and vacuum deliveries, episiotomy and repair of vaginal/perineal lacerations, and amniocentesis. PGY 2 residents may start a cesarean delivery in an emergency. Selected operative procedures may be performed such as dilatation and curettage, LEEP, diagnostic laparoscopy and hysteroscopy, and assist with major GYN cases such as hysterectomies.

OBSTETRICS

* Spontaneous vaginal delivery
* Episiotomy and repair, repair of all lacerations
* Low forceps and vacuum deliveries
* May start cesarean section in an emergency with the attending summoned \*
* Amniocentesis
* D & C for postpartum hemorrhage/retained placenta
* Postpartum tubal ligation
* External cephalic versions
* Medical management of second trimester termination with supervision

GYNECOLOGY

* D & C, cervical conization, D & E, suction curettage
* Operative Laparoscopy
* Diagnostic and operative hysteroscopy
* Emergency laparotomy with the attending summoned
* Vaginal Surgery

3. PGY-3

Residents obtain more experience with complex cases in Obstetrics and Gynecology, Gynecologic Oncology, Reproductive Endocrinology/Infertility and Urogynecology. PGY 3 residents supervise junior residents in routine cases. PGY 3 residents are expected to function similarly to PGY 4 residents. Procedures include but not limited to the following:

OBSTETRICS

* Spontaneous vaginal delivery
* Episiotomy and repair of lacerations
* Low forceps and vacuum deliveries
* Mid forceps (non-rotational) and vacuums
* Breech delivery
* May start cesarean section in an emergency
* Amniocentesis
* Medical management of second trimester termination
* D&C for postpartum hemorrhage/retained placenta
* Postpartum tubal ligation
* External cephalic versions

GYNECOLOGY

* D & C, cervical conization, D & E, suction curettage
* Operative Laparoscopy
* Diagnostic and operative hysteroscopy
* Emergency laparotomy
* Vaginal Surgery

4. PGY-4

Perform at advanced level in the areas of Obstetrics and Gynecology, including Maternal Fetal Medicine, Reproductive Endocrinology/Infertility, and Gynecologic Oncology. They undertake both administrative and supervisory roles within the Department. Procedures include, but are not limited to the following:

OBSTETRICS

* Spontaneous vaginal delivery
* Episiotomy and repair of all lacerations
* Low forceps and vacuum deliveries
* Mid forceps (non-rotational) and vacuums
* Breech delivery
* Cesarean section in an emergency
* Amniocentesis
* Medical management of second trimester termination
* D & C for postpartum hemorrhage/retained placenta
* Postpartum tubal ligation
* External cephalic versions

GYNECOLOGY

* D & C, cervical conization, D & E, suction curettage
* Operative Laparoscopy
* Diagnostic and operative hysteroscopy
* Emergency laparotomy
* Vaginal Surgery

The following is in tabular form procedures that may be formed by program residents in Obstetrics and Gynecology. Below is the key by resident year in training. This serves only as a guide for expectations of residents by year in training:

1 = PGY 1

2 = PGY 2

3 = PGY 3

4 = PGY 4

Procedures may be performed by the designated level resident or higher level resident.

\*May commence a cesarean section if extreme emergency, mother’s condition stable and attending on way to OR

**Obstetric Procedures PGY-I**

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure/Privilege** | **Assist/Observe** | **Perform w/o Direct Supervision, After Instruction** | **Perform with Direct Supervision** |
| Obstetrical History/Physical including speculum and pelvic assessment |  | X |  |
| Pitocin Management |  | X |  |
| Second Trimester Termination Management Excluding Intra-amniotic Instillations |  | X |  |
| Amniocentesis – Genetic |  |  | X |
| Amniocentesis – Pulmonary maturity |  |  | X |
| Intra Amniotic Injection | X |  |  |
| Non Stress Test |  | X |  |
| Biophysical Profile |  | X |  |
| Intrapartum Fetal Heart Rate Assessment |  | X |  |
| Application of scalp electrodes |  | X |  |
| Fetal Scalp Sampling (pH) |  | X |  |
| Amnioinfusion |  | X |  |
| Vaginal Delivery – Cephalic |  |  | X |
| Episiotomy Repair |  | X |  |
| Perineal Laceration  First Degree  Second Degree  Third Degree  Fourth degree |  | X  X  X | X |
| Vaginal Laceration |  | X |  |
| Forceps Low/Outlet |  |  | X |
| Forceps Mid | X |  |  |
| Manual Rotation |  |  | X |
| Breech Delivery |  |  | X |
| Breech Extraction |  |  | X |
| External Version |  |  | X |
| Cesarean Section Primary |  | X |  |
| Cesarean Section Repeat |  | X |  |
| Post Partum Tubal Ligation |  |  | X |
| Manual Removal of Placenta |  | X |  |
| Post Partum Curettage |  |  | X |
| Uterine Inversion |  |  | X |
| Vacuum Extraction |  |  | X |
| Cesarean Hysterectomy | X |  |  |
| Repair of Ruptured Uterus | X |  |  |
| Internal Iliac Artery Ligation | X |  |  |
| Circumcision |  |  | X |

**Obstetric Procedures PGY-II**

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure/Privilege** | **Assist/Observe** | **Perform w/o Direct Supervision, After Instruction** | **Perform with Direct Supervision** |
| Obstetrical History/Physical including speculum and pelvic assessment |  | X |  |
| Pitocin Management |  | X |  |
| Second Trimester Termination Management Excluding Intra-amniotic Instillations |  | X |  |
| Amniocentesis – Genetic |  |  | X |
| Amniocentesis – Pulmonary maturity |  |  | X |
| Intra Amniotic Injection | X |  |  |
| Non Stress Test |  | X |  |
| Biophysical Profile |  | X |  |
| Intrapartum Fetal Heart Rate Assessment |  | X |  |
| Application of scalp electrodes |  | X |  |
| Fetal Scalp Sampling (pH) |  | X |  |
| Amnio Infusion |  | X |  |
| Vaginal Delivery – Cephalic |  |  | X |
| Episiotomy Repair |  | X |  |
| Perineal Laceration  First Degree  Second Degree  Third Degree  Fourth degree |  | X  X  X | X |
| Vaginal Laceration |  | X |  |
| Forceps Low/Outlet |  |  | X |
| Forceps Mid | X |  |  |
| Manual Rotation |  |  | X |
| Breech Delivery |  |  | X |
| Breech Extraction |  |  | X |
| External Version |  |  | X |
| Cesarean Section Primary |  | X |  |
| Cesarean Section Repeat |  | X |  |
| Post Partum Tubal Ligation |  |  | X |
| Manual Removal of Placenta |  | X |  |
| Post Partum Curettage |  |  | X |
| Uterine Inversion |  |  | X |
| Vacuum Extraction |  |  | X |
| Cesarean Hysterectomy | X |  |  |
| Repair of Ruptured Uterus | X |  |  |
| Internal Iliac Artery Ligation | X |  |  |
| Circumcision |  |  | X |

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure/Privilege** | **Assist/Observe** | **Perform w/o Direct Supervision, After Instruction** | **Perform with Direct Supervision** |
| Obstetrical History/Physical including speculum and pelvic assessment |  | X |  |
| Pitocin Management |  | X |  |
| Second Trimester Termination Management Excluding Intra-amniotic Instillations |  | X |  |
| Amniocentesis – Genetic |  |  | X |
| Amniocentesis – Pulmonary maturity |  | X |  |
| Intra Amniotic Injection |  |  | X |
| Non Stress Test |  | X |  |
| Biophysical Profile |  | X |  |
| Intrapartum Fetal Heart Rate Assessment |  | X |  |
| Application of scalp electrodes |  | X |  |
| Fetal Scalp Sampling (pH) |  | X |  |
| Amnio Infusion |  | X |  |
| Vaginal Delivery – Cephalic |  | X |  |
| Episiotomy Repair |  | X |  |
| Perineal Laceration  First Degree  Second Degree  Third Degree  Fourth degree |  | X  X  X  X |  |
| Vaginal Laceration |  | X |  |
| Forceps Low/Outlet |  | X |  |
| Forceps Mid |  |  | X |
| Manual Rotation |  | X |  |
| Breech Delivery |  |  | X |
| Breech Extraction |  |  | X |
| External Version |  |  | X |
| Cesarean Section Primary |  | X |  |
| Cesarean Section Repeat |  | X |  |
| Post Partum Tubal Ligation |  | X |  |
| Manual Removal of Placenta |  | X |  |
| Post Partum Curettage |  |  | X |
| Uterine Inversion |  | X |  |
| Vacuum Extraction |  |  | X |
| Cesarean Hysterectomy |  |  | X |
| Repair of Ruptured Uterus |  |  | X |
| Internal Iliac Artery Ligation |  |  | X |
| Circumcision |  | X |  |

**Obstetric Procedures PGY-III** Obstetric Procedures PGY-IV

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure/Privilege** | **Assist/Observe** | **Perform w/o Direct Supervision, After Instruction** | **Perform with Direct Supervision** |
| Obstetrical History/Physical including speculum and pelvic assessment |  | X |  |
| Pitocin Management |  | X |  |
| Second Trimester Termination Management Excluding Intra-amniotic Instillations |  | X |  |
| Amniocentesis – Genetic |  |  | X |
| Amniocentesis – Pulmonary maturity |  | X |  |
| Intra Amniotic Injection |  | X |  |
| Non Stress Test |  | X |  |
| Biophysical Profile |  | X |  |
| Intrapartum Fetal Heart Rate Assessment |  | X |  |
| Application of scalp electrodes |  | X |  |
| Fetal Scalp Sampling (pH) |  | X |  |
| Amnio Infusion |  | X |  |
| Vaginal Delivery – Cephalic |  | X |  |
| Episiotomy Repair |  | X |  |
| Perineal Laceration  First Degree  Second Degree  Third Degree  Fourth degree |  | X  X  X  X |  |
| Vaginal Laceration |  | X |  |
| Forceps Low/Outlet |  | X |  |
| Forceps Mid |  | X |  |
| Manual Rotation |  | X |  |
| Breech Delivery |  | X |  |
| Breech Extraction |  | X |  |
| External Version |  | X |  |
| Cesarean Section Primary |  | X |  |
| Cesarean Section Repeat |  | X |  |
| Post Partum Tubal Ligation |  | X |  |
| Manual Removal of Placenta |  | X |  |
| Post Partum Curettage |  | X |  |
| Uterine Inversion |  | X |  |
| Vacuum Extraction |  | X |  |
| Cesarean Hysterectomy |  |  | X |
| Repair of Ruptured Uterus |  | X |  |
| Internal Iliac Artery Ligation |  |  | X |
| Circumcision |  | X |  |

**Department of Obstetrics and Gynecology**

Residency Education Program

**Competency Based Rotation Goals and Objectives by Rotation and Postgraduate Year**

**LABOR & DELIVERY/OBSTETRICS (L&D-A/D)**

**OVERVIEW:**

The Labor and Delivery section is dedicated to the diagnosis and management of conditions or disorders evolving from or related to pregnancy. The resident will be trained to properly evaluate, diagnose, and treat a variety of obstetrical conditions, as well as make appropriate assessments.

**LEARNING FORMAT:**

Residents on Labor & Delivery currently rotate through ***Grady Memorial Hospital (A) PGY 1-4, and Dekalb Medical Center PGY 2-4 during their L&D rotation***. Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management, and coverage of the L&D Floor.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding Obstetrics include evidence based knowledge of and competency in the following;

**Patient Care**

* Antepartum care including: preconception, genetic counseling, prenatal care, and antepartum fetal monitoring.

* Pregnancy Loss specifically 1st trimester spontaneous abortion and recurrent pregnancy loss.
* Obstetric complications including: 2nd trimester loss, preterm labor, 3rd trimester bleeding, pregnancy-induced hypertension/preeclampsia, multiple gestation, intrauterine growth retardation, postdates, premature rupture of membranes, gestational diabetes and intrauterine fetal demise, isoimmunization and alloimmune thrombocytopenia.
* Medical complications including: diabetes mellitus, urinary tract diseases, infectious diseases, hematologic disorders, cardiopulmonary disease, gastrointestinal disease, neurologic disease, endocrine disorders, collagen vascular disorders, psychiatric disorders, emergency care and substance abuse.
* Intrapartum care with the ability to perform and interpret all methods of fetal monitoring so as to appropriately assess the fetus; labor and delivery to include:
* Obtaining a history; performing a physical; appropriately evaluating contractions, membranes, progress of labor, abnormalities of labor; need for cervical ripening, medical induction, labor augmentation, anesthesia/analgesia; determining presentation/position; performing the delivery via spontaneous/operative vaginal method, Cesarean section or vaginal birth after Cesarean.
* Postpartum care:

**Newborn – Immediate assessment of the neonate and, if necessary, assigning Apgar scores,** resuscitation, obtaining and interpreting cord blood for analysis; performing circumcision.

Mother – Perform a focused physical exam; identify and treat any complications including: hemorrhage, infections, wound dehiscence, ileus, bladder/urinary tract/breast abnormalities, embolism, thrombosis, and postpartum depressive disorders, give contraceptive choices (reversible/permanent) and future pregnancy counseling.

* Procedures that the resident must be able to understand and/or understand and perform are listed on pages 27-33 in CREOG’s Educational Objectives, 11th edition.

**Medical Knowledge**

* Basic science and mechanisms of normal pregnancy and labor/delivery including: genetics, anatomy, physiology, pharmacology, embryology/developmental biology, pathology/neoplasia and microbiology/immunology
* Comprehensive patient presentations at conferences
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patient appropriately
* Counsels patients specifically regarding birth control and future pregnancies
* Referral to the appropriate sub-specialist/specialist when necessary

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of antenatal, laboratory, radiologic and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion, pregnancy and support resources
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Didactic & Educational Conference
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

**Basic Daily Schedule PGY 1-4**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **MON** | **TUE** | **WED** | **THU** | **FRI** | **SAT** | **SUN** |
|  | Grady L&D floor | Didactics  PGY 3/4 excused | Grady L&D floor | Grady L&D floor | Grady L&D floor | On call as per schedule | On call as per schedule |
|  | Grady L&D floor | Didactics  PGY 3/4 excused | Grady L&D floor | Grady L&D floor | Grady L&D floor | On call as per schedule | On call as per schedule |
|  | Grady L&D floor | Didactics  PGY 3/4 excused | Grady L&D floor | Grady L&D floor | Grady L&D floor | On call as per schedule | On call as per schedule |
|  | Grady L&D floor | Didactics  PGY 3/4 excused | Grady L&D floor | Grady L&D floor | Grady L&D floor | On call as per schedule | On call as per schedule |

**ATTENDING SUPERVISION:** Labor & Delivery day/night attending.

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. Residents will also be evaluated daily and/or weekly on individual procedures and evaluation of milestones. This evaluation will come from clinical faculty who have worked directly with the resident.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

**CONFERENCES:** Morning Report, Team Huddle, Perinatal Morbidity and Mortality, ~~Thursday~~ Team Strip Rounds (L&D A)

**MEALS:** on your own

**VACATION:** L&D A: not allowed

L&D D: allowed

**REFERENCES:**

*CORE Curriculum in Obstetrics and Gynecology, 10th edition, Unit 3, pgs. 29-52,* published by CREOG, 2013

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 2, pgs. 7-10,* published by CREOG, 2016

*Williams Obstetrics, by* Cunningham et al 24th edition

Prolog Obstetrics, 8th edition

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **GRADY LABOR AND DELIVERY ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Labor and Delivery (L&D-A)** | | | | | | **Kiwita Phillips, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 4 wks | | | 4 wks | | | 4 wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the maintenance of normal labor and the procedures associated with delivery. They will be exposed to patients throughout all trimesters and manage the complications associated with their care. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Morehouse faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | In-house Call as assigned by Chief Resident (under separate cover) | | | | | | | | | |
| **Conference** | | Morning Report, Team Huddle, Perinatal Morbidity and Mortality, Interdisciplinary Fetal Heart Tracing “Strip” Rounds | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**  **—-**  | | | | | | | | | |
| **PGY 1/2 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | L&D floor | | Didactics AM  L&D floor | L&D Floor | | | L&D Floor | | L&D Floor | |  |
| Off | L&D floor | | Didactics AM  L&D floor | L&D Floor | | | L&D Floor | | L&D Floor | | Call |
| Off | L&D floor | | Didactics AM  L&D floor | L&D Floor | | | L&D Floor | | L&D Floor | |  |
| Off | L&D floor | | Didactics AM  L&D floor | L&D Floor | | | L&D Floor | | L&D Floor | | Call |
| **PGY 3/4 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | L&D floor  Antepartum rounds | | Didactics AM  L&D floor  Antepartum rounds | L&D Floor  Antepartum rounds | | | L&D Floor  Antepartum rounds | | L&D Floor  Antepartum rounds | |  |
| Off | L&D floor  Antepartum rounds | | Didactics AM  L&D floor  Antepartum rounds | L&D Floor  Antepartum rounds | | | L&D Floor  Antepartum rounds | | L&D Floor  Antepartum rounds | |  |
| Off | L&D floor  Antepartum rounds | | Didactics AM  L&D floor  Antepartum rounds | L&D Floor  Antepartum rounds | | | L&D Floor  Antepartum rounds | | L&D Floor  Antepartum rounds | | Call |
| Off | L&D floor  Antepartum rounds | | Didactics AM  L&D floor  Antepartum rounds | L&D Floor  Antepartum rounds | | | L&D Floor  Antepartum rounds | | L&D Floor  Antepartum rounds | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **DEKALB LABOR AND DELIVERY ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Labor and Delivery (L&D-D)** | | | | | | **Cyril Spann, MD** | | | | | |
| **Resident Level** | |  | | | **PGY2** | | | **PGY3** | | **PGY4** | |
|  | | | 4 wks. | | | 4 wks. | | 4 wks. | |
| **Rotation Description** | | Residents will gain exposure to and experience with the maintenance of normal labor and the procedures associated with delivery. They will be exposed to patients throughout all trimesters and manage the complications associated with their care. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at Dekalb orientation; must reinitiated prior to start | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call; Grady weekend coverage as assigned | | | | | | | | | |
| **Conference** | | Departmental Didactics | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY 2-4 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | L&D floor | | Didactics AM  Continuity | L&D Floor | | | L&D Floor | | L&D Floor | | Off |
| Off | L&D floor | | Didactics AM  Continuity | L&D Floor | | | L&D Floor | | L&D Floor | | Off |
| Off | L&D floor | | Didactics AM  Continuity | L&D Floor | | | L&D Floor | | L&D Floor | | Off |
| Off | L&D floor | | Didactics AM  Continuity | L&D Floor | | | L&D Floor | | L&D Floor | | Off |

Labor & Delivery (L&D) Learning Objectives by Year

PGY – 1

Labor & Delivery (L&D)

**Objective:** General exposure to all aspects of inpatient obstetrics including intrapartum and postpartum management.

**Responsibilities:**

1. Assist in the management of labor and delivery floor
2. Participate in the management of patients on the labor floor
3. Assist in the management of all postpartum patients on the postpartum unit
4. Triage of gravid women in all trimesters
5. Present obstetric statistics to department
6. Participation in the continuity clinic
7. Data collection

**Attending:** L & D Attending

**Procedure/Skills:**

1. Vaginal Delivery
2. Operative Vaginal Delivery Assistant
3. Inpatient Assessment/Management
4. Circumcision
5. Fetal Monitoring
6. Fetal Scalp Electrode/Blood Sampling
7. Intra-uterine Catheterization/Infusion
8. Amniocentesis
9. Cesarean Section Assistant and primary surgeon
10. Management of normal and abnormal labor
11. Triage of gravid women in all trimesters
12. Management of premature labor
13. Management of antepartum complications of pregnancy
14. Coordination of inpatient and outpatient care
15. Vaginal ultrasound

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Didactic & Educational Conference
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

**PGY – 2**

Labor & Delivery (L&D)

**Objective:** Continued general exposure to all aspects of obstetrics with concentration on operative vaginal and abdominal interventions, fetal and maternal assessment, and multi-task management skills.

**Responsibilities**

1. Management of labor and delivery floor
2. Participate in the management of patients on the labor floor
3. Management of all postpartum patients on the postpartum unit
4. Triage of gravid women in all trimesters
5. Present obstetric statistics to department
6. Participation in the continuity clinic
7. Data collection

**Attending:** L & D Attending

**Procedure/Skills:**

1. Cesarean Section
2. Outpatient Assessment/Management
3. Vaginal Delivery
4. Operative Vaginal Delivery
5. Inpatient Assessment/Management
6. Fetal Monitoring
7. Fetal Scalp Electrode/Blood Sampling
8. Intra-uterine Catheterization/Infusion
9. Amniocentesis
10. Pre & post-operative delivery counseling
11. Advanced directives for the obstetrical patient
12. Informed obstetrical consent
13. Vaginal Birth after C/S
14. Vaginal probe ultrasound
15. Principles of local and regional anesthesia, IV sedation, and other pain management issues
16. Management of preterm labor

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Didactic & Educational Conference
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

PGY - 3

Labor & Delivery (L&D)

**Objective:** Exposure to all aspects of normal and high-risk pregnancies, active management of high risk patients, and supervision of the labor floor.

**Responsibilities:**

1. Direct and manage the labor and delivery floor
2. Coverage and management of high risk service, antepartum and postpartum patients
3. Oversight of the Perinatal Mortality & Morbidity conference
4. Data collection
5. Participation in continuity clinic

**Attending:** L&D Attending

**Procedure/Skills:**

1. Operative abdominal deliveries – primary and repeat
2. Amniocentesis
3. Outlet and low forceps deliveries
4. Fetal and maternal invasive and non-invasive monitoring
5. Repair of third and fourth degree lacerations
6. Management of labor and delivery
7. Prenatal diagnosis
8. Ultrasound for fetal assessment
9. Ultrasound for diagnosis
10. Prenatal testing and assessment of fetal well-being

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Didactic & Educational Conference
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

PGY-4

Labor & Delivery (L&D)

**Objective:** Exposure to normal and high-risk obstetrics as the first-line decision-maker on patient management issues. The rotation is designed to promote leadership and administrative skills and establish readiness for independent clinical management of antepartum, laboring, and postpartum patients.

