# Residency Program Manual 2008-2009

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Dear Doctor:

The members of this department are very pleased to have you in our residency training program. The Johns Hopkins University School of Medicine residency program in Gynecology and Obstetrics is carried out at the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Greater Baltimore Medical Center. The Johns Hopkins University School of Medicine Department of Gynecology and Obstetrics is responsible for the organization, content, and the overall administration of the residency program. This handbook is designed to serve as a reference so that you know what will be expected of you as well as what resources are available to you.

We are committed to maintaining an environment in which residents and faculty can improve their knowledge and skills and learn from each other. Residents will be incorporated into the department’s clinical, teaching and research activities in a supportive and collegial fashion. Residency is a combination of education and service under the supervision of the full time and volunteer faculty of the Department. You will participate in the care of women who are private patients as well as patients from your own clinics. Your appearance, attitude and concern for the patient’s health and feelings will determine in large measure the degree of success you have obtaining the clinical experiences that are essential to your education. Our goal is to provide excellent care for all patients while affording educational opportunities for students, residents, and others. Attending physicians will always be present during surgery, deliveries and other procedures. Their responsibility is to provide supervision and teaching appropriate to that resident’s or student’s level of training.

Learning objectives are clearly stated for each rotation and formal teaching sessions will be organized to meet the General and Special Requirements for Gyn/Ob residency programs.

Measurement of the successful attainment of learning objectives occurs through a defined process of resident evaluation, the CREOG in-training examination, and twice yearly progress reviews by the program director or assistant program directors.

It is our intention that each trainee will assume graded and increasing responsibility. Sensitivity and responsiveness to our residents’ needs are central to the success of the educational mission. To this end, help will be offered as needed for physical, emotional and didactic special needs.

During residency you will rely upon many members of the health care team: nurses in the inpatient units and outpatient clinics, and operating rooms; dieticians, social workers, ultrasound technicians and many others. These people have knowledge, and experience from which you may learn. All are members of the health care team, and your interactions with them should be professional and cooperative.
The residency includes many learning opportunities other than patient care. Attendance at the weekly grand rounds and case review conferences is required of all residents, and first year residents are required to attend the July didactic lectures. Elective surgical cases may not be scheduled in conflict with grand rounds or Friday afternoon ‘school’. Scheduled didactic sessions are also required unless prevented by emergency clinical responsibilities. The residents on specific services should attend other teaching conferences: e.g., the weekly perinatal conference, FHR tracing conference, the weekly oncology conference, the general gynecology conference, and the endocrine conferences, etc. Each fourth year resident is also expected to present a grand rounds topic as assigned. The faculty will be happy to help you select a topic and guide you during the preparation of your talk. In addition, residents will prepare and present other conferences as requested.

Library resources are available at each hospital participating in the residency to assist you in general learning and in the preparation of your presentations. Each resident will also be provided with access to an electronic data-retrieval system to many scientific and general databases. These can be accessed through computers provided within the department.

The Department will provide support for residents, whose research is selected for presentation at a national or regional meeting, to attend that meeting. A publication ready manuscript must be given to the program director prior to the date of the meeting.

Records will be kept of all those trained, to allow satisfactory proof of performance and advancement through the residency program. During residency you will rely upon many members of the health care team: nurses in the inpatient units and outpatient clinics, and operating rooms; dieticians, social workers, ultrasound technicians and many others. These people have knowledge and experience from which you may learn. All are members of the health care team, and your interactions with them should be professional and cooperative.

Whenever appropriate, residents will be consulted in institutional program decisions, and are encouraged to make policy recommendations in open forum, and through their representatives to the Resident Education Committee and Residency Steering Committee.

Each institution or program participating in the residency training program will provide a contractual agreement committing to ensure that residents are supervised in carrying out their patient care and other learning responsibilities. The level and method of supervision will be consistent with stated guidelines for Graduate Medical Education Programs (ACGME, American Medical Association, Chicago, Illinois, 1992).

In addition to your role as student, physician and trainee, you have an important role as a teacher of medical students and junior residents. Residents often have more extensive and direct contact with medical students than do the faculty. Therefore, you will have the most immediate opportunity to teach clinical skills, to evaluate student performance and to be a role model for students considering Gynecology and Obstetrics as a career. Please
remember that students will model their behavior upon how they see you treating your patients, colleagues, and staff.

Residents receive a stipend, liability insurance, health insurance, dental insurance, disability insurance, life insurance, a call room, meals on call, laboratory coats and laundry, necessary clerical services, library facilities, computer access, and limited research funding. Vacation, necessary medical leave and professional meeting times are also provided.

In return, it is expected that our residents will:

- Develop a personal program of self study and professional growth
- Conduct themselves in a professional manner by treating students, patients, nurses, faculty and ancillary staff with courtesy and respect
- Assume responsibility for teaching and mentoring more junior residents and students
- Participate in safe, effective, and compassionate patient care under a level of faculty supervision that is commensurate with the resident’s training and ability
- Apply cost containment measures in the provision of patient care
- Participate in the emergent transport of patients in need of help
- Participate in institutional programs and committees, especially those that relate to patient care and education
- Adhere to established departmental and institutional policies, practices and procedures, which includes the accurate and timely completion of medical records
- Keep accurate, current and well organized logs of all patient care experiences.

We are all looking forward to a four-year collaboration that will result in you becoming the best physicians you can be. We are also hoping to build relationships that will lead to the establishment of friendships and mutual trust. Please do not hesitate to call on us to help you on the exciting journey.

Jessica L. Bienstock, MD MPH
Residency Program Director
Department of Gynecology and Obstetrics
Mission Statement

The philosophical objectives of our program are to:

1. educate and train residents to be the best possible providers of health care for women for obstetrics, gynecology and primary care,
2. provide residents with a subspecialty-derived educational breadth and depth that will allow them to be effective consultants in their medical communities,
3. provide residents with the necessary education to enable them to function as primary care/primary contact physicians for women throughout their adolescent, reproductive and post-reproductive years,
4. instill and foster a spirit of mutual respect and work ethic, camaraderie, and teamsmanship, among the residents themselves and among the residents, attending physicians, faculty and program director in all clinical and administrative situations,
5. offer opportunities for residents to develop professional, ethical and leadership skills that can be used during their residency and practice years for the betterment of all concerned,
6. qualify residents to become board-certified by the American Board of Obstetrics and Gynecology and Fellows in the American College of Obstetricians and Gynecologists,
7. establish a habit of life-long continuing medical education and a desire to assist in the education and training of new generations of medical students and residents.
Section One

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Johns Hopkins University School of Medicine
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             Johns Hopkins Bayview: Andrew Satin, MD
             GBMC Gynecology: Francis Grumbine, M.D.

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             JHH MFM: Karin Blakemore, MD
             JHH Gyn Oncology: Robert Bristow, MD
             JHH REI: Howard Zacur, MD, PhD.

Residency Program Director: Jessica L. Bienstock, MD MPH

Associate Residency Program Directors:
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             GBMC: Mark Ellerkmann, MD

Residency Education Committee: H. Fox, J. Bienstock, A. Satin, K. Altman, M. Ellerkmann, F. Grumbine, Administrative Chief Residents.
Section Two

Learning Objectives
Learning Objectives

General Competencies

Listed below are the six Core Competencies identified by the ACGME as being essential to the development of all physicians. Residents will be expected to demonstrate mastery in each of these competencies as interpreted within the context of the rotation specific learning objectives which follow.

a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals

e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value
Learning Objectives

Training Level: PGY1
Rotation: Hopkins Hospital Gynecology Service

Educational Purpose:
This rotation represents the introduction of the PGY I resident to the management of the gynecologic patient who presents for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. During this rotation the resident will begin to develop the basic cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY I Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   - Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   - Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   - List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   - Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   - Describe the common vulvovaginidities
   - Identify the common benign vulvar lesions
   - Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
   - Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
   - Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same
• Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention
• Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis
• Describe the treatment both medical and surgical of endometriosis
• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

2. Patient Care (Clinical Skills)
• Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
  vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Demonstrate appropriate skills in some gynecologic procedures including hysteroscopy, D&C, D&E, and laparoscopic sterilization
• Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
• Conduct detailed preoperative assessment with consideration to the needs of special patient groups such as:
  o Children and adolescents
  o Elderly
Patients with co-existing medical conditions such as cardiopulmonary disease or coagulation disorders

3. Patient Care (Management Skills)
   - Develop an evidence based care plan for his/her Continuity Clinic patients
   - Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as:
     - Abnormal bleeding
     - Pelvic pain
     - Sexually transmitted diseases
     - Pelvic inflammatory disease
     - Endometriosis
   - Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
   - Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
   - Assist in the management of common postoperative complications such as:
     1. Fever
     2. Gastrointestinal ileus/obstruction
     3. Infection
     4. Wound complications
     5. Fluid electrolyte imbalance
     6. Respiratory problems
     7. Thromboembolism

4. Practice Based Learning
   - Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
   - Incorporate formative and summative feedback to improve knowledge and skill base
   - Maintain an updated gynecologic procedural log as detailed on the ACGME website
   - Participate in gynecologic quality assurance activities (M&M) of the department
   - Use personal experience with difficult and challenging patients to optimize future relationships with patients

5. Communication/Interpersonal Skills
   - Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
   - Counsel patients in language and manner that is appropriate to her educational background and emotional needs
• Inform patients and designated individuals of pertinent medical developments and complications
• Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

6. Professionalism
• Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
• Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
• Demonstrate accountability for one’s action and clinical decisions
• Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
• Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
• Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

7. Systems Based Practice
• Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
• The resident will review the curriculum prior to the first day of the rotation. The PGY I resident will actively participate in:
  o Gyn Continuity Clinic – once weekly
  o Pre-op Clinic / with 1st trimester ultrasound preceptorship (Wed AM)
  o Daily rounds
  o Weekly Morbidity and Mortality conference
  o Weekly “Professor’s rounds”
  o Attendance at a wide variety of gynecologic procedures
• All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback
• Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills, the resident will progress from assisting at minor surgical procedures (e.g. hysteroscopy, D&C) to major abdominal/vaginal procedures
• The first trimester ultrasound preceptorship is supervised by a Certified Ultrasonographer from the Department of Gyn/Ob, immediate feedback is given.
Types of Clinical Encounters:
- PGY I residents will participate in the gynecologic care of both faculty and resident clinic patients
- Outpatient experience in the PGY I year is achieved through Continuity Clinics and in Pre-op clinic
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

Resident Supervision:
- The resident will be under the supervision of his/her Chief Resident and an Attending physician at all times including nights, holidays and weekends. This is insured by 24-hour house coverage by the Attending staff

Reading List:
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

Method of Evaluation:
- Global evaluation of PGY I resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients. The gynecologic performance by the residents is included in this evaluation and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.


**Learning Objectives**

Training Level: PGY1  
Rotation: Hopkins Hospital Obstetrical Service

**Educational Purpose**

The PGY-1 obstetrical experience is a cornerstone for inpatient obstetrical care within the residency program. 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. Residents develop competence with performance of spontaneous vaginal delivery and are introduced to methods of operative vaginal delivery.

**Goals and Objectives**

By completion of the PGY-1 year, the resident should demonstrate skillful management of intrapartum and postpartum patients, as described within the context of the ACGME core competencies.

The resident should be able to:

1. **Medical Knowledge**
   - Describe the major physiologic changes in each organ system during pregnancy
   - Describe the impact of pregnancy on maternal medical conditions, and conversely, the impact of various maternal medical conditions upon pregnancy outcome
   - Order and interpret common diagnostic tests in the context of the normal physiologic changes of pregnancy
   - Demonstrate accurate and timely interpretation of intrapartum fetal heart rate patterns and implement appropriate interventions for such
   - Perform and interpret assessments of fetal well-being, including: non-stress testing, contraction stress testing, biophysical profile, fetal scalp stimulation, vibroacoustic stimulation, scalp pH testing
   - Describe the normal course of labor; identify abnormalities of labor and describe methods of labor augmentation
   - Describe appropriate indications for induction of labor, methods of cervical ripening / labor induction, and potential complications for each
   - Counsel parturients regarding various forms of obstetrical anesthesia, including: local, intravenous, pudendal, epidural, spinal and general
• Demonstrate understanding of pharmacologic agents commonly used in obstetrics: labor inducing agents, tocolytics, analgesics, antibiotics, insulin, heparin, etc.

• Evaluate and provide immediate care for the newborn, including: neonatal resuscitation, Apgar score assignment, and cord blood analysis

• Describe maternal complications that may arise in the postpartum period and methods for their resolution

• Provide basic supportive care of the postpartum patient, including: contraceptive needs, emotional evaluation and lactation consultation

2. Patient Care (Clinical Skills)
   • Conduct focused patient histories and physical examinations, including:
     i. Comprehensive primary care examination
     ii. Focused examination of the obstetrical patient
     iii. Serial cervical examination of parturients
     iv. Clinical pelvimetry
     v. Leopold’s Maneuvers / estimated fetal weight
     vi. Accurate assessment of presenting fetal part and position
     vii. Ultrasonographic examination of the fetus

   • 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

3. 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
   • 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

4. 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
• Keep an updated patient log as detailed in the ACGME website
• Participate in quality assurance activities (PBLI conference) of the department
• Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

5. Communication/Interpersonal Skills
• Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion
• Demonstrate caring and respectful interactions with the obstetrical 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.

6. Professionalism
• Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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

7. 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 and L&D 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

Types of Clinical Encounters
PGY-1 residents interact with and are responsible for the care of all patients presenting to the triage area of Labor and Delivery and the inpatient management of all laboring and post-partum patients. A wide variety of both normal / physiologic and abnormal obstetrical pathology is encountered in these antepartum, intrapartum, and postpartum patients.

The PGY-1 resident will assist in the management of a variety of medical conditions complicating pregnancy, including:
  ▪ Diabetes mellitus
  ▪ Diseases of the urinary system
  ▪ Infectious diseases
  ▪ Hematologic disorders
  ▪ Cardiopulmonary disease
  ▪ Gastrointestinal disease
  ▪ Neurologic disease
  ▪ Endocrine disorders
  ▪ Collagen vascular disorders
  ▪ Psychiatric disorders
  ▪ Substance abuse
  ▪ Emergency care / trauma

In addition, the resident will be introduced to various pregnancy related complications (to be enhanced in the PGY-2 year), including:
  ▪ Cervical incompetence
  ▪ Second and third trimester bleeding
  ▪ Multi-fetal gestation
  ▪ Fetal malpresentation
  ▪ Pre-term labor and PPROM
  ▪ Isoimmunization
  ▪ Hypertensive disorders of pregnancy
  ▪ Fetal growth restriction
  ▪ Intrauterine fetal death
  ▪ Post-term pregnancy

Procedures to be mastered in the PGY-1 year:
  ▪ Full term spontaneous vaginal delivery
  ▪ Episiotomy and repair
  ▪ Administration of anesthetic: local, pudendal
  ▪ Postpartum tubal sterilization
  ▪ Basic real-time Ultrasonography

Procedures introduced in the PGY-1 year (but mastered in the PGY-2 year):
- Operative vaginal delivery
- Preterm spontaneous vaginal delivery
- Cesarean delivery
- External cephalic version

**Rotation Structure**

The PGY-1 resident will review the curriculum prior to the first day of the rotation.

The PGY-1 resident will actively participate in:

- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB Practice Based Learning and Improvement Conf (daily).
- Fetal Heart Rate Monitoring “strip rounds” (weekly)
- At all other times, it is expected that the PGY-1 resident will remain on the labor floor, involved directly with patient care encounters (with the exception of Friday “school” for which the resident will be excused from clinical duties).

**Resident Supervision**

The resident's daily activities fall under the management of the PGY2 and Chief Resident; this provides opportunity for immediate feedback.

Deliveries and procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

**Reading List and Educational Materials**

- William’s Obstetrics or Gabbe
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

**Method of Evaluation**

- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-I residents are performed at the completion of the 6 week block by the MFM faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Nursing staff will complete evaluations of selected skills of each resident at the completion of each block.
- Cognitive assessment of the residents’ obstetrical skills is achieved by the obstetrical score from the CREOG examination.
Learning Objectives

Training Level: PGY1
Rotation: Greater Baltimore Medical Center Gynecology

Educational Purpose:
This rotation represents the introduction of the PGY I resident to the management of the gynecologic patient who presents for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. During this rotation the resident will begin to develop the basic cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY I Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   - Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   - Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   - List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   - Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   - Describe the common vulvovaginidities
   - Identify the common benign vulvar lesions
   - Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
   - Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
   - Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same
• Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention
• Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis
• Describe the treatment both medical and surgical of endometriosis
• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

8. Patient Care (Clinical Skills)
• Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
  vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Demonstrate appropriate skills in some gynecologic procedures including hysteroscopy, D&C and laparoscopic sterilization
• Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
• Conduct detailed preoperative assessment with consideration to the needs of special patient groups such as:
  o Children and adolescents
  o Elderly
  o Patients with co-existing medical conditions such as cardiopulmonary disease or coagulation disorders
9. Patient Care (Management Skills)
   - Develop an evidence based care plan for his/her Continuity Clinic patients
   - Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as:
     - Abnormal bleeding
     - Pelvic pain
     - Sexually transmitted diseases
     - Pelvic inflammatory disease
     - Endometriosis
   - Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
   - Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
   - Assist in the management of common postoperative complications such as:
     - Fever
     - Gastrointestinal ileus/obstruction
     - Infection
     - Wound complications
     - Fluid electrolyte imbalance
     - Respiratory problems
     - Thromboembolism

10. Practice Based Learning
   - Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
   - Incorporate formative and summative feedback to improve knowledge and skill base
   - Maintain an updated gynecologic procedural log as detailed on the ACGME website
   - Participate in gynecologic quality assurance activities (M&M) of the department
   - Use personal experience with difficult and challenging patients to optimize future relationships with patients

11. Communication/Interpersonal Skills
   - Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
   - Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

12. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
- Demonstrate accountability for one's action and clinical decisions
- Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
- Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
- Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

13. Systems Based Practice
- Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
- The resident will review the curriculum prior to the first day of the rotation. The PGY I resident will actively participate in:
  - Daily rounds
  - Daily didactic conferences
  - Weekly GBMC Grand Rounds
  - Attendance at a wide variety of gynecologic procedures
- All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback
- Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills, the resident will progress from assisting at minor surgical procedures (e.g. hysteroscopy, D&C) to major abdominal/vaginal procedures

Types of Clinical Encounters:
- PGY I residents will participate in the gynecologic care of the patients cared for by the attending staff of GBMC
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology
Resident Supervision:
- The resident will be under the supervision of his/her Chief Resident and an Attending physician at all times.

Reading List:
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

Method of Evaluation:
- Global evaluation of PGY I resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
Learning Objectives

Training Level: PGY1
Rotation: Johns Hopkins Bayview Gyn/Ob

Educational Purpose
The PGY-1 Gyn/Ob inpatient experience at the Bayview campus is a crucial component of the residency program. 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 and develops basic skills in the management of patients presenting to the emergency department with gynecologic complaints. Residents develop competence with performance of spontaneous vaginal delivery and minor gynecologic surgeries.

Goals and Objectives
By completion of the PGY-1 year, the resident should demonstrate skillful management of intrapartum, postpartum and gynecologic patients, as described within the context of the ACGME core competencies.

The resident should be able to:

8. Medical Knowledge
   - Describe the major physiologic changes in each organ system during pregnancy
   - Describe the impact of pregnancy on maternal medical conditions, and conversely, the impact of various maternal medical conditions upon pregnancy outcome
   - Order and interpret common diagnostic tests in the context of the normal physiologic changes of pregnancy
   - Demonstrate accurate and timely interpretation of intrapartum fetal heart rate patterns and implement appropriate interventions for such
   - Perform and interpret assessments of fetal well-being, including: non-stress testing, contraction stress testing, biophysical profile, fetal scalp stimulation, vibroacoustic stimulation, scalp pH testing
   - Describe the normal course of labor; identify abnormalities of labor and describe methods of labor augmentation
   - Describe appropriate indications for induction of labor, methods of cervical ripening / labor induction, and potential complications for each
• Counsel parturients regarding various forms of obstetrical anesthesia, including: local, intravenous, pudendal, epidural, spinal and general
• Demonstrate understanding of pharmacologic agents commonly used in obstetrics: labor inducing agents, tocolytics, analgesics, antibiotics, insulin, heparin, etc.
• Evaluate and provide immediate care for the newborn, including: neonatal resuscitation, Apgar score assignment, and cord blood analysis
• Describe maternal complications that may arise in the postpartum period and methods for their resolution
• Provide basic supportive care of the postpartum patient, including: contraceptive needs, emotional evaluation and lactation consultation
• The resident will be able to diagnose and develop a management plan for patients with:
  i. upper and lower genital tract infections
  ii. threatened, incomplete, inevitable and missed abortion
  iii. ectopic pregnancy
  iv. dysfunctional uterine bleeding
  v. contraceptive needs

9. Patient Care (Clinical Skills)
 • Conduct focused patient histories and physical examinations, including:
  i. Comprehensive primary care examination
  ii. Focused examination of the obstetrical or gynecologic patient
  iii. Serial cervical examination of parturients
  iv. Clinical pelvimetry
  v. Leopold’s Maneuvers / estimated fetal weight
  vi. Accurate assessment of presenting fetal part and position
  vii. Ultrasonographic examination of the fetus

• 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
• Demonstrate the ability to perform:
  i. Incision & Drainage of a Bartholin’s abcess with placement of a Word catheter
  ii. Endometrial aspiration biopsy
  iii. Vulvar biopsy
  iv. Hysteroscopy
  v. Dilation and Curettage
  vi. Suction Curettage
vii. Diagnostic laparoscopy
viii. Laparoscopic sterilization
ix. Surgical management of ectopic pregnancy

- The resident will be able to recognize and initiate management of common post-operative problems such as infection, ileus, hemorrhage, and fluid and electrolyte imbalances.

10. Patient Care (Management Skills)
- Multi-task and triage the care of all antepartum and intrapartum patients in the labor and delivery area and gynecologic patient in the emergency department or on the gyn service.
- 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 or unstable gynecologic patients in the emergency department or on the gyn service 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

11. 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
- Keep an updated patient log as detailed in the ACGME website
- Participate in quality assurance activities (PBLI conference) of the department
- Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

12. Communication/Interpersonal Skills
- Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion
- Demonstrate caring and respectful interactions with the obstetrical 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.

13. Professionalism
- Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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

14. 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 and L&D 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

Types of Clinical Encounters
PGY-1 residents interact with and are responsible for the care of all patients presenting to the triage area of Labor and Delivery and the inpatient management of all laboring and post-partum patients. In addition, the PGY1 will perform the initial assessment of all gynecologic patients on the inpatient service for whom there are medical needs that require attention and for patients in the Emergency Department who require gynecologic evaluation. A wide variety of both normal / physiologic and abnormal obstetrical and gynecologic pathology is encountered in these patients.

The PGY-1 resident will assist in the management of a variety of medical conditions complicating pregnancy, including:
- Diabetes mellitus
- Diseases of the urinary system
- Infectious diseases
- Hematologic disorders
- Cardiopulmonary disease
- Gastrointestinal disease
- Neurologic disease
- Endocrine disorders
- Collagen vascular disorders
- Psychiatric disorders
- Substance abuse
- Emergency care / trauma

In addition, the resident will be introduced to various pregnancy related complications (to be enhanced in the PGY-2 year), including:
- Cervical incompetence
- Second and third trimester bleeding
- Multi-fetal gestation
- Fetal malpresentation
- Pre-term labor and PPROM
- Isoimmunization
- Hypertensive disorders of pregnancy
- Fetal growth restriction
- Intrauterine fetal death
- Post-term pregnancy

**Procedures to be mastered in the PGY-1 year:**
- Full term spontaneous vaginal delivery
- Episiotomy and repair
- Administration of anesthetic: local, pudendal
- Postpartum tubal sterilization
- Basic real-time Ultrasonography
- Incision & Drainage of a Bartholin’s abscess with placement of a Word catheter
- Endometrial aspiration biopsy
- Vulvar biopsy
- Hysteroscopy
- Dilation and Curettage
- Suction Curettage
- Diagnostic laparoscopy
- Laparoscopic sterilization

Procedures introduced in the PGY-1 year (but mastered in the PGY-2 year):
- Operative vaginal delivery
- Preterm spontaneous vaginal delivery
- Cesarean delivery
- External cephalic version
- Surgical management of ectopic pregnancy

**Rotation Structure**
The PGY-1 resident will review the curriculum prior to the first day of the rotation.
The PGY-1 resident will actively participate in:

- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB/Gyn Practice Based Learning and Improvement Conf (daily).
- Fetal Heart Rate Monitoring “strip rounds” (monthly)
- At all other times, it is expected that the PGY-1 resident will remain on the labor floor or in the gyn OR, involved directly with patient care encounters (with the exception of Friday “school” for which the resident will be excused from clinical duties).

**Resident Supervision**

The resident’s daily activities fall under the management of the Chief Resident; this provides opportunity for immediate feedback.

Deliveries and surgical procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

**Reading List and Educational Materials**

- William’s Obstetrics or Gabbe
- Novak’s textbook of Gynecology
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

**Method of Evaluation**

- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-I residents are performed at the completion of the 6 week block by the Bayview faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- Residents’ procedural skills will be assessed after each index procedure using the on-line C-BASS evaluation tool (OSATS)
Educational Objectives for the PGY-1 Rotation in Gynecologic Oncology
The Kelly Gynecologic Oncology Service (KGOS)

Training Level: PGY1
Rotation: Gynecologic Oncology

A. Educational Purpose
Each PGY-1 resident will spend one block rotation assigned to the Gynecologic Oncology service, with responsibility for participating in the clinical activities of the service under the direction of the senior residents and clinical fellows, and for supervising and teaching third and fourth year medical students. The educational goals are that upon completion of the first year of residency, each resident will have a working knowledge base in the diagnosis of gynecologic cancers, and will begin to understand the complexities of the medical and surgical management of these malignancies. He or she will develop surgical skills and be well versed in post-operative care, including the management of post-operative complications. Consistent and thorough reporting of changes in patient status and of results of consultations and diagnostic testing to senior members of the team is of key importance. At the core of this educational experience for the first year resident is a set of cognitive and behavioral objectives outlined below, which will serve to assist the resident in the above areas.

   o For each of the specific objectives listed below, there is a relationship between it and one or more of the general competencies (see grid). The evaluation tools for this rotation correspond to these learning objectives and the competencies addressed by each.

B. Goals and Objectives

1. Cognitive:
   a. Demonstrate a working knowledge of pelvic anatomy. Understand the normal anatomic relationships between the uterus/fallopian tubes/ovaries and other pelvic structures. Understand the potential for variation from normal anatomic relationships, in patients with and without cancer, and begin to understand how to identify these variations and to prevent surgical complications by understanding anatomy. Know the vascular supply and drainage of the pelvic organs, and begin to develop knowledge of the lymphatic drainage and neurologic supply.

   b. Know the chemotherapeutic agents most commonly used in the treatment of gynecologic malignancies, and the most common adverse effects of these agents. Describe the medications most commonly used to treat chemotherapy complications, including marrow suppression, nausea and vomiting, hemorrhagic cystitis, peripheral neuropathy, renal toxicity, and cardiac toxicity. Prescribe these agents showing respect for drug-drug interactions and costs.
c. For carcinoma of the breast, be able to describe the:
   • Pathophysiology and epidemiology
   • Risks based on personal and family history
   • Screening and diagnostic testing algorithms
   • Staging
   • Surgical and medical management
   • Prognosis

d. For carcinoma of the cervix, be able to describe the:
   • Clinical presentation
   • Histology, including grading
   • Staging
   • Epidemiology and pathogenesis
   • Prognosis

e. Understand the risk factors for endometrial hyperplasia and carcinoma. Know the classification and treatment of endometrial hyperplasia. Be able to describe the epidemiology, pathogenesis, histology, staging, and prognosis of endometrial carcinoma.

f. Understand the epidemiology, pathogenesis, risk factors, and clinical presentation of preinvasive neoplasias of the vulva, vagina, and cervix. Know the classification of such lesions (such as the Bethesda system for classification of Pap smears), the clinical evaluation and principles of both medical and surgical management.