**Responsibilities:**

1. Direct and manage the labor floor / postpartum obstetric team
2. Manage all resident obstetric service patients as the responsible decision-maker
3. Serve as a consultant for junior residents on all obstetric issues
4. Attend high-risk clinic and conference
5. Consult with attending fellow/physician on complicated management issues
6. Preside over a.m. and p.m. board sign-out
7. Perform primary and repeat caesarean sections with attending and junior level residents
8. Oversee the management of antepartum patients
9. Supervise junior resident and student teaching
10. Data collection and entry

**Attending:** L&D Attending

**Procedure/Skills:**

1. “Complete management” - intrapartum and postpartum care
2. “Complete management” - operative obstetrical cases
3. Primary and repeat caesarean sections
4. Postpartum hemorrhage
5. Vacuum and Forceps deliveries
6. Repair of obstetric lacerations
7. Caesarean hysterectomy
8. “Complete management” high risk obstetrical condition (PIH, pre-term labor, pre-eclampsia, multiple gestation, malpresentation, gestational diabetes, amniocentesis, etc.)
9. Promote social well-being of all obstetric patients
10. Allocation of team personnel to cover service responsibilities

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds/Board sign-out
2. Morning Report
3. Postpartum, antepartum and labor rounds/management
4. Management & Coverage of Labor floor (Labor Team)
5. Didactic & Educational Conference
6. Outpatient Continuity & High Risk Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage
9. Arrange teaching sessions for students/residents

GYNECOLOGY (GYN)

**OVERVIEW:**

The gynecology section is dedicated to the diagnosis and care of conditions evolving from or related to the female reproductive system. The resident will be trained to properly evaluate, diagnose, and treat a variety of gynecologic disorders, as well as make appropriate referrals.

**LEARNING FORMAT:**

**I. Out-patient Services**

The resident assigned to the Gynecology Service will rotate through ***Grady Memorial Hospital (PGY1-4), Wellstar-Atlanta Medical Center Main & South Campus (PGY3-4), Dekalb Medical Center (PGY3-4), Atlanta Veteran’s Affairs Medical Center (PGY1-2) and Piedmont Medial Center (PGY2).*** At Grady Memorial Hospital, Wellstar Atlanta Medical Center Main and South Campuses, Dekalb Medical Center, the Atlanta VA and Piedmont Medical Center, the resident will evaluate patients on an outpatient basis, under the supervision of clinical faculty.

Each resident will maintain a continuity clinic at Grady Hospital regardless of rotation placement.

**II. In-patient Services**

The gynecology resident will be responsible for all patients admitted to the Morehouse service at Grady Memorial Hospital when on GYN-A. All surgical procedures will be attended by the GYN resident, and be performed by that resident to the extent that his abilities and experience permit. The gynecology resident will also be responsible for all consults presented to the service.

The gynecology resident rotating at the Wellstar-Atlanta Medical Center Campuses, Dekalb Medical Center, Wellstar, Piedmont and the Atlanta VA Medical Center will be responsible for the post operative care of all patients in which the assigned resident participated in the surgical procedure performed. Residents are also to follow and assist with the care of consults as assigned by supervisory faculty.

Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the GYN Service.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding Gynecology include evidence-based knowledge of and competency in:

**Patient Care**

* Diagnosis, treatment (surgical and non-surgical) and complications of:
  + Urogenital tract disorders of abnormal uterine bleeding, vulvar/vaginal/cervical/ endometrial/ovarian/tubal disease or infection, sexually transmitted disease, pelvic inflammatory disease, pelvic support defects, urinary incontinence, pelvic tumors/cysts/abscesses, pelvic pain, endometriosis, urogynecologic disorders
  + Benign breast disease including: Galactorrhea, pathophysiologic conditions, focused physical examination, perform/interpret test results to assess breast abnormality
  + Management of ectopic pregnancy
  + Pregnancy loss specifically 1st trimester spontaneous abortion, recurrent pregnancy loss and ectopic pregnancy
  + The geriatric patient
  + Gynecologic Procedures: Lower genital tract and perineum, Cervix, Uterus, Fallopian tubes and Ovaries, Peritoneal cavity and abdominal wall Urethra and Bladder and Breast
* Critical care including: toxic shock syndrome, septic shock, adult respiratory distress syndrome, hemodynamic assessment, cardiopulmonary resuscitation allergic drug reactions
* Preoperative histories and physicals for patients undergoing gynecologic surgery or evaluation/ management admissions
* Postoperative care
* Review laboratory and radiologic studies and any other pertinent diagnostic testing necessary for the safe and effective performance management of the patient
* Daily rounds for all patients in whose care the resident has participated
* The resident must understand and/or understand and perform the gynecologic surgical procedures listed on pgs. 34-40 of CREOG’s *Educational Objectives,* 11th edition.

**Medical Knowledge**

* Basic science and mechanism of the diseases, disorders and defects encompassed in Gynecology including: genetics, anatomy, physiology, pharmacology, embryology/developmental biology, pathology/neoplasia and microbiology/immunology
* Comprehensive patient presentations at conferences
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patient appropriately
* Refers to sub-specialist/specialist when necessary

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory, radiologic and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion, disease prevention and support resources
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the GYN Service.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Coverage/Management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Coordination of Pre-Op Conference / OR Scheduling
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

**ATTENDING SUPERVISION:** GYN Attending / GYN Affiliate Site Supervisor

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculty who has worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

REFERENCES:

A complete description of the objectives for Gynecology can be found in *Educational Objectives, CORE Curriculum in Obstetrics and Gynecology,* 10th edition, Unit 4, pgs 53-78, published by CREOG.

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 3, pgs. 11-13,* published by CREOG, 2016

*Comprehensive Gynecology* by Stenchever, et al, Fourth Edition G

*Williams Gynecology*. Hoffman, et. al., Third Edition

*Rock Telinde’s Operative Gynecology* by Gershenson, et al., Tenth Edition

Prolog Gynecology, 8th Edition

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **GRADY GYN ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Gynecology (GYN A)** | | | | | | **Frederick Bright, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 8 wks | | | 4 wks | | | 4 wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core surgical skills based on their competency level. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Morehouse faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | In-house Call as assigned by Chief Resident (under separate cover) | | | | | | | | | |
| **Conference** | | Morning Report, PM signout, weekly preoperative conference, Morbidity and Mortality conference | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**  ---  | | | | | | | | | |
| **PGY1 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM – OR  PM - HSG | | | AM – OR  PM – Colpo | | AM- Floor  Continuity | |  |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM – OR  PM - HSG | | | AM – OR  PM – Colpo | | AM- Floor  Continuity  PM- REI | |  |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM – OR  PM - HSG | | | AM – OR  PM – Colpo | | AM- Floor  Continuity  PM - REI | |  |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM – OR  PM - HSG | | | AM – OR  PM – Colpo | | AM- Floor  PM - REI | |  |
| **PGY2 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | Consult/Floor  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM– OR | | | AM – OR  PM – Colpo | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM – OR  PM – Colpo | | AM- OR  PM - Floor | |  |
| Off | Consult/Floor  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM – OR  PM – Colpo | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM – OR  PM – Colpo | | AM-Continuity  PM - Floor | |  |
| **PGY3 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM– OR | | | AM/PM– OR | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM/PM – OR | | AM- OR  PM - Floor | |  |
| Off | AM-Consult  PM-Urogyn | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM/PM – OR | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM/PM – OR | | AM-Continuity  PM - Floor | |  |
| **PGY4 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM– OR | | | AM/PM– OR | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM/PM – OR | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM/PM – OR | | AM-Continuity  PM - Floor | |  |
| Off | Consult/Floor | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | | AM/PM – OR | | AM-Continuity  PM - Floor | |  |

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **Wellstar Atlanta Medical Center GYN ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Gynecology (GYN B)** | | | | | | **Barbara Simmons, MD** | | | | | |
| **Resident Level** | | **PGY1** | | **PGY2** | | | | **PGY3** | | **PGY4** | |
| - | | - | | | | 8wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core surgical skills based on their competency level. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call | | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY3 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM– OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM – OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM – OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM – OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| **PGY4 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM– OR | | AM/PM– OR | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM – OR | | AM/PM– OR | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM – OR | | AM/PM– OR | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics  PM-Surgical Clinic | | AM/PM – OR | | AM/PM– OR | | AM/PM– OR | |  |

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | |
| **Dekalb Medical Center GYN ROTATION** | | | | | | | | | | |
| **Rotation Name** | | | | | **Faculty Leader** | | | | | |
| **Gynecology (GYN D)** | | | | | **TBD** | | | | | |
| **Resident Level** | | **PGY1** | | **PGY2** | | | **PGY3** | | **PGY4** | |
| - | | - | | | 8 wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core surgical skills based on their competency level. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | |
| **Meals** | | On your own | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | |
| **Call** | | No call | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | |
| **PGY 3/4 GENERAL SCHEDULE** | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM– OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM – OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM – OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM – OR | | AM – OR  PM – Colpo | | AM/PM– OR | |  |

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | |
| **Piedmont Medical Center GYN ROTATION** | | | | | | | | | | |
| **Rotation Name** | | | | | **Faculty Leader** | | | | | |
| **Gynecology (GYN D)** | | | | | **Ramon Suarez, MD** | | | | | |
| **Resident Level** | | **PGY1** | | **PGY2** | | | **PGY3** | | **PGY4** | |
| - | | 8 weeks | | | - | | - | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core surgical skills based on their competency level. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | |
| **Meals** | | On your own | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | |
| **Call** | | No call | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | |
| **PGY 2 GENERAL SCHEDULE** | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM– OR | | AM – OR | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM – OR | | AM – OR | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM – OR | | AM – OR | | AM/PM– OR | |  |
| Off | AM/PM– OR | | AM- Didactics/OR  PM-Continuity | AM/PM – OR | | AM – OR | | AM/PM– OR | |  |

Gynecology (GYN) Learning Objectives By Year

**PGY-1**

Gynecology (GYN-A & E)

**Objective**: Exposure to all aspects of gynecology

**Responsibilities:**

1. Operating room coverage as per Gynecology chief
2. Emergency Room coverage
3. Data collection
4. Participation in continuity clinic, and gynecology specialty clinic
5. Coverage of the general gynecology inpatient service

**Attending**: Gynecology Attending/GYN OR Attending

**Procedure/Skills:**

1. Knot tying
2. Operative Hysteroscopy
3. Laparotomy incisions and closure
4. Hysterectomy
5. Diagnostic and Operative Laparoscopy
6. Management of Gynecology in-patient issues
7. Pre & Post Surgical Counseling
8. Advanced directives for gynecologic admissions
9. Myomectomy
10. Vaginal Hysterectomy (assist)
11. Management of Gynecology emergencies
12. Outpatient gynecology assessment and management
13. Informed gynecologic consent

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the GYN Service.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Coverage/Management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Coordination of Pre-Op Conference / OR Scheduling
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

**PGY-2**

Gynecology (GYN-A, E, & F)

**Objective:** Exposure to all aspects of gynecology

**Responsibilities:**

1. Operating room coverage as per GYN chief
2. Emergency Room coverage
3. Data collection
4. Participation in continuity clinic and gynecology specialty clinics
5. Coverage of the general gynecology inpatient service
6. Provide gynecological consultation to other inpatient services
7. Present GYN statistics to department on a monthly basis

**Attending:** GYN Attending / GYN Affiliate Site Supervisor/ Gyn OR Attending

**Procedure/Skills:**

1. Operative Hysteroscopy
2. Laparotomy incisions and closure
3. Hysterectomy
4. Diagnostic and Operative Laparoscopy
5. Management of Gynecology Inpatient issues
6. Pre & Post Surgical Counseling
7. Advanced directives for gynecologic admissions
8. Myomectomy
9. Vaginal Hysterectomy
10. Management of gynecology emergencies
11. Outpatient gynecology assessment and management
12. Informed gynecologic consent
13. Management of cervical dysplasia

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the GYN Service.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Coverage/Management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Coordination of Pre-Op Conference / OR Scheduling
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

PGY-3

Gynecology (GYN-A, B, D)

**Objective:** Exposure to all aspects of benign gyn surgery with the development of operative skills and techniques, and the management of the post-operative patient.

**Responsibilities:**

1. Operating room coverage
2. Emergency Room coverage
3. Participation in continuity clinic and gynecology specialty clinics
4. Coverage of the general gynecology inpatient service
5. Provide gynecological consultation to other inpatient services
6. Present GYN statistics to department on a monthly basis
7. Coverage of the assigned operative cases
8. Management of the gynecology team
9. Data collection

When scheduled, will act as GYN Chief with the additional responsibilities

1. Supervise junior resident and student teaching with scheduled/unscheduled conference
2. Consult with on-service attending prior to elective admission and/or surgery

**Attending:** GYN Monthly Attending / GYN Affiliate Site Supervisor/GYN OR Attending

**Procedure/Skills:**

1. Complete pre-operative and post-operative assessment of patient management issues
2. Medical management of acute gynecologic problems
3. Knowledge of pelvic anatomy
4. Myomectomy
5. Abdominal hysterectomy
6. Vaginal hysterectomy
7. Laparoscopically assisted vaginal hysterectomy
8. Pelvic reconstruction
9. Ovarian cystectomy
10. Lysis of intra-abdominal adhesions
11. Oophorectomy
12. Operative laparoscopy
13. Management of invasive gynecologic cancer patients

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the GYN Service.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Coverage/Management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Coordination of Pre-Op Conference / OR Scheduling
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

**PGY-4**

**Gynecology (GYN A, B, D)**

**Objective:** Exposure to the full range of pre-operative, operative, and post-operative gynecologic conditions normally encountered in general practice as the primary decision-maker on the gynecology team in conjunction with clinic and on-service attending. This is designed to promote leadership, operative and administrative skills, along with the clinical management of outpatient and inpatient gynecology patients.

**Responsibility:**

1. Direct and manage the gynecology teams.
2. Provide a schedule and coverage for all gynecology surgery
3. Conduct daily rounds on the resident gynecology service
4. Supervise junior resident and student teaching with scheduled/ unscheduled conference
5. Consult with on-service attending prior to elective admission and/or surgery
6. Consult with coverage attending for all emerging admissions/surgery
7. Continuity clinic
8. Data collection and entry
9. Provide gynecology consultation to other inpatient services

**Attending:** GYN Attending / GYN Affiliate Site Supervisor/ Gyn OR Attending

**Procedure/Skills:**

1. Full range of gynecologic procedures as the primary operating surgeon
2. Abdominal hysterectomy
3. Vaginal hysterectomy
4. Laparoscopically assisted vaginal hysterectomy
5. Myomectomy
6. Oophorectomy – abdominal and laparoscopic
7. Ovarian cystectomy – abdominal and laparoscopic
8. Omentectomy
9. Anterior/posterior colporraphy
10. Lysis of intra-abdominal adhesions
11. Repair enterotomy
12. Repair of bladder injury
13. Operative management of bladder dysfunction
14. Operative management of pelvic organ prolapse and pelvic floor dysfunction
15. Operative laparoscopy for ectopic pregnancy
16. Complete management – preoperative, operative, postoperative – of resident gynecology service patients
17. Outpatient assessment of potential gynecology operative patients
18. Teaching of students/residents – rounds, conferences, operating room

**Schedule:** Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the GYN Service.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Coverage/Management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Coordination of Pre-Op Conference / OR Scheduling
7. Outpatient and Continuity Clinic as scheduled
8. Operating room as necessary
9. Emergency room coverage

**REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY (REI)**

OVERVIEW:

Reproductive Endocrinology & Infertility (REI) is the subspecialty of Obstetrics and Gynecology devoted to the diagnosis, treatment of, and care of disorders of the reproductive endocrine system(s), and the evaluation and treatment of disorders that result in the inability to conceive (infertility). The general obstetrician/gynecologist must be able to evaluate and manage common reproductive endocrine disorders and refer appropriately.

LEARNING FORMAT:

Residents on REI currently rotate through ***Grady Memorial Hospital (PGY 1, 2, 4) and selected community-based practices***. Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the REI & GYN Service.

**I. Outpatient Services**

The resident assigned to the REI service will rotate through the Morehouse REI Clinic at Grady Memorial Hospital and selected community-based practices. The resident participates in all activities of the clinic during this rotation. He or she constructs detailed reports and presents and discusses all patients seen with the reproductive endocrinology faculty.

**II. Inpatient Activity**

The resident on the REI service will be involved in the evaluation and treatment of all inpatients on the REI service and have responsibility for in-house consults at all Morehouse inpatient facilities. The resident will present all consults to the REI staff, construct detailed consultant reports, and assist on all REI surgical procedures in both the inpatient and same day surgery setting.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding REI include evidence based knowledge of and competency in:

**Patient Care**

* Menstrual and endocrine disorders of dysmenorrhea, dysfunctional uterine bleeding, amenorrhea, polycystic ovarian syndrome, galactorrhea, premenstrual syndrome, hirsutism, recurrent pregnancy loss, infertility and reproductive technologies
* Management of climacteric period
* Vaginal probe ultrasound
* Pediatric/adolescent gynecology to include: developmental anomalies of the urogenital tract; common gynecologic problems of the pediatric (birth to menarche) patient; testing /diagnosing/treating the common gynecologic problems of the adolescent patient; testing/diagnosing/treating the patient with precocious or delayed puberty
* Procedures that the resident must be able to understand and/or understand and perform are listed on page 34-40 of CREOG’s *Educational Objectives*, 11th edition

**Medical Knowledge**

* Understanding of normal reproductive embryology, anatomy, and physiology
* Know the following clinical presentations/workup

1. Delayed & Precocious puberty
2. Ambiguous Genitalia
3. Dysmenorrhea
4. Dysfunctional Uterine Bleeding
5. Amenorrhea & Menstrual Disorders
6. Premenstrual Syndrome
7. Hyperandrogenemia (Hirsutism)
8. Hyperprolactinemia
9. Developmental Anomalies of the Reproductive Tract
10. Menopause
11. Endocrinology of normal & abnormal pregnancy (including ectopic pregnancy and recurrent pregnancy loss).
12. Endometriosis
13. Contraception (hormonal & nonhormonal)

* Evaluation and Treatment of the Infertile Couple

1. Ovulatory dysfunction & induction
2. Male factor infertility (semen analysis interpretation, treatment options)
3. Immunologic and cervical factor infertility
4. Tubal factor infertility
5. Endocrine factors (thyroid, adrenal, pituitary)
6. Diagnostic tests (hysterosalpingoraphy, ultrasonography, endocrine assays and testing)
7. Assisted reproductive technologies (ART) –IVF, ICSI, insemination, and related procedures.

* Surgical Aspects of Reproductive Endocrinology & Infertility

1. Endoscopic principals and procedures (including diagnostic and surgical hysteroscopy & laparoscopy)
2. Microsurgical technique and procedures
3. Use of laser and other advanced surgical technologies
4. Endometrial ablation techniques
5. Abdominal surgical treatment via laparotomy or endoscopic approach salpingoplasty, myomectomy uterine anomalies, endometriosis, ectopic pregnancy
6. Adhesion prevention and adjunctive therapy

* Medical Therapies

1. Clomiphene
2. Bromocriptine
3. Estrogens and Progestins
4. GnRH Analogs, GnRH
5. Danazol
6. Glucocorticoids
7. Antiandrogens and Androgens
8. Antibiotics

* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patients appropriately
* Counsels patient specifically regarding perimenopausal and menopausal issues
* Referral to the appropriate sub-specialist/specialist when necessary

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory, radiologic and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion, perimenopausal/menopausal and support resources
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the REI & GYN Service.

1. Morning Report
2. Rounds on REI patients
3. REI operating room coverage
4. Coverage of the GYN Floor
5. Outpatient Continuity and REI clinics
6. Community Based REI patients
7. Didactic & Educational Conferences
8. REI conferences

**ATTENDING SUPERVISION:** REI Attendings **/** GYN Attending

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical

faculty who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

REFERENCES:

Educational Objectives, CORE Curriculum in Obstetrics and Gynecology, 10th edition, Unit 5, pgs 79-94, published by CREOG.