2. Behavioral:

a. Elicit a complete history and physical examination from the patient presenting with signs and/or symptoms of gynecologic malignancy (vulvar, vaginal, cervical, uterine, ovarian). Perform competent breast examination. Perform complete pelvic examination including cervical cytology, appropriate biopsies, and collection of microbiologic specimens. Present findings to attending or fellow physician and include a working diagnosis and treatment plan. Explain the plans and rationale to the patient in appropriate, culturally sensitive terms.

b. Perform and interpret the results of common office or bedside procedures, including but not limited to the below. Describe the procedure and potential complications to the patient in understandable terms.
   • Microscopic evaluation of vaginal discharge
   • Colposcopy
   • Biopsy of vulvar, vaginal or cervical lesion
   • Endometrial biopsy
   • Paracentesis
   • Thoracentesis
c. Order, obtain and interpret results, and incorporate into staging and treatment planning, the following tests, in a medically sound and cost effective manner:

- Pelvic ultrasound
- Computed tomography
- Intravenous pyelography
- Serum tumor markers
- Cytologic analysis of pleural or peritoneal fluid

d. Perform appropriate preoperative evaluation for gynecologic surgery patients, including major and minor procedures. Recognize the indications for preoperative medical clearance, obtain such clearance when indicated, and accurately identify the patient whose medical problems make her not a surgical candidate. Describe the procedures and potential complications to the patient in understandable terms. Recognize and manage post-operative complications in both the immediate post-operative period and after discharge from the hospital, utilizing guidance from senior residents and attending physicians.

e. Perform, under attending physician supervision, the following surgical procedures:

- Excisional (cone biopsy, LEEP) and ablative (cryotherapy, laser) procedures for cervical dysplasia

Assist with the following surgical procedures:

- Hysterectomy, abdominal
- Removal of adnexa, in conjunction with hysterectomy or separately in the appropriate clinical setting
- Hysterectomy, vaginal
- Staging laparotomy, including cytologic washings, peritoneal biopsies, upper abdominal exploration, and infracolic omentectomy
- Wide local excision of vulvar lesions
- Hysterectomy, radical
- Lymph node dissection, pelvic and paraaortic
- Resection of large and small bowel
- Colostomy

C. Objective Grid

Following is a grid diagram that cross-references each of the objectives listed above to the six general competencies, and lists the assessment tools to be used for each of the learning objectives.

Patient Care – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Medical Knowledge – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
Practice-based Learning and Improvement – Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Interpersonal and Communication Skills – Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

Professionalism – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-based Practice – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
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Rotation Structure

The PGY1 resident will review the curriculum prior to the first day of the rotation. The PGY1 resident will actively participate in the following activities:
- Daily attending rounds
- Surgical procedures for the KGOS
- Gyn Oncology clinics
- Weekly Gyn/Gyn Onc Professor’s rounds
- Weekly Morbidity and Mortality Conferences
- Weekly Colposcopy clinic
- Weekly Colposcopy correlation conference
- Weekly Tumor Board

Resident Supervision

The resident’s daily activities fall under the management of the senior residents on the Gyn Onc service, the Gyn Oncology fellow and KGOS faculty; this provides opportunity for immediate feedback.

Patient examinations, diagnostic procedures and surgical procedures are performed under the direct supervision of an attending physician at all times.

Reading List

The educational materials for this rotation consist of:
- TeLinde’s Operative Gynecology, Rock and Thompson, 2003
- DeSaia and Creasman, Gynecologic Oncology
- The KGOS notebook of key readings in Gyn Oncology
- Pertinent ACOG Educational and Practice Bulletins (page references are from the 2005 Compendium)
  - Diagnosis and Treatment of Cervical Carcinomas, PB 35, pp. 390-402.

Methods of Evaluation

- Residents will receive on-site timely formative feedback from the fellow and attending physician(s) during this rotation.
- Global evaluations of PGY-I resident is performed at the completion of the block by the KGOS faculty and reflect input from the attending staff, nurses and patients. These evaluations will be available to the residents via the E*value system and will be
reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.

- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- See also grid above

Summary

The intent of this educational experience is to initiate the education of the obstetrics and gynecology resident in the area of gynecologic oncology. Upon completion of the first year, each resident will have begun to develop a sound knowledge base in this area. He or she will have a solid core set of surgical skills and be prepared to undertake more complex procedures. Upon successful completion of this experience, the resident will have demonstrated:

- Competency in the basic evaluation of the patient with gynecologic cancer;
- Competency in the performance of common office procedures, in assisting with minor, major and radical gynecologic surgery, and emerging competency in performing minor and major gynecologic surgery;
- Competency in the post-operative care of patients with reproductive cancers, and with complications of their disease and/or its treatment, with an attentiveness to providing this care in an efficient and cost-effective manner.
Goals and objectives SICU/WICU Rotation – JHH

To become familiar with the routine post-operative management of complex cases
To recognize and manage common post-operative complications
To learn ICU triage for surgical and trauma patients

Specifics system goes below: (not limited to such a more detailed curriculum is available in the Fellowship Directors office)

Neurologic:

1. To manage recovery from anesthetics, including assessment of neuromuscular blockade and reversibility from same
2. To manage epidural narcotics and local anesthetics
3. To manage pain control with fentanyl and morphine to relief of post-operative pain

Respiratory:

1. Identification and management of respiratory failure
2. Routine weaning and extubation of post-operative patients
3. Complex weaning of patients with prolonged ventilation
4. Management of ARDS
5. Prevention and treatment of nosocomial pneumonia

Cardiovascular

1. Management and prevention of perioperative ischemia
2. Treatment of perioperative MI
3. Recognition and treatment of supraventricular arrhythmias
4. Assessment and management of hemodynamic instability
5. Assessment and management of hypovolemia, hypervolemia

GI:

1. Support of the failing liver (fulminant hepatic failure)
2. Management of the liver transplant immediately post-op and common short and long-term complications
3. Nutritional management and assessment

Renal:

1. Assessment and management of common electrolyte, acid base and volume disorders
2. Management of ATN
3. Common ICU renal replacement strategies
Nosocomial Infection

1. Recognition and management of perioperative nosocomial infections
2. Pharmacodynamic management of aminoglycosides

Heme:

1. Assessment and management of the bleeding patient
2. Coagulation disorders related to massive transfusion, tissue injury and hypothermia

Ethics/Law/End-of-Life/Brain Death/Organ Donation

1. Recognize and identify barriers to end-of-life discussions in a post-operative patient
2. Brain death determination
3. Organ donation protocol

**Minimum for achieving a passing status is “novice status” (exposed and some knowledge of) above AND demonstrated ability to collect a history, conduct a physical examination, gather pertinent data from available sources (computer, radiology and health care team members) and present these items as well as a basic assessment and plan on morning rounds.**
Emergency Medicine – PGY1

Training Site: Johns Hopkins Hospital

I. **Educational Purpose:**
The resident on this rotation will develop an understanding of the specialty of emergency medicine, including the scope of emergency medicine practice, the approach to the emergency care patient, and the relationship of emergency medicine to the hospital and the health care system.

II. **Goals, Objectives and Competencies:**
At the completion of this 4 week rotation the resident should be able to:

- Demonstrate competence in evaluating clinical scenarios and prioritizing care for the emergency care patient (patient care)
- To obtain a focused history and physical in accordance with the patient’s clinical presentation (patient care)
- Present an expeditious and concise assessment of the presenting complaint and pertinent findings to the attending physician (interpersonal skills and communication)
- Coordinate appropriate patient care with nursing personnel, with ancillary laboratory and radiographic services and with consulting physicians when appropriate (systems-based practice)
- Demonstrate competence in the management of the common clinical presentations of urgent disease processes (medical knowledge) including:
  - Upper and lower respiratory tract infection
  - Asthma
  - Conjunctivitis
  - Otitis media
  - Urinary tract infection
  - Hypertension
  - Acute and chronic gastrointestinal diseases
  - Headache
  - Uncomplicated inflammatory skin diseases
  - Diabetes
  - Thyroid dysfunction
  - Alcoholism and other substance abuse
  - Cerebrovascular accident
- Chest pain
  - Demonstrate his/her skill in the performance of procedures, possibly including lumbar puncture, paracentesis, suture repair of lacerations, wound management, and arterial blood gases (patient care)
  - Demonstrate caring and empathetic behavior and adherence to ethical principals in providing care to all patients and their families (professionalism)
  - Establish effective pathways of communication with patients and their families (interpersonal skill and communication)
  - Demonstrate insight into the specific emotional, cultural, and social needs of a very diverse patient population (interpersonal and communication skills)

III. Scope of Clinical Experience:
The PGY I Ob-Gyn resident experience will focus on acute care with secondary exposure to intermediate care. Residents will have first hand experience with the full spectrum of acute patient presentations as well as a direct role in their management.

IV. Teaching Methods:
Resident will review the curriculum prior to the beginning of the rotation.
During this one month rotation, the PGY I resident will evaluate patients in both the acute and intermediate care units. Residents will provide initial assessment and present all patients to the designated attending physician for review and discussion. Residents will receive formative timely feedback from these physicians at the time of the encounter.

The resident will attend the weekly “school” held by the Department of Gyn/Ob (Fridays 1-4 PM) and will be released from their duties in the Dept of Emergency Medicine to attend these sessions.

V. Resident Supervision:
The resident will be under the direct supervision of the Emergency Department attending physician. The clinical history and pertinent findings of all patients will be presented for review and discussion with the attending. Residents will enter appropriate notes on the charts, but attendings will also provide written documentation.

VI. Reading List:
- Tintanelli Emergency Medicine
VII. **Method of Evaluation:**
The resident will receive regular formative feedback with each case reviewed by the attending.

The resident will receive a global evaluation at the completion of the rotation in the competency format. This written evaluation will be available to the resident in the E*value system. The evaluation will be based on the resident’s clinical performance and his/her acceptance of the clinical responsibilities of the program.
Learning Objectives

Training Level: PGY1
Rotation: Ultrasound/Genetics

Educational Purpose

The PGY-1 Ultrasound/Genetics experience introduces the resident to the basic knowledge and skills of Obstetric Ultrasound. In this rotation the resident acquires the basic ultrasound skills necessary to aid in the care of both routine and high risk obstetrical patients. Residents develop competence with performance of a comprehensive first trimester pregnancy ultrasound as well as in the performance of tests of fetal wellbeing and basic obstetrical ultrasound examinations. In addition they learn skills needed to correctly counsel patients about a variety of genetic conditions and fetal anomalies. This rotation provides a month-long experience in obstetric sonography and genetics during which the resident will function under the supervision of the Maternal Fetal Medicine faculty and the Ob sonographers. This rotation provides an intense experience in prenatal diagnostic techniques for evaluation of aneuploidy, birth defects and fetal well-being.

Goals and Objectives

By completion of the PGY-1 year, the resident should demonstrate skills needed for the initial ultrasound evaluation of obstetric patients, as described within the context of the ACGME core competencies.

The resident should be able to:

15. Medical Knowledge
   - Describe the clinical significance of karyotype abnormalities, such as:
     o Trisomy
     o Monosomy
     o Deletions
     o Inversions
   - Describe the clinical significance of heritable diseases, such as cystic fibrosis, Tay-Sachs disease, and hemophilia.

16. Patient Care (Clinical Skills)
   - Be able to perform and describe the indications, contraindications, advantages, and disadvantages of antepartum diagnostic tests, such as:
     o Nonstress test

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The resident will verbalize how ultrasound is used to establish dating criteria in each trimester of pregnancy.

- The resident will demonstrate correct sonographic attainment of fetal biometry measurements.
- The resident will be able to identify and obtain the correct views for a basic obstetrical ultrasound including:
  - Fetal lie
  - Amniotic fluid volume
  - Cardiac activity
  - Placental position
  - Fetal biometry
  - Fetal number

- The resident will become familiar with the standard views obtained during a comprehensive fetal anomaly ultrasound.
- The resident will be able to formulate a detailed differential diagnosis and management plan for a variety of fetal anomalies base on sonographic findings. Examples of these anomalies include:
  - Intrauterine growth restriction
  - Open neural tube defects
  - Anterior abdominal wall defects
  - Cardiac defects

- The resident will learn techniques for screening and diagnostic evaluation of aneuploidy together with the risks and limitations of these procedures.

17. 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
   - Keep an updated patient log as detailed in the ACGME website
   - Participate in quality assurance activities (Wed 4PM Ultrasound Conference) of the department
   - Use information technology: UpToDate, PubMed literature search, Cochrane Database, etc. to obtain current clinical information

18. Communication/Interpersonal Skills
   - 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
• Interact respectfully and professionally with all members of the patient care team, including: attending physicians, nursing staff, resident staff, medical students, sonographers, etc.

19. Professionalism
• Maintain sensitivity to issues of diversity, with patients and with staff
• Participate actively in the education of fellow residents and medical students

20. Systems-Based Practice
• Demonstrate an understanding for the roles and responsibilities of healthcare team members

Types of Clinical Encounters
To achieve these objectives the PGY1 resident will:
1. Spend at least two half-day sessions with the prenatal assessment nurse in the Fetal Assessment Center performing NSTs, BPPs, and AFIs;
2. Attend and perform ultrasound examinations done in the Maternal-Fetal Diagnostic and Treatment Center throughout the rotation;
3. Act as an observer for at least 4 patient sessions with the genetic counselors. Ideally these will include sessions addressing the following patient problems:
   a. Advance maternal age
   b. Abnormal 1st or 2nd trimester serum screening
   c. Fetal anomaly
   d. Medication or toxin exposure
4. Attend the weekly Genetic Conferences (Every other Monday 12-1PM and every Wed 1-3 PM), Maternal-Fetal Medicine Conference (Wed 3:15-4PM) and Ultrasound Conference (Wed 4-5PM).

Resident Supervision
The resident’s daily activities fall under the management of the MFM faculty and Ob sonographers; this provides opportunity for immediate feedback.

Reading List and Educational Materials
1. ACOG patient pamphlet on Ob Ultrasound
2. ACOG Committee Opinion on Non-medical use of Ob Ultrasound
3. ACOG Practice Bulletin #58 on Ultrasonography in Pregnancy
4. Johns Hopkins Manual of Gyn and Ob, Chapters
   a. 4 – Preconception Counseling
   b. 6 – Fetal Assessment
c. 12 – Congenital Anomalies

Method of Evaluation

- Residents will receive on-site timely formative feedback from the sonographers, genetic counselors, MFM fellow and attending physician(s) during this rotation.
- Global evaluations of PGY-I resident is performed at the completion of the 6 week block by the Ob sonographers with input from the MFM faculty, genetic counselors, and the other staff of the Maternal-Fetal Diagnostic and Treatment Center. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
Learning Objectives

Training Level: PGY2
Rotation: Hopkins Hospital Obstetrics Service

Educational Purpose
The PGY-2 obstetrical experience further builds upon those skills developed during the first year. In this rotation the resident perfects the basic skills necessary for management of routine and high-risk obstetrical patients during the intrapartum and postpartum periods. Residents become competent with performance of operative vaginal delivery, cesarean sections, and multiple gestations. In addition, managerial responsibilities are developed, as the PGY-2 resident is responsible for supervising and educating interns and medical students rotating on the labor and delivery unit. Exposure to antepartum care is achieved by regular attendance at high-risk obstetrics clinic at The Women's Health Center.

Goals and Objectives
By completion of the PGY-2 year, the resident should demonstrate skillful management of antepartum, intrapartum, and postpartum patients, as described within the context of the six core competencies.

The resident should be able to…

21. Medical Knowledge
- Describe the impact of pregnancy on maternal medical conditions, and conversely, the impact of various maternal medical conditions upon pregnancy outcome.
- Implement appropriate medical and surgical management for patients with medical complications of pregnancy.
- Describe the risk factors for, etiologies of, complications of, and management of late trimester pregnancy loss, intrauterine growth restriction, intrauterine fetal demise, preterm labor and PPROM.
- Perform and interpret assessments of fetal well-being, including: non-stress testing, contraction stress testing, biophysical profile, fetal scalp stimulation, vibroacoustic stimulation, scalp pH testing.
- Describe the factors that predispose to multiple gestation, diagnose multiple gestation by physical findings and sonographic examination, manage complications associated with multiple gestation, and develop proper delivery plans for such.
- Describe the appropriate criteria for and contraindications to VBAC, and recognize and treat possible complications.
22. Patient Care (Clinical Skills)

- Perform uncomplicated operative vaginal deliveries with attending physician supervision.
- Demonstrate skillful repair of third and fourth degree perineal lacerations, cervical and vaginal lacerations.
- Appropriately manage obstetrical emergencies
  - i. obstetrical hemorrhage
  - ii. shoulder dystocia
  - iii. fetal bradycardia
  - iv. uterine rupture
  - v. trauma
- Perform external cephalic version with attention to potential maternal and/or fetal complications.
- Demonstrate level-appropriate skills in cesarean delivery.
- Demonstrate competence as a surgical assistant during the performance of cesarean hysterectomy.
- Perform a comprehensive work up for intrauterine fetal demise, and properly manage labor induction or uterine evacuation for the patient with an IUFD.
- Accurately assess the obstetrical patient with multiple gestation, including fetal growth assessment, fetal positioning, and delivery plan.
- Deliver routine prenatal care to high risk obstetrical patients in the outpatient setting.
- Manage an infected or dehisced operative incision, and demonstrate adequate wound care treatment.

Patient Care (Management Skills)

- Multi-task and triage the care of all antepartum and intrapartum patients in the labor and delivery unit.
- Multi-task and manage intern and medical student staff for the best utilization of manpower.
- Respond to acute intrapartum 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 intern, medical student and nursing student education.

23. 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.
• Keep an updated patient log as detailed in the ACGME website.
• Participate in quality assurance activities of the department.
• Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

24. Communication/Interpersonal Skills
• Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion.
• Demonstrate caring and respectful interactions with the obstetrical 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.

25. Professionalism
• Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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.

26. 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 and L&D 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.

Types of Clinical Encounters
PGY-2 residents interact with and are responsible for the care of all patients in the inpatient hospital setting. A wide variety of both normal / physiologic and abnormal obstetrical pathology is encountered in these antepartum, intrapartum, and postpartum patients.

The PGY-2 resident will be responsible for managing a variety of medical conditions complicating pregnancy, including:
- Diabetes mellitus
- Diseases of the urinary system
- Infectious diseases
- Hematologic disorders
- Cardiopulmonary disease
- Gastrointestinal disease
- Neurologic disease
- Endocrine disorders
- Collagen vascular disorders
- Psychiatric disorders
- Substance abuse
- Emergency care / trauma

In addition, the PGY-2 resident will become proficient in the diagnosis and management of various pregnancy related complications, including:
- Chronic pregnancy loss
- Cervical incompetence
- Second and third trimester bleeding
- Multi-fetal gestation
- Fetal malpresentation
- Pre-term labor and PPROM
- Isoimmunization
- Hypertensive disorders of pregnancy
- Fetal growth restriction
- Intrauterine fetal death
- Post-term pregnancy

Procedures to be mastered in the PGY-2 year:
- Pre-term spontaneous vaginal delivery
- Operative vaginal delivery
- Repair of third and fourth degree perineal lacerations
- Cesarean delivery
- External cephalic version
Rotation Structure
The PGY-2 resident will review the curriculum prior to the first day of the rotation.
The PGY-2 resident will actively participate in:
- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB Practice Based Learning and Improvement Conf (daily).
- Fetal Heart Rate Monitoring “strip rounds” (weekly)
- High Risk Ob Clinic (weekly)
- The PGY2 will attend the weekly MFM clinical conferences and sono conferences as his or her patient care responsibilities allow.
- At all other times, it is expected that the PGY-2 resident will remain on the patient care floors involved directly with patient care encounters (with the exception of Friday “school” for which the resident will be excused from clinical duties).

Resident Supervision
The resident’s daily activities fall under the management of the Chief Resident; this provides opportunity for immediate feedback.

Deliveries and procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

Reading List and Educational Materials
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

Method of Evaluation
- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-2 residents are performed at the completion of the 6 week block by the MFM faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Nursing staff will complete evaluations of selected skills of each resident at the completion of each block.
- Cognitive assessment of the residents’ obstetrical skills is achieved by the obstetrical score from the CREOG examination.
Learning Objectives

Training Level: PGY2
Rotation: Johns Hopkins Bayview Gyn/Ob

Educational Purpose
The PGY-2 Gyn/Ob inpatient experience at the Bayview campus is a key component of the residency program. In this rotation the resident acquires the skills necessary for management of routine and high-risk obstetrical patients during the intrapartum and postpartum periods and develops more advanced skills in the management of gynecologic patients and patients presenting to the emergency department with gynecologic complaints. Residents develop competence with performance of advanced obstetrical procedures as well as major and minor gynecologic surgeries.

Goals and Objectives
By completion of the PGY-2 year, the resident should demonstrate skillful management of intrapartum, postpartum and gynecologic patients, as described within the context of the ACGME core competencies.

The resident should be able to:

27. Medical Knowledge
- Describe the impact of pregnancy on maternal medical conditions, and conversely, the impact of various maternal medical conditions upon pregnancy outcome.
- Implement appropriate medical and surgical management for patients with medical complications of pregnancy.
- Describe the risk factors for, etiologies of, complications of, and management of late trimester pregnancy loss, intrauterine growth restriction, intrauterine fetal demise, preterm labor and PPROM.
- Perform and interpret assessments of fetal well-being, including: non-stress testing, contraction stress testing, biophysical profile, fetal scalp stimulation, vibroacoustic stimulation, scalp pH testing.
- Describe the factors that predispose to multiple gestation, diagnose multiple gestation by physical findings and sonographic examination, manage complications associated with multiple gestation, and develop proper delivery plans for such.
Describe the appropriate criteria for and contraindications to VBAC, and recognize and treat possible complications.

Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.

Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding

List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding

Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods

Describe the common vulvovaginidities

Identify the common benign vulvar lesions

Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV

Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention

Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same

Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention

Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis

Describe the treatment both medical and surgical of endometriosis

Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management

Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy

Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis
28. Patient Care (Clinical Skills)

- Perform uncomplicated operative vaginal deliveries with attending physician supervision.
- Demonstrate skillful repair of third and fourth degree perineal lacerations, cervical and vaginal lacerations.
- Appropriately manage obstetrical emergencies
  - i. obstetrical hemorrhage
  - ii. shoulder dystocia
  - iii. fetal bradycardia
  - iv. uterine rupture
  - v. trauma
- Perform external cephalic version with attention to potential maternal and/or fetal complications.
- Demonstrate level-appropriate skills in cesarean delivery.
- Demonstrate competence as a surgical assistant during the performance of cesarean hysterectomy.
- Perform a comprehensive work up for intrauterine fetal demise, and properly manage labor induction or uterine evacuation for the patient with an IUFD.
- Accurately assess the obstetrical patient with multiple gestation, including fetal growth assessment, fetal positioning, and delivery plan.
- Deliver routine prenatal care to high risk obstetrical patients in the outpatient setting
- Manage an infected or dehisced operative incision, and demonstrate adequate wound care treatment.

Patient Care (Management Skills)

- Multi-task and triage the care of all antepartum and intrapartum patients in the labor and delivery unit.
- Multi-task and manage intern and medical student staff for the best utilization of manpower.
- Respond to acute intrapartum 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 intern, medical student and nursing student education.
- Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  - i. Abnormal bleeding
  - ii. Pelvic pain
  - iii. Pelvic mass
  - iv. Sexually transmitted diseases
  - v. Pelvic inflammatory disease
  - vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
• The resident will demonstrate competence in performing
  o Marsupialization of a Bartholin’s gland abscess
  o Laparotomy
  o Lysis of adhesions
  o Total abdominal hysterectomy and bilateral salpingoopherectomy
  o Myomectomy
  o Ovarian cystectomy
  o Colposcopy and cervical biopsy
  o Cervical conization
• The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
  o Dilation and curettage
  o Diagnostic laparoscopy

29. 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.
• Keep an updated patient log as detailed in the ACGME website.
• Participate in quality assurance activities of the department.
• Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.
30. Communication/Interpersonal Skills
- Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion.
- Demonstrate caring and respectful interactions with the obstetrical 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.

31. Professionalism
- Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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.

32. 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 and L&D 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

Types of Clinical Encounters
PGY-2 residents interact with and are responsible for the care of all patients presenting to the triage area of Labor and Delivery and the inpatient management of laboring and post-partum patients. In addition, the PGY2 will
perform the assessment of gynecologic patients on the inpatient service for whom there are medical needs that require attention and for patients in the Emergency Department who require gynecologic evaluation. A wide variety of both normal / physiologic and abnormal obstetrical and gynecologic pathology is encountered in these patients.

The PGY-2 resident will assist in the management of a variety of medical conditions complicating pregnancy, including:

- Diabetes mellitus
- Diseases of the urinary system
- Infectious diseases
- Hematologic disorders
- Cardiopulmonary disease
- Gastrointestinal disease
- Neurologic disease
- Endocrine disorders
- Collagen vascular disorders
- Psychiatric disorders
- Substance abuse
- Emergency care / trauma
- Cervical incompetence
- Second and third trimester bleeding
- Multi-fetal gestation
- Fetal malpresentation
- Pre-term labor and PPROM
- Isoimmunization
- Hypertensive disorders of pregnancy
- Fetal growth restriction
- Intrauterine fetal death
- Post-term pregnancy

**Procedures to be mastered in the PGY-2 year:**

- Diagnostic laparoscopy
- Laparoscopic sterilization
- Operative vaginal delivery
- Preterm spontaneous vaginal delivery
- Cesarean delivery
- External cephalic version
- Surgical management of ectopic pregnancy

**Rotation Structure**

The PGY-2 resident will review the curriculum prior to the first day of the rotation.

The PGY-2 resident will actively participate in:

- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB/Gyn Practice Based Learning and Improvement Conf (daily).
- Fetal Heart Rate Monitoring “strip rounds” (monthly)
- At all other times, it is expected that the PGY-2 resident will remain on the labor floor or in the gyn OR, involved directly with patient care encounters (with the exception of Friday “school" for which the resident will be excused from clinical duties).

**Resident Supervision**
The resident’s daily activities fall under the management of the Chief Resident; this provides opportunity for immediate feedback.