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 5, pg. 26,* published by CREOG, 2016

Clinical Gynecologic Endocrinology and Infertility by Speroff, 8th Edition

PRECIS - Reproductive Endocrinology & Infertility (American College of Obstetricians and Gynecologists)

PROLOG - Reproductive Endocrinology & Infertility (American College of Obstetricians & Gynecologists), 8th Edition

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Reproductive Endocrinology & Infertility REI (A)** | | | | | | **Dorothy Mitchell-Leaf, MD**  **Desiree McCarthy-Keith, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 4 wks | | | 4 wks | | | - | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core concepts in reproductive endocrinology and basic infertility management. Patients will be counseled and treated. Surgical procedures as deemed appropriate will be done. Residents will be exposed in the community clinics to the breath of infertility. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call | | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY 1/2/ 4 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | Community Clinic | | AM- Didactics  PM-Continuity | Community Clinic  PM – HSG | | | AM - Community Clinic  PM - Colpo | | AM - Continuity | |  |
| Off | Community Clinic | | AM- Didactics  PM-Continuity | Community Clinic  PM – HSG | | | AM - Community Clinic  PM - Colpo | | AM - Continuity  PM – Grady REI Clinic | |  |
| Off | Community Clinic | | AM- Didactics  PM-Continuity | Community Clinic  PM – HSG | | | AM - Community Clinic  PM - Colpo | | AM - Continuity  PM – Grady REI Clinic | |  |
| Off | Community Clinic | | AM- Didactics  PM-Continuity | Community Clinic  PM – HSG | | | AM - Community Clinic  PM - Colpo | | AM - Continuity  PM – REI Clinic | |  |

Reproductive Infertility and Endocrinology (REI) Learning Objectives By Year

PGY-1

**Objective:** Exposure to basic office infertility and endocrinology with the evaluation of outpatients.

**Responsibilities:**

1. Coverage of REI faculty practice office
2. Participation in continuity clinic
3. Participation as assigned to community based practice partners

**Attending:** REI Attending **/** GYN Monthly Attending

**Procedure/Skills:**

1. History and physical exams of REI patients
2. Outpatient assessment of infertile couple
3. Understanding of normal physiology and abnormalities of the menstrual cycle
4. Assessment of ovulation
5. Management of ovulatory dysfunction
6. Endometrial biopsy
7. Hysterosalpingogram
8. Principles of oocyte retrieval
9. Ultrasound scanning for follicle development and early pregnancy

**Schedule:** Please refer to Program Director’s Protocols and the Affiliate Guide in the Residency Education Handbook for further instruction on procedure, management and coverage of the REI & GYN Service.

1. Morning Report
2. Rounds on REI patients
3. REI operating room coverage
4. Coverage of the GYN Floor
5. Outpatient Continuity clinic
6. Outpatient Community clinic
7. Didactic & Educational Conferences
8. REI conferences

PGY-2, 3 & 4

Reproductive Endocrinology & Infertility – Operative (REI)

**Objective:** Exposure to the full range of REI operative procedures as the primary or assistant operating surgeon.

**Responsibilities:**

1. Coverage of the REI operating rooms
2. Rounds on REI patients in consultation with REI attending
3. Participation as assigned to community based practice partners
4. Daily morning conferences
5. Data collection and entry

**Attending:**  REI Attending **/** GYN Monthly Attending

**Procedure/Skill:**

1. Myomectomy
2. Hysterectomy
3. Hysteroscopy – diagnostic and operative
4. Removal of septum
5. Hysteroscopic myomectomy
6. Endometrial ablation
7. Operative laparoscopy:

* Ectopic pregnancy management
* Tuboplasty
* Lysis of adhesions
* Endometriosis (excision, biopsy, fulgeration including laser)
* Oophorectomy
* Salpingectomy
* Cystectomy
* Diagnostic laparoscopy
* Myomectomy
* Tubal reanastamosis

**Schedule:** Please refer to Program Director’s Protocols and the Affiliate Guide in the Residency Education Handbook for further instruction on procedure, management and coverage of the REI & GYN Service.

1. Morning Report
2. Rounds on REI patients
3. REI operating room coverage
4. Coverage of the GYN Floor
5. Outpatient Continuity clinic
6. Outpatient Community clinic
7. Didactic / Educational Conferences
8. REI conferences

**GYNECOLOGIC ONCOLOGY (ONC)**

**OVERVIEW:**

The detection and treatment of gynecologic malignancies are important objectives in gynecologic practice. Although a select group of physicians devote their full practice to the care of patients with gynecologic malignancies, the resident in obstetrics and gynecology should become familiar with the therapeutic principals underlying the treatment of these patients and, more important, the identification of patients who are at risk for, or who may already have, malignancies of the pelvic organs or breast.

The policies, procedures, and protocols contained herein are complied in an effort to enhance patient care and resident education. It is readily recognized however, that each patient must be treated as an individual with special needs and, therefore, rigid adherence to any set of guidelines is impossible. In many situations, multiple treatment options exist and no list of protocols can include all of these options.

These protocols are submitted as general guidelines for patient care with the acknowledgement that deviation from such protocols may be indicated and appropriate at the discretion of the physician and/or patient.

**LEARNING FORMAT:**

Residents in OB/GYN currently rotate through ***Grady Memorial Hospital and Dekalb Medical Center*** during their GYN/ONC rotations.

Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the GYN Oncology service and patients.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding Oncology include evidence-based knowledge of and competency in: the diagnosis, treatment and complications of:

Patient Care

* Vaginal/vulvar, pre-invasive and invasive cancer
* Cervical, pre-invasive and invasive, cancer
* Uterine neoplasia including endometrial hyperplasia and carcinoma
* Ovarian and tubal cancer
* Gestational trophoblastic disease including hydatidiform mole and malignant GTD
* Radiation, chemotherapy and terminal care
* Careful, precise surgical technique and surgical anatomy of the abdomen and pelvis.
* Appropriate perioperative and medical management of extremely ill patients with emphasis on critical care.
* Basic concepts of radiation therapy and chemotherapy in gynecologic malignancies.
* Goal oriented approach to patients with curable critical illness and patients with terminal disease.
* The importance of careful review and understanding of surgical pathology and cytology in gynecologic oncology.
* In addition to the above, the care of these patients will consistently demand your best efforts as a physician and require above average perseverance, endurance, and compassion.
* The resident must understand and/or understand and perform the procedures listed on pages 108 & 109 of CREOG’s *Educational Objectives, 10th Edition ( 34-40, 11th edition)*

**Medical Knowledge**

* Basic science and mechanisms of pelvic pre-malignant and malignant disease including: genetics, anatomy, physiology, pharmacology, embryology/developmental biology, pathology/neoplasia and microbiology/immunology
* Psychosocial problems and depressive disorders associated with the diagnosis of breast and pelvic malignancies.
* Comprehensive patient presentations
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patient appropriately
* Counsels patients specifically regarding premalignant and malignant disease
* Referral to the sub-specialist/specialist when necessary

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory, radiology and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion and disease prevention
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the GYN Oncology service and patients.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Assist with coverage/management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Outpatient and Continuity Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage
9. Gynecologic oncology pathology conference

**ATTENDING SUPERVISION:** MSM Gynecologic Oncology Division, Oncologists, Roland Matthews, Giuseppe Del Prioreand and the GYN Monthly/Weekly Attending. At Dekalb Medical Center Cyril Spann, Jr. MD and Joseph Bovari, MD.

**EVALUATION/ASSESSMENT:**

The resident will be evaluated based on his/her presentations, consult report constructions, surgical and clinical skills, and general knowledge of the subspecialty. The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculties who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

REFERENCES:

Educational Objectives, CORE Curriculum in Obstetrics and Gynecology, 10th edition, Unit 6 (Oncology), pgs 95-109 published by CREOG

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 5, pg. 26,* published by CREOG, 2016

This is no conclusive text for the myriad of topics that comprise the essential of gynecologic oncology. The following is a limited list of textbooks that may be useful.

1. Drogemueller, Herbst, Mishell, Stenchever, Comprehensive Gynecology, C.V. Mosby Company, 2001.
2. Disaia, Creasman, Clinical Gynecologic Oncology, Eighth Edition, C.V. Mosby Company,2012.
3. Rock, Jones, Operative Gynecology, Eleventh Edition, Lippincott Williams and Wilkins Company, 2015.
4. Wheeless, Roenneburg , Atlas of Radical Pelvic Surgery, on line edition. Atlasofpelvicsurgery.com
5. Longo, Fauci, Kasper, Hauser, Jameso, Loscalzo, Harrison’s Principles of Internal Medicine, 19th Edition, McGraw Hill, 2015.
6. Siegel, Love, Medicine, & Miracles, Harper & Row Publishers, 1986.
7. Hindle, Breast Disease for Gynecologists, Appleton & Lange, 1990.

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | |
| **Grady Medical Center ONC ROTATION** | | | | | | | | | | |
| **Rotation Name** | | | | | **Faculty Leader** | | | | | |
| **Oncology (ONC -A)** | | | | | **Roland Matthews, MD** | | | | | |
| **Resident Level** | | **PGY1** | | **PGY2** | | | **PGY3** | | **PGY4** | |
| - | | 4 wks | | | 4wks | | - | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core concepts relevant to gynecologic oncology. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | |
| **Meals** | | On your own | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | |
| **Call** | | No call | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | |
| **PGY2/3 GENERAL SCHEDULE** | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM- Floor  PM – Surgery Prep/Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM– OR | | AM – OR  PM - ONC | | AM- Continuity  PM - Floor | |  |
| Off | AM- Floor  PM – Surgery Prep/Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | AM – OR  PM - ONC | | AM- Continuity  PM - Floor | |  |
| Off | AM- Floor  PM – Surgery Prep/Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | AM – OR  PM - ONC | | AM- Continuity  PM - Floor | |  |
| Off | AM- Floor  PM – Surgery Prep/Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | AM – OR  PM - ONC | | AM- Continuity  PM - Floor | |  |

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **Dekalb Medical Center ONC ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Oncology (ONC-D)** | | | | | | **Cyril Spann, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| - | | | - | | | 4wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core concepts relevant to gynecologic oncology. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call | | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY 3/4 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | AM/PM - OR | | AM- Didactics  PM-Continuity | AM/PM– OR | | | AM – OR  PM - ONC | | AM/PM - OR | |  |
| Off | AM/PM - OR | | AM- Didactics  PM-Continuity | AM/PM – OR | | | AM – OR  PM - ONC | | AM/PM - OR | |  |
| Off | AM/PM - OR | | AM- Didactics  PM-Continuity | AM/PM – OR | | | AM – OR  PM - ONC | | AM/PM - OR | |  |
| Off | AM/PM - OR | | AM- Didactics  PM-Continuity | AM/PM – OR | | | AM – OR  PM - ONC | | AM/PM - OR | |  |

**Gynecologic Oncology (GYN-ONC) Learning Objectives By Year**

PGY-2

Oncology (ONC)

**Objective:** General exposure to all aspects of inpatient gynecologic oncology

**Responsibilities:**

1. Coverage of the GYN oncology inpatient service
2. Assist on the GYN oncology surgical procedures
3. Prepare cases for GYN oncology conference
4. Participation in continuity clinic

**Attending:** Gynecologic Oncology Attending

**Procedures/Skills:**

1. Post-operative management
2. Fluid management
3. Fundamental gynecologic surgical procedures
4. Principals of radial gynecologic oncology surgery
5. Chemotherapy fundamentals
6. Coordination of inpatient and outpatient care

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the GYN Oncology service and patients.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Assist with coverage/management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Outpatient and Continuity Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage
9. Gynecologic oncology pathology conference ((Tumor Board)

PGY-3 and 4

Oncology (ONC)

**Objective:** Exposure to all aspects of gynecologic oncology – pre and post-operative surgical management, chemotherapy, and operative experience. Management of a service as the senior resident

**Responsibilities:**

1. Coverage of the GYN oncology operating rooms
2. Management of inpatients
3. Coverage of continuity and colposcopy clinic
4. Participation in GYN oncology conferences/case presentations
5. Direct the GYN oncology resident team
6. Participation in morning rounds
7. Participation in afternoon rounds with Oncology attending
8. Data collection and entry

**Attending:** Gynecologic Oncology Attending/ Monthly GYN Attending

**Procedures/Skills:**

1. Advanced management of the gyn oncology surgical and post-operative patient
2. Surgical approach to the treatment of gyn malignancies
3. First assistance in radical procedures including lymph node dissection
4. Outpatient assessment/follow-up of gyn oncology patients
5. Counseling and support for patients and their families

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the GYN Oncology service and patients.

1. AM&PM Rounds GYN Team
2. AM&PM Board sign-out to NF Team
3. Morning Report
4. Assist with coverage/management of GYN Inpatient Service (GYN Team)
5. Didactic & Educational Conference
6. Outpatient and Continuity Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage
9. Gyn oncology pathology conference (Tumor Board)

**MATERNAL FETAL MEDICINE - MFM**

**OVERVIEW:**

The Maternal Fetal Medicine division assumes responsibility for high–risk patients. Perinatologists are available at all times for consultation and management. Prenatal diagnosis, ultrasound and genetics are an integral part of the resident experience.

**LEARNING FORMAT:**

Residents in MFM currently rotate through ***Grady Memorial Hospital (PGY 1)*** and see patients in the Perinatal Center. Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the MFM Service & L&D Floor.

**COMPETENCY BASED OBJECTIVES:**

The educational objectives of this residency regarding Maternal Fetal Medicine include evidence-based knowledge of and competency in:

**Patient Care**

* Antepartum fetal diagnostic testing including the performance and interpretation of:
  + 1st trimester ultrasound
  + 2nd trimester ultrasound - biometry, placenta, fluid assessment and biophysical profile
  + anatomic survey excluding cardiac outflow tract
  + Doppler flow studies
  + amniocentesis
* Interpretation of non stress test
* Genetic counseling
* Severe obstetric complications such as: prolonged premature rupture of membranes, preeclampsia and eclampsia, disseminated intravascular coagulation, preterm labor prior to 34 weeks gestation, multiple birth of > 2 fetuses, cervical incompetence, alloimmune thrombocytopenia and immunization
* Medical complications including: diabetes mellitus, urinary tract diseases, infectious diseases, hematologic disorders, cardiopulmonary disease, gastrointestinal disease, neurologic disease, endocrine disorders, collagen vascular disorders, psychiatric disorders, emergency care and substance abuse

**Medical Knowledge**

* Basic science and mechanisms of disease of medical complications of pregnancy including: genetics, anatomy, physiology, pharmacology, embryology/ developmental biology, pathology/neoplasia and microbiology/immunology
* Comprehensive patient presentations at conferences
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patient appropriately
* Refers to the appropriate sub-specialist/specialist when necessary
* Provides genetic counseling and referral to a certified counselor when appropriate

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of antepartum fetal diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion and disease prevention
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the MFM Service & Labor and Delivery Floor.

1. Perinatal Center
2. AM&PM Rounds (Attending)
3. AM&PM Board sign-out
4. Morning Report
5. Postpartum, antepartum and labor rounds/management
6. Coverage of Labor floor (Labor Team)
7. Didactic & Educational Conference
8. Outpatient and Continuity Clinic as scheduled
9. Operating room as necessary
10. Emergency room coverage

**ATTENDING SUPERVISION:** Maternal Fetal Medicine Division, Perinatologists: Franklyn H. Geary Jr., MD.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

**REFERENCES:**

Educational Objectives, CORE Curriculum in Obstetrics and Gynecology, 10th edition, Unit 3 (Obstetrics), pgs 29-52 and 113-115, published by CREOG

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 5, pg. 21-23,* published by CREOG, 2016

Maternal Fetal Medicine: Principles and Practice, Creasy & Resnick, Seventh Edition, 2014.

**Maternal Fetal Medicine (MFM) Learning Objectives By Year**

PGY-1

Maternal Fetal Medicine (MFM)

**Objective:** Exposure to inpatient and outpatient management of complicated pregnancies.

**Responsibilities:**

1. Coverage of the antepartum inpatient services
2. Assist in high-risk clinic

**Attending:** Maternal-Fetal Medicine Attending and L& D Attending

**Procedure/Skills:**

1. Management of complicated pregnancies
2. Performance and interpretation of antepartum testing
3. Performance of interpretation of antepartum surveillance (NST’s, biophysical Profiles)
4. Performance and interpretation of ultrasound
5. Coordination of inpatient and outpatient care
6. Appropriate use of consultants

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the MFM Service & L&D Floor.

1. Perinatal Center
2. AM&PM Rounds (Attending)
3. AM&PM Board sign-out
4. Morning Report
5. Postpartum, antepartum and labor rounds
6. Coverage of Labor floor (Labor Team)
7. Didactic & Educational Conference (Perinatal M&M/Emory Journal Club)
8. Outpatient and Continuity Clinic as scheduled
9. Operating room as necessary
10. Emergency room coverage

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **MFM ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Maternal Fetal Medicine (MFM)** | | | | | | **Franklyn Geary Jr., MD** | | | | | |
| **Resident Level** | | **PGY1** | | **PGY2** | | | | **PGY3** | | **PGY4** | |
| 4 | | - | | | | - | | - | |
| **Rotation Description** | | Residents will gain exposure to and experience with the diagnosis, assessment and management of high risk pregnancies from conception to delivery and postpartum. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leader | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | As assigned | | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality, Emory MFM Journal Club, Morning Report, PM Sign-out | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY1 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM – High Risk  PM – Continuity | | AM- Didactics  PM - MHC | | AM/PM – Perinatal Center | | AM/PM - MHC | | AM/PM- L&D | |  |
| Off | AM – High Risk  PM – Continuity | | AM- Didactics  PM - MHC | | AM/PM – Perinatal Center | | AM/PM - MHC | | AM/PM- L&D | |  |
| Off | AM – High Risk  PM – Continuity | | AM- Didactics  PM - MHC | | AM/PM – Perinatal Center | | AM/PM - MHC | | AM/PM- L&D | |  |
| Off | AM – High Risk  PM – Continuity | | AM- Didactics  PM - MHC | | AM/PM – Perinatal Center | | AM/PM - MHC | | AM/PM- L&D | |  |

**NIGHT FLOAT (NF)**

**OVERVIEW:**

The PGY-1-4 night float experience is an opportunity to gain basic obstetrical skills, experience in the management of acute and post-operative gynecologic patients and begin acquiring the skills of a consultant to other services including the emergency room.

In this rotation, the resident acquires the basic skills necessary for management of routine and high-risk obstetrical patients during the intrapartum and postpartum periods, management of routine and complex post-operative patients and acute gynecologic problems. Residents develop competence with performance of spontaneous vaginal delivery and are introduced to methods of operative vaginal delivery.

**LEARNING FORMAT:**

Resident on Night Float currently rotate at ***Grady Memorial Hospital* (PGY 1-4)** and provide coverage of the L&D Floor and GYN emergencies in the evenings beginning at 6:30 PM until 8:00 AM Sunday through Friday.

Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the L&D Floor.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding Night Float (L&D) include evidence based knowledge of and competency in:

**Medical Knowledge**

* Interpret common diagnostic tests in the context of the normal physiologic changes of pregnancy or gynecologic emergencies.
* Describe the anatomic changes that occur during the intrapartum period, such as cervical effacement and dilation.
* Describe the possible teratogenic effects of nonprescription drugs, such as:
  1. Alcohol
  2. Heroin
  3. Cocaine
  4. Tobacco
* Describe the typical presentation of gynecologic emergencies such as:
  1. Pelvic inflammatory disease
  2. Threatened abortion
  3. Incomplete abortion
  4. Complete abortion
  5. Septic abortion
  6. Ectopic pregnancy
  7. Urinary tract infections
* Perform a thorough history, assessing historical and ongoing risks that may affect pregnancy or gynecologic conditions.
* Perform a comprehensive history and physical examination.
* Order and interpret routine laboratory tests and those required because of risk factors during pregnancy or are appropriate to common acute gynecologic conditions.
* Schedule appropriate antepartum or gynecologic follow-up visits for routine and high-risk obstetric care and acute gynecologic conditions.
* Evaluate signs and symptoms of urinary tract pathology in pregnant and non-pregnant patients
* Describe the indications for the common diagnostic tests for renal disease in pregnancy.
* Interpret the results of common diagnostic tests for renal disease in pregnancy.
* Perform a history and physical examination for the diagnosis of gastrointestinal disease in pregnancy.
* Perform a focused history and neurologic examination in pregnant patients with a known or suspected neurologic disorder.
* Perform a focused history and physical examination in pregnant patients with a known or suspected endocrine disease.
* Perform a mental status examination.
* Describe the symptoms of common psychiatric disorders in pregnancy.
* Identify patients who require referral for psychiatric consultation.
* Perform a diagnostic history and physical examination in pregnant patients and those with a medical or surgical emergency.
* Perform diagnostic tests to confirm rupture of membranes.
* Assess patients with PROM for lower and upper genital tract infection.
* Perform and interpret the following methods of fetal monitoring:
  1. Intermittent auscultation
  2. Electronic monitoring
  3. Fetal scalp stimulation
  4. Vibroacoustic stimulation
* Describe the possible causes for, and clinical significance of, abnormal fetal heart rate patterns:
  1. Bradycardia
  2. Tachycardia
  3. Increased variability
  4. Decreased/absent variability
  5. Early decelerations
  6. Variable decelerations
  7. Late decelerations
  8. Sinusoidal waveform
* Obtain an accurate history, describing onset of uterine contractions and ruptured membranes.
* Perform a pertinent physical examination to assess:
  1. Status of membranes
  2. Presence of vaginal bleeding
  3. Fetal presentation
  4. Fetal position
  5. Fetal weight
  6. Cervical effacement
  7. Cervical dilation
  8. Station of the presenting part
  9. Clinical pelvimetry
  10. Uterine contractility
* Describe the normal course of labor.
* Assess the progress of labor.
* Document an accurate history of a patient’s previous operative delivery.
* Recognize and treat possible complications of VBAC/TOLAC, such as scar dehiscence, hemorrhage, fetal compromise, and infection.
* Describe the types of anesthesia that are appropriate for control of pain during labor and delivery:
  1. Epidural
  2. IV Narcotics
  3. Pudendal block
  4. Spinal
  5. Combined Spinal Epidural
* Perform an immediate assessment of the newborn infant and determine if resuscitative measures are indicated.
* Assign APGAR scores.
* Obtain cord blood for the following purposes:
  1. Blood gas analysis
  2. Determination of fetal blood type
* List signs and symptoms of abortion, including threatened, inevitable, incomplete, complete and septic abortions
* Enumerate the signs and symptoms of ectopic pregnancy
* Relate the signs and symptoms of acute pelvic inflammatory disease

**Patient Care (Clinical Skills)**

* Conduct focused patient histories and physical examinations, including:
  1. Comprehensive primary care examination
  2. Focused examination of the obstetrical patient and patients with acute gynecologic complaints
  3. Serial cervical examination of parturient
  4. Clinical pelvimetry
  5. Leopold’s Maneuvers/estimated fetal weight
  6. Accurate assessment of presenting fetal part and position
  7. Basic ultrasonographic examination of the fetus and gynecologic patient
* Evaluate symptoms and physical findings in pregnant patients to distinguish physiologic from pathologic findings
* Perform uncomplicated spontaneous vaginal deliveries
* Demonstrate level-appropriate skills in operative vaginal delivery
* Recognize the signs and symptoms of ectopic pregnancy
* Be familiar with the signs and symptoms of pelvic inflammatory disease
* Distinguish the signs and symptoms of early pregnancy loss

**Patient Care (Management Skills)**

* Multi-task and triage the care of all antepartum and intrapartum patients in the labor and delivery area
* Optimize the use of obstetrical anesthesia per patient preference and clinical situation
* Anticipate adverse pregnancy outcomes and prepare strategies to effectively manage them in a timely fashion
* Respond to acute intrapartum emergencies with appropriate interventions and recommendations for staff
* Act in response to acute gynecologic emergencies with appropriate interventions and recommendations for staff
* Continually update patient care team (attending physician, nursing staff, NICU staff, anesthesia, etc) on status of patient(s)
* Supervise and lend guidance to medical student and nursing student education

**Practice Based Learning**

* Formulate and answer important clinical questions that arise from patient care interactions
* Use personal experience with challenging patients to optimize future relationships with patients
* Incorporate feedback from evaluations to improve skill base
* Return all required departmental resident experience database forms and keep an updated patient log as detailed in the ACGME website
* Participate in quality assurance activities of the department
* Use of information technology: Up-To-Date, PubMed literature search, Cochrane Database, etc.