Deliveries and surgical procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

**Reading List and Educational Materials**
- William’s Obstetrics or Gabbe
- Novak’s textbook of Gynecology
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

**Method of Evaluation**
- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-I residents are performed at the completion of the 6 week block by the Bayview faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- Residents’ procedural skills will be assessed after each index procedure using the on-line C-BASS evaluation tool (OSATS)
Learning Objectives

Training Level: PGY2
Rotation: Johns Hopkins Hospital Weinberg Gyn/Gyn Onc Night Float

Educational Purpose:
During this rotation the PGY 2 resident will expand their ability to manage gynecologic patients who are admitted for care or who are post-op. The resident will also develop the skills necessary to assess and manage acute gynecologic complaints in the emergency department or on other JHH services. During this rotation the resident will develop the basic cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of a wide range of post-operative and gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY 2 Weinberg nights rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   - Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   - Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   - List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   - Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   - Describe the common vulvovaginidites
   - Identify the common benign vulvar lesions
   - Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
• Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
• Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same
• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

14. Patient Care (Clinical Skills)
• Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• The resident will demonstrate competence in performing
  o Marsupialization of a Bartholin’s gland abcess
  o Laparotomy
  o Ovarian cystectomy
  o Dilation and curettage
  o Diagnostic laparoscopy

15. Patient Care (Management Skills)
• Develop an evidence based care plan for his/her patients
• Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as;
  o Abnormal bleeding
  o Pelvic pain
Sexually transmitted diseases
Pelvic inflammatory disease

- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
- Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
- Management of common postoperative complications such as:
  i. Fever
  ii. Gastrointestinal ileus/obstruction
  iii. Infection
  iv. Wound complications
  v. Fluid electrolyte imbalance
  vi. Respiratory problems
  vii. Thromboembolism

16. Practice Based Learning
- Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
- Incorporate formative and summative feedback to improve knowledge and skill base
- Maintain an updated gynecologic procedural log as detailed on the ACGME website
- Use personal experience with difficult and challenging patients to optimize future relationships with patients

17. Communication/Interpersonal Skills
- Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
- Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

18. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
• Demonstrate accountability for one’s action and clinical decisions
• Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
• Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
• Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

19. Systems Based Practice
• Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
• The resident will review the curriculum prior to the first day of the rotation. The PGY 2 resident will actively participate in:
  o Daily rounds
  o Attendance at a wide variety of gynecologic procedures
• All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback
• Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills, the resident will progress from performing minor surgical procedures to major abdominal procedures

Types of Clinical Encounters:
• PGY 2 residents will participate in the gynecologic care of the patients cared for by the attending staff of JHH
• Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

Resident Supervision:
• The resident will be under the supervision of his/her Chief Resident and an Attending physician at all times.

Reading List:
• Up to Date (available to all residents)
• Comprehensive Gynecology - Droegmuller
• Te Linde’s Operative Gynecology
• Novak’s Gynecology
• ACOG Compendium of Selective Publications
**Method of Evaluation:**

- Global evaluation of PGY 2 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
Learning Objectives

Training Level: PGY2
Rotation: Greater Baltimore Medical Center Gynecology

Educational Purpose:
During this rotation the PGY 2 resident will expand their ability to manage gynecologic patients who present for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. During this rotation the resident will develop the basic cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of a wide range of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY 2 Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   • Describe the etiology, diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   • Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   • List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   • Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   • Describe the common vulvovaginidities
   • Identify the common benign vulvar lesions
   • Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
   • Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
• Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same
• Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention
• Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis
• Describe the treatment both medical and surgical of endometriosis
• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

20. Patient Care (Clinical Skills)
• Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
  vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
• The resident will demonstrate competence in performing
  o Marsupialization of a Bartholin’s gland abcess
  o Laparotomy
  o Lysis of adhesions

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- Total abdominal hysterectomy and bilateral salpingoophorectomy
- Myomectomy
- Ovarian cystectomy
- Colposcopy and cervical biopsy
- Cervical conization

- The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
  - Dilation and curettage
  - Diagnostic laparoscopy

21. Patient Care (Management Skills)

- Develop an evidence based care plan for his/her patients
- Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as;
  - Abnormal bleeding
  - Pelvic pain
  - Sexually transmitted diseases
  - Pelvic inflammatory disease
  - Endometriosis
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
- Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
- Assist in the management of common postoperative complications such as;
  i. Fever
  ii. Gastrointestinal ileus/obstruction
  iii. Infection
  iv. Wound complications
  v. Fluid electrolyte imbalance
  vi. Respiratory problems
  vii. Thromboembolism

22. Practice Based Learning

- Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
- Incorporate formative and summative feedback to improve knowledge and skill base
- Maintain an updated gynecologic procedural log as detailed on the ACGME website
- Participate in gynecologic quality assurance activities (M&M) of the department
- Use personal experience with difficult and challenging patients to optimize future relationships with patients

23. Communication/Interpersonal Skills
- Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
- Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

24. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
- Demonstrate accountability for one’s action and clinical decisions
- Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
- Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
- Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

25. Systems Based Practice
- Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
- The resident will review the curriculum prior to the first day of the rotation. The PGY 2 resident will actively participate in:
  - Daily rounds
- Daily didactic conferences
- Weekly GBMC Grand Rounds
- Attendance at a wide variety of gynecologic procedures
- All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback
- Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills, the resident will progress from assisting at minor surgical procedures (e.g. hysteroscopy, D&C) to major abdominal/vaginal procedures

Types of Clinical Encounters:
- PGY 2 residents will participate in the gynecologic care of the patients cared for by the attending staff of GBMC
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

Resident Supervision:
- The resident will be under the supervision of his/her Chief Resident and an Attending physician at all times.

Reading List:
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

Method of Evaluation:
- Global evaluation of PGY 2 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
Learning Objectives

Training Level: PGY2
Rotation: Reproductive Endocrinology and Infertility

Educational Purpose
The PGY-2 REI experience introduces the resident to the basic knowledge and skills of Reproductive Endocrinology. In this rotation the resident acquires the basic skills necessary for management of patients with gyn endocrine complaints and infertility. Residents develop competence with performance of a comprehensive medical and social history and a directed physical examination. In addition they learn to perform transvaginal ultrasound examinations for assessment of the uterus, fallopian tubes and ovaries and learn to perform minor gynecologic surgeries.

Goals and Objectives
By completion of the PGY-2 year, the resident should demonstrate skills needed for the initial evaluation of patients with gynecologic endocrine complaints or infertility, as described within the context of the ACGME core competencies.

The resident should be able to:

33. Medical Knowledge
• Describe the development and maturation of the hypothalamic-pituitary-ovarian axis from conception through menopause.

• Describe the normal development and disorders of mullerian, ovarian and genital development and their genetic basis.

• Describe the physiology of the normal menstrual cycle, gamete transport in the female reproductive tract, fertilization and implantation.

• Describe the biosyntheses, metabolism and mechanism of action, as well as the role of hypothalamic, pituitary, ovarian, adrenal and thyroid hormones.

• Discuss the mechanisms of action, indications for, physiologic and anatomic changes resulting from and complications associated with the use of exogenous estrogens, progesterone/progestins, androgens, oral
contraceptives, dopamine agonists, clomiphene, and other SERMs, gonadotropins, and GnRH-agonists.

- Discuss the basic causes, pathophysiology, evaluation and treatment of:
  - infertility
  - primary and secondary amenorrhea
  - hyperprolactinemia
  - chronic anovulation and oligo-ovulation
  - androgen excess disorders (hirsutism)
  - the menopausal transition and menopause
  - osteoporosis
  - premenstrual syndrome
  - endometriosis

34. Patient Care (Clinical Skills)
- Perform diagnostic laparoscopy and hysteroscopy and recognize pelvic anatomy as well as the common disorders detected by these techniques.

- 8) Perform and describe the indications for hysterosalpingography, postcoital testing, semen analysis and use of clomiphene citrate and gonadotropins in ovulation induction.

- 9) Perform transvaginal ultrasonography and be able to detect endometrial growth and follicular development during the menstrual cycle.

35. 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
- Keep an updated patient log as detailed in the ACGME website
- Participate in quality assurance activities (PBLI conference) of the department
- Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

36. Communication/Interpersonal Skills
- Present pertinent medical 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
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.

37. Professionalism
- Demonstrate responsibility for the welfare of all patients on the REI service
- 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

38. 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
- 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

Types of Clinical Encounters
To achieve these objectives the PGY2 resident will:
5. Attend and perform sonohysterograms.
6. Attend the weekly Reproductive Endocrinology Conference series. The resident will be expected to discuss case studies, interpret pelvic imaging studies and do library research to prepare for these conferences.
7. See patients with the REI faculty and fellows.
8. Participate in scheduled surgery with the REI faculty.
9. Attend ART follicle monitoring, egg retrievals and embryo transfers

Resident Supervision
The resident’s daily activities fall under the management of the REI fellow and REI faculty; this provides opportunity for immediate feedback.

Patient examinations, transvaginal ultrasounds and surgical procedures are performed under the direct supervision of an attending physician at all times.
Reading List and Educational Materials

- **Clinical Gynecologic Endocrinology and Infertility, Speroff**
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

Method of Evaluation

- Residents will receive on-site timely formative feedback from the fellow and attending physician(s) during this rotation.
- Global evaluations of PGY-2 resident is performed at the completion of the 6 week block by the REI faculty and reflect input from the attending staff, nurses and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
Learning Objectives

Training Level: PGY3
Rotation: Johns Hopkins Hospital Gynecology Service

Educational Purpose:
During this rotation the PGY 3 resident will continue to expand their ability to manage gynecologic patients who presents for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. The resident will develop more advanced skills in the cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of a wide range of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY 3 Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   - Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   - Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   - List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   - Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   - Describe the common vulvovaginidities
   - Identify the common benign vulvar lesions
   - Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
   - Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
• Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same
• Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention
• Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis
• Describe the treatment both medical and surgical of endometriosis
• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

26. Patient Care (Clinical Skills)

• Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
  vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
• The resident will demonstrate competence in performing
  o Operative laparoscopy
  o Complicated total abdominal hysterectomy
  o Appendectomy
• Repair of bowel or bladder injuries
• Surgery for pelvic inflammatory disease

• The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
  o Marsupialization of a Bartholin’s gland abscess
  o Laparoscopic tubal ligation
  o Ovarian cystectomy
  o Colposcopy and cervical biopsy

27. Patient Care (Management Skills)
• Develop an evidence based care plan for his/her patients
• Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as;
  o Abnormal bleeding
  o Pelvic pain
  o Sexually transmitted diseases
  o Pelvic inflammatory disease
  o Endometriosis
• Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
• Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
• Assist in the management of common postoperative complications such as;
  i. Fever
  ii. Gastrointestinal ileus/obstruction
  iii. Infection
  iv. Wound complications
  v. Fluid electrolyte imbalance
  vi. Respiratory problems
  vii. Thromboembolism

28. Practice Based Learning
• Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
• Incorporate formative and summative feedback to improve knowledge and skill base
- Maintain an updated gynecologic procedural log as detailed on the ACGME website
- Participate in gynecologic quality assurance activities (M&M) of the department
- Use personal experience with difficult and challenging patients to optimize future relationships with patients

29. Communication/Interpersonal Skills
- Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
- Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

30. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
- Demonstrate accountability for one’s action and clinical decisions
- Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
- Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
- Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

31. Systems Based Practice
- Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
- The resident will review the curriculum prior to the first day of the rotation. The PGY 3 resident will actively participate in:
  o Daily rounds
  o Weekly Professor’s Grand Rounds
  o Weekly colposcopy correlation conference.
Weekly Morbidity and Mortality conference
- Attendance at a wide variety of gynecologic procedures

- The PGY3 is considered the “Chief Resident” of the Gynecology service and is responsible for the education, supervision and evaluation of the medical students and junior residents on the gyn team.
- All procedures are performed under direct supervision by an attending physician. This provides the opportunity for immediate formative feedback
- Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills.

Types of Clinical Encounters:
- PGY 3 residents will participate in the gynecologic care of all patients on the JHH gynecology service (house staff, faculty and private patients)
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

Resident Supervision:
- The resident will be under the supervision of the faculty attending physician at all times.

Reading List:
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

Method of Evaluation:
- Global evaluation of PGY 3 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
**Expectations of the Chief Resident (PGY 3) on the Gynecology service:**

1. Communicate with the floor attending on a daily basis about pts on service and consults. It is the responsibility of the CR to contact the attending re: times for rounds and other meetings.
2. Make daily bedside rounds with the clinical team. The CR should see every pt on the service on a daily basis and should write notes on the pts they are personally following, as well as other pts when there are unexpected changes in the pts condition (e.g., pt becomes unstable, serious post-op complications, etc.)
3. Prepare divisional M&M on a bi-weekly basis. This list should include pt identifiers, including pt name, hx #, attending names, to be emailed to Dr. Anderson. All pt identifiers should then be removed before copies are made for the conference. Please also include uterine weights (when applicable), EBL on each case.
4. Prepare departmental M&M on a monthly basis.
5. Participate in medical student educational activities during the time they are on service. This includes discussing expectations at the beginning of the rotation, assigning pts and OR cases, assigning medical student topics for discussion, arranging times for informal educational conferences, and giving feedback on performance.
6. The CR should know about all gynecologic consults, including those seen in the ED at night. The CR should see all consults that are admitted from the ED and other inpt consults needing ongoing follow-up. The CR should actively participate in the consults (i.e., seeing, examining, and decision-making) when requested by Amy Lee CRNP or when she is not available or in other situations when warranted by the specific situation. It is the responsibility of the CR to ensure that all consults have been discussed with the Floor Attending.
7. Supervise the intern on service
8. Assign OR cases. This should be done the night before surgery.

**Expectations of the PGY 1 on the Gynecology service:**

1. Make daily rounds and other management of pts on service, as assigned by the CR. This includes writing notes, orders, evaluation of problems, dictation, etc.
2. Participate in surgical cases as assigned by the CR
3. See all consults (ED and inpatient) initially (unless in OR, clinic or Fri school). Perform history and basic examination; the pelvic exam should be done only under supervision (an exception may be made to this in some cases at the end of rotation at Amy Lee’s discretion). Discuss consults with Amy Lee and/or CR prior to formulating recommendations for further evaluation or management.
4. Participate in M&M, other educational conferences
5. Assist in medical student teaching.
6. Attend assigned clinics (FCC, continuity)

Expectations regarding surgical cases:
1. Review all assigned OR cases prior to surgery, including any available EPR notes, pathology, labs, radiology
2. Meet the pt in the preop area-review or complete H&P, consents. For initial cases (7:45 am) should ensure that all paper work is complete no later than 7:30 am.

Expectations of the Floor Attending:

1. Communicate with the CR on a daily basis about pts on service, consults, timing of rounds and conferences, etc.
2. Round on all housestaff and gyn division pts on a daily basis and write admission notes and daily attending notes.
3. Round at the bedside with residents and students at least 3 times during the week (teaching rounds).
4. Meet with the residents and students twice weekly for mini-didactic sessions.
5. Discuss all consults with Amy Lee and/or residents. The floor attending should see all consults who are inpatients with rare exceptions (e.g., pt on Psychiatry service with simple vaginal discharge) and should see ED consults when indicated.

Protocols for Consults on the Gynecology Service:

Appropriate consults include the following: (1) a gyn problem is identified or suspected that affects care or prognosis in a pt who is currently an inpatient; (2) a problem (including symptoms or findings on exam) is identified that may be a primary gyn condition and is of uncertain significance; (3) any request from the Pediatric or Adult ED to see and evaluate a woman presenting with signs or symptoms suggestive of a primary gyn process or when gyn pathology needs to be ruled out.

Ground Rules:

1. All consults must be directly communicated by a physician or midlevel provider (nurse practitioner, PA) on the pts. primary service. It is not acceptable for a consult to be requested/called in by a medical student, nurse, or other staff.
2. The primary service should have performed minimal evaluation of the problem generating the request for consult. This includes basic history and exam, excluding the pelvic exam. A request for consult should not be generated based only on pt request or observation by the patient’s nurse.
3. Requested consults must be problem-oriented (not routine care).
4. Consult form must be completed and in the chart.

Protocol:

During daytime hours M-F:

1. The PGY 1 on service will initially see and evaluate the pt, unless he/she is in OR, clinic, or resident school. If the intern is not available, the pt will be initially evaluated by Amy Lee, CRNP.
2. The PGY 1 will discuss the pt with Amy Lee (or with the CR, if she is not available) and they will complete the initial evaluation together, including pelvic
exam and formulate initial assessment and recommendations. A consult note will be written detailing pertinent findings, assessment and recommendations.

3. The Floor Attending for the week will be contacted to discuss further and determine official recommendations. The Floor Attending is responsible for seeing the pt., repeating history or exam, as indicated, and writing an attending note.

4. The Chief Resident on the service should be informed about each consult and be actively involved in the following circumstances:
   a. Amy Lee is not available
   b. The Floor Attending is unavailable for discussion
   c. At the request of the Floor Attending
   d. The pt needs or may need to go to the OR
   e. The pt is to be admitted to the GYN service
   f. The pt requires ongoing follow-up

5. A copy of the consult note will be kept in a binder on Weinberg 4-B.

6. All consults will be dictated into EPR.

At night/on weekends:

1. The pt will be initially evaluated by the PGY 1 or PGY 2 on call. IF PGY 1, pelvic exam should be done only under supervision.

2. The initial evaluation will be reviewed and discussed with the Chief Resident on call.

3. The CR will see and examine the pt in the following circumstances:
   a. Initial evaluation is by PGY 1
   b. As requested by the person doing initial evaluation
   c. Pt. may require admission or surgical management

4. The CR will discuss all inpt consults with the floor attending and all ED consults with the attending on call

5. The PGY 1 or 2 initially evaluating the pt will be responsible for dictating consult note
Learning Objectives

Training Level: PGY3
Rotation: Greater Baltimore Medical Center Gynecology

Educational Purpose:
During this rotation the PGY 3 resident will continue to expand their ability to manage gynecologic patients who presents for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. During this rotation the resident will develop more advanced skills in the cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of a wide range of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY 3 Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   • Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   • Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   • List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   • Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   • Describe the common vulvovaginidities
   • Identify the common benign vulvar lesions
   • Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
   • Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
- Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same
- Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention
- Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis
- Describe the treatment both medical and surgical of endometriosis
- Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
- Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
- Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

32. Patient Care (Clinical Skills)
- Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
  vi. Endometriosis
- Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
- Manage and counsel patients about post-operative recovery care
- Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
- Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
- Utilize sonography in the management of disorders in the first trimester of pregnancy
- Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
- The resident will demonstrate competence in performing
  o Operative laparoscopy
  o Complicated total abdominal hysterectomy
  o Appendectomy
- Repair of bowel or bladder injuries
- Surgery for pelvic inflammatory disease

- The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
  - Marsupialization of a Bartholin’s gland abscess
  - Laparoscopic tubal ligation
  - Ovarian cystectomy
  - Colposcopy and cervical biopsy

33. Patient Care (Management Skills)
- Develop an evidence based care plan for his/her patients
- Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as;
  - Abnormal bleeding
  - Pelvic pain
  - Sexually transmitted diseases
  - Pelvic inflammatory disease
  - Endometriosis
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
- Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
- Assist in the management of common postoperative complications such as;
  i. Fever
  ii. Gastrointestinal ileus/obstruction
  iii. Infection
  iv. Wound complications
  v. Fluid electrolyte imbalance
  vi. Respiratory problems
  vii. Thromboembolism

34. Practice Based Learning
- Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
- Incorporate formative and summative feedback to improve knowledge and skill base
- Maintain an updated gynecologic procedural log as detailed on the ACGME website
- Participate in gynecologic quality assurance activities (M&M) of the department
- Use personal experience with difficult and challenging patients to optimize future relationships with patients

35. Communication/Interpersonal Skills
- Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
- Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

36. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
- Demonstrate accountability for one’s action and clinical decisions
- Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
- Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
- Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

37. Systems Based Practice
- Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
- The resident will review the curriculum prior to the first day of the rotation. The PGY 3 resident will actively participate in:
  o Daily rounds
  o Daily didactic conferences
  o Weekly GBMC Grand Rounds
- Attendance at a wide variety of gynecologic procedures
  - All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback
  - Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills, the resident will progress from assisting at minor surgical procedures (e.g. hysteroscopy, D&C) to major abdominal/vaginal procedures

**Types of Clinical Encounters:**
- PGY 2 residents will participate in the gynecologic care of the patients cared for by the attending staff of GBMC
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

**Resident Supervision:**
- The resident will be under the supervision of his/her Chief Resident and an Attending physician at all times.

**Reading List:**
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

**Method of Evaluation:**
- Global evaluation of PGY 3 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
Educational Objectives for the PGY-3 Rotation in Gynecologic Oncology
The Kelly Gynecologic Oncology Service (KGOS)

Training Level: PGY3
Rotation: Gynecologic Oncology

A. Educational Purpose
Each PGY-3 resident will spend one block rotation assigned to the Gynecologic Oncology service, with responsibility for working in a cooperative manner with the PGY4 and gyn onc fellows, as well as supervising and teaching the PGY 1 and PGY 2 residents and third and fourth year medical students. The educational goals are that upon completion of residency, each resident will have a comprehensive knowledge base in the diagnosis and in the medical and surgical management of gynecologic cancers. He or she will be well prepared for general practice of obstetrics and gynecology and will be able to serve patients and the medical community in screening for gynecologic cancers and making appropriate referrals for subspecialty care. He or she would likewise be well prepared to enter post-residency training in this subspecialty area. Surgical skills and problem solving will be well developed. At the core of this educational experience for the third year resident is a set of cognitive and behavioral objectives outlined below, which will serve to assist the resident in the above areas.

B. Goals and Objectives

1. Cognitive:

a. Demonstrate a thorough knowledge of pelvic anatomy. Understand the normal anatomic relationships between the uterus/fallopian tubes/ovaries and other pelvic structures, as well as common variations seen under normal conditions and as seen in pathologic conditions, including ovarian and cervical cancer and in the post-radiation patient. Describe the vascular supply and drainage, lymphatic drainage, and neurologic supply of the pelvic organs.

b. Show an understanding of the role of genetics in reproductive cancers. Describe inheritance patterns, and know guidelines for screening for BRCA1 and BRCA2. Know the phases of the cell replication cycle most sensitive to radiation and chemotherapy.

c. Understand the epidemiology of and risk factors for gynecologic cancers. Be able to recommend to patients prevention and screening strategies based on their individual risk profile, taking into account family history, sexual and reproductive history, and environmental risk factors. Know the relative value of
various screening tests (Pap smear, Thin Prep, mammogram, etc.) in identifying patients with reproductive cancers as well as current recommendations for their use and the approximate costs of such testing.

d. Describe the general principles of, indications for, and mechanisms of action of radiation therapy for reproductive cancers. Recognize how decisions are made regarding use and dose of radiation therapy, and be able to recognize potential complications of radiation therapy.

e. Describe the principles of palliative care, including various modalities for palliation of cancer symptoms in terminally ill women. Know the indications for and the medical, ethical and legal consequences of a “Do Not Resuscitate” order. Be able to manage pain in the setting of terminal care.

2. Behavioral:

a. Elicit a complete history and physical examination from the patient presenting with signs and/or symptoms of gynecologic malignancy (vulvar, vaginal, cervical, uterine, ovarian). Perform competent breast examination. Perform complete pelvic examination including cervical cytology, appropriate biopsies, and collection of microbiologic specimens. Present findings to attending or fellow physician and include a working diagnosis and treatment plan. Explain the plans and rationale to the patient in appropriate, culturally sensitive terms.

b. Perform and interpret the results of common office or bedside procedures relevant to the patient with gynecologic cancer, including but not limited to the below. Describe the procedure and potential complications to the patient in understandable terms.
   - Microscopic evaluation of vaginal discharge
   - Biopsy of vulvar, vaginal or cervical lesion
   - Endometrial biopsy
   - Paracentesis
   - Thoracentesis

c. Based upon all relevant data, including physical findings and histopathologic studies, accurately stage reproductive cancers of all varieties.

d. Perform appropriate preoperative evaluation and post-operative care for gynecologic oncology surgery patients, including major and minor procedures. Counsel patients regarding surgical and non-surgical options when such options exist, giving proper weight to the priority of these options. Recognize the indications for preoperative medical clearance, obtain such clearance when indicated, and accurately identify the patient whose medical problems make her not a surgical candidate. Describe the procedures and potential complications to the patient in understandable terms.
e. Perform, under attending physician supervision, the following surgical procedures:
   - Hysterectomy, abdominal
   - Hysterectomy, vaginal
   - Removal of adnexa, in conjunction with hysterectomy or separately in the appropriate clinical setting
   - Staging laparotomy, including cytologic washings, peritoneal biopsies, upper abdominal exploration, and infracolic omentectomy
   - Wide local excision of vulvar lesions

Assist with, and perform at attending physician discretion, the following surgical procedures:
   - Hysterectomy, radical
   - Lymph node dissection, pelvic and paraaortic
   - Resection of large and small bowel
   - Colostomy

Provide instruction to junior residents in the achievement of learning objectives in the surgical arena, and assist them in developing the skills of a good surgical assistant for the above procedures. Dictate and review operative notes for these procedures.

C. Objective Grid

Following is a grid diagram that cross-references each of the objectives listed above to the six general competencies, and lists the assessment tools to be used for each of the learning objectives.

Patient Care – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Medical Knowledge – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Practice-based Learning and Improvement – Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Interpersonal and Communication Skills – Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.
Professionalism – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-based Practice – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
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* assessment, focused assessment of competency, 360° evaluation
Rotation Structure

The PGY3 resident will review the curriculum prior to the first day of the rotation. The PGY3 resident will actively participate in the following activities:
- Daily attending rounds
- Surgical procedures for the KGOS
- Gyn Oncology clinics
- Weekly Gyn/Gyn Onc Professor’s rounds
- Weekly Morbidity and Mortality Conferences
- Weekly Colposcopy correlation conference
- Weekly Tumor Board

Resident Supervision

The resident’s daily activities fall under the management of the PGY4 on the Oncology service, the Gyn Oncology fellow and KGOS faculty; this provides opportunity for immediate feedback.

Patient examinations, diagnostic procedures and surgical procedures are performed under the direct supervision of an attending physician at all times.

Reading List

The educational materials for this rotation consist of:
- TeLinde’s Operative Gynecology, Rock and Thompson, 2003
- DeSaia and Creasman, Gynecologic Oncology
- The KGOS notebook of key readings in Gyn Oncology
- Pertinent ACOG Educational and Practice Bulletins (page references are from the 2005 Compendium)
  - Diagnosis and Treatment of Cervical Carcinomas, PB 35, pp. 390-402.

Methods of Evaluation

- Residents will receive on-site timely formative feedback from the fellow and attending physician(s) during this rotation.
- Global evaluations of PGY-3 resident is performed at the completion of the block by the KGOS faculty and reflect input from the attending staff, nurses and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents' obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- See also grid above
**Learning Objectives**

Training Level: PGY3  
Rotation: Johns Hopkins Bayview Gyn/Ob - nights

**Educational Purpose**

The PGY-3 Gyn/Ob experience at the Bayview campus is a key part of the residents' development of the ability to function as an independent gynecologist/obstetrician. In this rotation the resident acquires the skills necessary for management of routine and high-risk obstetrical patients during the intrapartum and postpartum periods and develops more advanced skills in the management of gynecologic patients and patients presenting to the emergency department with gynecologic complaints. They also develop skills required to competently supervise and educate junior residents. Residents develop competence with performance of advanced obstetrical procedures as well as major and minor gynecologic surgeries.

**Goals and Objectives**

By completion of the PGY-3 year, the resident should demonstrate skillful management of intrapartum, postpartum and gynecologic patients, as described within the context of the ACGME core competencies.

The resident should be able to:

39. **Medical Knowledge**

- Describe the impact of pregnancy on maternal medical conditions, and conversely, the impact of various maternal medical conditions upon pregnancy outcome.
- Implement appropriate medical and surgical management for patients with medical complications of pregnancy.
- Describe the risk factors for, etiologies of, complications of, and management of late trimester pregnancy loss, intrauterine growth restriction, intrauterine fetal demise, preterm labor and PPROM.
- Perform and interpret assessments of fetal well-being, including: non-stress testing, contraction stress testing, biophysical profile, fetal scalp stimulation, vibroacoustic stimulation, scalp pH testing.
- Describe the factors that predispose to multiple gestation, diagnose multiple gestation by physical findings and sonographic examination, manage complications associated with multiple gestation, and develop proper delivery plans for such.
• Describe the appropriate criteria for and contraindications to VBAC, and recognize and treat possible complications.

• Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.

• Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding

• List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding

• Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods

• Describe the common vulvovaginitides

• Identify the common benign vulvar lesions

• Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV

• Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention

• Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same

• Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention

• Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis

• Describe the treatment both medical and surgical of endometriosis

• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management

• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy

• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis
40. **Patient Care (Clinical Skills)**

- Perform uncomplicated operative vaginal deliveries with attending physician supervision.
- Demonstrate skillful repair of third and fourth degree perineal lacerations, cervical and vaginal lacerations.
- Appropriately manage obstetrical emergencies
  - i. obstetrical hemorrhage
  - ii. shoulder dystocia
  - iii. fetal bradycardia
  - iv. uterine rupture
  - v. trauma
- Perform external cephalic version with attention to potential maternal and/or fetal complications.
- Demonstrate level-appropriate skills in cesarean delivery.
- Demonstrate competence as a surgical assistant during the performance of cesarean hysterectomy.
- Perform a comprehensive work up for intrauterine fetal demise, and properly manage labor induction or uterine evacuation for the patient with an IUFD.
- Accurately assess the obstetrical patient with multiple gestation, including fetal growth assessment, fetal positioning, and delivery plan.
- Deliver routine prenatal care to high risk obstetrical patients in the outpatient setting
- Manage an infected or dehisced operative incision, and demonstrate adequate wound care treatment.

**Patient Care (Management Skills)**

- Multi-task and triage the care of all antepartum and intrapartum patients in the labor and delivery unit.
- Multi-task and manage intern and medical student staff for the best utilization of manpower.
- Respond to acute intrapartum 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 intern, medical student and nursing student education.
- Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  - i. Abnormal bleeding
  - ii. Pelvic pain
  - iii. Pelvic mass
  - iv. Sexually transmitted diseases
  - v. Pelvic inflammatory disease
  - vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Function as the primary assistant in the performance of more advanced gynecologic surgical procedures
• The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
  o Dilation and curettage
  o Diagnostic laparoscopy
  o Marsupialization of a Bartholin’s gland abscess
  o Laparotomy
  o Ovarian cystectomy
  o Operative laparoscopy

41. 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.
• Keep an updated patient log as detailed in the ACGME website.
• Participate in quality assurance activities of the department.
• Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

42. Communication/Interpersonal Skills
• Present pertinent history and physical findings to team members and consultants in a clear, concise fashion.
• Demonstrate caring and respectful interactions with the obstetrical 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.

### 43. Professionalism
- Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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.

### 44. 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 and L&D 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

#### Types of Clinical Encounters
PGY-3 residents are responsible for the supervision of the care of all patients presenting to the triage area of Labor and Delivery and the inpatient management of laboring and post-partum patients. In addition, the PGY3 will supervise the junior resident’s assessment of gynecologic patients on the inpatient service for whom there are medical needs that require attention and for patients in the Emergency Department who require gynecologic evaluation. A wide variety of both normal / physiologic and abnormal obstetrical and gynecologic pathology is encountered in these patients.
Rotation Structure
The PGY-23 resident will review the curriculum prior to the first day of the rotation.
The PGY-3 resident will actively participate in:
- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB/Gyn Practice Based Learning and Improvement Conf (daily).

Resident Supervision
Deliveries and surgical procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

Reading List and Educational Materials
- William’s Obstetrics or Gabbe
- Novak’s textbook of Gynecology
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

Method of Evaluation
- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-3 residents are performed at the completion of the 6 week block by the Bayview faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- Residents’ procedural skills will be assessed after each index procedure using the on-line C-BASS evaluation tool (OSATS)
Learning Objectives

Training Level: PGY3
Rotation: High Risk Obstetrics (MFM) Service

Educational Purpose
In this rotation the resident develops the educational foundation necessary for management of high-risk antepartum patients in both the inpatient and outpatient setting. Residents acquire the knowledge to properly counsel patients regarding their risk for various medical and obstetrical conditions, as well as make recommendations for their management / treatment and possible future interventions. Residents participate in the performance of invasive prenatal diagnostic techniques (amniocentesis, cvs, fetal blood sampling). Exposure to antepartum outpatient care is achieved by regular attendance at high-risk prenatal clinics at both the JHOC Women’s Health Center and the Johns Hopkins Bayview Medical Center.

Goals and Objectives
By completion of the MFM rotation, the resident should demonstrate skillful management of antepartum patients, as described within the context of the six core competencies.

The resident should be able to:

45. Medical Knowledge
- Describe the basic structure and replication of DNA, and the clinical significance of karyotype abnormalities.
- Distinguish between various forms of genetic inheritance and describe the clinical significance of heritable diseases.
- Describe the possible teratogenic effects of various prescription and non-prescription drugs.
- Describe the indications for, and limitations of, noninvasive diagnostic screening tests for fetal aneuploidy and structural malformations.
- Describe the risks and benefits of various methods of invasive fetal testing, including: amniocentesis, CVS, PUBS.
- Detail appropriate medical and surgical management for patients with medical complications of pregnancy.
- Describe the factors that predispose to multiple gestation, and demonstrate understanding of the different types of twinning.
- Describe modalities used to determine fetal lung maturity status.
- Describe the association between genital tract infection and adverse perinatal outcomes.
• Demonstrate knowledge of the White Classification of diabetes in pregnancy, interpret screening tests for gestational diabetes, and demonstrate understanding of methods of blood sugar control (diet and medical).

46. Patient Care (Clinical Skills)
• Elicit a history for inherited disorders, ethnic- or race-specific risks, and teratogen exposure.
• Demonstrate the ability to counsel a patient regarding...
  i. the impact of pregnancy on maternal medical conditions
  ii. the impact of maternal medical conditions upon pregnancy outcome
  ▪ future reproduction and the long-term health implications of patients with a chronic medical condition
  ▪ management options for a pregnancy with an abnormal fetus
  ▪ risks for recurrence of adverse fetal outcomes and interventions possible for subsequent pregnancies
  ▪ fetal effects of indicated diagnostic studies utilizing radiation
  ▪ indications for, and limitations of, noninvasive diagnostic screening tests for fetal aneuploidy and structural malformations
  ▪ risks and benefits of various methods of invasive fetal testing
• Order and interpret appropriate maternal and fetal/neonatal tests to evaluate possible causes of adverse pregnancy outcomes.
• Perform and interpret antepartum diagnostic tests accurately and integrate the interpretation of such tests into clinical management algorithms.

Patient Care (Management Skills)
• Assess, diagnose, and manage fetal and/or maternal complications of all antepartum inpatients on the Obstetrics Unit.
• Continually update patient care team (attending physician, nursing staff, NICU staff, anesthesia, etc) on status of patient(s).
• Monitor and manage the blood sugar of High Risk Ob outpatients with diabetes.
• Accurately assess the obstetrical patient with multiple gestation, including fetal growth assessment, fetal position, and delivery plan.
47. 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.
- Keep an updated patient log as detailed in the ACGME website.
- Participate in quality assurance activities (M&M) of the department.
- Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

48. Communication/Interpersonal Skills
- Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion.
- Demonstrate caring and respectful interactions with the obstetrical 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.
- Counsel other health care professionals about fetal effects of indicated diagnostic studies utilizing radiation.

49. Professionalism
- Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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 when applicable.

50. 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 and L&D 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.

Types of Clinical Encounters
Residents on the MFM service interact with and are responsible for the care of both resident service and private practice attending physicians’ patients in the inpatient hospital setting. A wide variety of obstetrical pathology is encountered in these antepartum patients. The MFM resident will be responsible for managing a variety of medical conditions complicating pregnancy, including:

- Diabetes mellitus
- Diseases of the urinary system
- Infectious diseases and HIV
- Hematologic disorders
- Cardiopulmonary disease
- Gastrointestinal disease
- Neurologic disease
- Endocrine disorders
- Collagen vascular disorders
- Psychiatric disorders
- Substance abuse
- Critical care / trauma

In addition, the MFM resident will become proficient in the diagnosis and management of various pregnancy related complications, including:

- Fetal anomalies and genetic syndromes
- Cervical incompetence
- Second and third trimester bleeding
- Multi-fetal gestation
- Pre-term labor, PPROM, and infection
- Disorders of amniotic fluid volume
- Isoimmunization
- Hypertensive disorders of pregnancy
- Fetal growth restriction
Rotation Structure
The resident will review the curriculum prior to the first day of the rotation.
The MFM resident will actively participate in:

- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB Practice Based Learning and Improvement Conf (daily).
- Fetal Heart Rate Monitoring “strip rounds” (weekly)
- Weekly JHH High Risk Ob Clinic
- Weekly JH Bayview High Risk Ob Clinic
- Weekly MFM-Genetics Conference
- Weekly MFM Conference
- Weekly MFM Sono Conference

Resident Supervision
The resident’s daily activities fall under the management of the Director of Maternal-Fetal Medicine and the MFM faculty; this provides opportunity for immediate feedback.
Procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

Reading List and Educational Materials
- Maternal Fetal Medicine, Creasy
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation

Method of Evaluation
- Residents will receive on-site timely formative feedback from the MFM attending physician(s) during this rotation.
- Global evaluations of PGY-3 residents are performed at the completion of the 6 week block by the MFM faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Nursing staff will complete evaluations of selected skills of each resident at the completion of each block.
- Cognitive assessment of the residents’ obstetrical skills is achieved by the obstetrical score from the CREOG examination.
Educational Objectives for the PGY-3 Rotation in Gynecologic Oncology
at the Greater Baltimore Medical Center

Training Level: PGY3
Rotation: Gynecologic Oncology

A. Educational Purpose
Each PGY-3 resident will spend one block rotation assigned to the Gynecologic Oncology service at GBMC with responsibility for leading the clinical activities of the service in a cooperative manner with the clinical fellow. The educational goals are that upon completion of residency, each resident will have a comprehensive knowledge base in the diagnosis and in the medical and surgical management of gynecologic cancers. He or she will be well prepared for general practice of obstetrics and gynecology and will be able to serve patients and the medical community in screening for gynecologic cancers and making appropriate referrals for subspecialty care. He or she would likewise be well prepared to enter post-residency training in this subspecialty area. Surgical skills and problem solving will be well developed. At the core of this educational experience for the fourth year resident is a set of cognitive and behavioral objectives outlined below, which will serve to assist the resident in the above areas.

B. Goals and Objectives

1. Cognitive:

   a. Demonstrate a thorough knowledge of pelvic anatomy. Understand the normal anatomic relationships between the uterus/fallopian tubes/ovaries and other pelvic structures, as well as common variations seen under normal conditions and as seen in pathologic conditions, including ovarian and cervical cancer and in the post-radiation patient. Describe the vascular supply and drainage, lymphatic drainage, and neurologic supply of the pelvic organs.

   b. Show an understanding of the role of genetics in reproductive cancers. Describe inheritance patterns, and know guidelines for screening for BRCA1 and BRCA2. Know the phases of the cell replication cycle most sensitive to radiation and chemotherapy.

   c. Understand the epidemiology of and risk factors for gynecologic cancers. Be able to recommend to patients prevention and screening strategies based on their individual risk profile, taking into account family history, sexual and reproductive history, and environmental risk factors. Know the relative value of various screening tests (Pap smear, Thin Prep, mammogram, etc.) in identifying
patients with reproductive cancers as well as current recommendations for their use and the approximate costs of such testing.

d. Describe the general principles of, indications for, and mechanisms of action of radiation therapy for reproductive cancers. Recognize how decisions are made regarding use and dose of radiation therapy, and be able to recognize potential complications of radiation therapy.

e. Describe the principles of palliative care, including various modalities for palliation of cancer symptoms in terminally ill women. Know the indications for and the medical, ethical and legal consequences of a “Do Not Resuscitate” order. Be able to manage pain in the setting of terminal care.

2. Behavioral:

a. Elicit a complete history and physical examination from the patient presenting with signs and/or symptoms of gynecologic malignancy (vulvar, vaginal, cervical, uterine, ovarian). Perform competent breast examination. Perform complete pelvic examination including cervical cytology, appropriate biopsies, and collection of microbiologic specimens. Present findings to attending or fellow physician and include a working diagnosis and treatment plan. Explain the plans and rationale to the patient in appropriate, culturally sensitive terms.

b. Perform and interpret the results of common office or bedside procedures relevant to the patient with gynecologic cancer, including but not limited to the below. Describe the procedure and potential complications to the patient in understandable terms.
   - Microscopic evaluation of vaginal discharge
   - Biopsy of vulvar, vaginal or cervical lesion
   - Endometrial biopsy
   - Paracentesis
   - Thoracentesis

c. Based upon all relevant data, including physical findings and histopathologic studies, accurately stage reproductive cancers of all varieties.

d. Perform appropriate preoperative evaluation and post-operative care for gynecologic oncology surgery patients, including major and minor procedures. Counsel patients regarding surgical and non-surgical options when such options exist, giving proper weight to the priority of these options. Recognize the indications for preoperative medical clearance, obtain such clearance when indicated, and accurately identify the patient whose medical problems make her not a surgical candidate. Describe the procedures and potential complications to the patient in understandable terms.
e. Perform, under attending physician supervision, the following surgical procedures:

- Hysterectomy, abdominal
- Hysterectomy, vaginal
- Removal of adnexa, in conjunction with hysterectomy or separately in the appropriate clinical setting
- Staging laparotomy, including cytologic washings, peritoneal biopsies, upper abdominal exploration, and infracolic omentectomy
- Wide local excision of vulvar lesions

Assist with, and perform at attending physician discretion, the following surgical procedures:

- Hysterectomy, radical
- Lymph node dissection, pelvic and paraaortic
- Resection of large and small bowel
- Colostomy

Provide instruction to junior residents in the achievement of learning objectives in the surgical arena, and assist them in developing the skills of a good surgical assistant for the above procedures. Dictate and review operative notes for these procedures.

C. Objective Grid

Following is a grid diagram that cross-references each of the objectives listed above to the six general competencies, and lists the assessment tools to be used for each of the learning objectives.

Patient Care – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Medical Knowledge – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Practice-based Learning and Improvement – Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Interpersonal and Communication Skills – Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.
Professionalism – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-based Practice – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
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<th>Learning Objective</th>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Practice-based learning and improvement</th>
<th>Interpersonal / communication skills</th>
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Rotation Structure

The PGY3 resident will review the curriculum prior to the first day of the rotation. The PGY3 resident will actively participate in the following activities:

- Daily attending rounds
- Surgical procedures for the GBMC Gyn Oncology service
- Gyn Oncology office hours with Dr. Grumbine
- Daily resident educational conferences led by gyn faculty

Resident Supervision

The resident's daily activities fall under the management of the Gyn Oncology fellow and Gyn Oncology faculty; this provides opportunity for immediate feedback.

Patient examinations, diagnostic procedures and surgical procedures are performed under the direct supervision of an attending physician at all times.

Reading List

The educational materials for this rotation consist of:

- TeLinde’s Operative Gynecology, Rock and Thompson, 2003
- DeSaia and Creasman, Gynecologic Oncology
- The KGOS notebook of key readings in Gyn Oncology
- Pertinent ACOG Educational and Practice Bulletins (page references are from the 2005 Compendium)
  - Diagnosis and Treatment of Cervical Carcinomas, PB 35, pp. 390-402.

Methods of Evaluation

- Residents will receive on-site timely formative feedback from the fellow and attending physician(s) during this rotation.
- Global evaluations of PGY-3 resident is performed at the completion of the block by the GBMC Gyn Oncology faculty and reflect input from the attending staff, nurses and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- See also grid above
Resident Level: PGY3

Howard County Hospital Gynecology Rotation Resident Curriculum

Goals and Objectives

The PGY3 resident assigned to Howard County will participate in a general gynecology rotation of 5-6 weeks in duration. Rotation experiences will include major and minor gynecologic surgery including the pre-operative and post-operative portions of these patients’ care. Educational objectives are organized according to ACGME/RRC competencies.

Medical knowledge

Scientific Reasoning
- Demonstrate a sound understanding of the basic science background of reproductive medicine and apply this knowledge to the clinical care of gynecology patients.
- Demonstrate the ability to use the scientific method and the deductive reasoning process.

Anatomy
- Describe the anatomic relationship between the reproductive organs and the nongynecologic abdominal viscera.
- Describe the gross and histologic anatomy of the external genitalia, including arterial blood supply, venous and lymphatic drainage, neurologic innervation.
- Describe the gross and histologic anatomy of the pelvic viscera, including arterial blood supply, venous and lymphatic drainage, and neurologic innervation.

Specific Diseases:

ENDOMETRIOSIS
- Describe the theories of the pathogenesis of endometriosis
- Describe the typical history of a patient with endometriosis

ECTOPIC PREGNANCY
- Describe the indications for, and complications of, surgical management of an ectopic pregnancy
- Describe the long-term follow-up that is indicated for a patient treated for an ectopic pregnancy
- Counsel patients regarding the recurrence risk for an ectopic pregnancy and prognosis for a normal intrauterine pregnancy.
PELVIC MASSES
➤ Describe the appropriate follow-up, specific to the diagnosis, for patients who have been treated for a benign pelvic mass.

CHRONIC PELVIC PAIN
➤ Describe the appropriate long-term follow-up for a patient with chronic pelvic pain

PELVIC SUPPORT DEFECTS & UROGYNECOLOGIC DISORDERS
➤ Describe the normal anatomic support and dynamics of the vagina, rectum, bladder, urethra, and uterus.
➤ Describe the principal etiologies of pelvic support defects
➤ Describe the major suspected causes of urogynecologic disorders, such as: obesity, pulmonary disease, multiparity, medications, and infection
➤ Describe the typical symptoms experienced by a patient with a urogynecologic disorder
➤ Describe the appropriate follow-up for a patient who has been treated for a pelvic support defect.

Patient Care
➤ Perform a complete and accurate medical history and physical examination of:
  o A patient with a pelvic mass
  o A patient with chronic pelvic pain
  o A patient with abnormal vaginal bleeding
  o A patient with primary infertility and a patient with secondary infertility
  o A patient with suspected endometriosis
  o A patient with a suspected pelvic support defect to include identification of:
    ▪ cystocele and urethrocele
    ▪ rectocele and enterocele
    ▪ uterine descensus or vaginal vault prolapse

➤ Interpret the results of diagnostic tests to include
  o serum human chorionic gonadotropin (hCG) titer and pattern
  o pelvic sonography
  o endometrial biopsy
  o cervical biopsies
  o laparoscopic biopsy
  o histopathology of intrauterine contents and tubal contents in pregnant patients

➤ Make an initial diagnosis and evidence-based decisions on the management of
- A patient with abnormal uterine bleeding
- A patient with a possible spontaneous abortion
- A patient with a possible ectopic pregnancy

Prescribe medications in a rational, thoughtful and safe manner.

Safely and correctly perform the following surgical procedures:
- Trochar placement and tissue identification for diagnostic laparoscopy
- Pfannensteil and midline abdominal entry and closure for laparotomy
- Hysterectomy – abdominal, vaginal, and laparoscopically assisted
- Myomectomy, abdominal and laparoscopic
- Oophorectomy, abdominal and laparoscopic
- Salpingostomy, abdominal and laparoscopic
- Salpingectomy, abdominal and laparoscopic
- Tubal sterilization, laparoscopic
- Laparoscopic ablation and excision of endometrial implants
- Lysis of adhesions, abdominal and laparoscopic
- Hysteroscopy, diagnostic
- Ablative procedures (cervix, endometrium, vagina, vulva)
- Colporrhaphy, anterior and posterior, with perineorrhaphy
- Conization, cold knife and loop electrical excision

Interpersonal and Communication Skills

- Communicate effectively with other healthcare professionals.
- Communicate with patients and their families in easily understood and culture-sensitive language.
- Work effectively as a member of a professional group.
- Consistently demonstrate sensitivity to patients from different cultures.

Maintain comprehensive, timely, and legible medical records

Practice-based learning and improvement

Demonstrate the ability to use information technology and feedback to improve the practitioner's fund of knowledge and technical skills and, ultimately, provide a better care to patients.

Systems-based practice

Demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care of optimal value. Residents are expected to:
- Practice cost-effective healthcare and resource allocation that does not compromise quality of care.
o Advocate for quality of patient care and assist patients in dealing with system complexities.
o Know how to partner with healthcare managers and providers to assess, coordinate, and improve healthcare and know how these activities can affect system performance.

Evaluation Strategies

Learner Evaluation
The residency program uses a number of assessment tools to provide residents with feedback on progress in professional development as clinicians. Residents on the Howard County Gynecology block will be assessed using an attending global rating form and a procedure mastery form. This form will be completed by the Chair of the Department of Obstetrics and Gynecology in consultation with the other members of the department at the conclusion of the resident’s block.

Program Evaluation
Residents are required to keep an electronic log of each of their surgical cases. These logs are reviewed on a semi-annual basis by the Program Director and are used to assess surgical volumes provided by each resident rotation.

At the conclusion of each block (q 5-6 weeks) the resident completes a rotation evaluation form. The Program Director and Residency Education Committee reviews the evaluations of each clinical rotation on a semi-annual basis.

Supervision
The resident will function under the direct supervision of the Chair of the Department of Obstetrics and Gynecology and the private attending physicians of Howard County Hospital.

Recommended Introductory Reading and References

Droegemueller: Comprehensive Gynecology
TeLinde’s Operative Gynecology
Speroff and Daney: Clinical Guide for Contraception
Azziz: Operative Laparoscopy and Hysteroscopy
Walters and Karram: Urogynecology and Reconstructive Pelvic Surgery
Nichol: Vaginal Surgery
Learning Objectives

Training Level: PGY4
Rotation: Hopkins Hospital Obstetrics Service

Educational Purpose

The PGY-4 obstetrical experience is the culmination of the knowledge base and clinical skill sets developed during the preceding three years. In this rotation the chief resident perfects their management of routine and high-risk obstetrical patients during the antepartum, intrapartum and postpartum periods. Mastery of obstetric and surgical procedures is accomplished during this time. The chief resident is afforded the most technically difficult procedures and supervisory responsibilities are also developed. The chief resident is responsible for the direction and training of all junior residents and medical students rotating on the obstetrics service.

Goals and Objectives

The chief resident continues to practice and further perfect the same competencies achieved during the preceding three years of training, but now performs at a higher level of excellence. By completion of the PGY-4 year, the resident will possess the ability and confidence to function as an independent practitioner of obstetrics.

In addition to the competencies listed in the curricula of the PGY 1-3 years, the chief resident should also be able to:

51. Medical Knowledge
   - Possess a sufficient knowledge base as to function as an independent practitioner of obstetrics.
   - Successfully complete the ABOG written examination at the completion of the PGY-4 year.
   - Counsel patients regarding disease mechanisms, risk factors, pregnancy physiology, fetal anomalies, obstetric complications, care interventions, obstetrical and/or surgical procedures, and postpartum care.

52. Patient Care (Clinical Skills)
   - Perform all obstetric procedures competently and independently (but with appropriate attending physician supervision) as to be credentialed for future attending level appointment.
• Appropriately manage both routine and high-risk obstetrical patients during the antepartum, intrapartum, and postpartum periods.

Patient Care (Management Skills)
• Multi-task and triage the care of all patients cared for on the labor and delivery suite as well as those on the obstetrical inpatient floors
• Supervise and manage junior resident and medical student staff for the best utilization of manpower.
• Continually update the patient care team (attending physicians, junior residents, nursing staff, NICU staff, anesthesia, etc) on status of patient(s).

53. 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.
• Keep an updated patient log as detailed in the ACGME website.
• Participate in quality assurance activities of the department.
• Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

54. Communication/Interpersonal Skills
• Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion.
• Demonstrate caring and respectful interactions with the obstetrical 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.

55. Professionalism
• Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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.

56. 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 and L&D 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.

Types of Clinical Encounters
PGY-4 residents interact are responsible (as if they were the patient’s attending physician) for the care of Women’s Health Center (clinic) patients. A wide variety of both normal / physiologic and abnormal obstetrical pathology is encountered in these antepartum, intrapartum, and postpartum patients.

Rotation Structure
The PGY-4 resident will review the curriculum prior to the first day of the rotation.

The PGY-4 resident will actively participate in:
• 7:00 am Interdisciplinary Obstetrics Rounds (daily).
• OB Practice Based Learning and Improvement Conf (daily).
• Fetal Heart Rate Monitoring “strip rounds” (weekly)
• OB Morbidity and Mortality case presentations (monthly)
• The PGY4 will attend the weekly MFM clinical conferences and sono conferences as his or her patient care responsibilities allow.
• At all other times, it is expected that the PGY-4 resident will remain on the patient care floors involved directly with patient care encounters.
Resident Supervision
Deliveries and procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

Reading List and Educational Materials
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

Method of Evaluation
- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-4 residents are performed at the completion of the 6 week block by the MFM faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Nursing staff will complete evaluations of selected skills of each resident at the completion of each block.
- Cognitive assessment of the residents’ obstetrical skills is achieved by the obstetrical score from the CREOG examination.
Training Level: PGY4  
Rotation: Johns Hopkins Bayview Gynecology Service

Educational Purpose:
During this rotation the PGY 4 resident will continue to expand their ability to manage gynecologic patients who presents for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. The resident will develop more advanced skills in the cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of a wide range of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY 4 Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
- Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
- Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding.
- List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding.
- Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods.
- Describe the common vulvovaginidities.
- Identify the common benign vulvar lesions.
- Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV.
- Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention.
- Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same.
• Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention
• Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis
• Describe the treatment both medical and surgical of endometriosis
• Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management
• Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy
• Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

38. Patient Care (Clinical Skills)
• Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  i. Abnormal bleeding
  ii. Pelvic pain
  iii. Pelvic mass
  iv. Sexually transmitted diseases
  v. Pelvic inflammatory disease
  vi. Endometriosis
• Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent
• Manage and counsel patients about post-operative recovery care
• Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion
• Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient
• Utilize sonography in the management of disorders in the first trimester of pregnancy
• Function as the primary assistant in the performance of advanced gynecologic surgical procedures
• The resident will demonstrate competence in performing
  o Operative laparoscopy
  o Complicated total abdominal hysterectomy
  o Appendectomy
  o Repair of bowel or bladder injuries
  o Surgery for pelvic inflammatory disease
The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures:

- Marsupialization of a Bartholin’s gland abscess
- Laparoscopic tubal ligation
- Ovarian cystectomy
- Colposcopy and cervical biopsy
- Incision & Drainage of a Bartholin’s abscess with placement of a Word catheter
- Endometrial aspiration biopsy
- Vulvar biopsy
- Hysteroscopy
- Dilation and Curettage
- Suction Curettage
- Diagnostic and operative laparoscopy
- Laparoscopic sterilization
- Surgical management of ectopic pregnancy
- Laparotomy
- Lysis of adhesions
- Total abdominal hysterectomy and bilateral salpingoophorectomy
- Myomectomy
- Cervical conization
- Appendectomy
- Repair of bowel or bladder injuries
- Surgery for pelvic inflammatory disease

39. Patient Care (Management Skills)

- Develop an evidence based care plan for his/her patients
- Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as:
  - Abnormal bleeding
  - Pelvic pain
  - Sexually transmitted diseases
  - Pelvic inflammatory disease
  - Endometriosis
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
- Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
• Assist in the management of common postoperative complications such as;
  i. Fever
  ii. Gastrointestinal ileus/obstruction
  iii. Infection
  iv. Wound complications
  v. Fluid electrolyte imbalance
  vi. Respiratory problems
  vii. Thromboembolism

40. Practice Based Learning
• Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
• Incorporate formative and summative feedback to improve knowledge and skill base
• Maintain an updated gynecologic procedural log as detailed on the ACGME website
• Participate in gynecologic quality assurance activities (M&M) of the department
• Use personal experience with difficult and challenging patients to optimize future relationships with patients

41. Communication/Interpersonal Skills
• Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
• Counsel patients in language and manner that is appropriate to her educational background and emotional needs
• Inform patients and designated individuals of pertinent medical developments and complications
• Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

42. Professionalism
• Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
• Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
• Demonstrate accountability for one’s action and clinical decisions
• Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
• Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
• Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

43. Systems Based Practice
• Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
• The resident will review the curriculum prior to the first day of the rotation.
• The PGY 4 resident will actively participate in:
  o Daily rounds
  o OB/Gyn Practice Based Learning and Improvement Conf (daily).
  o Weekly Morbidity and Mortality conference
  o Attendance at a wide variety of gynecologic procedures
• The PGY4 is considered the “Chief Resident” of the Gynecology service and is responsible for the education, supervision and evaluation of the medical students and junior residents on the gyn team.
• All procedures are performed under direct supervision by an attending physician. This provides the opportunity for immediate formative feedback
• Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills.