**Communication/Interpersonal Skills**

* Present pertinent obstetrical or gynecological history and physical findings to team members and consultants in a clear, concise fashion
* Demonstrate caring and respectful interactions with the patient and her family
* Counsel patients in language and manner appropriate to their educational and emotional / maturity level
* Continually update patient care team (attending physician, nursing staff, NICU staff, anesthesia, etc) on status of patient(s)
* Interact respectfully and professionally with all members of the patient care team, including: attending physicians, nursing staff, resident staff, medical students, social services, translators, etc.

**Professionalism**

* Demonstrate responsibility for the welfare of all patients on the labor and delivery, postpartum units, emergency room and other hospital units
* Demonstrate accountability for one’s actions and clinical decisions
* Acknowledge errors or omissions in patient care, and work toward timely resolution or alleviation of such
* Demonstrate truthful and timely disclosure of adverse outcomes to the patient and designated individuals
* Advocate for patients within the healthcare system
* Maintain sensitivity to issues of diversity, with patients and with staff
* Uphold the ethical principles of our specialty, as detailed by ACOG
* Participate actively in the education of fellow residents and medical students

**Systems-Based Practice**

* Order diagnostic tests with attention to cost-effectiveness and clinical relevance
* Effectively use consultants and ancillary services personnel to create an effective patient care team
* Follow clinical pathways as detailed in triage, L&D and emergency room protocols
* Demonstrate judicious and efficient resource utilization
* Demonstrate an understanding for the roles and responsibilities of healthcare team members
* Participate in quality improvement activities of the department

**SCHEDULE:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Operating room as necessary
7. Emergency room coverage

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculty who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

**REFERENCES:**

*CORE Curriculum in Obstetrics and Gynecology*, 10th edition, Unit 1-4, pgs 1 - 78, and Unit 6, pgs 95-110, published by CREOG.

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 1-3, pg. 1-13,* published by CREOG, 2016

*Williams Obstetrics,* Cunningham et al

*Maternal Fetal Medicine*, Creasy & Resnick

*Comprehensive Gynecology* by Stenchever, et al

*Rock Telinde’s Operative Gynecology* by Gershenson, et al.

Prolog Gynecology

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **GRADY NIGHT FLOAT ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Night Float (NF)** | | | | | | **Kimberly Carroll, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 8 wks | | | 4 wks | | | 8 wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the maintenance of normal labor and the procedures associated with delivery as well as associated antepartum, intrapartum and postpartum complications.  Residents will gain experience with managing patients who present via the emergency room and will treat and mange their care as deemed appropriate. Finally, residents will be responsible for managing the immediate postoperative period of patients who have undergone gynecologic surgery. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call, night float coverage only | | | | | | | | | |
| **Conference** | | Morning Report, Team Huddle, Perinatal Morbidity and Mortality, Interdisciplinary Fetal Heart Tracing “Strip” Rounds | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**  ---  | | | | | | | | | |
| **PGY1-4 GENERAL SCHEDULE** | | | | | | | | | | | |
| **Sunday** | **Monday** | | **Tuesday** | **Wednesday** | | | **Thursday** | | **Friday** | | **Saturday** |
| **AM – Off**  **PM- NF** | **PM - NF** | | **PM - NF** | **PM - NF** | | | **PM - NF** | | **PM - NF** | | **OFF** |
| **AM – Off**  **PM- NF** | **PM - NF** | | **PM - NF** | **PM - NF** | | | **PM - NF** | | **PM - NF** | | **OFF** |
| **AM – Off**  **PM- NF** | **PM - NF** | | **PM - NF** | **PM - NF** | | | **PM - NF** | | **PM - NF** | | **OFF** |
| **AM – Off**  **PM- NF** | **PM - NF** | | **PM - NF** | **PM - NF** | | | **PM - NF** | | **PM - NF** | | **OFF** |

Night Float (NF) Learning Objectives By Year

**PGY - 1**

**OB/GYN – Night Float (NF)**

**Objective:** General exposure to all aspects of in-patient obstetrics including intrapartum and postpartum.

**Responsibilities:**

1. Participate in the management of patients on the labor floor
2. Management of all postpartum patients on the postpartum unit
3. Triage of gravid women in all trimesters
4. Data collection

**Attending:** Night Call Attending

**Procedure/Skills:**

1. Vaginal Delivery
2. Operative Vaginal Delivery Assistant
3. Inpatient Assessment/Management
4. Circumcision
5. Fetal Monitoring
6. Fetal Scalp Electrode/Blood Sampling
7. Intra-uterine Catheterization/Infusion
8. Amniotomy
9. Cesarean Section Assistant & Primary Surgeon
10. Management of normal and abnormal labor
11. Triage of gravid women in all trimesters
12. Management of antepartum complications of pregnancy
13. Coordination of inpatient and outpatient care

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Post-partum, antepartum and labor rounds
5. Coverage of Labor floor (Labor Team)
6. Operating room as necessary
7. Emergency room coverage

**PGY- 2**

OB/GYN Night Float (NF)

**Objective:** Continued general exposure to all aspects of obstetrics with concentration of operative vaginal and abdominal interventions, fetal and maternal assessment, and multi-task management skills.

**Responsibilities:**

1. Assist in the management of labor and delivery floor.
2. Data collection
3. Provide Consultations to the emergency department and inpatient services
4. Triage of gravid women in all trimesters

**Attending:** Night Call Attending

**Procedure/Skills:**

1. Cesarean Section
2. Outpatient Assessment/Management
3. Vaginal Delivery
4. Operative Vaginal Delivery
5. Inpatient Assessment/Management
6. Fetal Monitoring
7. Fetal Scalp Electrode/Blood Sampling
8. Intra-uterine Catheterization/Infusion
9. Amniotomy
10. Pre & post-operative delivery counseling
11. Advanced directives for the obstetrical patient
12. Informed obstetrical consent
13. Vaginal Birth after C/S
14. Vaginal probe ultrasound
15. Principles of local and regional anesthesia, IV sedation, and other pain management issues
16. Emergency Gynecologic surgery - laparotomy and laparoscopy

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds
5. Coverage of Labor floor (Labor Team)
6. Outpatient and Continuity Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage

**PGY- 3**

OB/GYN Night Float (NF)

**Objective:** Postoperative management, emergency gynecologic consultation and surgery

**Responsibilities:**

1. Management of Labor and Delivery Floor
2. Data Collection
3. Primary consultant to the Emergency Department
4. Emergency operating room coverage
5. Assistance with the labor floor team as necessary

**Attending:** Night Call Attending

**Procedure/Skills:**

1. Cesarean Section
2. Outpatient Assessment/Management
3. Vaginal Delivery
4. Operative Vaginal Delivery
5. Inpatient Assessment/Management
6. Fetal Monitoring
7. Fetal Scalp Electrode/Blood Sampling
8. Intra-uterine Catheterization/Infusion
9. Amniotomy
10. Pre & post operative delivery counseling
11. Advanced directives for the obstetrical patient
12. Informed obstetrical consent
13. Vaginal Birth after C/S
14. Vaginal probe ultrasound
15. Principles of local and regional anesthesia, IV sedation, and other pain management

issues

1. Management of routine and emergent postoperative issues
2. Evaluation and management of urgent and emergent patients in the Emergency Department
3. Diagnosis and management of ectopic pregnancy
4. Emergency surgical procedures

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Outpatient and Continuity Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage

PGY- 4

OB/GYN Night Float (NF)

**Objective:** Complete management of all inpatients, Emergency Department and inpatient consults and obstetric triage patients.

**Responsibilities:**

1. Manage patients on the labor floor.
2. Direct junior residents in the management of inpatients
3. Provide consultations to the Emergency and inpatient services
4. Perform Cesarean sections on patients on the resident obstetrics service
5. Perform emergency gynecologic surgery

**Attending:** Night Call Attending

**Procedure/Skills:**

1. Complete obstetrics care to patients on the labor floor
2. Emergent evaluation of obstetric and gynecologic patients
3. Management of gynecologic emergencies
4. Emergent gynecologic surgery
5. Coordination of night float team

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the L&D Floor.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Postpartum, antepartum and labor rounds/management
5. Coverage of Labor floor (Labor Team)
6. Outpatient and Continuity Clinic as scheduled
7. Operating room as necessary
8. Emergency room coverage

**UROGYNECOLOGY (URO)**

**OVERVIEW:**

The urogynecology service attends to the needs of patients with medical and surgical problems related to incontinence and pelvic floor disease. Residents will be exposed to both diagnostic and operative procedures.

**LEARNING FORMAT:**

Residents on Urogynecology rotate through ***Grady Memorial Hospital in PGY 2, 3&4 years.*** Residents also attend urogynecology clinics with Drs. Donald Culley and Anne Wiskind.

Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Urogynecology Service.

**COMPETENCY BASED OBJECTIVES:**

The education goals of this residency regarding Urogynecology include evidence-based knowledge of and competency in:

**Patient Care**

* Office evaluation and management of urinary and fecal incontinence, pelvic support defects and voiding dysfunction
* Complex urodynamic testing including uroflowmetry, cystometric and voiding pressure studies are conducted using a Medtronic urodynamic system.
* Surgical management of pelvic support defects, urinary and fecal incontinence and genital fistulas
* Preoperative history and physical for patients undergoing urogynecologic surgery
* Review laboratory and radiologic studies and any other pertinent preoperative test necessary for the safe and effective performance of the planned surgery.
* Vaginal and abdominal reconstructive procedures as well as advanced laparoscopic techniques, and intra-operative cystoscopy
* Post operative rounds for all patients on whom resident performed or assisted during surgery
* Understanding the indications, contraindications, principals of and/or the performance of urogynecologic surgical procedures listed on pgs 59-62 of CREOG’s *Educational Objectives, 10th edition* (pages 34-40, 11th edition)

**Medical Knowledge**

* Basic science and mechanism of the diseases, disorders and defects encompassed in urogynecologic surgery including: genetics, anatomy, physiology, pharmacology, embryology/developmental biology, pathology/neoplasia and microbiology/immunology.
* Standard terminology and staging systems for urinary tract dysfunction and pelvic organ prolapse as recommended by the International Continence Society.
* Comprehensive patient presentations at conferences
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patient appropriately

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory, radiologic and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion and support resources
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols and the Affiliate Guide in the Residency Education Handbook for further instruction on procedure, management and coverage of the Urogynecology Service.

1. AM&PM Rounds (Attending)
2. Morning Report
3. Outpatient and Continuity Clinic as scheduled
4. Operating room as necessary
5. Urogynecology outpatient office hours as scheduled
6. Didactic & Educational Conference

**ATTENDING SUPERVISION:** Donald Culley, MD/PhD, Urologist, Anne Wiskind, MD and GYN weekly/monthly attending.

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculty who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

**REFERENCES:**

*CORE Curriculum in Obstetrics and Gynecology*, 10th edition, Unit 4, pgs 59- 62, published by CREOG.

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 5, pg. 26,* published by CREOG, 2016

*Ostergardt ‘s Urogynecology and Urodynamics*, 6th edition, Bent, Cundiff and Swift.

*Urogynecology and Reconstructive Pelvic Surgery*, 4th edition, Walters and Karram.

Urogynecology (URO) Learning Objectives By Year

PGY-2

Urogynecology (URO)

**Objective:** To gain knowledge of and experience with the techniques of outpatient evaluation and medical and non-surgical management of female bladder and pelvic floor dysfunction.

**Responsibilities:**

1. Participate in outpatient office hours with the Urogynecology faculty
2. Participate in urodynamic testing
3. Participation in Community based urogynecology clinics.

**Attending:** Urogynecology Attending, On-Call day attending

**Procedures/Skills:**

1. Perform and interpret urodynamic testing
2. Principles and methods of non-surgical management of bladder and pelvic floor dysfunction
3. Pre-op evaluation and preparation for urogynecologic and pelvic floor surgery
4. Pessary placement
5. Medical management of bladder dysfunction
6. Assessment of the patient with pelvic relaxation

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Urogynecology Service.

1. AM&PM Rounds (Attending)
2. Morning Report
3. Outpatient and Continuity Clinic as scheduled
4. Operating room as necessary
5. Urogynecology outpatient office hours as scheduled
6. Didactic & Educational Conference

PGY-3 and 4

Urogynecology (URO)

**Objective:** To gain knowledge of and experience with the techniques of outpatient evaluation and medical and non-surgical management of female bladder and pelvic floor dysfunction.

**Responsibilities:**

1. Participate in outpatient office hours with the Urogynecology faculty
2. Participate in urodynamic testing
3. Participation in Community based urogynecology clinics.
4. Coverage of Operative room cases

**Attending:** Urogynecology Attending, On-Call day attending

**Procedures/Skills:**

1. Perform and interpret urodynamic testing
2. Principles and methods of non-surgical management of bladder and pelvic floor dysfunction
3. Pre-op evaluation and preparation for urogynecologic and pelvic floor surgery
4. Pessary placement
5. Medical management of bladder dysfunction
6. Assessment of the patient with pelvic relaxation

**Schedule:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Urogynecology Service.

1. AM&PM Rounds (Attending)
2. Morning Report
3. Outpatient and Continuity Clinic as scheduled
4. Operating room as necessary
5. Urogynecology outpatient office hours as scheduled
6. Didactic & Educational Conference

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **GRADY UROGYNECOLOGY ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Urogynecology (URO)** | | | | | | **Anne Wiskind, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| -- | | | 4 wks | | | 4 wks | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the ambulatory management of patients with urologic concerns as well as the core urologynecologic surgical skills based on their competency level. Residents will learn to follow patients from the preoperative setting, through surgery and into the postoperative phase. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Morehouse faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | In-house Call as assigned by Chief Resident (under separate cover) | | | | | | | | | |
| **Conference** | | Weekly preoperative conference, Morbidity and Mortality conference | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   -- | | | | | | | | | |
| **PGY2-4 GENERAL SCHEDULE** | | | | | | | | | | | |
| **Sunday** | **Monday** | | **Tuesday** | **Wednesday** | | | **Thursday** | | **Friday** | | **Saturday** |
| **Off** | **AM /PM Ambulatory Clinic** | | **AM- Didactics**  **PM- Surgical Clinic** | **AM /PM – Grady Urogyn clinic** | | | **AM/PM – OR** | | **AM- Continuity** | |  |
| **Off** | **AM /PM Ambulatory Clinic** | | **AM- Didactics**  **PM-Surgical Clinic** | **AM /PM – Grady Urogyn clinic** | | | **AM/PM – OR** | | **AM- Continuity** | |  |
| **Off** | **AM /PM Ambulatory Clinic** | | **AM- Didactics**  **PM-Surgical Clinic** | **AM /PM– OR** | | | **AM/PM – OR** | | **AM- Continuity** | |  |
| **Off** | **AM /PM Ambulatory Clinic** | | **AM- Didactics**  **PM-Surgical Clinic** | **AM /PM – Grady Urogyn clinic** | | | **AM/PM – OR** | | **AM- Continuity** | |  |

**AMBULATORY OBSTETRICS AND GYNECOLOGY (AMB)**

**OVERVIEW:**

To facilitate development of the physician-patient relationship through the ongoing management of a cohort of patients in an ambulatory care setting. General exposure to common problems in women’s health

**LEARNING FORMAT:**

Participation in the outpatient care of women seeking gynecologic care. Residents gain experience in other specialties directly related to women’s health (eg: dermatology, gastroenterology, breast disease). Residents rotate on ***AMB OB/GYN during the PGY 1 and 4 years*** ***on service at Grady Memorial Hospital***.

Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Ambulatory Service.

**COMPETENCY BASED OBJECTIVES:**

The educational objectives for the Ambulatory OB/GYN rotation include evidence-based knowledge of and competency in:

**Patient Care/Clinical Skills**

* Comprehensive history taking including medical, nutritional, sexual, family, genetic, and social behavior data, and the ability to assess health risks
* Complete physical examination
* Periodic health assessments and interventions for high risk factors as described on pgs. 1-28 in *Educational Objectives: Core Curriculum in Obstetrics and Gynecology*, 10th edition
* Emergency care
* Ambulatory primary care problems of the geriatric patient including:
  + Health maintenance of the elderly patient such as immunizations, hormone replacement therapy and cancer screening
  + Diagnosis/treatment of osteoporosis
  + Drug-drug interactions and avoidance of “polypharmacy” in the elderly
  + Independent living issues
* Procedures, which the resident must understand and/or understand and perform, are on page 28 of CREOG’s *Educational Objectives,* 10th edition (Pages 27-40, 11th edition)

**Medical Knowledge**

* Behavioral medicine and psychosocial problems, including domestic violence, sexual assault and substance abuse
* Reviews and comprehends all diseases and treatments as described on pages 1–28 in *Educational Objectives: Core Curriculum in Obstetrics and Gynecology*, 10th edition and Unit 4, 11th edition.
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Patient education and counseling

**Professionalism**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patient appropriately
* Recognizes needs of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory studies and diagnostic techniques
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion and disease prevention recognized as evidence based
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

A complete description of the educational objectives for Intrinsic Objectives: Office Practice can be found in *Educational Objectives, CORE Curriculum in Obstetrics and Gynecology,* 11th edition, Pgs. 15-18.

**SCHEDULE:** As outlined by the OB/GYN Master Rotation Schedule and Monthly Call Schedule. Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Ambulatory Service.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Outpatient and Continuity Clinic as scheduled
5. Operating room as necessary
6. Emergency room coverage
7. Didactic & Educational Conference

**ATTENDING SUPERVISION:** OB/GYN Day Attending

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculty who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

**REFERENCES:**

*CORE Curriculum in Obstetrics and Gynecology*, 10th edition, Unit 2, pgs 9-28, published by CREOG.

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 4, pg. 15-18,* published by CREOG, 2016

*Williams Obstetrics,* Cunningham et al

*Comprehensive Gynecology* by Stenchever, et al

*Rock Telinde’s Operative Gynecology* by Gershenson, et al.

Prolog Gynecology, 8th Edition

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | |
| **GRADY AMB ROTATION** | | | | | | | | | | |
| **Rotation Name** | | | | | **Faculty Leader** | | | | | |
| **Ambulatory (AMB)** | | | | | **Dr. Kiwita Phillips**  **Dr. Hedwige Saint Louis** | | | | | |
| **Resident Level** | | **PGY1** | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 4 wks | | -- | | | -- | | 4 wks | |
| **Rotation Description** | | Residents will gain exposure to and experience with the ambulatory care of women across the age continuum from their teens into the postmenopausal state. They will gain experience with routine maintenance of care, within the gynecologic specialties, and the intersection of other specialties to provide comprehensive preventive and specialty care. | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | |
| **Meals** | | On your own | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | |
| **Faculty** | | Morehouse faculty as assigned | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | |
| **Call** | | In-house Call as assigned by Chief Resident (under separate cover) | | | | | | | | |
| **Conference** | | Morning Report, PM signout, weekly preoperative conference, Morbidity and Mortality conference | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | |
| **PGY1 GENERAL SCHEDULE** | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-FP | AM – OR  PM - FP | | AM – International Clinic  PM - Colpo | | AM-  Continuity | |  |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-FP | AM – OR  PM - FP | | AM – International Clinic  PM - Colpo | | AM-  Continuity | |  |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-FP | AM – OR  PM - FP | | AM – International Clinic  PM - Colpo | | AM-  Continuity | |  |
| Off | AM – LEEP  PM-Continuity | | AM- Didactics  PM-FP | AM – OR  PM - FP | | AM – International Clinic  PM - Colpo | | AM-  Continuity | |  |
| **PGY4 GENERAL SCHEDULE** | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | Thursday | | Friday | | Saturday |
| Off | AM – MFM  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM– OR | | AM – URO  PM - Colpo | | AM-Continuity | |  |
| Off | AM – MFM  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | AM – URO  PM - Colpo | | AM-Continuity | |  |
| Off | AM – MFM  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | AM – URO  PM - Colpo | | AM-Continuity | |  |
| Off | AM – MFM  PM-Continuity | | AM- Didactics  PM-Surgical Clinic | AM/PM – OR | | AM – URO  PM - Colpo | | AM-Continuity | |  |

Ambulatory – OB/GYN (Women’s Health) (AMB-OB/GYN)

PGY 1 Ambulatory

OB/GYN (Women’s Health) (AMB-OB/GYN)

**Objective:** General exposure to common problems in women’s health.

**Responsibilities:**

1. Participation in the outpatient care of women seeking gynecologic care
2. Experience with other specialties directly related to women’s health (e.g.: dermatology, gastroenterology, breast disease)

**Attending:** OB/GYN Clinic Attending, GYN Attending

**Procedure/Skills:**

1. Directed history and physical
2. Coordination of outpatient/home based care
3. Management of common problems related to women’s health
4. Coordination across disciplines

**Schedule:** As outlined by the OB/GYN Master Rotation Schedule and Monthly Call Schedule. Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Ambulatory Service.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Outpatient, High Risk and Continuity Clinic as scheduled
5. Operating room as necessary
6. Didactic & Educational Conference

Ambulatory – OB/GYN (Women’s Health) (AMB-OB/GYN)

PGY 4 Ambulatory

OB/GYN (Women’s Health) (AMB-OB/GYN)

**Objective:** General exposure to common problems in women’s health.

**Responsibilities:**

1. Participation in the outpatient care of women seeking gynecologic care
2. Experience with other specialties directly related to women’s health (e.g.: dermatology,

gastroenterology, breast disease)

1. Participation in OB/GYN specialty clinics – High Risk, Family Planning, REI,

Urogynecology and Continuity clinics

4. Multidisciplinary coordination of care in the ambulatory setting

**Attending:** OB/GYN Clinic Attending, GYN Monthly Attending

**Procedure/Skills:**

1. Directed history and physical
2. Coordination of outpatient/home based care
3. Management of common problems related to women’s health
4. Coordination across disciplines

**Schedule:** As outlined by the OB/GYN Master Rotation Schedule and Monthly Call Schedule. Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the Ambulatory Service.