Types of Clinical Encounters:
• PGY 4 residents will participate in the gynecologic care of all patients on the Johns Hopkins Bayview gynecology service (house staff, faculty and private patients)
• Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

Resident Supervision:
• The resident will be under the supervision of the faculty attending physician at all times.

Reading List:
• Up to Date (available to all residents)
• Comprehensive Gynecology - Droegmuller
• Te Linde’s Operative Gynecology
Method of Evaluation:

- Global evaluation of PGY 4 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
- Cognitive assessment of the residents’ obstetrical and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- Residents’ procedural skills will be assessed after each index procedure using the on-line C-BASS evaluation tool (OSATS).
Learning Objectives

Training Level: PGY4
Rotation: Greater Baltimore Medical Center Gynecology

Educational Purpose:
During this rotation the PGY 4 resident will continue to expand their ability to manage gynecologic patients who presents for surgery, inpatient management or assessment of acute gynecologic complaints to the emergency department. During this rotation the resident will develop advanced skills in the cognitive, attitudinal, technical and psychomotor skills necessary for the diagnosis and management of a wide range of gynecologic problems.

Competencies, Goals and Objectives:
By the completion of the PGY 4 Gynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge
   • Describe the etiology diagnosis and management for common gynecologic problems including: abnormal/dysfunctional bleeding, threatened abortion, pelvic pain, evaluation of the pelvic mass, first trimester pregnancy loss, and sexually transmitted disease.
   • Describe the principle causes of abnormal uterine bleeding and distinguish abnormal uterine bleeding from dysfunctional uterine bleeding
   • List the laboratory and diagnostic tests which are helpful in the management of abnormal/dysfunctional bleeding
   • Outline the therapeutic modalities for the treatment of abnormal/dysfunctional uterine bleeding using both surgical and non-surgical methods
   • Describe the common vulvovaginidities
   • Identify the common benign vulvar lesions
   • Discuss the pathogenesis, epidemiology, diagnosis and treatment of sexually transmitted disease including; chlamydia, gonorrhea, syphilis, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), herpes simplex, and HPV
   • Outline the diagnostic criteria for pelvic inflammatory disease and discuss appropriate therapeutic intervention
Outline the major causes of the pelvic mass and the diagnostic tests which assist in the evaluation of same

Define chronic pelvic pain; outline the various causes; list the tests useful in establishing the diagnosis; and discuss the indications for surgical and non-surgical intervention

Summarize the theories of pathogenesis of endometriosis and the typical clinical history of a patient with endometriosis

Describe the treatment both medical and surgical of endometriosis

Discuss first trimester pregnancy loss including the differential diagnosis, the principle causes, the use of appropriate laboratory/ultrasound testing and the clinical management

Describe the major factors that predispose to ectopic pregnancy and discuss the diagnostic tests that assists in the diagnosis of ectopic pregnancy

Summarize indications and compose appropriate preparation plans for pre-op gynecologic patients including bowel prep, antibiotic use, and thromboembolism prophylaxis

44. Patient Care (Clinical Skills)

- Obtain a focused gynecologic history and pelvic exam to investigate several clinical disorders such as:
  - Abnormal bleeding
  - Pelvic pain
  - Pelvic mass
  - Sexually transmitted diseases
  - Pelvic inflammatory disease
  - Endometriosis

- Counsel patients regarding planned surgical procedures including risks and benefits and obtain a valid and meaningful informed consent

- Manage and counsel patients about post-operative recovery care

- Perform outpatient procedural skills such as endometrial biopsy, and word catheter insertion

- Utilize all types of contraceptive technology and guide patients in choices which are both medically appropriate and acceptable to the patient

- Utilize sonography in the management of disorders in the first trimester of pregnancy

- Function as the primary assistant in the performance of more advanced gynecologic surgical procedures

- The resident will demonstrate competence in performing
  - Operative laparoscopy
  - Complicated total abdominal hysterectomy
  - Appendectomy
- The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures:
  - Incision & Drainage of a Bartholin’s abscess with placement of a Word catheter
  - Marsupialization of a Bartholin’s gland abscess
  - Endometrial aspiration biopsy
  - Vulvar biopsy
  - Hysteroscopy
  - Dilation and Curettage
  - Suction Curettage
  - Diagnostic and operative laparoscopy
  - Laparoscopic sterilization
  - Surgical management of ectopic pregnancy
  - Laparotomy
  - Lysis of adhesions
  - Total abdominal hysterectomy and bilateral salpingoophorectomy
  - Myomectomy
  - Ovarian cystectomy
  - Colposcopy and cervical biopsy
  - Cervical conization
  - Breast cyst aspiration
  - Appendectomy
  - Repair of bowel or bladder injuries
  - Surgery for pelvic inflammatory disease

- The resident should become familiar with the indications for the following gynecologic procedures and the essentials of how they are performed:
  - Repair of vaginal fistulas
  - Repair of ureteral injuries
  - Radical hysterectomy
  - Lymph node dissection and omentectomy
  - Surgical correction of congenital uterine anomalies
  - Brachytherapy
- Assisted reproductive techniques

45. Patient Care (Management Skills)
- Develop an evidence based care plan for his/her patients
- Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis such as;
  - Abnormal bleeding
  - Pelvic pain
  - Sexually transmitted diseases
  - Pelvic inflammatory disease
  - Endometriosis
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
- Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
- Assist in the management of common postoperative complications such as;
  - Fever
  - Gastrointestinal ileus/obstruction
  - Infection
  - Wound complications
  - Fluid electrolyte imbalance
  - Respiratory problems
  - Thromboembolism

46. Practice Based Learning
- Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
- Incorporate formative and summative feedback to improve knowledge and skill base
- Maintain an updated gynecologic procedural log as detailed on the ACGME website
- Participate in gynecologic quality assurance activities (M&M) of the department
- Use personal experience with difficult and challenging patients to optimize future relationships with patients
47. Communication/Interpersonal Skills
- Present pertinent history and physical findings to gynecologic team members and consultants in a clear concise fashion
- Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the gynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

48. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
- Demonstrate accountability for one’s action and clinical decisions
- Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
- Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
- Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

49. Systems Based Practice
- Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient gynecologic patient

Teaching Methods and Rotation Structure:
- The resident will review the curriculum prior to the first day of the rotation. The PGY 3 resident will actively participate in:
  - Daily rounds
  - Daily didactic conferences
  - Weekly GBMC Grand Rounds
  - Attendance at a wide variety of gynecologic procedures
- All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback
- Resident surgical experience will be progressive and gradual with demonstration of level appropriate skills, the resident will
progress from assisting at minor surgical procedures (e.g. hysteroscopy, D&C) to major abdominal/vaginal procedures

**Types of Clinical Encounters:**
- PGY 4 residents will participate in the gynecologic care of the patients cared for by the attending staff of GBMC
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

**Resident Supervision:**
- The resident will be under the supervision of his/her an Attending physician at all times.

**Reading List:**
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

**Method of Evaluation:**
- Global evaluation of PGY 4 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
Learning Objectives

Training Level: PGY4  
Rotation: Greater Baltimore Medical Center Urogynecology

Educational Purpose:  
During this rotation the PGY 4 resident will develop their ability to manage patients who present with complaints of urogenital prolapse and incontinence. The purpose of this rotation is to provide the senior resident with experience in the care of women with pelvic floor disorders such as urinary incontinence, fecal incontinence, and pelvic organ prolapse. Less commonly, this service manages patients referred for other common gynecologic problems, including pelvic pain, vulvar conditions, surgical gynecology, and menopause.

Competencies, Goals and Objectives:  
By the completion of the PGY 4 Urogynecology rotation the resident should demonstrate satisfactory achievement of several skill sets. He/She should be able to:

1. Medical Knowledge  
a. Demonstrate a thorough knowledge of the anatomy of the pelvis, pelvic floor and ureter. Describe common variations in anatomic relationships, including both normal variations and those seen in pathologic conditions, especially pelvic organ prolapse.

b. Understand the physiology of micturition and bladder control, including neurologic circuits and the role of both autonomic and somatic innervation.

c. Be able to differentiate stress from urge urinary incontinence, using history, physical examination and adjunct testing. State appropriate indications for referral of a patient for multichannel urodynamic studies. Understand the large-scale economic impact of urinary incontinence, as well as the psychological, social, and sexual impact on the individual patient.

d. Understand neurologic control of anorectal function and fecal continence. Recognize the different types of fecal incontinence and the means by which to differentiate between them (history, physical findings, adjunct studies). State appropriate indications for imaging or neurologic testing. Understand the psychological, social, and sexual impact of fecal incontinence on the individual patient.
e. Understand the neurologic control of pelvic floor function including maintenance of pelvic floor support during voiding, defecation, and increased intraabdominal pressure. Describe the obstetric events that can affect pelvic floor function and potential measures to prevent such sequelae. Understand the prevalence, etiologies, symptoms, and anatomic findings of the various pelvic support defects.

f. Understand the treatment modalities appropriate to different types of urinary incontinence, including surgery, pharmacologic management, including the costs of and contraindications to the various agents, and pelvic floor exercise/behavior modification.

g. Understand the appropriate evaluation of patients with chronic pelvic pain, with particular understanding of abdominal wall and pelvic floor myofascial pain.

50. Patient Care (Clinical Skills)

a. Elicit a complete history relevant to the presenting problem (pelvic organ prolapse, incontinence, sexual dysfunction, pelvic pain). Perform a physical examination that appropriately assesses the patient’s complaint. Adequately describe to the attending physician the findings at patient examination and formulate a plan (surgical or otherwise) based on the examination. Perform an appropriate preoperative workup, including referral for necessary tests. Explain the plans and rationale to the patient in appropriate, culturally sensitive terms.

b. Perform and interpret the results of office testing appropriate to this subspecialty area:
   - Urinalysis and culture
   - Post-void residual
   - Q-tip test
   - Stress test
   - Pelvic organ prolapse quantitative examination (POP-Q)
   - Single channel cystometrogram
   - Voiding diary

c. Recognize candidates for the use of vaginal pessaries and incontinence devices, and appropriately fit and care for complications of the use of such devices.

d. Understand indications for, independently perform, and dictate operative notes for the following surgical procedures:
   - Intraoperative cystoscopy
- Minimally invasive sling
- Burch colposuspension
- Anterior and posterior colporrhaphy
- Repair of rectovaginal septum defect
- Perineorrhaphy

With all of these procedures, the resident should state an understanding of surgical alternatives, the relative pros and cons of both abdominal and vaginal approaches, and demonstrate an understanding of relevant anatomy (see also objective 1b above).

e. Understand and manage the following post-operative complications:
   - Urinary tract injury
   - Third and fourth degree obstetric laceration
   - Breakdown of episiotomy repair
   - Urinary retention

State appropriate techniques for prevention of such injuries.

f. Diagnose and treat infections of the urinary tract in non-pregnant and pregnant women. Understand the role of prophylaxis against recurrent infection. Indicate an understanding of the role of and indications for in-depth evaluation.

51. Patient Care (Management Skills)
- Develop an evidence based care plan for his/her patients
  o Perform, interpret, and utilize lab tests and other diagnostic procedures (e.g. ultrasound, CT scan, MRI) in the management of a variety of clinical diagnosis
- Provide comprehensive postoperative care including fluid and electrolyte management and appropriate pain control based on the surgical procedure, the degree of patient discomfort and co-existing morbidities
- Respond to intraoperative and postoperative emergencies with appropriate interventions and recommendations for staff
- Assist in the management of common postoperative complications such as;
  i. Fever
  ii. Gastrointestinal ileus/obstruction
  iii. Infection
  iv. Wound complications
  v. Fluid electrolyte imbalance
  vi. Respiratory problems
  vii. Thromboembolism
52. Practice Based Learning
- Formulate and answer important questions that arise from patient care and demonstrate improved gynecologic skills that arise from these inquiries
- Incorporate formative and summative feedback to improve knowledge and skill base
- Maintain an updated gynecologic procedural log as detailed on the ACGME website
- Participate in gynecologic quality assurance activities (M&M) of the department
- Use personal experience with difficult and challenging patients to optimize future relationships with patients

53. Communication/Interpersonal Skills
- Present pertinent history and physical findings to urogynecologic team members and consultants in a clear concise fashion
- Counsel patients in language and manner that is appropriate to her educational background and emotional needs
- Inform patients and designated individuals of pertinent medical developments and complications
- Update the urogynecologic care team (attending physicians, fellow residents, anesthesiologists, medical student and nursing staff) on the status of patient(s)

54. Professionalism
- Conduct all patient interactions (outpatient and inpatient gynecology) with sensitivity, respect, and compassion
- Provide patient centered gynecologic care in a non-judgmental fashion that is responsive to the emotional, educational and social needs of the patient
- Demonstrate accountability for one’s action and clinical decisions
- Demonstrate truthful and timely disclosure of adverse events to the patient and designated individuals
- Acknowledge errors in omission in the pre-operative, intraoperative, and postoperative care of the surgical patient and work toward remediation of these errors
- Participate in the gynecologic education of the attending staff, fellow residents, medical students and nursing staff

55. Systems Based Practice
- Organize appropriate consultations (e.g. anesthesia, internal medicine, cardiology) for the comprehensive care of the outpatient and inpatient urogynecologic patient
Teaching Methods and Rotation Structure:
- The resident will review the curriculum prior to the first day of the rotation. The PGY 4 resident will actively participate in:
  - Daily rounds
  - Daily didactic conferences
  - Weekly GBMC Grand Rounds
  - Attendance at a wide variety of gynecologic procedures
- All procedures are performed under direct supervision by an Attending Physician. This provides the opportunity for immediate formative feedback

Types of Clinical Encounters:
- PGY 4 residents will participate in the gynecologic care of the patients cared for by the attending staff of GBMC
- Residents will encounter a wide variety of both outpatient and inpatient gynecologic pathology

Resident Supervision:
- The resident will be under the supervision of his/her an Attending physician at all times.

Reading List:
- Ostergard and Bent, Urogynecology
- Assigned reading from the peer-reviewed literature
- Up to Date (available to all residents)
- Comprehensive Gynecology - Droegmuller
- Te Linde’s Operative Gynecology
- Novak’s Gynecology
- ACOG Compendium of Selective Publications

Method of Evaluation:
- Global evaluation of PGY 4 resident is conducted at the conclusion of the 6 week long rotation and reflects input from the attending staff, medical students, nurses and patients and is reported to the resident in the competency format as a written document available through the E*value system. This document is then reviewed with the resident during their semi-annual evaluation with their assigned mentor.
**Learning Objectives**

**Training Level:** PGY4

**Rotation:** Johns Hopkins Bayview Obstetrics Service

**Educational Purpose**
The PGY-4 obstetrical experience is the culmination of the knowledge base and clinical skill sets developed during the preceding three years. In this rotation the chief resident perfects their management of routine and high-risk obstetrical patients during the antepartum, intrapartum and postpartum periods. Mastery of obstetric and surgical procedures is accomplished during this time. The chief resident is afforded the most technically difficult procedures and supervisory responsibilities are also developed. The chief resident is responsible for the direction and training of all junior residents and medical students rotating on the obstetrics service.

**Goals and Objectives**
The chief resident continues to practice and further perfect the same competencies achieved during the preceding three years of training, but now performs at a higher level of excellence. By completion of the PGY-4 year, the resident will possess the ability and confidence to function as an independent practitioner of obstetrics.

In addition to the competencies listed in the curricula of the PGY 1-3 years, the chief resident should also be able to:

57. **Medical Knowledge**
- Possess a sufficient knowledge base as to function as an independent practitioner of obstetrics.
- Successfully complete the ABOG written examination at the completion of the PGY-4 year.
- Counsel patients regarding disease mechanisms, risk factors, pregnancy physiology, fetal anomalies, obstetric complications, care interventions, obstetrical and/or surgical procedures, and postpartum care.

58. **Patient Care (Clinical Skills)**
- Perform all obstetric procedures competently and independently (but with appropriate attending physician supervision) as to be credentialed for future attending level appointment.
• Appropriately manage both routine and high-risk obstetrical patients during the antepartum, intrapartum, and postpartum periods.

**Patient Care (Management Skills)**
• Multi-task and triage the care of all patients cared for on the labor and delivery suite as well as those on the obstetrical inpatient floors
• Supervise and manage junior resident and medical student staff for the best utilization of manpower.
• Continually update the patient care team (attending physicians, junior residents, nursing staff, NICU staff, anesthesia, etc) on status of patient(s).

**59. 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.
• Keep an updated patient log as detailed in the ACGME website.
• Participate in quality assurance activities of the department.
• Use of information technology: UpToDate, PubMed literature search, Cochrane Database, etc.

**60. Communication/Interpersonal Skills**
• Present pertinent obstetrical history and physical findings to team members and consultants in a clear, concise fashion.
• Demonstrate caring and respectful interactions with the obstetrical 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.

**61. Professionalism**
• Demonstrate responsibility for the welfare of all patients on the labor and delivery and postpartum 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.

62. 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 and L&D 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.

Types of Clinical Encounters
PGY-4 residents interact are responsible (as if they were the patient’s attending physician) for the care of Women’s Health Center (clinic) patients. A wide variety of both normal / physiologic and abnormal obstetrical pathology is encountered in these antepartum, intrapartum, and postpartum patients.

Rotation Structure
The PGY-4 resident will review the curriculum prior to the first day of the rotation. The PGY-4 resident will actively participate in:

- 7:00 am Interdisciplinary Obstetrics Rounds (daily).
- OB Practice Based Learning and Improvement Conf (daily).
- Fetal Heart Rate Monitoring “strip rounds” (monthly)
- OB Morbidity and Mortality case presentations (monthly)
- At all other times, it is expected that the PGY-4 resident will remain on the patient care floors involved directly with patient care encounters.
Resident Supervision
Deliveries and procedures are performed under the direct supervision of an attending physician at all times, including nights, weekends, and holidays. This is ensured by 24-hour in-house coverage by attending staff.

Reading List and Educational Materials
- ACOG Compendium
- UpToDate Clinical Reference Library
- Drugs in Pregnancy and Lactation
- PubMed & Cochrane Database

Method of Evaluation
- Residents will receive on-site timely formative feedback from the Chief Resident and attending physician(s) during this rotation.
- Global evaluations of PGY-4 residents are performed at the completion of the 6 week block by the Bayview faculty and reflect input from the attending staff, nurses, medical students, and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetrical skills is achieved by the obstetrical score from theCREOG examination.
- Residents’ procedural skills will be assessed after each index procedure using the on-line C-BASS evaluation tool (OSATS).
Educational Objectives for the PGY-4 Rotation in Gynecologic Oncology
The Kelly Gynecologic Oncology Service (KGOS)

Training Level: PGY4

Rotation: Gynecologic Oncology

A. Educational Purpose
Each PGY-4 resident will spend one block rotation assigned to the Gynecologic Oncology service, with responsibility for leading the clinical activities of the service in a cooperative manner with the clinical fellows, and for supervising and teaching the PGY 1-3 residents and third and fourth year medical students. The educational goals are that upon completion of residency, each resident will have a comprehensive knowledge base in the diagnosis and in the medical and surgical management of gynecologic cancers. He or she will be well prepared for general practice of obstetrics and gynecology and will be able to serve patients and the medical community in screening for gynecologic cancers and making appropriate referrals for subspecialty care. He or she would likewise be well prepared to enter post-residency training in this subspecialty area. Surgical skills and problem solving will be well developed. At the core of this educational experience for the fourth year resident is a set of cognitive and behavioral objectives outlined below, which will serve to assist the resident in the above areas.

B. Goals and Objectives

1. Cognitive:

a. Demonstrate a thorough knowledge of pelvic anatomy. Understand the normal anatomic relationships between the uterus/fallopian tubes/ovaries and other pelvic structures, as well as common variations seen under normal conditions and as seen in pathologic conditions, including ovarian and cervical cancer and in the post-radiation patient. Describe the vascular supply and drainage, lymphatic drainage, and neurologic supply of the pelvic organs.

b. Show an understanding of the role of genetics in reproductive cancers. Describe inheritance patterns, and know guidelines for screening for BRCA1 and BRCA2. Know the phases of the cell replication cycle most sensitive to radiation and chemotherapy.

c. Understand the epidemiology of and risk factors for gynecologic cancers. Be able to recommend to patients prevention and screening strategies based on their individual risk profile, taking into account family history, sexual and...
reproductive history, and environmental risk factors. Know the relative value of various screening tests (Pap smear, Thin Prep, mammogram, etc.) in identifying patients with reproductive cancers as well as current recommendations for their use and the approximate costs of such testing.

d. Describe the general principles of, indications for, and mechanisms of action of radiation therapy for reproductive cancers. Recognize how decisions are made regarding use and dose of radiation therapy, and be able to recognize potential complications of radiation therapy.

e. Describe the principles of palliative care, including various modalities for palliation of cancer symptoms in terminally ill women. Know the indications for and the medical, ethical and legal consequences of a “Do Not Resuscitate” order. Be able to manage pain in the setting of terminal care.

2. Behavioral:

a. Elicit a complete history and physical examination from the patient presenting with signs and/or symptoms of gynecologic malignancy (vulvar, vaginal, cervical, uterine, ovarian). Perform competent breast examination. Perform complete pelvic examination including cervical cytology, appropriate biopsies, and collection of microbiologic specimens. Present findings to attending or fellow physician and include a working diagnosis and treatment plan. Explain the plans and rationale to the patient in appropriate, culturally sensitive terms.

b. Perform and interpret the results of common office or bedside procedures relevant to the patient with gynecologic cancer, including but not limited to the below. Describe the procedure and potential complications to the patient in understandable terms.
   - Microscopic evaluation of vaginal discharge
   - Biopsy of vulvar, vaginal or cervical lesion
   - Endometrial biopsy
   - Paracentesis
   - Thoracentesis

c. Based upon all relevant data, including physical findings and histopathologic studies, accurately stage reproductive cancers of all varieties.

d. Perform appropriate preoperative evaluation and post-operative care for gynecologic oncology surgery patients, including major and minor procedures. Counsel patients regarding surgical and non-surgical options when such options exist, giving proper weight to the priority of these options. Recognize the indications for preoperative medical clearance, obtain such clearance when indicated, and accurately identify the patient whose medical problems make her not a surgical candidate. Describe the procedures and potential complications to the patient in understandable terms.
e. Perform, under attending physician supervision, the following surgical procedures:

- Hysterectomy, abdominal
- Hysterectomy, vaginal
- Removal of adnexa, in conjunction with hysterectomy or separately in the appropriate clinical setting
- Staging laparotomy, including cytologic washings, peritoneal biopsies, upper abdominal exploration, and infracolic omentectomy
- Wide local excision of vulvar lesions

Assist with, and perform at attending physician discretion, the following surgical procedures:

- Hysterectomy, radical
- Lymph node dissection, pelvic and paraaortic
- Resection of large and small bowel
- Colostomy

Provide instruction to junior residents in the achievement of learning objectives in the surgical arena, and assist them in developing the skills of a good surgical assistant for the above procedures. Dictate and review operative notes for these procedures.

C. Objective Grid

Following is a grid diagram that cross-references each of the objectives listed above to the six general competencies, and lists the assessment tools to be used for each of the learning objectives.

Patient Care – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

Medical Knowledge – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Practice-based Learning and Improvement – Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Interpersonal and Communication Skills – Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.
Professionalism – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-based Practice – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
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Rotation Structure

The PGY4 resident will review the curriculum prior to the first day of the rotation. The PGY4 resident will actively participate in the following activities:

- Daily attending rounds
- Surgical procedures for the KGOS
- Gyn Oncology clinics
- Weekly Gyn/Gyn Onc Professor’s rounds
- Weekly Morbidity and Mortality Conferences
- Weekly Colposcopy correlation conference
- Weekly Tumor Board

Resident Supervision

The resident’s daily activities fall under the management of the Gyn Oncology fellow and KGOS faculty; this provides opportunity for immediate feedback. Patient examinations, diagnostic procedures and surgical procedures are performed under the direct supervision of an attending physician at all times.

Reading List

The educational materials for this rotation consist of:

- TeLinde’s Operative Gynecology, Rock and Thompson, 2003
- DeSaia and Creasman, Gynecologic Oncology
- The KGOS notebook of key readings in Gyn Oncology
- Pertinent ACOG Educational and Practice Bulletins (page references are from the 2005 Compendium)
  - Diagnosis and Treatment of Cervical Carcinomas, PB 35, pp. 390-402.

Methods of Evaluation

- Residents will receive on-site timely formative feedback from the fellow and attending physician(s) during this rotation.
- Global evaluations of PGY-4 resident is performed at the completion of the block by the KGOS faculty and reflect input from the attending staff, nurses and patients. These evaluations will be available to the residents via the E*value system and will be reviewed by the resident with their faculty mentor during the resident’s semi-annual evaluation meeting.
- Cognitive assessment of the residents’ obstetric and gynecologic skills is achieved by the obstetrical score from the CREOG examination.
- See also grid above
A few thoughts about the use of the educational objectives…

The educational objectives are patterned after the CREOG Educational Objectives, and residents and faculty will be expected to incorporate its details into the program in general and the individual rotations and educational activities in specific. As one uses the “Learning Objective” detailed in each rotation, please understand the following:

1. While identical to the CREOG Educational Objectives in most areas, the “Learning Objectives” have been modified through additions and deletions where necessary to better serve the purpose of our program’s educational expectations.

2. The assignment of specific objectives to specific rotations should not be considered absolute; it is fully recognized that many objectives initially defined for lower level rotations will not be fulfilled completely until upper level rotations are completed. For the most part, however, work and study toward the fulfillment of each objective should begin at the PGY level in which it is first stated.

3. Given the breadth and depth of our specialty, the “Learning Objectives,” while very comprehensive, cannot and should not be considered to cover the totality of our specialty; much learning in topic areas not specifically defined in objectives will occur through daily patient care, formal and informal didactic sessions and one’s reading of the literature of our specialty.
THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
GUIDELINES FOR CONDUCT IN TEACHER/LEARNER RELATIONSHIPS

I. Statement of Philosophy

The Johns Hopkins University School of Medicine is committed to fostering an environment that promotes academic and professional success in learners and teachers at all levels. The achievement of such success is dependent on an environment free of behaviors which can undermine the important missions of our institution. An atmosphere of mutual respect, collegiality, fairness, and trust is essential. Although both teachers and learners bear significant responsibility in creating and maintaining this atmosphere, teachers also bear particular responsibility with respect to their evaluative roles relative to student work and with respect to modeling appropriate professional behaviors. Teachers must be ever mindful of this responsibility in their interactions with their colleagues, their patients, and those whose education has been entrusted to them.

II. Responsibilities in the Teacher/Learner Relationship

A. Responsibilities of teachers

Treat all learners with respect and fairness.
Treat all learners equally regardless of age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation.
Provide current materials in an effective format for learning.
Be on time for didactic, investigational, and clinical encounters.
Provide timely feedback with constructive suggestions and opportunities for improvement/remediation when needed.

B. Responsibilities of learners

Treat all fellow learners and teachers with respect and fairness.
Treat all fellow learners and teachers equally regardless of age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation.
Commit the time and energy to your studies necessary to achieve the goals and objectives of each course.
Be on time for didactic, investigational, and clinical encounters.
Communicate concerns/suggestions about the curriculum, didactic methods, teachers, or the learning environment in a respectful, professional manner.

III. Behaviors Inappropriate to the Teacher-Learner Relationship

These behaviors are those which demonstrate disrespect for others or lack of professionalism in interpersonal conduct. Although there is inevitably a subjective element in the witnessing or experiencing of such behaviors, certain actions are clearly inappropriate and will not be tolerated by the institution. These include, but are not limited to, the following:
unwanted physical contact (e.g. hitting, slapping, kicking, pushing) or the threat of the same;
sexual harassment (including romantic relationships between teachers and learners in which the teacher has authority over the learner’s academic progress) or harassment
based on age, gender, race, ethnicity, national origin, religion, disability or sexual orientation;
loss of personal civility including shouting, personal attacks or insults, displays of temper (such as throwing objects);
discrimination of any form including in teaching and assessment based upon age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation;
requests for others to perform inappropriate personal errands unrelated to the didactic, investigational, or clinical situation at hand;
grading/evaluation on factors unrelated to performance, effort, or level of achievement.

IV. Avenues for Addressing Inappropriate Behavior in the Teacher/Learner Context

A. Learners’ Concerns

Learners may address situations in which they feel that they have been the object of inappropriate behavior at various levels. At the most basic level, the most effective way to handle a situation may be to address it immediately and non-confrontationally. Oftentimes, a person is simply unaware that his/her behavior has offended someone, or even if aware, will correct the behavior appropriately if given the opportunity to do so in a way that is not threatening. The way to raise such an issue is to describe the behavior factually (“When you said…”), describe how the behavior made you feel (“I felt …”), and state that the behavior needs to stop or not be repeated (“Please, don’t do that again.”)

Sometimes, such a request is not successful, or the person repeats the behavior, or the learner does not feel comfortable speaking directly to the teacher about his/her behavior. In those cases, it may be helpful to discuss the behavior with course directors, laboratory mentors, program directors, or department chairs. Students may also elect to speak to their respective Associate or Assistant Deans for informal advice and counsel about these issues. These individuals may offer additional suggestions for resolving the matter informally, such as, for example, speaking to the individual on the learner’s behalf or on behalf of an entire class, raising the general issue in a faculty meeting, assisting the learner with writing to the individual teacher or even direct intervention to get the behavior to stop.

If no satisfactory resolution is reached after these discussions or the learner does not feel comfortable speaking to these individuals, he/she may bring the matter formally to the attention of the School of Medicine administration. The avenues for this more formal reporting vary depending upon the status of the reporting individual.

1. If the person reporting the behavior is a medical student:

The student should speak with one of the Associate or Assistant Deans in the Office of Student Affairs.

2. If the person reporting the behavior is a graduate student or M.D./Ph.D. student pursuing their graduate studies:

The student should speak with the Associate Dean for Graduate Student Affairs and/or the Director of the M.D./Ph.D. program.
3. If the person reporting the behavior is a post-graduate trainee (i.e. resident or clinical fellow):

The trainee should speak with the Associate Dean for Graduate Medical Education.

4. If the person reporting the behavior is a research fellow:

The trainee should speak with the Associate Dean for Postdoctoral Affairs.

B. Teachers’ Concerns

If a teacher feels that a learner has engaged in inappropriate behavior, it is likewise most effective to address the situation immediately and non-confrontationally. If the matter is not resolved satisfactorily, the teacher should contact the course director, program director, or laboratory mentor to discuss the matter. If the teacher wishes to make a formal allegation of misconduct, they should contact the following members of the administration:

1. If the matter involves a medical student, contact the Associate/Assistant Dean for Student Affairs;

2. If the matter involves a graduate student, contact the Associate Dean for Graduate Student Affairs;

3. If the matter involves a postgraduate trainee, contact the Associate Dean for Graduate Medical Education;

4. If the matter involves a research fellow, contact the Associate Dean for Postdoctoral Affairs.

These allegations will be handled according to established School of Medicine policies published elsewhere.

V. Procedures for Handling Allegations of Inappropriate Behavior in the Teacher/Learner Context

A. Upon being notified of alleged inappropriate behavior, the Associate or Assistant Dean will notify senior administration officials in a written report within 5 business days of the allegation as follows:

1. If the complaint is lodged against a faculty member, the Vice Deans for Education and Faculty will be notified. Other than those matters referred to the Office of Equal Opportunity and Affirmative Action Programs, the matter will be handled in accordance with the School of Medicine’s Procedures for Dealing with Issues of Professional Misconduct.

2. If the complaint is lodged against a post-graduate trainee, the Vice-Dean for Education and the Associate Dean for Graduate Medical Education will be notified. If the complaint is lodged against a research fellow, the Vice Dean for Education and the Associate Dean for Postdoctoral Affairs will be notified. Other than those matters
referred to the Office of Equal Opportunity and Affirmative Action Programs, if based on the written report, those Deans decide that a formal investigation is merited, they will convene an ad hoc committee to investigate the complaint and will notify the complainant, the respondent and appropriate department chairs and program directors of such an action. The ad hoc committee will be composed of three faculty members from departments other than those of the complainant or respondent. The committee will be responsible for gathering information and interviewing the complainant, respondent, and other individuals as they deem appropriate. Based upon information gathered and their deliberations, the committee will submit a written report to the Deans involved within thirty days from when they were convened which will include their findings and recommendations for dismissal of the complaint or for disciplinary action(s). The senior Deans will then communicate to the complainant and respondent in writing that a determination has been made. If the committee finds against a post-graduate trainee, the findings will be communicated to the appropriate Department Chair and Program Director and sanctions will be determined and enforced according to the policy on Probation, Suspension, and Termination of Post-Doctoral Fellows published elsewhere which also includes an avenue of appeal.

B. If the behavior involves unlawful discrimination or sexual or other forms of unlawful harassment, the matter will be referred to the Office of Equal Opportunity and Affirmative Actions Programs and be handled through University policies established for that office. The student may also directly contact that office.

C. If the behavior involves unwanted physical contact or other forms of violent or threatening acts, the matter may be referred for evaluation under the University’s Policy Addressing Campus Violence.

D. The School of Medicine is committed to the fair treatment of all individuals involved in this process. All efforts will be made to maintain the confidentiality of the resolution process to the extent possible and subject to the overriding concern of a prompt and fair investigation and/or resolution of the complaint.

E. The School of Medicine will not tolerate any form of retaliatory behavior toward learners who make allegations in good faith. Individuals who believe that action has been taken against them in retaliation for raising concerns under this policy, may address those concerns through the procedures described in this policy.

F. Records of all communications as well as the written reports of the Associate Deans and ad hoc committee will be kept in the Office of the Vice Dean for Education.

G. If it is determined that the allegations from the complainant were not made in good faith, the student or post-graduate trainee will be referred for disciplinary action under the appropriate University procedures which are described elsewhere.

Last Published: 08/09/2005
Section Three

Program Overview
Schedule of Rotations 2008-2009

PGY-1
Hopkins Gynecology
Hopkins Ob (1/2 nights)
Bayview Ob/Gyn (days)
Bayview Ob/Gyn (nights)
Emergency Medicine (1 week vacation)
Hopkins Oncology
GBMC Gyn
SICU
Ultrasound/Genetics (2 weeks vacation)

PGY-2
Hopkins High Risk OB
Hopkins High Risk OB (nights)
Hopkins Oncology
Reproductive Endocrinology and Infertility (1 week vacation)
Hopkins Gynecology and Oncology (Weinberg nights) (1 week vacation)
Bayview Ob/Gyn
Bayview Ob/Gyn
Bayview nights
GBMC Gynecology (2 weeks vacation)

PGY-3
Hopkins Gyn Chief
Hopkins Oncology
High Risk OB Chief
Bayview Gyn and Ob (nights)
GBMC Gynecology (1 week vacation)
GBMC Oncology
Howard County General Hospital (1 week vacation)
Elective (2 weeks vacation)

PGY-4
Hopkins OB
Hopkins OB/Gyn (nights)
Hopkins Oncology
Bayview OB
Bayview Gyn (Urogyn)
GBMC Gyn (1-2 weeks vacation)
GBMC Urogyn (1-2 weeks vacation)
GBMC Day Float (1-2 weeks vacation)
Resident Supervisory Lines of Responsibility

All residents are directly supervised by a faculty member in ambulatory care sites. The resident is expected to discuss each patient with the supervising faculty member prior to the patient’s leaving the ambulatory care area. Specific lines of responsibility for inpatient activities are outlined below.

PGY-1
- Functions as a specialist-in-training under the supervision of attending physicians and senior residents.
- Reports directly to PGY-2 on the service in all clinical and operating activities.
- Supervises care by medical students on the service.
- Note: PGY-1 residents are not permitted to write orders for patient restraint.

PGY-2
- Functions as a specialist-in-training under the supervision of attending physicians and senior residents.
- Reports directly to PGY-3 or PGY-4 on service or attending physician.
- Supervises care by PGY-1 residents and medical students on the service.

PGY-3
- Functions as a specialist-in-training under the supervision of attending physicians and PGY-4 residents.
- Assists the PGY-4 in the coordination of care of all patients admitted to the service.
- Develops leadership and teaching skills by organizing, supervising, and teaching house officers and students on the service.
- Supervises care by PGY-1 and PGY-2 residents and medical students on the service.

PGY-4
- Functions as a specialist in obstetrics and gynecology under the supervision of the attending physician.
- Participates in and coordinates care of all patients admitted to the service.
- Supervises junior residents and students in staff deliveries and surgeries.
- Directs administrative and clinical activities of residents assigned to their service.
- Develops leadership and teaching skills by organizing, supervising, and teaching house officers and student on the service.
Rotation Responsibilities PGY-1

JHH OB Rotation: PGY-1

Weekday schedule (daytime):

1. Daily weekday rounds at 7am; weekend rounds at 8am. The night float will stay for board rounds.
2. Intern schedule: the first two weeks of the month, the ER intern works 7a-7p and the ob intern works 7p-7a; they switch for the second half of the month. The intern schedule is posted on L&D. They both preround in the mornings. If the suite is busy, the day intern covers the suite during rounds while the night intern rounds with the team; if not busy, the day intern comes to rounds too. The night intern then signs out to the day intern and goes home immediately. The ED interns are required to attend their departmental lectures on Fridays, 7-11am, so plan accordingly.
4. Tuesdays: 8:10a - Ob interdisciplinary case conference
5. Wednesday:

-8:30a –Ob anesthesia conference.

-1:00 pm – prenatal diagnostic conference.

-3:00 pm - MFM conference (Phipps lecture hall); once monthly, includes ob M&M conference and stats (Dr. Witter will provide data). You and the day pgy-2 should attend this conference every week whenever possible.

6. Thursdays: 7:30a Grand Rounds (Phipps lecture hall)
7. Fridays:

-8:00 am – NICU rounds in the NICU.

-8:30 am – High Risk Clinic Rounds (JHOC 8th Floor, Pod C). Both PGY2’s (Days and Nights) are required to attend. L&D will be covered by the OB Chief, Intern, and a MFM fellow.

-1:00p Fox lunch

-2:00-4:00p: school (Phipps lecture hall)

Shifts:

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In general, ER intern works days (7a-7p) and the ob intern works nights (7p-7a) for the first two weeks of the month. They switch for the second half of the month.

Note that the Friday night person works an extra hour and the Sunday day person works one less hour since weekend rounds start at 8a.

In the middle of each month, the interns will switch days and nights.

**Days:**

1. Daily rounds at 7a.

Preround on your patients before rounds. In general, you’ll be seeing routine postpartum patients.

2. At 7a, the board is signed out to the day team by the previous night’s pgy-2. Pay close attention! You’ll be covering the suite by yourself while the day team and the night intern round on the floor, go to conferences, etc. However, if the suite is quiet, the day intern should also go to rounds.

3. You’re responsible for triaging all patients on the suite. See the patient, then present the case to your pgy-2. Once the two of you have discussed the plan, you’ll present it to the ob chief if it’s a housestaff patient, or to the attending if it’s a Group, JHCP, or other patient. If you have any questions about the exam, ask the pgy-2 BEFORE you examine the patient. You’d hate to have to repeat part of the pelvic exam because you didn’t get cultures that you need, or worse, to cause a bleeding previa because you digitalized the wrong patient.

4. You’re also responsible for following patients once they’ve been admitted to the suite, most of whom will be laboring. In general, progress note should be written every two to three hours or with any change in status, cervical exam, etc.

5. Note about patients on MgSO4 for preterm labor or pre-eclampsia: there’s a Mg flowsheet to be kept updated on an hourly basis, including pt’s symptoms, BP, chest exam, reflexes, hourly/total inputs and outputs, and current MgSO4 dose. Full progress notes still need to be written, but only every 2 hours.

6. You will get calls from the floor for problems with routine postpartum patients. Occasionally, you will be called for a post-Csxn patient; it’s appropriate for you to deal with these calls too. If you have questions, ask your pgy-2. Antepartum problems on the floor should be dealt with by the pgy-2. If the pgy-2 is scrubbed in a Csxn when an ante is acting up, use your judgment. You can always page the ob chief or walk over to the OR to ask.

7. Csxns are done by the pgy-2. Later in the year, some pgy-2’s may pass down uncomplicated sections to the ob intern. If the suite is quiet, the ER intern may scrub as second assistant for a section.

8. Postpartum tubal ligations are done by both interns. If you tie a patient’s tubes, she becomes your patient to follow postoperatively, even if you didn’t deliver her.

9. Both interns responsible for D&C’s.

10. You are responsible for following all patients who deliver vaginally during your shift, even if you didn’t deliver them. You’ll deliver all housestaff patients and some Group and JHCP patients. Some Group and JHCP attendings prefer to do the delivery themselves. The privates (Atienza, etc.) also deliver their own patients. You still have all the paperwork to do, though. (Yes, it can get a little
frustrating. You’ll learn which attendings do this as your month progresses.) The key to delivering non-housestaff patients is to be there. You won’t do the delivery if you’re not at the bedside.

11. Sometimes, the pgy-2 will step in for an operative vaginal delivery (forceps or vacuum); if so, that person should follow the patient.

12. The pgy-2 is your resource and your helper. Her/his main job is to run the suite. This job includes not only formulating plans for the patients with the ob chief and attendings, but helping you with the work. The pgy-2 should not be relaxing while exam room patients are stacking up and progress notes go unwritten. If you need help, ASK. Sometimes the pgy-2 doesn’t realize that you’re feeling swamped.

13. Tucking in admissions is a team effort. In general, the pgy-2 fills out the front sheet (the H&P), while you complete the physical exam, scan the patient for presentation (can defer if presentation clear on cervical exam), and have the patient sign the L&D consent forms.

14. In the evening, run the board with the night intern to get her/him up to speed, then sign out your patients before going home (leave a verbal and a written signout).

Nights:

1. Preround on your patients before 7a rounds. Board signout is at 7a and is done by the pgy-2. (You may need to sign out the board if the pgy-2 is in a cesarean, so be prepared to do so.) Afterwards, you and the day team will go to the floor to round. The day intern covers the suite during floor rounds. The team will round on your patients first, so that you can go home.

2. See the “day” section for your responsibilities on the suite.

3. Sign out your patients to the day intern before going home (give verbal and written sign out), including any scut to do (labs to check, etc.).

Other:

1. Dictations: you’re responsible for dictating all of your patients’ charts upon discharge. The charts stay on the floor usually for 48 hours. Then they go to medical records. It’s easiest to dictate as you go along, but getting charts from medical records isn’t (usually) too difficult. Undictated charts WILL come back to haunt you (or in the case of the ER intern, to haunt your ER successor). You can pull undictated charts from the CDC (clinical documentation center), located behind L&D. Ob interns’ charts should be pulled already in their names; if the chart you need hasn’t been pulled, ask for the charts you need. ED interns will need to ask for charts to be pulled. Ask in advance; it often takes several hours-a day for charts to arrive in the CDC.

2. Op notes: don’t forget to dictate operative notes for your tubal ligations and D&C’s.

3. Saturday: your day off! The 24 hour period (Saturday 8a-Sunday 8a) is covered by ob/gyn interns from another call pool. Leave the Saturday intern a written signout. On Saturday morning, the Saturday intern rounds on the day person’s patients; on Sunday morning, she/he rounds on the night person’s patients. Note that the Saturday intern is NOT responsible for dictating charts, so if you have a patient going home on Saturday morning, you’re still responsible for the dictation. The day and night interns should split the patients picked up by the Saturday intern equitably.
4. Paperwork: can be the bane of your existence. Ask the pgy-2 to show you the paperwork on your first day. Don’t forget the following:

- to complete the H&P with the pgy-2.
- to complete the delivery record/birth certificate after the delivery on QS. Includes charting the cord gas.
- to add the person to the list, including labs, feeding method, and birth control method.
- to fill out the discharge paperwork and prescriptions (motrin, colace, prenatal vitamin, tylox (if C/S, postpartum BTL, or 3rd degree laceration), birth control method).
- to chart labs in the diagnostics section, including H8, STS, and urine tox.

It’s considerate to have the paperwork all done on the patients that the Saturday intern is covering for you, so try to keep up with it. A lot of paperwork can be done during down times on the suite.

**Routine postpartum notes: (on prepared template)**

Follow the following format for your notes:

**IPN PPD#1 s/p FTSVD**


O: Tm 37.1 Tc 36.5 BP 108-122/56-70 (give range) P100-115 R18-20

Abd: fundus firm/NT/below umbilicus

Ext: no c/c/e

Labs: Rh+/rubella immune/STS neg/utox neg

A/P: 22 yo P1001 on PPD#1 s/p FTSVD as above.

Routine postpartum care.

Bottle/Depo

**Notes:**

Always ask postpartum patients about the B’s: bleeding (lochia), breasts, bottom (perineum), bladder, baby, baby blues.
1. Bleeding: normal postpartum bleeding can be as heavy or occasionally a little heavier than a period. If pt reports passing clots, ask about clot size using the “fruit” or “coin” scales (i.e. lemon sized, quarter sized, etc). Clots up to the size of plums or half dollars are normal. If pt’s having significant bleeding, ask about dizziness/lightheadedness/SOB/CP. Ask the nurses to check orthostatics and post pt for a H8 if she’s symptomatic.

2. Bottom: it’s normal to have perineal tenderness, even in patients without lacs or episiotomies, though in general, the bigger the lac, the more sore the perineum. Some patients will complain of stinging while voiding. Cold packs for the first 24 hours then sitz baths are routine. You can order americaine spray for patients with particularly sore bottoms. Patients with third or fourth degree lacerations may require Tylox for pain.

3. Breasts: if patient is breast-feeding, ask how it’s going. If baby’s in the NICU, a breast pump can be used. If any problems, order a lactation consult. The biggest frustration for breast-feeding patients is not making much (if any) milk in the immediate postpartum period. Initially, the breasts produce colostrum, a watery, antibody-rich substance; milk “comes in” after a few days. Reassure patients that this is normal and that the volume will increase. If bottle-feeding, patients may have problems with breast engorgement. Patients may even spike temps due to breast engorgement. Treat with tight bra and ice packs. Remind the bottle-feeding patient to avoid any breast stimulation, which delays the process of breasts “drying up.” Mastitis is a complication that doesn’t happen often. If one quadrant of one breast is particularly firm, tender, and erythematous, start the patient on dicloxacillin. Breast abscesses are rare and require incision and drainage. Both mastitis and breast abscesses can afflict breast-feeding patients as well. Those patients should continue to nurse as frequently as possible in order to drain the affected breast as much as possible.

4. Bladder: if patient complains of dysuria, clarify whether it’s true dysuria or external stinging during voiding due to a laceration. Send a UA and urine culture if necessary. Don’t bother sending clean catch specimens on postpartum patients since lochia will inevitably throw off the results.

5. Baby: important to ask how the baby’s doing, especially if in the NICU. If there’s been a bad outcome, especially perinatal death, PLEASE sign that out to anybody cross-covering for you.

6. Baby blues: postpartum depression is a significant problem. Most patients don’t start having problems until they’ve gone home, but if a patient is having trouble sleeping, is tearful or upset, has minimal support system, has a history of depression, drug abuse, or other psychological/psychiatric history, she’s at much higher risk, and it’s worth asking about. You can have patients follow up in one week postpartum in clinic for a check if you’re particularly concerned. Order a social work consult for any history of depression.

7. Postpartum physical exam: note that pregnant and postpartum patients tend to have higher pulses (10-15 points higher) and lower blood pressures. Greater degrees of tachycardia may be due to dehydration, blood loss, pain, etc. Higher blood pressures may secondary to pain or some type of hypertension (chronic or gestational). You’ll want to comment on elevated BP’s in your assessment and plan. When examining the routine postpartum patient, you may skip the heart, lungs, etc, unless she’s having any complaints, is febrile, etc. Focus on the abdomen and extremities. The most important part of the abdominal exam is the uterine fundus: the normal postpartum fundus is firm, nontender, and at or below
the umbilicus. A boggy fundus brings uterine atony to mind: how heavy is her bleeding? A tender fundus may be a sign of endometritis, so don’t document a tender fundus without commenting on it.

patient’s Rh status. If Rh-, what’s the baby’s Rh status? (Check EPR.) If baby Rh+, has mom gotten Rhogam (check nursing record)?

Rubella immunity. If patient nonimmune or equivocal, she’ll need MMR the day of discharge.

(Not given until discharge due to the theoretical risk of spreading live attenuated virus to an antepartum patient. No case reports of this happening, though.)

results of STS/urine tox.

Whether breast or bottle feeding.

Choice of contraception. Counsel her on her choice. Common choices in our patient population:

1. Depo Provera: no effect on breast feeding. Remind her to come to clinic in 12 weeks for her next shot. Warn her to expect some irregular bleeding. After months of Depo treatment, some women become amenorrheic. Also tell her that some women note extra hair loss in the months after delivery; this is normal and not due to the Depo (common patient misperception). Weight gain can be a problem for some women. Patient compliance with Depo is much better with appropriate counseling, so don’t skip it.

2. OCP’s: safe with breast feeding, but there’s some evidence that combination OCP’s (estrogen and progesterone) may decrease milk production. Consider using Micronor instead (progesterone only), though it’s less effective and MUST be taken at exactly the same time every day. Another solution (better for many patients) is to start a combination OCP six or eight weeks postpartum, when milk supply is established.

Common postpartum problems:

1. Postpartum fevers: most common causes after vaginal delivery: breast engorgement; endometritis; bladder infection. After caesarian delivery: breast engorgement; endometritis; wound infection; atelectasis; bladder infection. If s/p general anesthesia, you should think about pneumonia as well. For fevers above 38.0, consider sending urine culture and H8. For fevers above 38.5, definitely send urine cx and H8 and consider blood cultures. Start antibiotics based on clinical suspicion for etiology of fever. For breast engorgement, tight bras/ice packs used. If mastitis, start dicloxacillin. If exam’s completely unremarkable and temp is over 38.5, we’ll usually treat empirically for endometritis with amp/gent/clinda.
2. Elevated blood pressure: pre-eclampsia should always be at the back of your mind. Is patient symptomatic? (i.e. headache, scotomota, RUQ pain?) Careful physical exam: hyperreflexia or clonus? Significant hand or facial edema? Check a urine dip for protein (get a cath specimen if lochia present). If a patient’s already been treated for pre-eclampsia, don’t repeat a urine dip postpartum unless her pressures worsen or she otherwise worsens clinically. (Note that proteinuria in context of normal BP may be due to UTI.)

3. Get social work consult for: adolescent; late registrant or no prenatal care; h/o drug use; h/o depression; other psychosocial problems.

**Triaging patients:**

Pts come into the exam room because:

1. they’re pregnant
2. for labor checks
3. for nausea/vomiting
4. for shortness of breath
5. for dizziness
6. etc.

When evaluating the exam room patient, check her prenatal chart (if available) for the following important facts (you’ll learn to quickly find the following info):

1. EDC and how it’s been established. (By LMP only? Confirmed by sono?)
2. Past medical and obstetrical history
3. Current meds
4. Other visits to the exam room for the same or other problems
5. If second/third trimester: where is patient’s placenta (you don’t want to put a finger through a previa)? Has her cervix been checked recently—if so, how dilated was she (important for determining whether patient’s having labor or “just” contractions)?
6. For unregistered patients, gather a quick history while measuring her fundal height (quick and dirty confirmation of gestational age) and scanning her for gestational age/placental location (your pgy-2 should help you with scans until you become comfortable with them).
7. Use your common sense: if she’s screaming that the baby’s coming, don’t waste your time on the preliminaries.

**Physical exam in triage room:**

note vital signs/urine dip/fetal heart tracing as appropriate for gestational age.

direct your exam. If she’s there for a labor check, you can skip the cardiovascular/lung exam. Always examine the abdomen and extremities.

pelvic exam: until you’re experienced, always do both speculum and digital exams; get cultures/wet preps/fern & nitrazine tests from everyone. If concern for preterm labor, FIRST collect Fetal Fibronectin. Then send UA/Ucx/GC/CT/GBS. Do NOT digitalize
preterm patients who are ruptured (increases risk of chorio) or patients with placenta previa (can cause bleeding). In those cases, evaluate cervical dilation visually only (remember that visual evaluation of cervical dilation is unreliable). If in doubt about ROM in a preterm patient, defer digital exam until you’ve checked the fern test.

Bayview Days: PGY-1

Very important - before you start at Bayview, make sure you have a Meditech ID and password. This is the only way you can place orders.

The intern's duties at JHBMC are not as clearly defined as they are at JHH. You will be first page for all floor questions for both antes and posts. As always, as the intern, consult your elders and constantly communicate everything. The key to Bayview (and all the rotations) is team work. We all take care of our patients together and we have to constantly update each other.

In general, and in no order (different on days you have clinic):

1. Primary LSTCS
2. Vaginal deliveries
3. Bilateral tubal ligations
4. Triage
5. Clinics
6. Dictation
7. Floor duties – postpartums and antepartums

Schedule:
Board sign-out is at 7:00 am on weekdays, 8:00 am on weekends and holidays. The night float arrives at 5:30 for evening sign-out. Each morning, pre-round for board sign-out. You should get your people all tucked in prior to board sign out. This means hand making sure discharge sheets and prescriptions are written, entering discharge orders, and taking care of any miscellaneous orders needed. This is important b/c some mornings you have clinic so need to have everything done.