1. AM&PM Rounds (Attending)
2. AM&PM Board sign-out
3. Morning Report
4. Outpatient, High Risk and Continuity Clinic as scheduled
5. Operating room as necessary
6. Didactic & Educational Conference

**EMERGENCY CARE CENTER (ECC)**

**OVERVIEW:**

Exposure to all patients with ambulatory care emergencies such as asthma, chest pain, abdominal pain, drug overdose, and requiring minor surgical procedures. Involvement in the care of acute emergencies including but not limited to stroke, myocardial infarction, uncontrolled diabetes or blunt force trauma.

**LEARNING FORMAT:**

The PGY-1 experience in Emergency Medicine consists of 1 month of rotation through the Emory School of Medicine, ***Emergency Medicine Department at Grady Memorial Hospita***l. The Department of Emergency Medicine faculty serves as the supervising physicians for the rotation. Attendance will be determined by the Emergency Medicine Physician Liaison in coordination the Program Director. The schedule of Continuity Clinic assignments will be made by the OB-Chief Resident in coordination with the Program Director.

Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of MSM OB/GYN Services while on rotation with ECC.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding the Emergency Care Center include evidence-based knowledge of and competency in:

**Patient Care**

* Diagnosis and treatment of patients presenting for urgent care with complaints relative to any medical condition and including obstetric or gynecologic problems
* Exposure to ambulatory care emergencies such as asthma, chest pain, abdominal pain, drug overdose, minor surgical procedures especially regarding the female patient.
* Medical emergencies requiring admission

**Medical Knowledge**

* Basic science/mechanisms of general medical diseases and conditions which may present as an emergent problem
* Comprehensive patient presentations at conferences
* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patients appropriately
* Counsels patient
* Refers to the appropriate specialist when necessary

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory, radiologic and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** As outlined by the Emergency Medicine Department.Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of MSM OB/GYN Services while on rotation with ECC.

1. Emergency call as outlined by ECC
2. AM&PM Rounds (Attending)
3. Continuity Clinic as scheduled
4. Didactic & Educational Conference

**ATTENDING SUPERVISION:**

Emergency Medicine Attending and the Emergency Room medical staff

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculty who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

**REFERENCES:**

*CORE Curriculum in Obstetrics and Gynecology*, 10th edition, published by CREOG.

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| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **GRADY ECC ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **Emergency Care Center (ECC)** | | | | | | **Emory ER Faculty** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 4 wks | | | -- | | | -- | | -- | |
| **Rotation Description** | | Residents will gain exposure to the urgent and emergent care of all patients who present to the Grady Emergency Room. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Emergency Room faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call , ECC shifts as assigned | | | | | | | | | |
| **Conference** | | Weekly didactics, ECC am/pm rounds | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY1 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled |
| Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled |
| Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled |
| Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | Shift 8-12 hrs as scheduled | | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled | | Shift 8-12 hrs as scheduled |

Learning Objective by Year

PGY-1

Emergency Care Center (ECC)

**Objective:** General exposure to all aspects of emergency and urgent acute care.

**Responsibilities:**

1. Provide acute care to patients in the Emergency Department
2. Data Collection
3. Documentation

**Attending:** ECC Attending

**Procedure/Skills:**

1. Assessment/Management of the Acute Care Emergent patient.
2. Management of acute medical condition
3. Various emergent peripheral lines
4. Emergent physical examination
5. Coordination of care among specialties
6. Appropriate use of consultants
7. Arrangement of appropriate follow-up

**Schedule:** As outlined by emergency medicine department. Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of MSM OB/GYN Services while on rotation with ECC.

1. Emergency call as outlined by ECC
2. AM&PM Rounds (ECC Attending)
3. Continuity Clinic as scheduled
4. Didactic & Educational Conference

**FAMILY PLANNING (FP)**

OVERVIEW:

The Family Planning rotation is geared toward the development of clinical skills in family planning and abortion services (residents may opt out of providing abortion services) and to develop awareness of the larger role that access to these services play in the lives of our patients. The aims of the rotation are to prepare residents to provide outpatient patient care and counseling that is compassionate, appropriate and effective for the treatment of outpatient reproductive and basic primary care problems. The rotation will provide opportunities for residents to master clinical skills including antepartum care, contraceptive counseling, pregnancy options counseling, manual vacuum aspiration, transvaginal ultrasound, and permanent and long-acting reversible contraceptive methods (LARC). Residents are under the supervision of the family planning attending or advanced practitioner staffing the ambulatory clinic.

LEARNING FORMAT:

Residents on FP currently rotate through ***Grady Memorial Hospital (PGY 1) and selected community-based practices***. Please refer to Program Director’s Protocols for further instruction on procedure, management and coverage of the Family Planning Service.

**I. Out-patient Services**

The resident assigned to the FP service will rotate through the Morehouse FP Clinic at Grady Memorial Hospital and selected community-based practices. The resident participates in all activities of the clinic during this rotation. He or she constructs detailed reports and presents and discusses all patients seen with the assigned faculty. Residents will perform all procedures that are deemed appropriate as seen in the Grady OB triage area.

**II. In-patient Activity**

The resident on the FP service will be involved in the evaluation and treatment of all inpatients on the postpartum service and assist on all FP surgical procedures in both the inpatient and same day surgery setting.

**COMPETENCY BASED OBJECTIVES:**

The educational goals of this residency regarding FP include evidence based knowledge of and competency in:

**Patient Care**

* Counsel patient about all alternatives available to them for unplanned pregnancy including induced abortion
* Perform bimanual pelvic exam and transvaginal and/or abdominal ultrasound to date early pregnancies
* Procedures that the resident must be able to understand and/or understand and perform are listed on page 34-40 of CREOG’s *Educational Objectives*, 11th edition

**Medical Knowledge**

* Understanding of normal reproductive embryology, anatomy, and physiology
* Understand and comply with state laws regarding abortion or sterilization
* Understand pre-operative evaluation and elicit pertinent history from patients requesting induced abortion.
* Describe techniques and appropriate timing for pregnancy termination methods including suction curettage, dilation and evacuation, and medical abortion. Residents opting to perform abortions will demonstrate initial procedural skill with manual vacuum aspiration, electric suction aspiration (D&C), and evaluation of POCs.
* Describe and understand treatment of potential complications of pregnancy termination.
* Know the following clinical presentations/workup

1. Endocrinology of normal & abnormal pregnancy (including ectopic pregnancy and recurrent pregnancy loss)
2. Contraception (hormonal & nonhormonal)

* Surgical Aspects of Family Planning

1. Endoscopic principals and procedures (including surgical laparoscopy)
2. Abdominal surgical treatment via laparotomy or endoscopic approach salpingectomy partial and complete
3. LARC insertions and Removal
4. Suction Dilation and Curettage
5. Suction Dilation and Evacuation

* Medical Therapies

1. Oral Contraceptives
2. Intrauterine devices - hormonal and nonhormonal
3. Mifepristone
4. Methotrexate

* Review of appropriate texts and references

**Interpersonal/Communication Skills**

* Introduces self to patient cordially and makes eye contact
* Uses appropriate language and terminology
* Summarizes treatment plan succinctly and completely
* Educates patients appropriately
* Counsels patient specifically regarding contraception or abortion services
* Referral to the appropriate sub-specialist/specialist when necessary

**Professionalism**

* Humanistic approach to patients
* Uses appropriate discussion style
* Recognizes needs/concerns of patients, families, faculty, office staff, and other health care personnel
* Follows a patient/plan through until problem remedied
* Cognizant of patient safety

**Practice-Based Learning Improvement**

* Appropriate use of laboratory, radiologic and other diagnostic testing recognized as evidence based
* Analyze and improve a specific practice behavior
* Reflects on learning needs and engages in self-directed learning
* Review and analysis of appropriate journal articles

**System-Based Practice**

* Community medicine, including health promotion and support resources
* Appropriate use of community resources and other physicians through consultation when necessary
* Health care delivery systems and practice management

**SCHEDULE:** Please refer to Program Director’s Protocols in the Residency Education Handbook for further instruction on procedure, management and coverage of the FP Service.

1. Morning Report
2. Rounds on Postpartum patients
3. Outpatient Continuity and FP clinics
4. Community Based Family planning clinics
5. Didactic & Educational Conferences
6. FP conferences

**ATTENDING SUPERVISION:** Attendings for Family Planning Clinic**/** GYN Attending

**EVALUATION/ASSESSMENT:**

The resident will be evaluated after each rotation on his/her clinical and surgical skills, as well as his/her general fund of knowledge. This evaluation will come from clinical faculty who have worked directly with the resident. Each resident will be evaluated using one or all of the below listed assessment methods.

**Core competencies to be assessed include: 1) Patient Care; 2) Medical Knowledge; 3) Practice-Based Learning & Improvement; 4) Professionalism; 5) Interpersonal & Communication Skills; and 6) Systems-Based Practice**

Each resident will be evaluated using one or all of the below listed assessment methods:

1. Evaluations by Faculty
2. Multi-Source Assessment/Evaluation (360)
3. Evaluations by allied health professionals
4. Direct Observation
5. Attending Rounds
6. Morning Report
7. Patient Surveys
8. Weekly Didactic and Clinical Conference
9. Journal club
10. Faculty critique of resident presentations at didactic and clinical conferences
11. Annual CREOG
12. Presentation of OB/GYN Cases
13. Written Assessments

REFERENCES:

*CORE Curriculum in Obstetrics and Gynecology, 11th edition, Unit 5, pg. 25,* published by CREOG, 2016

Williams Gynecology

PROLOG - Gynecology (American College of Obstetricians & Gynecologists), 8th Edition

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Morehouse School of Medicine OB/GYN Residency Program** | | | | | | | | | | | |
| **FAMILY PLANNING ROTATION** | | | | | | | | | | | |
| **Rotation Name** | | | | | | **Faculty Leader** | | | | | |
| **FAMILY PLANNING ROTATION (A)** | | | | | | **Hedwidge Saint Louis, MD** | | | | | |
| **Resident Level** | | **PGY1** | | | **PGY2** | | | **PGY3** | | **PGY4** | |
| 4 wks | | | - | | | - | | - | |
| **Rotation Description** | | Residents will gain exposure to and experience with the core concepts in family planning. Patients will be counseled and treated. Surgical procedures as deemed appropriate will be done. Residents will be exposed in the community clinics to the breath of contraceptive care. | | | | | | | | | |
| **Required Reading** | | Selected reading as assigned by faculty leaders | | | | | | | | | |
| **Objectives** | | As outlined by PGY Level | | | | | | | | | |
| **Meals** | | On your own | | | | | | | | | |
| **Parking** | | Obtained at orientation | | | | | | | | | |
| **Faculty** | | Faculty as assigned | | | | | | | | | |
| **Evaluation & Competency Assessment**  **SCHEDULE** | | Faculty are encouraged to provide direct verbal and web based feedback  Residents will be evaluated via New Innovations web-based evaluation system at the end of each rotation  Residents will be evaluated by staff, patients and other residents  Problems which appear to be of a more urgent nature, will be brought immediately to the attention of the residency program director  Residents will evaluate faculty via New Innovations to provide feedback regarding the rotation and faculty. This information is shared anonymously and used for course/faculty development | | | | | | | | | |
| **Call** | | No call | | | | | | | | | |
| **Conference** | | Departmental Morbidity and Mortality | | | | | | | | | |
| **Vacation** | | **Allowed Not Allowed**   --- | | | | | | | | | |
| **PGY 1 GENERAL SCHEDULE** | | | | | | | | | | | |
| Sunday | Monday | | Tuesday | Wednesday | | | Thursday | | Friday | | Saturday |
| Off | AM/PM - L&D | | AM- Didactics  PM-FP Clinic | AM - FP Clinic  PM – HSG | | | AM/PM - L&D | | AM/PM Community Clinic | |  |
| Off | AM/PM - L&D | | AM- Didactics  PM-FP Clinic | AM - FP Clinic  PM – HSG | | | AM/PM - L&D | | AM/PM Community Clinic | |  |
| Off | AM/PM - L&D | | AM- Didactics  PM-FP Clinic | AM - FP Clinic  PM – HSG | | | AM/PM - L&D | | AM/PM Community Clinic | |  |
| Off | AM/PM - L&D | | AM- Didactics  PM-FP Clinic | AM - FP Clinic  PM – HSG | | | AM/PM - L&D | | AM/PM Community Clinic | |  |

Family Planning Learning Objectives By Year

PGY-1

**Objective:** Exposure to basic contraceptive medical and surgical options.

**Responsibilities:**

1. Coverage of FP ambulatory clinic
2. Evaluation of Postpartum patients for contraceptive counseling
3. Participation in continuity clinic
4. Participation as assigned to community based ambulatory settings

**Attending:** Family Planning Attending **/** GYN Monthly/Weekly Attending

**Procedure/Skills:**

1. History and physical exams of FP patients
2. Outpatient assessment of patient desiring contraception
3. Understanding of normal physiology of the menstrual cycle
4. Understanding basics of contraception - emergency and non-emergency and LARCs use and placement
5. Ultrasound scanning for dating of pregnancy - abdominal and transvaginal

**Schedule:** Please refer to Program Director’s Protocols and the Affiliate Guide in the Residency Education Handbook for further instruction on procedure, management and coverage of the Family Planning Service

1. Morning Report
2. Rounds on Postpartum patients
3. FP operating room coverage
4. Outpatient Continuity clinic
5. Outpatient FP clinic
6. Outpatient Community-based family planning clinics
7. Didactic & Educational Conferences
8. FP conferences

Clinical Education Protocols

Definitions

Chief Resident:

(Senior Resident) The 4th year level

Most-Senior Resident:

The Highest Upper Level Resident present at a given time.

Administrative Chief Resident:

The 4th year resident who is the intermediary between faculty and residents. This position is selected by the Chairman &/or the Residency Coordinator. Duties include call & clinic schedule preparation and conference facilitation.

Upper Level:

Residents who have successfully completed greater than 2 years of OB/GYN.

Lower Level: PGY 1 & PGY 2

Intern:

The resident in their 1st postgraduate year of training.

Off-Service Resident:

The resident rotating away from their respective specialty choice.

Chief of Service:

The faculty member in charge of the respective OB or GYN specialty in the department.

General Procedures

Call Schedule:

* Weekday call begins at 6:30pm and ends at 8am the following day.
* Weekend call begins at 8am and ends at 8am the following day.
* The post-call residents on Sunday are to leave by 8am.
* Holiday call is treated like weekend day call.

Resident’s on-call are responsible for contacting the Administrative Chief Resident and Program Administration if they are late or are ill. The resident that misses their call must arrange alternate coverage. Upper level residents who are late or ill should contact the attending on call at that time.

Average call frequency is based on respective residency level. There is a night float system. Average monthly call for all levels averages 2 weekend days per month.

Call frequency during vacation months should be averaged according to the days the resident is present in the hospital. There should be a minimum of one upper level resident & one lower level resident on-call each night.

Work hours:

According to RRC guidelines, residents are to work no more than 80 hours per week. Residents are to work no more than 24 hours with six additional hours for clinic, didactics or other required function. There are to be at least 10 hours off between shifts or daily responsibilities and 1 day in seven completely off. (See APPENDIX A for further details)

Post-call:

Residents are to be dismissed from duties by 8:00 AM on Saturdays and by 8:00 AM on Sundays.

Call Room:

Call rooms are provided for upper and lower level residents and may be shared. Residents should ensure that call rooms are clean & secured when leaving.

Overnight Sign-out:

The most senior resident must ensure that the entire patient census with problem list is given to the relieving teams’ most senior resident. Any pending procedures (BTL’s, Circumcisions, etc.) must be communicated.

Resident Lounge/Library:

Residents are provided a lounge with computer instructional materials & resource library on the 4th floor. Residents should ensure that reading materials are maintained.

Weekend Coverage:

Patients to be seen should be assigned to respective residents prior to sign-out. Residents not on-call are not required to be present on weekends. The on-call resident(s) are responsible for all services on the weekends.

Cross Coverage:

In an effort to maximize patient care efficiency, residents, irrespective of monthly service, should be willing and may be called to assist other services when needed.

Vacation Coverage & Scheduling:

Residents have 3 scheduled weeks of vacation per year. Vacations should be scheduled in advance and provided to the Residency program. . The residency program must be updated on any changes to previously scheduled vacations.

Call scheduling should not necessitate residents making up calls during a month when vacation is scheduled.

Senior residents on vacation must ensure that an alternate senior resident manages the vacationing resident’s team and clinic duties.

Attempts may be made to allow residents to have the weekend days before and after their week of vacation; this is not guaranteed. Days pre and post vacation are subject to be lost if resident responsibilities are not fulfilled (e.g. medical records).

Vacation Scheduling Restrictions

No vacations may be scheduled during the month of July.

No vacations may be scheduled during the period December 15 thru January 5.

Only one resident in the Grady Call Schedule may take vacation at a time.

No vacations may be scheduled during the rotations listed below:

PGY 1 – No vacation during L&D, and Night Float (NF).

PGY 2 – No vacation during Night Float (NF), and L&D.

PGY 3 – No vacation during Night Float (NF), L&D/MFM, and GYN-A.

PGY 4 – No vacation during L&D/MFM, Night Float (NF), and GYN-A.

Fellowship Interviews:

*Residents are not allowed to use administrative leave for fellowship or employment interviews.*

Holiday Scheduling

Residents may alter scheduling during the latter part of the year for Thanksgiving, Christmas, & New Years but a minimum of 2 residents must be present every night for call. Clinic assignments must not be neglected.

The Administrative Chief Resident must FIRST approve all leave requests.

Education Leave/CME:

Residents may have leave only for conferences approved by the Residency Program Director. Leave must be scheduled separately from vacation time. Residents may not take an extended period off except with the permission of the Program Director. Except for extreme circumstances, residents may not take an extended period off to prepare for an exam unless approved by the Program Director.

Professional Leave:

Residents are only allowed to take administrative leave when traveling or participating in a designated department or residency activity approved by the Program director or department chair. Residents are not allowed to use administrative leave for fellowship or employment interviews.

Sick Leave:

Residents may take sick leave up to 12 paid days/year. If unforeseen illness or emergencies arise, and it is possible, the resident must ensure that another resident covers their assigned duties (clinic, etc.) Residents must notify the Program Manager , Program Director and the respective Chief Resident of their absence. Residents taking more than 2 consecutive days of sick leave must have a valid documented excuse to be submitted to the Program Coordinator. (Please refer to the GME Policy Manual for further details on resident leave policy)

**Resident Concern and Complaint Process**

To ensure that Residents are able to raise concerns, complaints, and provide feedback without intimidation or retaliation, and in a confidential manner as appropriate, the following options and resources are available and communicated to Residents and Faculty annually.

**Step One**

Discuss the concern or complaint with your Chief Resident, Service Director, Program Manager, Associate Program Director and/or Program Director as appropriate.

**Step Two**

If the concern or complaint involves the Program Director and/or cannot be addressed in step one, Residents have the option of discussing issues with the Department Chair or Service Chief of a specific hospital as appropriate.

**Step Three**

If you are not able to resolve your concern or complaint within your program, the following resources are available:

1. For issues involving program concerns, training matters or work environment, Residents can contact the Graduate Medical Education Director (404-752-1011 or [tsamuels@msm.edu](mailto:tsamuels@msm.edu))
2. For problems involving interpersonal issues, the Resident Association President or President Elect may be a comfortable option to discuss confidential informal issues apart and separate from the resident’s parent department.
3. Residents can provide anonymous feedback/concerns/complaints to any department at Morehouse School of Medicine by completing the online form - GME Feedback <http://fs10.formsite.com/bbanks/form33/index.html> .  Comments are anonymous and cannot be traced back to individuals.
   1. **Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if residents elect to include their name and contact information in the comments field.**
4. MSM Compliance Hotline – **1-888-756-1364** is an Anonymous and confidential mechanism for reporting unethical, noncompliant and /or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:
   1. Harassment – sexual, racial, disability, religious, retaliation
   2. Environment Health & Safety – Biological, Laboratory, Radiation, Laser, Occupational, Chemical and Waste Management Safety issues.
   3. Other Reporting Purposes:
      1. Misuse of Resources, Time, or Property Assets
      2. Accounting, Audit and Internal Control Matters
      3. Falsification of Records
      4. Theft, Bribes, and Kickbacks

Please refer to the [2016-17 GME Adverse Academic Decisions and Due Process Policy.pdf](file:///C:\Users\nclemons\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\Downloads\2016-17%20GME%20Adverse%20Academic%20Decisions%20and%20Due%20Process%20Policy.pdf) for detailed information.