Your weekly schedule varies greatly each day:

Monday:
8:30 - noon: Colposcopy clinic. Attendings are Chou/Trimble. You work colpo along with a chief. Every few weeks there is a path conference after clinic. Great hands on experience with colpo.
Afternoon: L&D

Tuesday:
8:15-1pm (or whenever the last pt is seen!): HROB clinic – headed by the HROB chief. Dr. Neale is the attending. Get there at 8:15 to review the list. Take notes on each pt and hit on the key issues during their visit. You are accompanied by the 4th yr on OB days. A long, busy clinic.
**1pm-5pm:** FCC clinic – this is the pre-operative clinic for the TA's which are done in the FAC on Wednesdays. You pre-op the pts, place laminaria and get experience at US. Burke/Singh/Jamshidi are the attendings. Both clinics are in the same location, and the FCC attendings will let you get lunch between clinics.

**Wednesday:**
L&D all day. Routine OB stuff – deliveries, sections, triage, floor work.

**Thursday:**
Board sign out at 6:30 am then to JHH for grand rounds when applicable. Otherwise, sign out is at 7am. On L&D all day. Routine OB stuff – deliveries, sections, triage, floor work.

**Friday:** On the floor until 12:30pm. Routine OB stuff – deliveries, sections, triage, floor work. 1:00 is the Fox lunch at JHH followed by school. You will likely be on call over the weekend on L&D at the 'view.

**Triage:** Evaluate the patient, be problem oriented, get tremendous experience at TV and Abd US. This is the best place to increase your US skills. Triage can be hectic. Take the time to fully and carefully document everything in QS. Once again, communication to the other residents is the key. We all depend on each others' notes and the better they are, the better care we can provide.

**Dictations:** Try to dictate all of your charts immediately, preferably before rounds the morning you anticipate discharge. The dictations pile up amazingly fast due to our rapid turnover. The charts are on the floor for 24 hours and then they go to coding. There is a phone dedicated to resident dictations and a bin on A2W. Bourque and Garland are private attendings - we don't dictate their patients (which is nice b/c they have a lot of patients).

**Bayview Nights: PGY-1**

- Nurses are REALLY helpful and mean well and WILL know more than you, so listen to what they have to say
- Your main role – none…you get to do it all! If stuck, call your chief and she/he will understand. Here’s the list of stuff you will get to do:
  - Triage
    - Everybody gets asked CTX, VB (vag bld), LOF (leak of fluid), FM (fetal mov)
    - Labor checks – strip (reactive?, CTX?), pooling, nitrazine, ferning, digital exam (as long as not PPROM!)
    - SROM – strip (reactive?, CTX?), pooling, nitrazine, ferning (if equivocal→AFI), digital ex
    - Vaginal bleed, 2nd-3rd trimester, no pain – sono for placenta previa, Rh status for RhoGam, o/w like labor chk
- Vaginal bleed, 2nd-3rd trimester, c pain – trauma?, high BP?, coagulopathy?, abruption labs: PT/PTT, KB (fetal blood in mom), T&S (Rh status for RhoGam)
- Vaginal bleed 1st trim – cramping?, VB?, speculum: blood?, B-hCG quant, T&S (Rh status), CBC (crit status), sono (differentiate miscarriage vs. ectopic, also need for D+C)
- Sharp lower abd pain early in preg – may be ovarian corpus luteum cyst, ectopic, appy \(\rightarrow\) transvag sono
- Nausea/Vomit – UA for ketones (dehydration?), IV NS bolus, d/c after cleared UA ketones, tolerate PO + script for vit b6/antiemetics
- Preterm CTX – Always do **FFN first** then collect UA/UCx, GC/CT, GBS, wet prep, pooling, nit, ferning, digital exam (if not PPROM!). PO hydration to stop CTX if flimsy o/w IV hydration if adequate CTX on Toco…terbutaline 0.25 SQ if cont ctx and consider tocolytics prn
- Abd pain not consistent c CTX – fever?, surgical abd (apppy)?, CVA tend(pyelo)?, CBC, CMP, amylase/lipase, UA, Ucx

**Labor and delivery**
- Labor/IOL
  - “L&D labor” order set on meditech
  - IOL - If Cx favorable place foley bulb, if Cx unfavorable (i.e. cl/lg/very posterior) cytotec or cervidil. Then Pit
  - Remember to write a note after: checking a pt, rupturing membranes, placing cytotec, placing a foley bulb
  - Remember to advance the board
  - Delivery – controlled delivery of head, check for nuchal cord, suction as appropriate, restitution of head, directly down, then directly up (have chief protect perineum initially)
  - Lac repair – vicryl 3-0 for midline perineal, 4-0 for mucosal labial tears
  - After you deliver the baby: 1) change the board to s/p FTSVD, 2) delivery info on QS, 3) “A2W s/p vag delivery” order set, 4) put pt on the list, 5) D/c paperwork and Rx
  - PEC labs – CBC, CMP, LDH, PT/PTT, fibrinogen, uric acid, UA, maybe 24 hr urine for prot
  - During labor, AROM will help speed up things, but make sure the head is engaged (low station)… always check for cords s/p AROM
  - If cervical dilation has not progressed over 2hrs, AROM and insert IUPC to assess adequacy of CTX and pit optimization
  - FSE (fetal scalp electrode) for bad FHT (NOT on HepB/C or HIV pts)
- C-sections…u will do them!
  - Go help anesthesia once the pt is pulled to the or
  - Pt on Op table – teds + SCD (sequential compression device)
  - Left tilt cushion on
  - SCRUB
  - Drape pt c assist
  - Allen test for anesthesia level
• Ask for pen - Find pubic symphisis, 2 finger breaths above mark midline, mark ~6cm lateral on each side
• Ask for 2 laps and blade (some prefer second knife after skin incision). Follow the line…cut, dab, look for vessels (clamp, clamp, Bovie), cont. cutting to fascia (cut in the middle only), blunt finger separation of tissues (may need blade/Bovie to separate lateral edges)
• score the fascia
• ask for pickups c teeth plus Mayo scissors – pull fascia up and undermine in smiling fashion, cut c Mayo’s (twist scissor tips upward), twist ur body over pt’s legs to do ur side
• ask for Kocher clamps times two – 1-2 cm from midline, pull up, finger sweep up and out, pass to assist
• ask for Mayo scissors – cut right above muscle
• Bovie vessels visualized
• Kocher out and pass to inferior flap, blunt finger sweep
• Ask for Mayo – again cut just superior to muscle, down to symphisis
• Ask for medium Rich
• open diastasis to peritoneum
• Ask for pickups c teeth times two, Metzys – hold peritoneum, assist will hold across from u to make a flap, ask for Metzy’s, visualize clearing, enter peritoneum, then stretch
• Ask for bladder blade and reposition Rich
• Feel for position of uterus
• Ask for pickups c teeth times two, Metzys – pick up uterine visceral peritoneum above bladder line (someone will tell u) and nick, undermine in smiling fashion up c tips up, cut angling tips upward, same for opposite side twisting your body
• Ask for Kelly times two – clamp bladder flap of two sides and bluntly dissect bladder away: push fingers in medially (finger tip over uterus) and sweep laterally pushing the uterus backward (NOT bladder forward) down to the symphisis
• Reposition bladder blade over bladder flap
• Ask for blade and have suction ready – score a big smile, then cut in the middle, feel for thinning on every swipe
• Once open, insert two fingers at incision edges and pull cephalad vs. use of bandage scissors
• Delivery hand (review c chief…very difficult, the trick is flexing the head and pulling cephalad) then have chief apply pressure for delivery
• Clamp and cut cord, hand baby to peds
• Get blood gas and cord blood
• Massage externally vs. manual extraction of the placenta for practice
• Ask for wet and dry lap - Exteriorize the uterus, cover the uterus c wet lap, curettage c dry lap
• Ask for rings – clamp uterince incision edges
- Ask for vicryl 0 and Russians – close the uterus (assist will guide u). Always feel for vessels before getting apex.
- Look at tubes and ovaries
- Irrigate behind uterus
- Return uterus to abdomen
- Ask for wet laps and sterile saline for irrigation – push laps in gutters, fill c saline, push suction against lap, visualize gutter, repeat other side
- Ask for maxon 1 and pick ups c teeth – close fascia, remember get both layers
- Ask for vicryl 3-0 if sub-q fat more than 4 cm – close dead space (scarpas)
- Ask for Adsons times two and stapler or vicryl 4-0 on straight or curved needle plus steristips for skin
- Ask for wet lap – clean wound
- Ask for dry lap – dry wound
- Take off second gloves
- Ask for blue cloth - Cover wound
- Pull drape off the pt while holding blue cloth down
- Ask for abdominal pad – over incision
- Ask for tape – hold pad down
- Help turn pt on side for epidural removal and roller, push pt on stretcher
- Get EBL, crystalloid, UO for dictation
- Change board, Fill out QS delivery info, A2W s/p C-section order set, update the list, put in PBL book, OP note, dictate, d/c paperwork and Rx
  - Gynecology – for NOS (night of surg) note use gray book format
  - Floor pages – try to respond as soon as you can
    - Headache – Tylenol, then reglan, if spinal (severe when sitting up) Caffeine drip+anesth consult
    - Gas – simethicone
    - Pain – tylox, oxycodone, dilaudid 1-2 mg IV/PO vs increase PCA early s/p C-section
    - N/V – phenergan/reglan
    - abn vitals (BP up) – PEC sx, labs prn
    - bleeding/CTX in PTL – place pt on the monitor and evaluate
  - ER pages
    - Important questions when answering on the phone - get pt’s full name, MR#, location, why they came in, course while in ER, the specific question being asked
    - go history the patient, bring the pt to the gyn exam room, page your chief to examine the pt, the attending will get involved, follow their recommendations
  - The list
    - at MN advance the list!
    - Distributing pts – this is somewhat of a pickle. Have your chief help at first, but the bottom line is equal distribution.
Rounding

- Always start @ 4:00am…preventative as the triage bus may arrive at 6:00am (all of them fully dilated)…by the way if this happens: #1 pelvic for Cx dilation, #2 sono for presentation, #3 check GBS status, #4 report to chief

Board presentation – by some, the hardest part of this rotation

- Begin c labor room #, where prenatal care was given, name of pt (spell last name)…followed by one liner: like this…”xx yo, Para xxxx, at xx wks by Dates Exam and some-week sono, here for…”
- If housestaff transport (HSTX) - what happened in other hospital after one liner
- If our pt – go to GBS status, Rh status, Rubella status, prenatal labs of significance (HIV: last CD4 and VL, HepB/C: last AST/ALT), sono of significance (C-section: where is the placenta, twins: lie and presentation, GDM: EFW, Oligo: last AFI), previous pregnancies (all; especially baby wt’s for suspected macrosomia), PE (if IOL last pelvic exam documented, if PPROM Cx visually whatever cm), announce Crit, platelet, other labs, plan:
  - Labor – pit augmentation PRN, epidural PRN pain, IUPC/FSE and when
  - IOL – cytotec/cervadil vs. bulb (when it was placed o/n, how many cytotec, when it last finished/fell off, next cytotec), IUPC/FSE and when
  - PEC – BP’s o/n (stable or elevated), started Mg @ time and where is it now, s/sx of toxicity, no s/sx of fluid retention
  - PTL/PPROM- started tocolytics, contractions throughout the night?, started on latency abx for PPROM, first BMZ (betamethasone) @ and next dose today @, NICU aware.
  - Mg sz prophylaxis – time of delivery, no s/sx of toxicity, no s/sx of fluid retention, diuresing well (include last I/O total and amt per hour)

JHH GYN: PGY-1

Schedule:

Morning rounds usually before 7a. The gyn pgy-3 and the attending pick specific time, depending on how many patients are on service and whether there’s a 7:30a case, grand rounds or M&M. NOTE: The Weinberg call resident should be relieved of the gyn beeper no later than 7:00a, and earlier if possible (the intern should make a habit of picking up the beeper as soon as he/she comes in to pre-round).

Monday:

5:30 PM Professorial Rounds with Dr. Anderson (Weinberg Conference Room)
-Gyn team and Onc team alternate having a case ready to present.

Tuesday:

-8:30-12:00 Colposcopy Clinic w/ Dr. Trimble (JHOC 8th Floor)
-1:00-5:00 Intern Clinic

Wednesday:

-8:30-12:00 Pre-op/FCC w/ Dr. Huggins and Amy Lee (JHOC 8th Floor)

Thursday:

-7:30am: Grand Rounds (Phipps Lecture Hall)

-4:30pm every other week: Colpo Correlation (Weinberg Pathology)

Friday

-7:00am: gyn/gyn onc M&M conference (Weinberg Conference Room)

-1:00pm: Fox lunch (Phipps Conference Rm 246)

-2:00-4:00pm: school (Phipps Lecture Hall)

**Responsibilities:**

1. Pre-round on assigned patients. Number of patients usually divided equally among all team members. It’s nice to pair patients with the residents who did their surgeries, but often not possible since the pgy-3 does more operating.
2. Round with gyn pgy-3 and the attending. Pgy-1 is to have a list of patients ready for the team prior to rounds starting.
3. Complete floor work. The pgy-1 with the help of the pgy-3 makes a list of the scut work to be done during the day. Shared by pgy-1 and Amy Lee. The pgy-3 occasionally will help, but has other responsibilities (OR cases, preparing M&M, etc).
4. Gyn pgy-3 will assign OR cases on a daily basis. Usually, that person will let you know which cases are yours the night before. In general, the gyn pgy-3 will do most abdominal and all vaginal cases. At times the pgy-1 will have the opportunity to be the second assist on major cases. Some attendings may even allow the pgy-3 and pgy-1 to do the case together. Try to learn as much as you can even while retracting by reading about the case in advance, asking questions, etc.
5. Weinberg OR patients need to be seen in the pre-op area in advance to make sure their H&P/consents are done. The resident doing the case should do the pre-op if available, but if that person (usually the pgy-3) is scrubbed in, she/he may delegate this job to a junior resident. Significant delays can occur if paperwork isn’t done, so you want to complete this task in a timely fashion.
6. Postoperatively, most Weinberg OR patients are admitted. Post-op paperwork: operative note, orders, PCA orders, path sheet. You can fill out a lot before the case, which saves time. NOSN should be written 6 hours after surgery.

7. JHOC cases are the domain of the pgy-1. More complicated cases (i.e. operative laparoscopies) or cases in which we’re deficient in numbers (i.e. cone biopsies) occasionally may go to a more senior resident. You need to arrive at JHOC with time to pre-op the patient. If the patient is housestaff, she should have an H&P/consents in the pre-op notebook (ask pgy-3). If they’re missing, or for non-housestaff patients, you will need to quickly fill these forms out. Other paperwork includes orders (sign the pre-stamped order sheet), discharge summary form, patient instruction sheet, and prescriptions. You can save a lot of time by completing as much as you can pre-operatively. Post-operatively, you’ll need to write an operative note and dictate the case. After accompanying the patient to the recovery room, ask the attending if you have questions about the dictation. Also don’t forget to sign the path sheet if any specimen is going to path. Don’t forget to log your cases in at the ACGME website. Try not to fall behind on this.

**Keep a blurb on all JHOC pts and give to PGY3 for their M&M. Include: name, medical record #, age, parity, brief history, procedure, EBL, OR time, complications, and what was sent to path.**

8. ER beeper is generally carried by pgy-1. The resident carrying the ER beeper answers calls and sees consults in ER and on floor. For ER consults, see the consult and then call Amy Lee or the gyn chief when done to dispo. Some juggling may be necessary if everyone is scrubbed or in clinic. If you need help prioritizing (ER demanding consult, you’re stuck doing cases in JHOC), call the chief or Amy Lee for guidance. All consults should be dictated as an unstructured note into EPR.

9. Floor consults: You will be called for consults for a variety of reasonable and unreasonable indications. In general, it’s tough to fight a stupid consult; better to expend your energy getting the consult over with. If it’s a pregnant patient, usually the ob team should take care of the consult. If it’s just for a Pap smear, have the primary team page Lynn, the pap smear nurse. For the rest of the consults, see the patient alone and do a directed H&P (summarize non-gyn stuff unless it’s relevant). Call the gyn chief to run the case by her/him. You can leave a one sentence note (“patient examined. Full consult to follow”) or brief recommendations based on chief’s suggestions in patient’s chart. Then the team, together with the floor attending, sees the patient later that day or the following morning during rounds. If you are an intern, ask the chief/attending if they want to be present for the pelvic exam, especially early in the year.

10. Pre-op clinic/FCC. Everyone not in the OR goes to this clinic. Run by Amy Lee.


12. Ectopic book/bottom of gyn list: the domain of the pgy-1 and Amy Lee, supervised by pgy-3. Write up each patient on a blank sheet (found in notebook). Sift through labs at least 2x/week. Document all phone calls on patient’s sheet. Run all active patients by pgy-3 once a week. If a patient is particularly non-compliant about following up, consider dictating an unstructured note describing case, recommendations, your efforts to follow up, the patient’s failure to do so, etc. Also dictate an unstructured note (#39) for anyone receiving methotrexate. When patients are done being followed (i.e. quant now zero), their sheets should be sent to JHOC medical records.

13. Friday school is mandatory even if scut isn’t done.
14. The gyn team prepares a detailed signout of its patients for the weinberg call resident and night or weekend call chief. Before signing out for the day, try to tuck things in as much as possible, i.e. get NOSN’s done, finish scut, etc. Any consult called in after 5PM should be signed out to the Weinberg nightfloat.

15. Weekends: For rounding, Weinberg call person splits gyn and gyn/onc list w/ oncoming call person and onc senior resident. Carry gyn and gyn/onc pager to address inpatient needs and any consults. Run any issues or consults by chief on L&D.

Pre-op Clinic/FCC:

**Wednesday morning.** Attending: Dr Huggins. Run by Amy Lee. Housestaff patients present for pre-ops mainly for tubal ligations and terminations; occasionally for major cases. You also will see post-op follow-ups.

1. Routine pre-op:
   a. Write H&P and sign consents (make sure consents are witnessed, otherwise are invalid). For tubal ligations, if patient has medical assistance, the MA form needs to be signed at least 30 days in advance of the surgery, but not more than 180 days before. When patients sign the MA form, always give them a copy in case medical records loses their chart.
   b. Each patient should have a GC/CT gene probe done within 30 days and a Pap smear within six months prior to her procedure. If in doubt, repeat the tests.
   c. Write patient’s home or other contact phone numbers at top of H&P. Make copies of H&P/consents for yourself and for Michelle Alston (hand-carry to her or fax them to 410-502-6917, attn Michelle). Your copy goes into the pre-op notebook (kept organized by date). When the date arrives, the paperwork then can be taken to the OR.
   d. Be sure to follow up on labs in a timely fashion.
   e. If patient has definitive diagnosis of cancer, refer her to gyn onc clinic for appointment. If questionable diagnosis (i.e. adnexal mass), run the patient by a gyn onc attending (catch gyn onc attending in clinic if possible, so she/he can meet the patient; if not possible, contact by phone is OK). Patient’s surgical case then may or may not be scheduled with gyn onc.
   f. For all patients, remember to fill out the billing sheet, not forgetting the diagnosis on the back of the sheet.
   g. Posting patient: Cases can be posted in JHOC (minors only) or Weinberg (majors). Minors are generally posted with whichever attending is available when it’s convenient for the patient to have the procedure. If minor is uncomplicated and noncontroversial (i.e. tubal ligation), you don’t need to call the attending in advance, but if any question about management, definitely call the attending. If you want to post a major case with a particular attending, call the gyn office and find out if that attending is available. If yes, book the case with the gyn office, then call Michelle and tell her the gyn office has cleared the case. Call the attending in question to discuss the case as soon as possible. Fill out the posting sheet (blank copies found at front of pre-op notebook). List amt of time needed,
special instruments, whether patient needs pre-op anesthesiology appt, etc (For example, request endo-loops for laparoscopic BTL’s). Give posting sheets to Michelle, who will post the cases. Follow up to make sure she’s done so and that the patients know when they’ve been scheduled. For any pregnant patients (except terminations), post for Weinberg OR instead of JHOC, AND call L&D to post the case in the black scheduling book so nursing will be available for continuous fetal monitoring. Speak personally with the charge nurse as well so that nursing staff knows to have extra people available that day.

2. Terminations
   
a. Can be done up to 12 6/7 wks at JHH. If gestational age 12 6/7-20 wks, refer the patient to Bayview. Between 20-24 weeks, refer to appropriate clinics.
   
b. All patients get official sono Wednesday morning. Good time to get transvaginal ultrasound experience w/ the ultrasound techs. Take advantage.
   
c. When pre-oping patients for terminations, encourage them to choose their post-op contraception. (Note: medical assistance does not allow tubal ligations to be performed with terminations). If patient wants an interval tubal ligation, have her sign the MA form and tubal consents, then schedule the tubal ligation after the termination.
   
d. Seek guidance from Amy Lee for filling out all of the appropriate paperwork, which can get complicated.

3. important numbers for pre-op clinic

Precertification for surgery: 410-614-5211

**REI: PGY-1**

Resident obligations on REI service:

- Every Friday an REI fellow will make the schedule for the following week. Please let this fellow know when you have your weekly continuity clinic. The fellow will assign you to various clinics and OR cases to attend. You will be expected to see patients at Greenspring Station as well.

- Assist with clinics and surgeries as assigned by the REI fellows and communicate daily with the fellow-on-call for updates on clinic/surgery assignments.

- You are responsible at all times for being aware of the REI inpatient roster, and should serve as the liaison between the REI service and the GYN housestaff – this particularly applies to the transition of coverage from weekday to weekend.
- Be reachable by beeper Mon-Fri from 7am-5pm while on service.
- Review and present a journal paper or topic for one division meeting while on service (the paper is usually picked for you).
- Write a morning note on any in-patient if you have assisted in that patient’s care.
- Organize the monthly REI/Path conference as needed.
- By the end of the REI rotation, the resident should be able to fulfill the following requirements:
  - Perform basic vaginal sonography
  - Perform basic diagnostic and operative hysteroscopy and laparoscopy
  - Perform the basic evaluation and work-up for infertility, menopause, anovulation, hirsutism, and amenorrhea
  - Maintain a written record of all surgical procedures performed and assisted, numbers of ultrasound procedures, and a written log describing the number of outpatient cases seen listed by diagnosis
- Must sign out to the L&D chief and the Weinberg night float every evening.
- Must inform the Gyn team if you are not able to round on an REI patient over the weekend.

**GYN/ONC: PGY-1**

General schedule of the day for the intern with weekly events mixed in:

**1. PRE-ROUND** (come in as early as you think you’ll need PLUS some extra! DO NOT BE LATE FOR ROUNDS even if the attending IS!)

- There should be an updated list and printed progress note already prepared by the night float pgy-2. See your patients and write your progress note.
- You’ll need to gather the vitals (ALL of them, current AND ranges) and put them on your note, talk with the nightfloat and nurse to find out what happened overnight. Remember to record all I/Os for prior 24 hours and since MN from each possible tube/outlet.
- Check for all the new labs not recorded on the chart from the day before. (EPR)
- Update the “Diagnostics Section” of the chart (with the lab flowsheets).
- Check over any orders that have been made overnight.
- Remember that for eclipsys monitored floors, you’ll need to check that system for vitals. If you don’t have an eclipsys and POE and EPR password yet, call 955-HELP and get one ASAP. You can call that number any time 24-7 for help too with logging in, etc.
- Make sure that the meds are fully updated/correct (check the MAR in the drug room on Weinberg or in POE on those floors).
- Talk with the patient and EXAMINE her heart/lungs/abd/incision/drains/extremities and get clear ideas about the problems that the patient needs addressed by you and by the team.
- Create your plan for the day and WRITE BY ORGAN SYSTEMS (Bristow is into this, but note that he wants you to PRESENT BY PROBLEMS with plans).
- Read a little the night before or quick in the morning about the patient’s main diagnosis, staging, main treatments and surgeries (general!), and chemo mechanisms/toxicities. It’s likely you’ll be pimped. 😊
• Have a differential generated in your head about each problem on your list and a CONCRETE plan.
• Write any of the needed orders of the day (e.g. – discharges, electrolyte repletions, diet advances, foley d/c’s, etc).
• Sit down either before (if you’re lucky) or after rounds and update the discoveries from the night on the team’s list on the ONC computer.
• As much as you can get done on pre-rounds will really set up your patients for the day.
• If you have any time left over, offer to round on someone else’s patient(s) or help out in any way possible. Ask your upper levels.
• Get your discharge paperwork done EARLY. Fill out the discharge form (be completely OCD and write EVERY diagnosis and EVERY procedure down, write the prescriptions, get the appointments made, etc).
• Get the charts all together and push the chart out to the first room and prepare the first one for the attending by opening it to the day’s progress note or the first page of the H&P if you’re presenting a brand new patient.

2. ROUND (may start anytime from 5:30am till 7:30am depending on pts and attending schedule)

• Different teams will have different “flavors” and systems, but generally try to have the cart set up at each room ahead of the team, open the chart to the correct page, get into the room to listen to the discussion and jot down notes about the plans for the day.
• WRITE ORDERS as much as possible DURING ROUNDS. That makes the post-rounds frenzy a lot less stressful. Remember that the upper levels will desert you for cases at 7:30am or so and YOU may be the only one left on the floor who needs to know all the patients and plans and has to execute those plans for the day.
• Present your patients. Summarize all your findings, new data (the important stuff only) and present your plan in a logical and succinct way. Make sure patient doors are closed. The general presentation is: “Ms. XX, post op day X s/p XXXX for XXXX.” Then go through interval events (subjective only) → vitals and objective data that’s relevant → your relevant exam findings → relevant lab data, → new studies → A&P.
• Be prepared for a little pimping. . . it’s fun.

3. GET THE PLAN IN MOTION (after rounds till whenever)

• You’ll help Melissa order studies and call in consults and order tests and write orders and TPN/PPN etc. after rounds. Get everything done so that the nurses can execute things.
• Melissa Gerardi (the PA on the service) is an ANGEL. . . she will teach you a TON and help you get things done in the big Hopkins system. If there’s one thing that you can learn well on ONC it’s figuring out all the pitfalls and sabotage that can thwart your plans for the day. And how to avoid them! Ask her lots of questions. Let her teach you how to do both the practical admin stuff and procedural stuff too.

4. OTHER RESPONSIBILITIES (variable)
• Around 8:30 (unless you have an OR case that may start at 7:30) you may be headed to Colposcopy clinic (Tuesday mornings at 8:30 on JHOC 8) or your own continuity clinic (as scheduled, BE SURE TO CHECK THE SCHEDULE AND EPR APPTS EACH WEEK SO THAT YOU KNOW WHEN/WHERE YOU NEED TO BE and give your chief a heads-up).
• You may cover benign gyn minor cases from time to time. . . the chiefly folks will let you know.
• Get the appointments made with Ina for the discharged patients.
• Write prophylactic transfer orders for patients potentially coming up from the WICU or IMC’s.
• Thursday mornings are Grand Rounds (off for the summer).
• Friday mornings are teaching mornings . . . you’ll have M&M, Tumor Board, and then journal club (maybe) with Giuntoli. Have your articles well-read and ask your chief what the choice pimp questions will be. They’ll help get you prepped and tell you what to read over.