Attending/Resident Dispute:

The covering attending or on-call attending is primarily responsible for patients on the service. This faculty member has final jurisdiction over patient management decisions. Disputes not related to patient management should be handled according to the Residency Handbook. Attending/Resident disputes or disagreements should not be discussed in any way on the patient’s medical record or in the presence of patients.

Obtaining Consultations:

Consultation may be obtained on inpatients only when approved by the attending or an upper level resident.

Attending Supervision:

Attending supervision &/or approval is expected for all invasive surgical procedures prior to the performance of the procedure.

Certified Nurse Midwives (CNM’s):

CNM’s are an integral part of our department and provide patient care, resident supervision, and student teaching. CNM services may be used when residents are in teaching conferences, retreats, preparation for and taking the CREOG exam. CNM’s also participate in quality improvement for the department and institution.

Physician Assistant Participation:

PA’s are an integral part of our patient care. PA services may be used when residents are in teaching conferences or when residents are unavailable due to extenuating circumstances. An upper level resident or attending must discuss and approve the services provided by a PA in the triage setting.

Faculty Advisor Role:

Faculty advisors should meet with assigned resident advisee(s) at least quarterly. Faculty advisors are not to be considered mediators for any disputes, unless involved directly in the situation.

Faculty Research Mentor Role:

Faculty research mentors should meet with assigned resident advisee(s) at least monthly. Faculty research mentors are expected to provide guidance to residents for preparation of their research projects for presentation at the Annual Nelson McGhee MD, PhD Resident Research Day (required for graduation), Annual William Booth and James Zaidan Research Day at Grady, GOGS annual meeting, ACOG, APGO-CREOG annual meeting, NMA Resident Forum, and any other meeting where projects have been accepted for presentation. Research mentors are expected to also guide residents with their projects for publication.

Training Permit/USMLE Step 3/Resident Licensure:

All Residents are required to have a residency training permit to be able to initiate training. The training permit is issued annually. The residency office will gather and submit all paperwork to the GME office for processing. Residents will be notified by the residency office of receipt of individual training permits. OB/GYN Residents are required to take USMLE 3 by the by the eighteenth month of training. Resident who have not taken and passed USMLE 3 by the eighteenth month of training will be subject to non-renewal of their contract. (Please refer to the GME Policy Manual available on the MSM Website for further details on USMLE Step 3 requirements) Residents may apply for State licensure after passing USMLE 3.

**Of note, a State license is required to be able to sit for the ABOG written exam at completion of residency.**

Moonlighting:

OB/GYN residents are not permitted to moonlight or participate in any outside clinical professional activities. (Please refer to the GME Policy Manual available on the MSM Website for further details on resident moonlighting policy)

Education

Didactic Conferences:

Residents are only excused from Didactic conferences if operating at affiliate sites or involved in emergencies at Grady. Special permission by the Program Director may be given after approval by the Administrative Chief Resident.

Grand Rounds:

Residents are expected to attend grand rounds as scheduled. Residents may be excused if immediate patient care issues prevent their attendance.

Journal Club:

Residents will be assigned journal club articles by the Program administration. The article will be shared with didactic participants in advance of presentation. Any pre-presentation assignments will be reviewed during the article review.

**Preop-Conference:**

All GYN cases are reviewed by faculty and residents to discuss the indications for, and to evaluate the appropriateness of, the planned procedure(s).

Gyn Morbidity & Mortality Conference:

Inpatient cases in which mortality occurs whether OB or GYN should be entered into the morbidity/mortality log. Morbidity & Mortality conference is done every month on the previous month’s cases. Morbidity cases must meet the pre-determined prerequisites for significant morbidity. The administrative chief resident will assign residents to conferences. Typically, the senior and junior resident on service for the month presents the cases. Residents are responsible for making themselves aware of conference scheduling & determining patients to be discussed.

Perinatal Mortality Conference:

Obstetrical cases in which mortality has occurred will be reviewed. Cases are identified by the Grady Health System Perinatal Mortality Case Manager. The conference is done monthly if there are cases to be presented. The L&D/MFM senior resident will present the cases at these conferences.

Fetal Monitoring Conference:

Fetal monitoring conference should be conducted monthly. Any level resident may request review of a fetal tracing for discussion. The junior OB resident will present the OB history and labor course.

OB/GYN Statistics:

Statistics should be presented during didactic conference on the first week of each month. Statistics should be for the previous month(s). The administrative chief resident will assign residents to this duty.

Faculty Lectures:

Faculty lectures are to be conducted by the assigned faculty as scheduled. The program manager should notify the assigned attending at least 1 month prior to their assigned lecture(s) to confirm the faculty’s availability and participation. If they are unavailable, the Program Director should be informed so that a replacement lecturer may be found.

Resident Lectures:

These lectures (grand rounds, student lectures, etc.) are to be conducted by the assigned resident as scheduled. The Administrative Chief Resident is to ensure compliance.

Resident Case Lists & Primary Care Audit Charts:

Each resident should maintain a personal diary of all inpatients that they manage. Residents are required to enter all OB/GYN procedures into the ACGME Resident Case Log system on a daily basis. Residents should enter cases for each week no later than the following Monday. The program assistant monitors Resident Case entry weekly (Monday morning). Residents who are non-compliant with weekly data entry are subject to disciplinary action including loss of weekend time pre or post vacation.

Effective July 2008 the ACGME case log system will no longer include data entry for primary and preventive ambulatory care cases. The documentation of this experience will shift from volume of cases to the content of care provided. Residents must review 5 well women examinations every six months for compliance with 20 essential components of primary and preventive care. Documentation of the examinations will be completed on the Primary & Preventive Care Chart Audit form. Senior level residents may audit charts for Junior level residents. The attending faculty will be expected to audit the PGY-4 charts. (See APPENDIX F for further details and requirements)

Supplemental Educational Aides:

Countdown to CREOG, True Learn question bank, and Prologs are examples of additional educational materials that may be used. Learning is mostly self-directed with guidance by the department. Residents are expected to increase their medical knowledge using a variety of sources and tools.

Teaching Rounds: (Morning Reports)

Attending rounds are conducted every weekday & weekends at the discretion of the individual supervising attending. All residents on the respective services are expected to be present for teaching rounds. Residents & students may be assigned topics for discussion on teaching rounds.

Supplemental Education Aides:

**Truelearn, Core Cases, Prologs, Countdown to CREOG, Board review Course(s), MyTip Report**

Student Teaching:

Resident participation in teaching medical students is an integral part of the OB/GYN duties. The senior resident on each service may assign topics of discussion to each group of students at least once per month. The senior resident should make the attending on service aware of assigned topics prior to the date of presentation.

CREOG In-Service Exam:

This test given annually is used to monitor progress of residents in comparison to residents nationwide at the same level of training. Review time for CREOG is not an excuse for failure to perform, or be available for assigned service duties. Chief residents should arrange regular CREOG reviews and elicit faculty participation.

Licensure Examination:

**Part 1 on the certification process is the ABOG written exam. This exam is taken by eligible candidates at the completion of residency training. Of note, a State license is required to be able to sit for the ABOG written exam at completion of residency.**

Resident Evaluations:

Faculty will be expected to submit written evaluations on all residents on each service on a monthly basis. A composite evaluation will be completed by designated faculty. This composite evaluation will include the number of faculty reviewers who participated in the assessment. Faculty should be evaluating resident based on capacity to affect accurate patient care, using the appropriate medical knowledge when assessing patients. Practiced-based learning and improvement and interpersonal and communication skills will be evaluated based on direct observation of interaction with faculty, residents and direct patient care. **P**rofessionalism will be assessed by direct observation to include appearance, adherence to ethical principles and sensitivity toward diverse patient populations. System-based practice will be assessed by direct observation and interpretation of the resident’s awareness of system of healthcare and effective use of system resources to affect optimal patient care. Faculty evaluations may be reviewed by residents online using the New Innovations Residency Management Suite.

The Clinical Competency Committee will meet at least 2x/year to review collated resident evaluations and assign milestones as per ACGME protocol. This data will be uploaded into ACGME as well as New Innovations and discussed with Program administration to be discussed at semi-annual review sessions.

Patient feedback will be included for each resident as a multisource assessment.

The program director will meet semi-annually (twice per year) with each resident to review his/her evaluations.

Faculty Evaluations:

Residents are expected to submit evaluations on assigned faculty members on a quarterly basis.

Ward Duties

Rounds:

Rounds are to be conducted on each patient daily. The most senior resident on each service is responsible for ensuring that all patients are seen properly and in a timely fashion. The senior resident manages the service with the attending being informed of each patient’s condition & progress. Any change in primary diagnosis &/or treatment should be discussed & cleared with the service attending. All invasive tests or procedures done on inpatients must be with the consent of the ward or on-call attending.

Progress Notes:

All inpatients should have at least 1 progress note per day by an OB/GYN resident or intern. GYN patients, antepartum, non-laboring patients, high-risk postpartum patients and ALL postoperative patients should also have a note from an upper level resident daily. These notes should document faculty input/agreement and management plans. All obstetric intrapartum patients must have labor records completed with exam frequency determined on a case-by-case basis.

Intensive care unit patients should have at least 1 upper level resident note/ 8-hour shift. Notes that are more frequent may be required depending on the severity of the patient’s illness. Medical student progress notes must be read & cosigned by an OB/GYN resident.

Verbal Orders:

Verbal orders are intended to be used as an aide to physicians who are currently occupied by issues that are more critical. Verbal orders should not be used as a replacement for physically seeing & examining a patient. All verbal orders should be signed by the resident giving the verbal orders within 12 hours.

Response to Calls:

It is imperative that residents who receive calls about inpatients use the utmost diligence in eliciting information with which to gauge a patient’s condition.

Nursing calls must be returned in a timely fashion & any conditions which are unclear must be discussed with an upper level resident &/or attending.

Timeliness & Attendance:

Residents are expected to have seen their patients prior to morning report. The time of morning report may be changed at the discretion of the senior resident &/or attending.

For the service to run smoothly, all assigned residents should be present and ready for duties at the beginning of their shift. If residents are late, they are expected to contact the senior resident to inform them so that their duties may be re-assigned.

Obstetrics Service

General:

The entire OB service is to be managed by the coordinated efforts of the OB team with the most senior resident serving in a managerial & overseer capacity. The senior resident should know the condition of all patients on their respective service. MFM patients fall under the guidance of the most senior MFM resident. If the upper level MFM resident is unavailable then the most senior resident on service at Grady is responsible for MFM patient management.

Triage:

All patients presenting to OB triage are to be seen in order of severity. It is also advisable that OB triage patients be seen within 1 hour after arriving in an exam room. The first call to the triage area will be the intern or lower level OB resident who must discuss patients with an upper level resident &/or attending prior to discharging or admitting the patient.

Triage charts must be co-signed by an upper level resident or attending prior to discharging the patient. The upper level resident should inform the attending of any admissions or patients with unclear diagnosis. The chart should reflect the attending input.

The L&D team is to be 1st call for the Ob Triage/Fast track. All patients should be seen in a timely fashion (< 1 hr in a room) and disposition made within 4 hours. All patients seen by a PGY1 & 2 must be discussed with an upper level resident and the chart should document upper level input.

Admissions:

Patients admitted to L&D may be managed by a 2nd, 3rd or 4th year resident while in labor. Uncomplicated vaginal deliveries should be performed by a PGY-1 if available. Actively laboring patients should have a progress note every 2-3 hours.

Complicated Vaginal Deliveries:

Breech Extraction, Operative Vaginal Deliveries may be performed by any level resident with assistance by senior resident and Attending. All operative vaginal deliveries should be dictated immediately.

Postpartum Complications:

Such as PPH, retained placenta, cervix lacerations, 3rd & 4th degree laceration repairs should be managed with an upper level resident present. The Attending must be made aware of these complications.

Postpartum BTL’s:

Postpartum BTL’s may be performed by any level resident in conjunction with the covering attending. Patients must have a thorough valid informed consent, compliant sterilization papers and a progress note stating that risks, alternatives, failure rate and permanence were explained to the patient.

Cesarean Section:

Uncomplicated Primary C/S’s may be performed by the PGY-1 in conjunction with an upper level teaching resident. Repeat C/S & complicated Primary C/S such as breech or obvious fetal asphyxia should be a resident at 2nd year level or higher or at the discretion of the Attending. All patients undergoing Cesarean Section should have a preoperative “disposition note.” Final assignment of operative roles is at the discretion of the attending.

OB Perinatal Transfers/Admits:

Transfers from other hospital/clinics and direct admits from clinic must go through the clinic Attending or on-call Attending. The senior resident should always be made aware of any admissions.

OB ICU :

The OB ICU patients are to be seen by the upper level MFM resident in the morning. The L&D team manages the patient throughout the day and night.

Missed Abortion:

D&C or medical evacuation, as appropriate, should be offered at the time of diagnosis. Scheduled D&C’s are to be posted in the electronic procedure log and to be assigned to the lower level GYN resident.

Serial Quant BHCG:

Patients with early pregnancy & unclear diagnosis who require serial quants must be followed closely. Patient information should be entered in the EHR and kept up-to-date on the resident sign-out sheet. The L&D senior resident should ensure that patients are followed at the specified intervals. Certified letters should be sent to appropriate patients who cannot be contacted by phone.

Methotrexate Follow-up:

The upper level resident and/or the attending may give patients with ectopic pregnancy who meet ALL the criteria listed in the methotrexate protocol methotrexate upon approval. These patients must be entered in the EHR & follow-up continued until HCG is undetectable. Any patients who cannot be contacted by phone & have not completely resolved their pregnancy state should have certified letters sent to their mailing address. Record of certified letter should be scanned into the electronic medical record system.

Postpartum Service

Circumcisions:

These may be performed after informed consent is obtained from the mother or guardian. The presence of the Attending is mandatory for billing purposes & the chart must reflect the attending involvement. Upper level residents may supervise lower level residents.

Antepartum Service

The antepartum service falls under the guidance of the L&D/MFM service for all documented IUP’s. The attending of responsibility will be the MFM OB attending. The MFM resident will write daily notes on these patients. When an antepartum L&D/MFM patient goes into labor, the L&D team takes over responsibility with input from the MFM team as needed.

MFM Admissions:

L&D team admits from L&D and transfers to MFM. The MFM service follows these patients.

Gynecology Service

GYN Admissions:

The senior GYN resident who informs the GYN attending must approve all GYN admissions. The PGY-1 or 2 may write the initial H&P but a chief resident or covering attending admit note should accompany the lower level resident admit notes & clarify the plan of management if needed.

Gynecology - Inpatient Service

Inpatient Consultations & ECC:

When GYN consultations are requested by other services, the resident carrying the consult pager receiving the request must quickly ascertain the urgency of the consult & determine the pregnancy status of the patient. The resident receiving the call should dispose the patient as soon as possible. An upper level resident &/or Attending should be notified & involved prior to any consults or recommendations being placed on a patient’s chart. Consultations are to be done by PGY 2 resident or above. PGY 1 residents are not to do consults unless directed by the Attending.

Patient Transfers:

Any transfers from other services to GYN must only be made with attending approval. Patients may be transferred to other services only if approved by the other service & the OB/GYN attending.

Gynecologic Oncology **Service**

Gynecology Oncology falls under the guidance of Drs. Roland Pattillo and Evelyn Reynolds. Residents on the GYN ONC rotation are primarily accountable for following Oncology patients. These residents nevertheless are part of the OB/GYN team & as such may be called to other services by the OB or GYN chief resident for assistance in other areas if needed.

The GYN residents are responsible for Tumor and Colposcopy Clinic patients & LEEP procedures. The Georgia Cancer Center (GCC) maintains patient records. Residents are responsible for following up on all pathology specimens through the EPIC EHR.

The GYN and/or ONC resident should inform the GYN Oncologist Attending of any GYN ONC admissions. Care plans are to be determined by the GYN ONC specialist.

Surgical Procedures

Outpatient Procedures:

All patients in clinic, ECC, and OB Triage who require invasive procedures (LEEP, Colpo, EMS, Biopsies, I&D, circumcisions, etc.) must be discussed with a senior resident and an attending. Residents performing these procedures must obtain the patients phone # & follow up on results.

Surgical Scheduling:

All ambulatory & in-patient elective procedures are to be done on the scheduled MSM surgical day(s) unless otherwise advised by the Attending of record. A surgical operating room (OR) schedule will be available electronically so that OR days can be used optimally.

GYN/ONC cases may have priority for early start times on scheduled surgery days. All surgical cases must have attending approval before being scheduled.

Any patients requiring pre-surgical admissions should be stated on the surgical calendar & the GYN resident must sign out the in-patient to the on-call team the night prior to surgery. Pre-op H&P and orders are the responsibility of the pre-op and operating residents, not the on-call team.

Ambulatory Procedures:

Ambulatory cases must be approved by an attending and should be scheduled during pre-op clinic.

In-patient Procedures:

All H&P’s are to be done by the operating team or pre-op team. Procedures must be approved by an Attending prior to scheduling.

Urgent Cases:

During the day, patients requiring urgent surgery (within 6 hours) are the responsibility of the daily GYN team. Those patients admitted at night are to be operated on by the on-call team.

Emergency Procedures

These procedures are the responsibility of the resident who is present at the time of the emergency, whether day or night. The chief resident or upper level should write a pre-op note on these patients & the attending must be aware of the patient ASAP.

Informed Consent:

All patients that require an invasive surgical procedure must undergo written informed consent. Risks, benefits and alternatives must be explained & the patient or guardian must sign the consent form. The consent must be witnessed. In true acute surgical emergencies, verbal consent may suffice if witnessed by two physicians. An attempt should be made to obtain written consent after the procedure in these cases. Patients should not be given narcotic medications or sedatives if they are suspected of needing surgery unless informed consent has already been obtained.

Post Op Follow-up:

Patients undergoing elective surgery should be followed by their primary surgeon if possible. Patients undergoing emergency surgical procedures or procedures during an overnight call, should be followed post operatively by the OB or GYN team rather than the night call team.

Clinical Procedures

General Guidelines:

All patients seen in clinic should be signed out by an attending. Residents are to make sure that all clinic duties are complete prior to leaving clinic regardless of clinic assignment. Residents are to check with the senior resident before leaving clinic.

Punctuality:

Residents are expected to be present for clinic on time. If conditions necessitate a resident being late, the resident should contact the senior resident to request temporary coverage of their clinic duties.

Appearance:

Residents should maintain a professional appearance in clinic. This means, wearing clean clothes & having proper personal hygiene prior to arriving at clinic. In the event that scrubs are worn, a clean white coat should be worn covering the scrubs. Scrubs are only allowed in clinic when on-call, post-call, L&D, or assigned to the OR. Disciplinary actions may be enforced including loss of weekend time pre or post vacation.

Professionalism: ACGME CORE COMPETENCY

MSM strives to maintain a positive image of its faculty, residents, & staff. Professionalism is a 3-fold endeavor - professional appearance, professional behavior towards patients & caring attitude towards patient’s health needs. These factors should ensure patient satisfaction & return to our service for their care.

As a part of professional behavior residents are expected to maintain compliance of all required paperwork both personal and patient related. They are also expected to FULLY participate in all didactic activities as assigned. This includes attendance, limited or non-use of technology during sessions and prompt notification of all absences. Noncompliance to any of these requirements will be subject to disciplinary action as deemed appropriate by the Program Director.

Specialty Clinics

Surgical Clinic/Pre Op:

The most senior GYN resident in conjunction with an attending will manage these patients. All surgical patients must be seen and cleared by an Attending. All surgical patients must be logged in the electronic surgical logbook. The most senior resident should check clearance of ambulatory and inpatients at least 2 days prior to scheduled surgery. Alternate surgical patients should be contacted in the event a scheduled patient fails to get clearance. The most senior GYN resident should re-contact the surgical attending at least 1 day prior to the scheduled surgery day. Alternate supervising attending(s), if needed should be obtained by the scheduled OR attending and is not the responsibility of the residents. Cases should not be moved from another month without permission from that following month’s GYN resident.

Maternal Fetal (High Risk):

Patients who fulfill criteria for high-risk pregnancy are followed in the clinic that is supervised by the MFM specialist. The MFM patient log should be generated to facilitate management of MFM patients. Problem lists on these patients must be frequently updated.

Reproductive Endocrine:

The REI specialist supervises this clinic. Patients in this clinic are to be seen by the REI resident or assigned resident. The REI attending must clear procedures scheduled from this clinic (HSG’s, laparoscopies, hysteroscopies). The REI log should be maintained in the clinic area.

Colposcopy/Oncology:

This clinic is supervised by the GYN ONC specialist or assigned Attending. This GYN ONC resident or an upper level GYN resident is responsible for patients in this clinic. Follow up of patient results are required through the EPIC lab review system.

Continuity Clinics:

The goal of this clinic is to simulate private practice. These clinics are primarily the responsibility of each respective resident. Notice should be given to central scheduling by the Clinical Chief Resident at least 3 months prior to a residents scheduled vacation. The Clinical Chief Resident must ensure that patients are covered. Residents, who have patients that are left uncovered, may have their patients reassigned to another physician temporarily or permanently.

Elective Termination of Pregnancy

While we no longer have an elective termination of pregnancy service, patients are still counseled regarding elective termination of pregnancy. Select patients are specifically counseled regarding pregnancy termination for medical indications. Residents without objection may perform medically indicated terminations. Residents are not required to perform pregnancy terminations. However, they are expected to learn the techniques of performing the procedure with missed abortions.

Leep Clinic:

See above (Colposcopy/Oncology).

Walk-In:

This clinic is covered by PA’s, CNM’s and residents; residents sign out patients with the clinic attending.

Medical Records

Operative Dictations:

Must be dictated within 24 hours of the day of surgery by the primary surgeon, however should be dictated immediately following surgery. Written operative notes should be as thorough as possible to facilitate repeat dictation if necessary. Any resident not in compliance will forfeit weekend days pre and/or post vacation.

Discharge Summaries:

The assigned resident who discharges the patient in a timely fashion must dictate discharge Summaries. Discharge dictations should be completed within 24 hours of the patient’s discharge. All dictations should be proofread & signed at least weekly by each resident. Dictations are the responsibility of the primary team. Night float is not required to complete discharge summaries, but may be asked to complete short stay summaries on patients only seen by them overnight.

Patient Follow-Up

Histo-Pathology:

Surgical specimens whether obtained on an inpatient or outpatient basis must be followed up by the resident who performs the procedures.

Abnormal gestations such as molar pregnancies, ectopics, etc:

Should be followed by the L&D team.

Sexually Transmitted Infections:

Any patient who is presumptively treated for an STI should have cultures checked. The patient must be informed about any positive cultures whether or not they were adequately treated. Patients should be informed of the need for partner(s) to be treated and the medical record should reflect that statement.

Alternate Rotation Sites

Preceptor:

Each alternate site has its own assigned preceptor/site supervisor. Residents are expected to make the preceptor/site supervisor aware of their presence at the facility & to be available during all scheduled work hours.

Duties:

Duties at alternate sites are to be determined by the preceptor/site supervisor in conjunction with the OB/GYN program director.

Call:

While at alternate sites, residents are scheduled to take call at the primary site (Grady). This may be subject to change.

APPENDIX A

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Resident Duty Hour & Work Environment Policy

80 hour Rule

The ACGME has adopted the 80 hour workweek rule effective July 1, 2003. In addition to the weekly duty hour limit, the standards also include provisions for rest periods and days free from resident duties. (Please refer to the GME Duty Hour Policy available on the MSM Website for further details on resident duty hour and work environment policies.

Duty hours are defined as time spent on educational and clinical activities related to the residency program, including patient care, administrative duties related to patient care and academic activities. Specific provisions include:

* Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over four weeks.
* Residents must be given one day out of seven free from all clinical and educational responsibilities, averaged over four weeks.
* Residents cannot be scheduled for in-house call more than once every three nights, averaged over four weeks.
* PGY-1 Residents duty periods must not exceed 16 continuous hours.
* PGY-1 Residents should have at least 10 hours, and must have eight hours, free of duty between scheduled periods.
* Duty periods for PGY-2 Residents and above cannot last for more than 24 hours, although residents may remain on duty for four additional hours to transfer patients, maintain continuity of care or participate in educational activities.
* Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
* 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. Therefore, moonlighting is not permitted in the Department of OB/GYN at The Morehouse School of Medicine. Residents who engage in moonlighting activities are subject to disciplinary action and/or dismissal.
* For Rotations outside of OB, the 80hr/30hr rule will be in effect.

Patient Care

The following outlines Resident duty hours and patient care on the weekends.

Hours:

Interns/ 2nd Years

* L&D Days: Mon-Thurs 6:00 am-6:30 pm, Fri 6:00 am-5:00 pm (Sign out at 7:00 am for upper levels)
* Night Float: Sun-Fri 6:30 pm – 7:30 am (except Fridays, start at 5:00 PM)
* Weekend Coverage: 12 hour shifts between interns to cover 24 hrs on Saturday and Sunday AM
  + - Saturday 8:00 am – 8:00 pm intern A/ 8:00 pm–8:00 am intern B
    - Sunday 8:00 am- 6:30 pm (then night float starts at 6:30 pm)
* 3RD Years, 4th years
* L&D Days: Mon-Thurs 6:00 am-6:30 pm, Fri 6:00 am – 5:00 pm (Sign out at 7:00 am for upper levels)
* Night Float: No changes
  + - Sunday: 8:00 am – 7:00 am
    - Monday – Thurs: 6:30 pm – 7:30 am
    - Friday will be covered by senior resident taking Friday night call and junior resident on night float
* Call Schedule: Upper levels will cover Friday pm call and Saturday call
  + - Friday 5:00 pm – 8:00 am
    - Saturday (8:00 am-8:00 am)

Saturday Morning Patient Care:

1) The Friday night on-call and Saturday on-call teams will be responsible for rounding on ALL in-patients.

2) The in-patients seen by the Friday on-call team will be "signed out” to the Saturday on-call team prior to the Friday on-call team leaving the hospital.

3) After the Saturday on-call team has completed the remainder of in-patient rounds, the most-senior-level resident will contact the Saturday on-call Attending to schedule sit-down or bedside rounds on ALL in-patients. The time of Attending rounds should be close to 0900. The Friday on-call team is not expected to be at these rounds, but again ALL in-patients will be discussed with the Saturday on-call Attending.

Sunday Morning Patient Care:

1) The Saturday on-call and Night Float teams will be responsible for rounding on ALL in-patients.

2) The in-patients seen by the Saturday on-call team will be "signed out" to the Night Float team prior to the Saturday on-call team leaving the hospital.

3) After the Night Float team has completed the remainder of in-patient rounds, the night float team's most-senior -level resident will contact the Sunday on-call Attending to schedule sit-down or bedside rounds on ALL in-patients. The time of Attending rounds should be close to 0800.

Duty Hours Method of Compliance

To monitor Resident Duty Hours the OB/GYN Residency Program requires all residents log their duty hours/time on a weekly basis into the New Innovations Residency Management Suite. On Monday of each week the Program Director or his designee will monitor resident compliance. Logging duty hours is not optional and non compliance is subject to disciplinary action to include loss of weekend time pre or post vacation.

Resident Work Environment

The major objectives of the MSM residency training programs are to provide for education, patient care, and scholarly activities. Residency training programs shall provide clinical training and other programs designed to assure that the program shall provide the resident with the specialty “special requirements” and the program goals and objectives prior to the start of the Post Graduate Year (PGY). The program shall give each resident the rotation schedule and goals and objectives before the start of each rotation.

Faculty members involved in residency training shall be qualified to supervise and instruct residents and must be able to devote sufficient time to their assigned responsibilities.

Faculty supervision, professional criticism, the evaluation of professional work, and didactic instruction to supplement clinical practical experiences will be provided within the curriculum of the program. All program faculty shall be given their educational responsibilities in writing.

The resident should ideally participate in the care of a diverse patient population. Some clinical skills sought are: the taking of patient histories conducting physical examinations-recording the proper findings on charts to make a tentative diagnosis – and gaining the ability to recommend treatment in a problem – oriented fashion. Program content shall also address ethical, socioeconomic and medical-legal issues to support clinical training. Patients shall not be subjected to any unnecessary diagnostic procedures.

The training of physicians requires the provision of inpatient and ambulatory setting in which they may practice their specialty, within guidelines at all assigned facilities. The program shall assign the resident night rotation and weekend duties (when applicable) providing relief from “call” built into the schedule consistent with the “special requirements” of the specialty. They shall make on-call facilities (including sleeping rooms and secured storage areas) available at all inpatient training sites.

The program shall give the resident a written evaluation of his or her performance on each rotation in the residency program. They shall allow the resident to discuss his or her training evaluations with supervisors and advisors. The residency training director or his or her designee shall discuss the resident’s overall progress toward achieving the educational objectives of the training program at least semi-annually.

The resident shall be progressively responsible for the supervision and teaching of medical students and other residents on the service to which they assign him or her. The resident is also expected to evaluate the clinical and didactic aspects of the training program.

The resident shall be made aware of the current accreditation status of the Training Program, to include all provisos, and/or any anticipated change in the training requirements.

APPENDIX B

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Resident Supervision Policy

I. Purpose of Policy: The purpose of this policy is to define the process for resident supervision, including progressive responsibilities of residents for patient care and faculty responsibility for supervising resident patient care.

II. Process: The obstetrics and gynecology residency program has the following process in place for resident supervision:

* 1. A resident participates in didactic, research and clinical activities under the direct supervision of attending faculty physicians in accordance with the curriculum of his/her respective training program.
  2. Qualified faculty physicians supervise all patient care and their schedules are structured so that adequate supervision is available at ALL times.
  3. Attending faculty supervision is provided, appropriate to the skill level of the resident on the service.
  4. Specific responsibilities for patient care are included in the written description of each service/rotation by program year; this information is reviewed by residents at the beginning of each rotation. In general, the chief or senior level resident oversees the lower level residents. The faculty physician oversees the entire team and is available at all times. All surgical procedures require that a faculty physician be physically present in the room at the start (initial incision) and end (closure of the abdomen) of the procedure.
  5. A rapid, reliable system for communication with the supervisory physician is available.
  6. On-call responsibilities and supervision are documented through the call schedule, which the Department Chair.

INPATIENT SETTING:

Faculty supervision: In the inpatient setting, residents are supervised by an attending physician caring for a specific patient or by the physician on service or on call through our 24/7 coverage schedule.

Resident graduated responsibility for patient care: Depending on the patient’s complexity, inpatients are initially evaluated by the appropriate junior resident. The junior resident then presents the patient to the senior resident. The resident team then presents the patient and their plan to the appropriate attending, who will evaluate the patient and review the note before significant plans are enacted. The resident team presents management issues first to the senior resident, then to the attending on an ongoing basis. The residents contact the supervising attending and present their plan whenever significant changes in patient status occur, or before initiating new medications, ordering invasive tests, beginning procedures, or admitting or discharging patients.

Attendings must be physically present for all procedures, but may choose not to scrub for cases that can be safely and effectively done by a senior and junior resident.

EMERGENCY ROOM:

Faculty supervision: In the emergency room setting, residents are supervised by the Emergency Medicine attending caring for a specific patient or by the physician on call through our 24/7 coverage program.

Resident graduated responsibility for patient care: Patients are initially evaluated by the resident staff, presented to the senior resident, and then presented to the appropriate attending (individual attending or L&D physician on call).

GYN OPERATING ROOM:

Faculty supervision: In the operating room, residents are supervised by assigned attending physician caring for a specific patient or by the physician on call through our 24/7 coverage schedule. The specific job description and responsibilities of the physician on call are attached to this policy in addendum A. An attending is physically present and scrubbed for all GYN cases: the patient’s attending physician for elective cases and the 24/7 physician on call for emergency cases. Designated attendings then supervise the resident’s postoperative care.

Resident graduated responsibility for patient care: Patients are initially evaluated by the resident staff, presented to the senior resident and then to the appropriate attending (individual attending or 24/7 physician on call).

CONTINUITY CLINICS:

Faculty supervision: A supervising attending is assigned to the resident clinics (continuity & specialty) every session. This attending is physically present whenever the resident is seeing patients. Each attending documents their level of involvement on each case through the electronic medical record or on paper.

Resident graduated responsibility for patient care: Residents are assigned to see patients in the continuity clinic 1 to 2 half-days per week. Patients are initially evaluated by the resident staff. The case is then presented to the resident clinic attending and depending on complexity; the attending will assess the patient and guide the resident in developing a care plan and follow-up. Assignment of cases is limited in volume and scope by schedule templates that are reviewed prospectively by the administrative chief resident and the charge nurse to ensure appropriateness of patient care and resident progressive responsibility.

SPECIALTY CLINICS (REI, COLPO, PRE-OP URO-GYN):

Faculty supervision: An attending from the service is physically present whenever residents are seeing patients in any of the specialty clinics and provides immediate one-to-one supervision.

Resident graduated responsibility for patient care: Residents are assigned to see patients in the specialty clinics based on their level of training and clinical rotation.

APPENDIX C

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Transfer of Care Policy & Patient Sign-Out Protocol

Rationale: As modern medicine moves more towards a team approach to patient care and as we turn our focus toward patient safety, quality, and continuity of care, patient hand-off/transition of care communication has become increasingly important. Due to the 24-hour-a-day, 7-days-a-week nature of the practice of Obstetrics and Gynecology, we often “hand-over” patients to our colleagues that will go for procedures, need to be delivered, or may need intensive care. This makes our patient hand-off communication vitally important to patient safety and resident education.

Definition of Transition of Care: A transfer is a real time, active process of conveying the responsibility for the care of a patient from one entity to another. It may involve the discharge from one entity and the admission to another along with the patient’s medical/dental records or copies.

Definition “Sign-out”: “Sign-out” is the term that we use to refer to the verbal and written patient hand-off communication that takes place between the outgoing and on-coming teams at the change of shift. The OB/GYN Department uses both a verbal and written sign-out (see attached documents for sample written sign-out). There are separate sign-out for the three general services into which our residents are divided:

* Labor & Delivery/Postpartum
* Antepartum/Maternal Fetal Medicine
* GYN/GYN Oncology

Policy: A standardized approach to handovers/transfers at Morehouse School of Medicine Hospital sites provides an opportunity to ask and respond to questions. Caregivers involved in the sign out/hand-off process include, but are not limited to, physicians, nurses, therapists, technicians and transporters.

Key elements of patient information are included in the handover/transfer process as determined by the service or team of caregivers. Patient information related to current condition and present treatment patient information will include at a minimum:

* Patient name
* MR #
* Diagnosis
* Allergies
* Isolation status
* Potential changes in condition
* What to watch for or monitor during the next interval of care
* Plan of care to include pending consultations

Handover/transfer communication may include verbal face-to-face or telephone reports; written reports or handover/transfer templates developed at the unit or departmental level. Anytime written communication is used in a handover/transfer, the name and contact number of the caregiver handing off or transferring care will be included to facilitate the asking of questions.

Procedure:

* Caregivers will identify a quiet area, such as the Resident Workroom, to give report that is conducive to transferring information with limited interruptions.
* Caregivers will have at hand any supporting documentation or tools such as paper instructions, used to convey information and immediate access to patient record.
* All communication and transfers of information will be provided in a manner consistent with protecting patient confidentiality.
* Caregivers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed. If the contact is not made directly (face-to-face or telephone), the caregiver must provide documentation of name and contact information (extension, pager, or email address) to provide opportunity for follow up call or inquiry.
* The patient will be informed by the departing resident or attending of any transfer of responsibility even if temporary or brief.

Verbal Sign-out: Verbal sign-out is the verbal status update of all patients on all three of the services. This sign-out includes all new admission, deliveries, procedures performed and outcomes, as well as pertinent labs and new developments that occurred during a shift.

Resident sign-out occurs at 7AM and 6PM each weekday and at 8AM on Saturday and Sunday between the senior residents of each of the three services with the junior residents and both outgoing and on coming attending present. There is a formal sign-out on weekday mornings called “Morning Report” which is attended by faculty—the outgoing and on-coming faculty. Morning Report serves as a more academic discussion of cases, which serves not only as a patient hand-off communication, but also as a learning tool. The night call senior resident signs out all services to their respective day call senior residents in the morning, and the day call senior residents, in turn, sign their services out to the night call senior resident in the evenings. On the weekends, the on-call team covers all three services and will sign-out all services to the team providing relief.

Written Sign-out: Written Sign-out is the written patient hand-off communication used to keep record of patients on each of the three services. There are two written communications: the Labor and Delivery/Postpartum and Antepartum Sign-out, and the GYN/GYN Oncology Sign-out. The sign-out is kept on password-protected computers in locked physicians lounges that required key or code access. These written communications are updated throughout the shift as patients are admitted, undergo procedures, have status changes, or are discharged. Each senior resident is responsible for ensuring that the written communication for his or her service is updated.

Customarily, the written communication is printed for review during the verbal sign-out for visual re-enforcement and so that additional notes can be made. Additionally, the written sign-out includes outpatients that the residents of each service should follow up with for various reasons. For example, if a patient is to return to the labor and delivery floor for a laboratory study on a specific day, this will be listed in the “follow up” section of the Resident Labor & Delivery Sign-out so that the Labor and delivery team can contact the patient if the patient fails to report.

Electronic Sign-out: With EPIC electronic medical records capabilities, we are able to create patient lists to assist us with keeping track of certain populations, such as our GYN Oncology patients. These patient lists can be shared among all residents and faculty so that all have access to patient information.

APPENDIX D

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Protocol for Adequate Rest during Duty Period &

Remaining on Duty beyond Scheduled Hours

The ACGME requires all Residents in the Department of Obstetrics and Gynecology have 10 hours free of duty between scheduled work hours and restrict resident hours to 80 hours per week. The 80-hour rule does not apply to time spent reading outside the hospital(s) or at-home call. Residents are charged with the self-reporting of all violations of this system. Our Program takes this requirement very seriously and monitors work hours on a regular basis to ensure compliance.

ACGME Resident Duty Hour Restrictions:

Duty hours are defined as all clinical and academic activities related to the residency program, including inpatient and outpatient care, administrative duties relative to patient care, provision for transfer of patient care; time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do NOT include reading and preparation time spent away from the duty site.

1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

2. Residents are provided with at least 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties. At-home call cannot be assigned on these free days.

3. PGY-1 and PGY-2 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

4. Residents in the final years of education, PGY-3 and PGY-4 residents, must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient

or family] when these residents must stay on duty to care for their patients or return to

the hospital with fewer than eight hours free of duty. (a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education will be monitored by the program director.

5. Duty periods of PGY-1 residents must not exceed 16 hours in duration. (There is no 4 hour transition period)

6. PGY-2-4 residents must be scheduled for in-house call no more frequently than every-third-night. Averaging is not allowed.

7. Duty periods of PGY-2-4 residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital. It is essential for patient safety and resident education that effective transitions in care occur. This period of time must be no longer than an additional four (4) hours.

8. PGY-2 residents must have at least 14 hours free of duty after 24 hours of in-house duty.

9. No new patients may be accepted after 24 hours of continuous duty.

10. Residents must not be scheduled for more than six consecutive nights of night float.

11. At-home call (or pager call): At-home call is not so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call are provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

12. When residents are asked to assume patient care responsibility as part of the “risk/jeopardy” system (that is, to assume the clinical assignment of another resident because of that resident’s inability to assume that assignment for any reason), the above restrictions on clinical assignment are applied, and the hours worked for the absent resident are included in the resident’s duty hours.

13. The Program Director and Program Residency manager will monitor the clinical demands of all residents and will make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue, whatever the reason(s) for that fatigue.

Adequate Rest Protocol

If the event that a residents does not feel (s)he has had adequate rest during duty periods and may be unable to perform the required clinical responsibilities safely, the resident should notify the administrative chief resident or program manager so that coverage arrangements can be made.

1. PGY-1 and PGY-2 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

2. PGY-2 residents must have at least 14 hours free of duty after 24 hours of in-house duty.

3. PGY-3-4 residents must have at least 14 hours free of duty after 24 hours of in-house duty.

4. Residents in the final years of education, PGY-3 and PGY-4 residents, must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off- in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the Program Director and the Program Residency Coordinator.

Protocol for Episodes When Residents Remain on Duty Beyond Scheduled Hours

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must: (i) Appropriately hand over the care of all other patients to the team responsible for their continuing care (ii) Document the reasons in New Innovations for remaining to care for the patient in question (iii) The program director reviews each submission of additional service and tracks both individual resident and program-wide episodes of additional duty.

Monitoring of Compliance with Duty Hour Restrictions

Residents are required to maintain accurate records of their actual duty hours through use of New Innovations, an on-line, Web-based system for recording actual hours worked. New innovations can be accessed through the Internet for real time logging, editing, or retrospective recording of hours worked.

Compliance with duty hour restrictions will be monitored by the Program Director and the Program Residency Manager/Assistant using the reports available through New Innovations.

Failure to Comply

In all cases the Program Director should be informed of the occurrence and nature of situation in which the respite rule might have been an issue regarding duty hour standards compliance. All duty hour violation are monitored and recorded in New Innovations. Violations are automatically reported to the Program Director, Chair, and Manager electronically.

For residents at the PGY2 level and above, 2014 ACGME requirements include duty hours work limit of 24 continuous hours on duty. Residents may stay beyond that period for four (4) additional hours in order to carry out an effective patient care transfer. Beyond a 24-hour period of duty in the hospital the resident must have at least 14 hours free from duty. If a resident is in the situation where s/he will be out of compliance with the above, the resident is required to document the reasons for remaining to care for the specific patient and submit the information into New Innovations.

This documentation will allow the Program Director and/or the Program Manager to discuss the residents’ schedule with the chief resident with the goal of preventing future occurrences. In the short term, however, duty hour restrictions should not serve as a reason to jeopardize patient safety. Repeated instances of non-compliance will be regarded as failure to adhere to accepted standards of professionalism.

APPENDIX E

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Common Circumstances for Faculty Involvement Protocol

General Principles

This Protocol outlines faculty involvement in the care of complex patients, ICU transfers, DNR or other end-of-life decisions by each year/level of training.

Although Obstetrics and Gynecology generally deals with young, healthy patients who spend only short periods of time in the hospital, there are instances in which the patients in our care develop very serious and complex medical conditions requiring high acuity care from the team.

Obstetrics Service, Complex Care

In Obstetrics, the most complex patients are cared for by the MFM attending, General OB/GYN Attending staff, Chief Resident (PGY-4) of Ob, and Midlevel Resident (PGY-2 or -3) of Ob.

* The MFM attending and General OB/GYN Attending staff assumes all responsibility for the care and management of these patients while they are on L&D, in the Operating Room, on the Antepartum unit, in the Intensive Care Units, and on the postpartum unit.
* The MFM attending and General OB/GYN Attending staff provide supervision, direction and guidance to all other members of the team who will treat this patient during her hospital stay.
* All pertinent and necessary consultations are done with appropriate services for those issues which are out of the scope of practice of the MFM Attending (e.g., general surgery, internal medicine, hematology, nephrology, neurology, pulmonology).
* Formal discussion of the management takes place at multidisciplinary sign-out rounds each morning. Less formal, but nonetheless important, discussions occur throughout the day and at sign-out rounds in the evening.
* The MFM Attending is always available for consultation throughout the day and at night (if not on call) via cell phone. They will come in to provide urgent care if needed.
* The In-House Attending receives sign-out when on-call (at night) or covering L&D (during the day) from the MFM Attending and the Chief Resident of Ob in order to supervise care and maintain the plan of care as outlined by MFM.
* The Interns (PGY-1) and Midlevel Residents (PGY-2 and -3) will provide care as assigned by the Chief Resident of Ob and under close supervision by the faculty.
* DNR or other end-of-life decisions are made by the entire team.

Gynecology Service, Complex Care

In Gynecology, patients are cared for by the admitting Attending and Chief Resident (PGY-4) of Gyn. Complicated cases are to be discussed with the GYN monthly attending.

* The Gyn Attending assumes all responsibility for the care and management of these patients while they are in the operating room, in the Intensive Care Units, and on the postoperative units.
* All pertinent and necessary consultations are done with appropriate services for those issues which are out of the scope of practice of the Gyn Attending (e.g., general surgery, internal medicine, hematology, nephrology, neurology, pulmonology).
* Formal discussion of the management takes place at multidisciplinary rounds each morning. Less formal, but nonetheless important, discussions occur throughout the day and at sign-out rounds each evening.
* The PGY-4 under the supervision, direction, and guidance of the Gyn Attending will provide care to the patient as indicated during her hospital stay.
* The Interns (PGY-1) and Midlevel Residents (PGY-2 and -3) will provide care as assigned by the Chief Resident of Gyn and under close supervision by the faculty.
* DNR or other end-of-life decisions are made by the entire team.

Specific Situations

Residents MUST communicate with the appropriate supervising faculty in the following circumstances/events:

1. Hospital Admissions
2. Transfer of patients to the ICU
3. Impending death or death of a patient
4. Family wishes to speak to the attending physician
5. Significant change in the clinical status of hospitalized patients
6. Any uncertainty regarding diagnosis and/or management
7. Difficulty attaining timely subspecialty or specialty consultants
8. Any Type III fetal heart tracing or Type II tracing not responding to appropriate measures
9. Unstable status of the patient
10. Return of a patient to the OR
11. Postpartum or postoperative hemorrhage
12. Consultations
13. Any patient safety concern/issue
14. OB or GYN triage after initial evaluation
15. End-of-life decisions
16. Against medical advise
17. Medical error leading to patient harm
18. Cardiopulmonary resuscitation

APPENDIX F

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Resident Case List & Primary & Preventive Care Requirements

Resident Case List

Each resident should maintain a personal diary of all inpatients that they manage. Residents are required to enter all OB/GYN procedures into the ACGME Resident Case Log system on a daily basis. Residents should enter cases for each week no later than the following Monday. Resident Case entry is monitored weekly by the program manager. Residents who are non-compliant with weekly data entry are subject to disciplinary action including loss of weekend time pre or post vacation.

Primary & Preventive Medicine Chart Audit

OB/GYN RRC Requirements

Primary and preventive care is an essential component of training in Obstetrics and Gynecology residency programs. The documentation of this experience will shift to include the content of care provided. Programs must review 5 well woman or annual examination from each resident every 6 months for compliance with 20 essential components of primary and preventive care. Programs must keep records of each individual resident for at least each year of continuity clinic experience as part of the resident portfolio. The reports must be discussed at each resident’s semi-annual meeting, and the program must review summary data for each year.

Definitions for Assessment

Superior Performance (5) all elements are documented for each chart reviewed, in addition documentation reflects a superior quality of information and counseling

Above Expectations (4) all elements are documented for each chart reviewed

Meets Expectations (3) more than 80% of elements are documented for each chart

reviewed

Below Expectations (2) less than 80% of elements are documented, but > 50% for each chart reviewed

Unsatisfactory (1) less than 50% of the elements are documented for any chart reviewed

Chart Audit Protocol

Audits should occur in December and May of each year. Residents found to perform Below Expectations or Unsatisfactory will be re-audited in 3 months.

PGY1 & PGY2 Resident Chart Audit: GYN clinic faculty will review PGY1 and PGY2 charts for the above elements and complete the audit forms. They will review the audit form with the resident in clinic and obtain the residents’ signature. The Program Director will incorporate the signed audit sheets as part of the resident’s semi-annual evaluation.

PGY3 & PGY 4 Resident Chart Audit: PGY3 and PGY4 residents will be responsible for auditing their own charts in December and May of each year. They will present their audit form with the charts to the GYN clinic faculty member for review and final assessment. The Program Director will incorporate the signed audit sheets as part of the resident’s semi-annual evaluation.

Chart Audit Outcomes & Expectations

Recognizing the importance of primary and ambulatory care in OB/GYN is a critical element of the educational program. The Primary and Preventive Medicine Chart Audit will help to convey the importance of primary care interventions while stressing the need for complete documentation. In addition, the self-audit component will help to develop the resident’s awareness and skills in preparation for life-long learning, such as meeting the requirements of the ABOG MOC.

Ongoing chart audit documentation will become part of the resident’s semi-annual evaluation. The review with the clinic faculty and the Program Director will reinforce the resident’s competency and overall proficiency in primary and ambulatory care. Identified weaknesses or deficits will be addressed.

See separately attached audit form also located under department manuals on the New Innovations MSM OB/GYN site.

The Morehouse School of Medicine

Department of Obstetrics and Gynecology

Primary Care & Preventive Medicine Chart Audit

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PGY 1 2 3 4

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | CHART 1 | | | CHART 2 | | | | CHART 3 | | | CHART 4 | | | CHART 5 | | |
| Patient ID (MR#) |  | | |  | | | |  | | |  | | |  | | |
| Auditor/Reviewer  (Faculty or Self Review) |  | | |  | | | |  | | |  | | |  | | |
| Primary Care Elements | YES | NO | N/A | YES | NO | N/A | | YES | NO | N/A | YES | NO | N/A | YES | NO | N/A |
| Allergies: drugs, latex, foods, environmental exposures |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| List of current medications |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Menstrual history or history of abnormal vaginal bleeding |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Previous Pap smear results |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Contraception (age 15-50 yrs) |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Immunization history |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Smoking history |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Alcohol use |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Substance abuse |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Family history |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Depression screening |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| History of sexual dysfunction |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| History of sexual, physical or mental abuse |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Blood pressure evaluation |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Diet, weight, nutrition & exercise counseling |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Seat belt use |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Annual mammogram, age ≥ 40 or family history |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Lipid screen, age ≥ 45 |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Colonoscopy, age ≥ 50 or family history |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Counsel on osteoporosis ≥ 60 |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |
| Assessment   Superior Performance (5)   Above Expectations (4)   Meets Expectations (3)   Below Expectations (2)   Unsatisfactory (1) | | | | | | | Areas of Strength:  Areas of Weakness: | | | | | | | | | |

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Auditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPENDIX G

Medical Records Delinquency Protocol and Expectation

Sample Medical Record DELINQUENCY Letter

Dr. “Resident”

As per my previous discussion, any resident with delinquent operative reports (i.e. operative report(s) not dictated within 24 hours of surgery) will forfeit weekend day’s pre and post the week of their scheduled vacation.

You are reported by the Grady Medical Records Dept. to have a delinquent operative report on a patient who you operated on with Dr. “Attending” on “date inserted here”. By “date inserted here”, your report had not been dictated according to their records. If this is an error, please let me know so that I may support you with regards to the Medical Records Department.

This delinquency will be assessed at your next vacation. You are to be on-call the Saturday of the weekend prior to your vacation week. You are not to leave before the designated time that call has ended. In other words, you are expected not to leave the hospital prior to 7am on the following Sunday.

If there are any questions or clarifications please speak to me.

Franklyn Geary, M.D.

Residency Program Director

APPENDIX H

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Patient Safety / Quality Improvement (PS / QI) Curriculum

What is Patient Safety?

Patient Safety arises as a discipline in response to evidence that adverse medical events are widespread and preventable. It requires design of systems to make risky interventions reliable. Its success depends on a culture of openness to all relevant perspectives and the establishment of a “no blame” cultures.

What is Quality Improvement?

Quality of care has been defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. Quality Improvement is a systematic approach to assess the evidence-based standard of care and to improve the outcome of care.

Overall goal:

To avoid, prevent and ameliorate adverse outcomes or injuries stemming from the process of care

Objectives:

1. To understand the historical development and the current state of affair in PS /QI
2. To understand the importance of maintaining Patient Safety and continuation of Quality Improvement in Health Care System
3. To understand the terminology pertaining to PS / QI
4. To understand the PS / QI problems specific to OB/GYN
5. To understand the PS / QI problems specific to our current health care system (Grady)
6. To have performed at least one PS / QI project with formal oral / poster presentation
7. To be competent in teaching peers and co-workers on PS / QI at the end of training

Curriculum:

1. Didactics for the basic principles, terminology and tools during orientation for new and returning residents
2. Ongoing didactics for available tools and assessment models in PS / QI
3. All residents must complete CITI training (mandatory) within 3 months
4. Bimonthly didactic time assigned to PS / QI with ACTIVE involvement of faculty
   1. To formulate PS issues specific to OB/GYN at Grady
   2. Suggestion on potential QI projects
   3. To design QI projects
   4. To report interim progress or obstacles of projects
   5. To present the final results of projects
   6. To identify potential spin-off for future QI projects

APPENDIX I

Morehouse School of Medicine

Obstetrics and Gynecology Residency Training Program

Resident Research Curriculum

Introduction & Overview

The Department of Obstetrics and Gynecology has a requirement that all residents participate in research. Interns are exempt from this activity, but each Intern is required to present a case report, based upon a case in which she/he has participated and should have identified a research topic by the end of the intern year. Residents will be certified to participate in research by completing the CITI training modules from the University of Miami.

Each II and III year resident is expected to be involved in a continuing prospective research project, which will be initiated early in the II year of residency. This allows time to enroll patients, to complete research and to prepare a formal paper for presentation at the successful completion of the research project. All residents are required to present their research at the annual resident research symposium at the end of the third year of residency.

To assist in resident research, each resident will select a faculty research mentor by July 1 of the second residency year. The resident is to meet with her/his mentor at least monthly.

Intern Patient Case Report (PGY I)

Upon selection of the case, the first year resident is to recruit the faculty member who was responsible for patient care of the involved case. That Faculty member is to serve as a mentor for the intern in preparation of the case report. Once the case report is complete it is to be presented during II year of residency during Tuesday Conference.

Format for Patient Case Report

Case reports should include the following five sections: an abstract, an introduction an objective, with a literature review, a description of the case report, a discussion that includes a detailed explanation of the literature review, a summary of the case, and a conclusion as outlined below.

Abstract

Introduction

Case Presentation

Discussion

Conclusion

Please see attached article detailing the guidelines for writing and presenting patient case reports. 1

Formal Research Project

Topic Selection (PGY-I)

By July 1 of the second year of residency, a research topic is to be approved by the selected faculty mentor. With the assistance of the faculty mentor, the resident is to complete the research proposal and submit it to Dr. Hedwige Saint Louis for review by August 1 of the second year. During September, the resident is to meet with Dr. Saint Louis and his/her research mentor for review and critique of the research proposal. Thereafter, having made recommended changes in the project, formal application to the IRB is to be completed by October 1.

Submission of Proposal (PGY-II)

The proposal submitted to Dr. Hedwige Saint Louis should be a one-page summary, which includes the Title and introduction to the study, as well as pertinent background information. This proposal is to explain the objectives of the study, and the hypothesis to be tested. The methods section of the proposal should state the methodology that is to be used for the study, state what subjects will be recruited, how the subjects are to be enrolled, and what controls are established for the study.

Proposal Format (1 page)

Title and Introduction

Background Information

Objective(s)

Hypothesis

Methods

Time Line

A timeline is designed to guide the resident and mentor in completion of the research project in a logical and timely fashion. It is the responsibility of the faculty mentor to take an active and responsible role throughout the research project. Monitoring of the research progress is a part of the responsibility of the research mentor. Therefore, the resident is to meet with his/her mentor by the third Tuesday of each month to assess progress in completing the research project. The update should include whatever progress has been made, including preparation for the IRB protocol, recruitment of patients and summarization of data. The resident is responsible for scheduling these monthly conferences.

Final Preparation (PGY-III)

By April 1, of the third year the resident is to submit to Dr. Saint Louis for review and comment the completed research project summary. This summary should have the approval of the research mentor. Throughout April, changes in the research manuscript are to be completed after Dr. Saint Louis and the mentor have reviewed the document. Following each critique by Dr. Saint Louis and the research mentor, changes should be made in the manuscript. By April 30, the final research abstract is to be submitted to the Residency Manager for preparation for formal presentation on Resident Research Day.

Summary should include:

Specific Aim

Background and Significance

Preliminary data

Experimental strategies

Rationale

Approach

Anticipated results and data interpretation

General methods

Literature references

Research Abstract Format:

Title

Introduction

Objective

Materials and Methods

Results

Conclusions

Formal Presentation (PGY-III)

For the formal presentation on Resident Research Day, the resident is to:

1. Maintain patient confidentiality by obliterating any name identification from x-ray, sonographic and laboratory reports.
2. Present data in a logical coherent manner providing legible slides for reading.
3. Make presentation in a well-rehearsed manner, limiting the presentation to 15 minutes.
4. In presenting a case report, the 1st year resident must be well versed in the total care of the patient under consideration.

Submission of Publication or Presentation (PGY-IV)

The case report or research study should be of sufficient clinical or educational interest, a manuscript prepared by the resident and the attending faculty mentor should be submitted for publication to Dr. Saint Louis for final review by the Research Committee by June 15 of the third year.

The resident will provide the necessary documentation of the publications and/or the Clinical Conference the research has been submitted.

If the research abstract is accepted for publication or presentation, the department will cover any necessary expense for the resident to submit or present the research.

References

Henry Cohen. How to write a patient case report. AM J Health-Syst Pharm-Vol 63 Oct 1, 2006

**ADDITIONAL RESEARCH CURRICULUM**

The research curriculum is organized to allow each resident to complete a minimum of two projects and submit one publication or presentation at the end of the four year. Each year is organized along specific assignments that build upon each other to allow you the time needed to complete a project.

In addition to working with me, you will be assigned a research mentor according to your topic of interest. You will meet with your mentor a minimum of once a month so they can help you stay on task and complete the different steps in your project. If you have more than one project, then you will have more than one mentor and will be expected to meet with both on a regular basis.

Assignment by year are as follows:

Interns:

1. Complete a case report and generate a research idea and working hypothesis for their major project.
2. Your case report including literature search and presentation slides must be completed by April 30th, 2019 for presentation at the Morehouse Ob/Gyn Resident Research Day on May 31st, 2019.

Second year:

1. Complete research protocol and submit to the IRB & Grady Office of Research Review Committee for approval and start collecting preliminary data.
2. Protocols must be completed and approved by both the Morehouse IRB and Grady ROC no later than March 31st, 2019. Your resident research presentation slides must be completed and turned in by April 30th, 2019. Those projects will be presented at the Morehouse Ob/Gyn Residents Research Day on May 31, 2019.

Third and fourth year:

1. Completed project, ready for presentation and submission for publication.
2. Completed project including data collection and analysis must be ready no later than March 31th, 2019. Your presentation slides should be completed and turned in by April 30th 2019. Your project should be ready for publication at the time it is presented during Resident Research Day on May 31st, 2019.

The fourth year residents will be presenting during the joint annual Emory Morehouse Grady Research Day on Thursday May 23rd, 2019.

During your research month, you will focus on understanding the different designs and work on your research hypothesis and protocol and finally work on data collection and analysis. Due to the limited amount of time available to do research during residency, you will need to use your time wisely and are expected to have done some background reading prior to going into your research month so that you can make the best use of your time during that month. Research takes time and as a resident you will need to stay on task and accomplish small tasks on a regular basis to get your project completed on time. To that effect, you will meet with your mentor at least weekly during your research months.

Outside of your research month, you will be expected to meet with your research advisor at least monthly. During those meetings you will set tasks/ goals that you will complete prior to your next monthly meeting. In the content section of this notebook, you will find a handout that you will use to generate your monthly or weekly goals. Please use the form within this notebook so that your progress can be tracked. The form should be completed and reviewed during your meetings with your mentor.

Residents are to refer to the research timeline according to the residency year for further details regarding what needs to be completed. The Research Director will meet with the Residents on a quarterly basis to review his/her progress. 



Department of Obstetrics and Gynecology

Residency Education Program

RESIDENT RESEARCH CONTRACT

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have chosen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as my resident project. I have asked Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending

to be my mentor in this project and she/he has agreed to do so. I understand that the resident research project is a required project for the residency program at Morehouse School of Medicine, Department of Obstetrics and Gynecology, and is important to my growth and development as a physician. I agree to meet the scheduled deadlines. I recognize and agree to assume the primary responsibility for completing my project and I will strive to do my best to comply with all of the requirements.

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Resident Signature Date

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Faculty Mentor Signature Date

APPENDIX J

ACGME Specialty Program Requirements

Please see attached PDF for complete ACGME OB/GYN Program Requirements

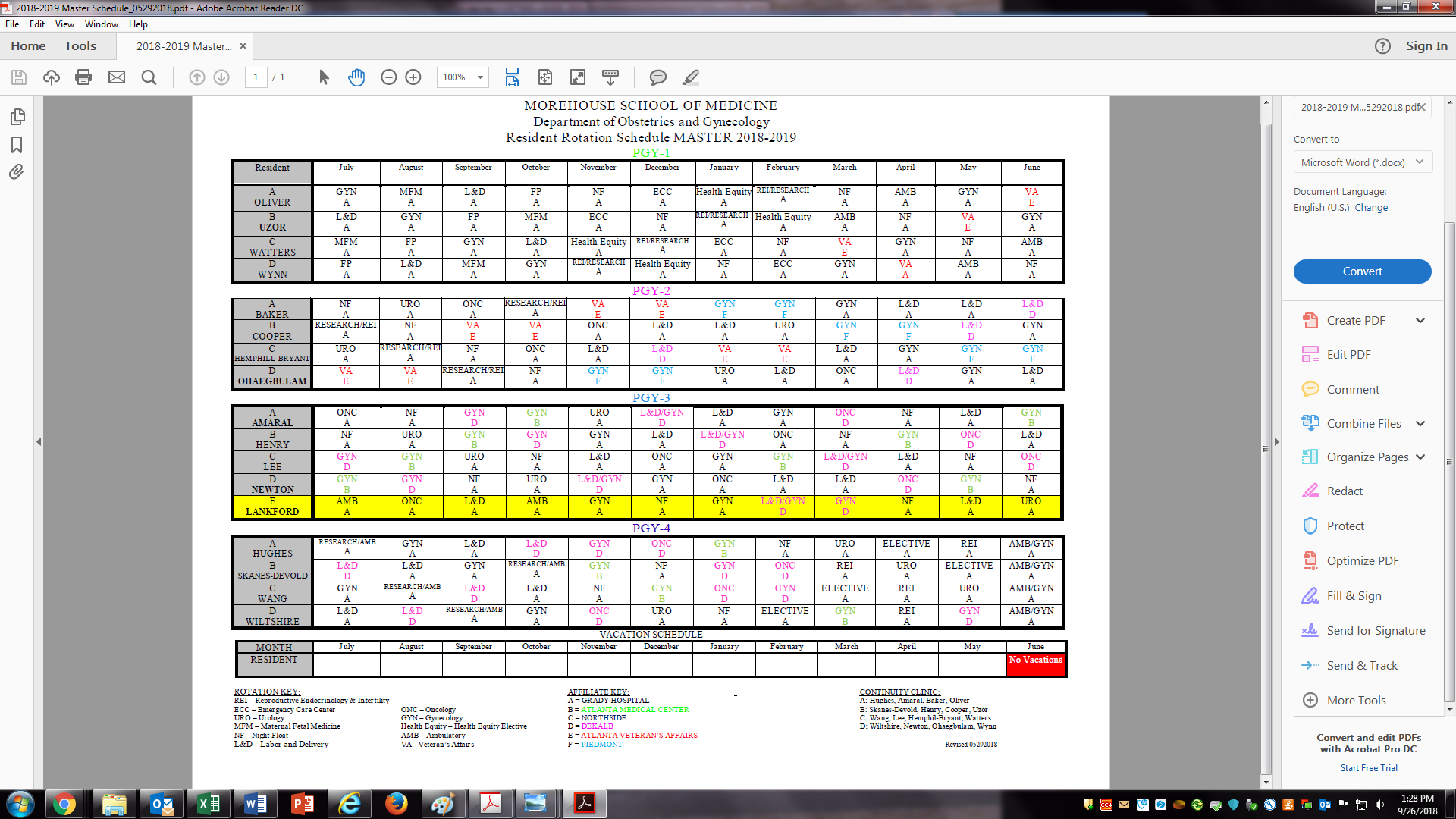
APPENDIX K

Educational Objectives - Core Curriculum in Obstetrics and Gynecology, Tenth Edition, Council on Resident Education in Obstetrics and Gynecology (Please see attached PDF File)

APPENDIX L

2018-2019 Master Schedule

See attached PDF (All schedules can be viewed online using the electronic residency management system – New Innovations).



APPENDIX M

Department Directory

(See attached PDF)