5. MIDDLE OF THE DAY (totally variable)
• Help with stuff on the floor (default for EVERYONE is the floor really)
• DO DICTATIONS. All the dictations should be done by 24 hours after discharge, per Bristow’s new thing related to getting full reimbursement. It will take you forever to start. Follow old examples and usually by organ systems for hospital course except for very simple chemo admissions or similar situations.
• READ.
• Update your work hours.
• Update your case log.
• You’ll be called to help with clinic too. Ask Larissa or Melissa how things go over there. You’re basically the paperworker and the pre-viewer, but you help the attendings move things along.
• You’ll get little questions and pages all day long. Go to the infusion center (Weinberg level 2) to see chemo patients and sign their consents/write orders/evaluate problems.
• Transmit and coordinate information for the team. KEEP YOUR CHIEFS INFORMED!
• Return pages as quickly as you can. As the nurses learn to trust you and know you’re reliable, they’ll take verbal orders more and more. Just back them up if something happens.

6. 4PM CLEANUP (your chance to help the team!)
• Start doing pm rounds on the patient for the team. You’ll need to check and record all the vitals, discover what’s happened for the day with your well-made plans (and how they’ve been sabotaged by patients, other services, and the system) and figure out what needs to be updated on the list and addressed by the team before signout.
• Afternoon rounds much faster and less intensive than am rounds. Just figure out the vitals, outputs, etc. and be able to report the service to your chief so that she/he can sign out to the many folks she/he has to update.
By the time you’ve finished rounding (other people will divide patients with you and help out) and updating the list and writing new overnight orders, it will probably be close to 6pm.

The nightfloat arrives at 6pm 😊!!! And if you’re lucky you’ll go home. . . usually it takes longer to get everything together, finish last dications, etc. etc. etc. so that everything’s tucked in before you do it again in a few short hours.

Other stuff that the intern does:

Call in Weinberg – similar to above, but you have a smaller team to round in the morning. Your chiefs will help you figure out how it works. Keep in close touch with your L&D chief to figure out what you’re doing. Oh, and NEVER biopsy a cancer patient on your own . . . unless ordered to do so by a chief. . . and then document it! You’ll cover benign gyn, ectopics, etc when you’re on Weinberg call as well. And maybe get to the OR!!! Oh, ask your nightfloat to go over the night routine with you before your first night call – preparing the progress notes for the team, printing lists, etc.

Save charts for dictation by you or others if they get into the lockbox at the clerk’s desk. Help keep the Dictation list up to date – write the discharged patients on there.

GBMC: PGY-1

First Day: Park in Garage D, there is a physicians entrance. Go in the Emergency Room entrance and just follow signs to Main Lobby, then take a right and look for Unit 46

Getting Around: The floorplan is slightly confusing, but here is a list of important places:

- Main Gyn area- Unit 46, this is where the AM Conference is
- Call Room- you need to call security to get your card access to this area, the code to the door lock is 330*
- Cafeteria- 5th floor
- Physicians Lounge- (with bagels, coffee, muffins!) 3rd floor on the hallway that leads to PPW
- Medical Library (great place to read, they have all the gyn texts) 3rd floor directly under Unit 46
- Surgical Posting Office – Unit 48, over by the higher numbered rooms
- General OR’s – 4th floor, take the elevators by the Emergency Room
- Women’s Pavilion OR’s – on 1st floor of PPW (have to go outside to get there or underground)

Schedule: Usually, we do informal rounds before 6:45, no official presenting the patients and attendings don’t come. You only round on patients you operated on, and help out if there are a lot others on the list. 6:45-7:15 is the AM Conference where we take turns presenting journal articles, topics. First cases start at 7:30, except Fridays when first case
is 8:45 after Grand Rounds. There are also Urogyn conferences every other Wed, but those are suspended in the summer. Someone from the team has to hold the Gyn Pager until night float comes in at 5:30, usually not more than once or twice a week per person. Otherwise you leave after your cases!

**Responsibilities:**
1) Rounding, progress notes – as per usual, except it is a little trickier since the attendings are all private: in general do all the advancing of diet, meds, and lab orders, but wait for attendings to put in discharge orders after they see the patient. Be sure to ask the attending at the end of the case for any specific instructions. Some of them have preferences re: when foley comes out, when they get regular diet, when dressing comes off, etc.
2) Pre-op: get to the pre-op area at least 15 mins before to take care of all the paperwork, meet patient, write scripts, etc. The main paperwork you have to do is the pre-op procedure note (on same sheet as Brief Op Note), Orders (discharge: d/c home after tolerates po, voids, vitals stable and meets recovery room criteria; or admitting order set), and Discharge Instructions with Prescriptions (usually follow up with surgeon in 2 wks, percocet 5/325 (#20) is popular with most attendings for s/p laparoscopic procedures).
3) Dictating: Depends on the attending, but always clarify if they want you to dictate.
4) Post-op: just put the patient on The List if they are being admitted and make sure all their orders are in.
5) Gyn Pager: mostly the calls you get are for floor patients, small issues, and then about 1-2 calls from the ED with consults per day. For consults, go see the patient and then grab a senior resident to do the exam with you, then discuss with the attending. There is an attending of the week for house staff pts (don’t have a doctor) or you call the patients GYN directly if they practice at GBMC.

**Cases you get to do:** D&C hysteroscopy; lots of laparoscopy – cystecomies, oopherectomies, diagnostics, tubals; LEEPS, CKC; laser ablations; endometrial ablations; TOT/TVT; sometimes you get lucky and get to do other bigger cases like TAH, LSCH, myomectomy, etc.

*Remember to wear blue scrubs!*

**Emergency Department Rotation: PGY-1**

* Total of 4 weeks in the ED.
* Interns work an average of 60 hours/wk with ~10 night shifts.
* Please contact the Administrative Chief WELL in advance if you have shift requests to be on or off. You will be put in contact w/ the ED chief for specific requests. Nothing is guaranteed.

* Interns are required to attend OB/GYN didactics every Friday (Fox lunch at 1:00pm and lectures from 2-4 pm). Attendance will be taken. The ED knows about our required didactics and should have taken this into considerations when making the OB/GYN intern shift schedule in the ED.

ED shifts typically are from 7am-3pm, 3pm-11pm, 11pm-7am, 7am-7pm, or 7pm to 7am.

During your ED rotation, you are responsible for covering L and D, either Thursday 7-11pm or Friday 7am-noon (you don't have to round on the patients). Whether you cover Thursday or Friday, depends on the ED intern working in L and D's schedule. If they are on nights, you cover Thursday night, if they are on days, you cover Friday am. The two weeks you are on vacation the REI interns covers. Please remind them.

Susan will forward you your schedule at some point before your rotation. When you get it, check your vacation. Also, check they haven't scheduled you for when you are covering L and D.

Show up a few minutes early for your shift. At shift change, people meet in front of the white patient board. This is also where the list of teams appears. Sometimes you round with attending, but other times you take informal sign out from the person you are relieving. The ED is divided into two teams, red and blue. Each team has 2-3 people. Red team takes care of acute and subacute, beds 26-33. Blue team covers IMC and Med/surg. Each resident takes care of the room/area assigned. If there is a third person, they cover the triage area and psych. If there are only two people, it is up to you take care of your room in addition to helping the other resident on your team cover in triage and psych. (This can be resident dependent, so discuss at the beginning of the shift.)

In your area, you evaluate the patient. There is a preprinted H and P form to fill out. You write orders on paper forms. The nurse will help you a lot with this. When you are ready to present, you find the attending etc. If you have quick questions about the patient the resident on your team is available. Some residents are more involved than others. For any procedures, discuss with resident first, they will help/supervise you. You decide on dispo etc. with attending. There are papers to fill out for admissions. Do not let patient go to the floor before the resident on the accepting service has seen the patient. (BIG No, No.) If really sick patient comes in, i.e. unstable vitals, don't wait. Get the basics, then let the attending know.

In triage, you briefly talk to the patient, order labs. If you think they are too sick to sit in the waiting room, you can move them to an area called the SU. If you think they can be discharged from triage, you discuss patient with the attending and can then send them home.
In psych, you are basically responsible for medically clearing patient. You interview patient briefly and do physical. Then tell psych nurse or resident about the patient.

Traumas/critical patients: they announce over head when they come in. Discuss with your resident at the beginning of the shift if you should go etc.
Rotation Responsibilities PGY-2

JHH OB Rotation: PGY-2

Weekday schedule (daytime):

a. Daily weekday rounds at 7am; weekend rounds at 8am. The night float will stay for board rounds.
b. Intern schedule:
   the first two weeks of the month, the ER intern works 7a-7p and the ob intern works 7p-7a; they switch for the second half of the month. The intern schedule is posted on L&D.
   1. They both preround in the mornings. If the suite is busy, the day intern covers the suite during rounds while the night intern rounds with the team; if not busy, the day intern comes to rounds too. The night intern then signs out to the day intern and goes home immediately.
   2. The ED interns are required to attend their departmental lectures on Fridays, 7-11am, so plan accordingly.
c. Wed 3:00 pm - MFM conference (Phipps lecture hall); once monthly, includes ob M&M conference and stats (Dr. Witter will provide data). You and the chief should attend this conference every week whenever possible.
d. Thursdays: 7:30a Grand Rounds (Phipps lecture hall)
e. Fridays:

   8:00 am – NICU rounds in the NICU.
   8:15 am – High Risk Clinic Rounds (JHOC 8th Floor, Pod C). The day PGY2 is required to attend (with the GBMC PGY2). L&D will be covered by the OB Chief, Intern, and a MFM fellow.

   1pm Fox lunch

   2:00-4:00p: school (Fellow covers L&D)

Night Schedule:

a. Sign out at 5:45pm between you, the night chief, day chief, day PGY2
b. Board rounds at 7AM

PGY-2 Responsibilities:

Days (7am-5:45pm Sunday-Thurs) and Nights (5:45pm-7am Sunday-Thur)
a. Run labor and delivery. Includes supervising and helping the intern (particularly with triage); being aware of what’s going on with all patients; making management decisions with the ob chief and/or attending for all patients. Managing all antepartum patients, calling housestaff transports primary doctors for updates. You MUST know the board.

b. Intern responsibilities: triaging patients and writing progress notes on all L&D patients. Progress notes should be written about every two hours. You supervise the intern and pitch in with those tasks when the suite is busy. If multiple triage patients come in at once, you should expect to see some of them. Similarly, if the intern is busy with triage, you’ll often need to keep up the notes on the laboring patients, update MgSO4 flowsheets, etc.

c. PGY2 Days should sign out L&D board to the PGY2 Nights resident when they come to take their shift at 5:45pm. The PGY2 Nights resident will sign out the board during morning rounds to the day team.

d. Admit all antepartum patients during your shift. Involves writing detailed H&P. Antepartums on suite are followed by the pgy-2 and intern; once antes go to the floor, the pgy-2 takes care of them. Decision-making for antepartum housestaff and housestaff/transport patients by you, the ob chief, and the attending; with all other patients, go straight to the attending.

e. All Caesarian deliveries. Later in the year, you may opt to pass down uncomplicated Cxsns to the ob intern. Of course, any C-hysts go first to the Chief.

f. PGY2 Nights will prepare skeleton H&P’s for all patients scheduled for induction of labor, Cxsns, etc. on the following day (check black scheduling book located near unit clerk).

g. Cover problems with any antepartums on the floor. If you’re busy, competent ob interns can check on antepartum problems, but ER interns shouldn’t unless an emergency arises (i.e. bleeding previa while you’re scrubbed in a section). Problems with postop patients can be delegated to the intern if the suite isn’t too busy. Problems with routine postpartum patients are the intern’s responsibility.

h. Pre-round on your patients in the morning.

i. Round with the team. The intern will cover the suite, but if it gets busy, you’ll be pulled back to L&D. Similarly, expect to go to the conferences unless the suite’s busy.

j. Friday school: the PGY2 days will go and the fellow will cover the suite. PGY2 nights is excused from Friday School.

1. PGY2 Days – circumcisions. This responsibility is shared with Anita Shulman. The weekends are entirely our responsibility

   • Check circ board on Osler 2. We are responsible for housestaff circs. The nurse practitioners occasionally mistakenly place private patients on the housestaff list; double check (look in mom’s H&P) if you’re uncertain.
   • Obtain consents from the mother. Pre-stamped consent forms can be found on Osler 2 and on L&D.
Circs done in procedure room in nursery. Baby should be NPO for 1 hour. Ask the nurses to apply emla cream one hour in advance if you use it; otherwise, you can find lidocaine in the procedure room. Both Mogen and Gomko kits available. Don’t forget to write a quick procedure note in the baby’s chart when done, and initial the circ board as well.

- Circs should be done the day that they’re posted, if at all possible, even if the baby isn’t going home that day. This policy avoids dumping on your colleagues and delaying babies’ discharges.
- The NICU will occasionally post circs. Call the NICU, ask for the baby’s nurse, and set up a time to meet at the newborn nursery procedure room to do the circ. Make sure the mother has signed the consent form first.
- If a complication occurs (usually bleeding), call the peds urology resident on call (paging operator will have his/her name and number).
- You may need to have the OB Chief cover L&D more if circs need to be done, or the L&D Chief can do the circ themselves if necessary.

2. There is NO continuity clinic during the PGY2 Days or Nights rotations.
3. If the suite allows, attend Wednesday afternoon conferences (obviously not for the PGY2 nights).
4. Cover floor consultations. After the patient has been evaluated, the PGY2 should discuss the patient with the Chief and the attending. If the PGY2 is too busy, the consult may have to be covered by the Chief.

Weekends:

1. Circumcisions done by on-call person.
2. Non-acute consults: try to take care of the consult when it’s called in if possible, but if the suite is hopping, the consult can be deferred until things calm down. Run by chief so he/she knows to cover for you while you see the consult.
3. Any antepartums admitted over the weekend, should be evenly divided when assigned to the OB PGY2 Days and Nights residents.
4. Rounds at 8a.

Conferences:

- Monday 8:30a conference –Strip rounds is every other week and the OB Chief will select an interesting tracing to be reviewed by Dr. Blakemore. Know the patient’s history and labor course. Dr. Blakemore will ask the intern or a pgy-2 to interpret the strip. She will then add editorial comments on the management of the patient.
- Wednesday prenatal diagnosis conference (1:00p). Discussion by PDC counselors, attendings.
- Wednesday MFM conference (3:00p). Interesting cases presented along with relevant imaging (usually ultrasound, but occasionally MRI).
- Thursday 7:30a Grand Rounds: September through June.
f. Friday 8:00a NICU conference. Given by NICU fellow. No preparation necessary by ob team; just be ready to ask about particular babies you’ve delivered.
g. Friday 8:15a High Risk Clinic– PGY2’s (Days and GBMC) are required to attend.
h. Friday 1:00p Fox lunch. Friday school (2:00-4:00p). MANDATORY for PGY2 (days), ob intern, and chief. The suite is covered by the fellow/attending while the residents go to lecture. If there’s a busy spell and a resident needs to stay back, make sure everyone gets to go sometimes

Weinberg Night Float- PGY-2

a. Weinberg NF will start every day (Sunday through Thursday) at **6:00 PM**. Pick up the GYN and ONC pagers from the respective teams and get written sign-out. You are expected to stay until 7:00 am or whenever you have both pagers picked up from the GYN and ONC teams in the morning.
b. You round with the ONC team in the morning, once rounds are finished you go home.
c. You need to round with the teams in the morning.
d. You need to come in at 5:30 PM on Mondays for professorial rounds with Dr. Anderson
e. You will have clinic Friday mornings
f. You should stay on Friday mornings for M&M
g. Responsible for any NOSN and floor issues.
h. Responsible for any ER/floor consults.
i. You must discuss any consult with the JHH Night Float Chief. Also discuss any complicated issues on the floor with the NF Chief.
j. You may be asked to help on L & D if necessary.
k. For the onc team: You are in charge of filling out the patient rounding sheets with their name, and one liner. It is helpful to fill in vital/labs/medications to help them pre-round, but not a requirement. You print out lists and attach the attending/Melissa/fellow lists to the clipboard on the onc cart. You should make sure all first cases in WBG are consented with H&Ps in the chart prior to rounds. Sometimes it will be necessary to do H&Ps if they have not been done.
l. Any patients admitted overnight to either service are your responsibility. You will present them on rounds, do their H&Ps and orders.
GYNECOLOGIC ONCOLOGY PGY2 RESPONSIBILITIES

PGY 2

a. -Rounding. See patients assigned to you in am. Time of rounds varies per attending and per day. Check with the chief to see when rounds are the following day. Number of patients is usually divided equally between all team members, including the subintern if you’re lucky enough to have one. This is regardless of whichever resident did the patient’s surgery (usually the PGY 4). All the patients are a team effort and not an individual resident’s responsibility.

b. -Blue and Black Teams: You will be on a team with the fourth year. The fourth year does the H&Ps for the scheduled OR cases for the week. When you are in the OR- you cover your assigned cases. You are usually given all the minors and then any majors are divided amongst you and the fellow and chief.

c. -Floor Scrut. When you are on the floor/clinic week the chief will assign your schedule. You and Melissa work together to complete all items on the to do column, and you hold the on-call pager. You cover any consults while you are the floor person. Floor work includes the to do list, charting labs, ordering studies, dictations, discussing disposition with social work, Floor and ED consults and infusion center consults.

d. -Consults. When you are holding the onc pager you are responsible for working up any consults that are called in. See the patient and write up a consult sheet, then go over it with the chief. Usually these patients are seen during morning rounds the following day with the attending.

e. -Weekends. PGY2/PGY1 will be on call during the weekend, chiefs will alternate Sat/Sun for rounds only. The JHH chief is the go-to person for consults/questions/updates.

Bayview Gyn and OB

PGY2s alternate at Bayview- with one half of the time on Gyn and the other half on OB. This has classically been up to you to work out with the other PGY2.

Gyn

a. Round on all in-house gyn patients. All gyn patients admitted overnight are the interns responsibility for presenting in rounds, but you should know about them prior to rounds as you will take care of them.

b. You round on all gyn patients, but it is helpful to round on OB patients if the OB team is overwhelmed. This is at your discretion.
c. Surgery schedule for each week can be found in EPR. Make sure all patients have orders/H&Ps/consents in the charts in the AM of surgery.

d. You will hold the call pager during the day, and handle all consults..

e. Schedule:

   i. Every third Wed of the month is the Gyn-Radiology conference. You are responsible for finding interesting cases, preparing their names and details and submitting these cases to Dr Freiden on the Friday prior to the conference. He will pull the ultrasounds, you have to be prepared to present the patients. It is helpful to know their disposition/dx after the workup.

   ii. Wed AMs are not a typically OR day. Options you can choose include doing terminations in FCC clinic or Dr Loveless’ pediatric gyn clinic in the pediatric clinic.

f. You will have clinic Wed, this has classically alternated every other week between the OB and Gyn PGY2s

   i. Thursday mornings after Grand Rounds you will go to Whole Womens Health as part of the Ryan residency abortion training. This typically last until 12 if you have PM OR cases, or if not you can stay all day

gh. Dictations: if you have extra time, you are the best person to do the old/outstanding dictations. Dr Altman will give the OB chief a list you can submit to MR, or you can search EPR for the outstanding summaries for each attending.

h. Every second Wed is M&M. You stay until 6:30pm these days so the nightfloat can have off 10 hours.

OB:

a. Round on all OB patients in the AM, divided evenly between you and the night and day PGY1

b. Your responsibility is all repeat c/s, the intern covers all primaries and FTSVD when available. The intern is gone Mon AM for colpo clinic, Tues all day for HROB/TAB clinic

c. You cover the suite by yourself every Tuesday usually the Chief is gone until 1-2 for HROB. You are in charge of everything at this time, Dr Hueppchen is usually the attending on these mornings

d. Every second Wed is M&M. You stay until 6:30pm these days so the night float can have off 10 hours.
e. Circs: your responsibility on the weekends and occasional weekdays if the usual circ nurse isn’t there.

f. You are second call for all floor issues.

GBMC:

a. Schedule as per the chief, usually you cover the abdominal hysterectomies, minors with predominantly laparoscopic surgeries. You can supplement any extra cases that don’t ask for a resident as your schedule permits

b. Clinic once weekly

c. Night Float for one week to be assigned. Arrive at 5:30pm, done after AM conference.

d. Call at JHH most weekends (usually 4/6 or all that aren’t night float/vacation)

e. Pager duty/phone duty (both exist at GMBC) divided amongst you and the intern.

f. Staying Late: per the chief, usually divided between you and the intern until night float arrives at 5:30. Sometimes chiefs will be part of the pool.

g. AM conferences at 6:45AM: Once weekly you will present either an article, ACOG bulletin, or Prolog questions. Occasional Wed are urogyn conference.

h. Rounds: round on all patients you operate on and any other patients assigned to you. Rounds must be done prior to conference so you can signout to each other

i. Round on your patient prior to leaving and fill in any items in the todo list. All patients on the list are your responsibility and you should NEVER leave until everything is taken care of, even if you are not the late person.

j. Friday: one of the PGY2 covers HROB every Friday mornings. This depends on vacation schedules and night float.

k. Friday grand rounds in the AM

l. Schedule can be picked up on the fourth floor after 2:30pm- when you are the late person.
## Rotation Responsibilities PGY-3

### JHH GYN

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<tr>
<td><strong>AM</strong></td>
<td>8:00 FCC clinic-JHOC 8</td>
<td>7:30 Grand Rounds-Phipps 240</td>
<td>7:00 M&amp;M-WB-4</td>
<td>7:30 Pre-op Conference-WB-4</td>
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<tr>
<td><strong>PM</strong></td>
<td>5:30 Professorial Rounds with Dr. Anderson-WB-4B</td>
<td>1:00 Colpo Clinic-JHOC 8</td>
<td>4:00 Colpo Correlation Conference-WB-2</td>
<td>1:00-4:00 Fox lunch/school Phipps</td>
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### Responsibilities:

1. Run the gyn service  
2. Oversee PGY-1 and medical students  
3. Daily communication with attending of the week  
4. Cover (or find coverage) for all gyn cases in JHOC and Weinberg  
5. Emergency department and in-house consults  
6. Prepare M&M conference every other week  
7. Prepare preop conference every week for the following week  
8. Sign out to night float team

### Floor:

You or PGY-1 must pick up pager from nightfloat resident by 7am. OR cases start at 7:30 in JHOC and Weinberg. Rounds on all in house patients must be done before OR cases. In general, you and intern will pre-round on patients then meet with attending for formal rounds. Whoever is not in OR takes care of floor work, Amy Lee will help with this as needed. The attending of the week sees all housestaff patients. JHCP attendings and other attendings (Drs Hamod, Genedry, Rao etc) will see their own patients sometime during the day, but plan to round and have note in chart in am. If there are issues with private patients, call their attendings directly. You and intern will do informal rounds in pm. It is your responsibility to call attending at end of day to discuss patients and set rounding time for the following day. PGY-1 will carry gyn pager unless in clinic or in OR. Amy Lee will carry during these times with back up from you if she is not there.

### OR:

195
In general, PGY-1 covers all minors and you cover majors. If intern isn’t busy, bring to cases with you. All OR cases have to be covered. The OR schedule for the week will be put in your mailbox the Wednesday before. You should also verify the schedule daily on EPR as things often change at the last minute. You will assign cases. If you or PGY-1 can’t cover cases, Amy Lee can scrub in. Otherwise, it is your responsibility to find coverage. You can ask REI PGY-1 or 3, GBMC people, selective, or elective people if they are around. Occasionally an onc junior is available but must be cleared by onc fellow. Prior to cases, make sure the H&P and consents are on the chart and if not, do them.

Consults:

Consults should be seen the day they are received. In general, PGY-1 and/or Amy Lee will see consult then they will run patient by you. Run all consults by attending who will staff the consult by the following day. ED consults need to be seen as soon as possible and urgently if concern for ectopic or torsion. PGY-1 can start consult, but if early in year or difficult case plan to do pelvic exam as well.

Conferences:

M&M- conference is every Friday at 7am. It will alternate between you and gyn onc. You will need to prepare a list of all cases for the previous 2 weeks, including history, procedure, complications, and pathology. Dr. Anderson will want a list with patient names and attendings on it, but for all others, just put initials.

Pre-op conference-each week when you get the OR schedule you will need to prepare a list of all the cases for the following week including history, indications, planned procedure, and pertinent pre op labs and imaging. You will go over this list with Dr. Anderson following M&M each week.

Professorial rounds-each Monday Dr. Anderson will meet with the gyn and onc team. Either you or onc PGY-3 will prepare a case for discussion. Once a month, Dr. Shen will run journal club instead of this—she will get you the articles ahead of time. You should assign the med students these articles to present. And about every 4-6 weeks Dr. Lee will run radiology conference instead. You should keep a list of interesting cases and will need to present the history on these patients.

Colpo correlation-this conference is run by the selective person. If you and intern are not busy you should plan to attend this conference.

Clinics:

You will not have continuity clinic while on service.
PGY-1 will need to go to FCC clinic and their continuity clinic every week.

Ectopic follow-up:

List kept at bottom of sign out list. In general, Amy Lee will follow labs and contact patients if they have missed a lab draw and update you.
Sign-out:

Sign-out is at 6pm every night when the nightfloat resident comes in. You also must sign out to chief on L&D and fax them over an updated list.

Weekends:

Junior residents take call on WB on the weekends and will see any in house gyn patients and round with the attending on call. You do not have to come in on the weekends to round unless you have a particularly complicated patient or if you are on call on L&D you may want to come by and see your patients before L&D signout.

Call:

You will take call approximately every other weekend on L&D.

**High Risk OB Johns Hopkins**

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<td>AM</td>
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<td>BV clinic</td>
<td>New pt clinic-BV (every other week)</td>
<td>JHH clinic</td>
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<tr>
<td>PM</td>
<td>Cover L&amp;D</td>
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<td>MFM conferences</td>
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<td>Resident school</td>
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Responsibilities:

1. Run the High Risk Obstetrics Service
2. Maintain the “list” of high risk patients for Bayview and JHH
3. Prepare for and attend high risk clinic each week at BV and JHH
4. Attend the new HROB pt clinic at BV every other wed am
5. Follow up labs, studies, consults, etc of all HROB pts
6. Cover L&D when chief goes to clinic
7. Round daily with the JHH OB team (except Tuesdays when you go to BV)
8. Oversee OB PGY-2 management of antepartum patients and help with scut
9. Attend MFM conferences from 1-5 every Wednesday

L&D:

You are the chief of the antepartum service and are responsible for rounding daily with the team at 7am and overseeing the PGY-2s and their management of the patients. Help out the juniors with the antepartum service as needed. You should make sure that you or the attending are in contact weekly with any referring doctors of transport patients that
are in house (or when they deliver or are discharged). You will also cover L&D when the OB chief goes to clinic one half day per week.

Clinic:

BV-Your BV contact is Shannon or Barbara. You will have to call the clinic on Monday and get the schedule for the following day and prepare the clinic list. The clinic number is 550-0340. Pt labs are either done at BV or quest or occasionally labcorp. Barbara will give you a username and password so you can access quest labs online. Also, all labs and sonos will be put in a folder in the clinic for your review and signature as they come in. After clinic, update the list and bring new copy to L&D. Dr. Neale or Holcroft usually run this clinic and you will also have a first year fellow, the chief and PGY-1 from L&D.

Every other Wednesday there is a new patient clinic at BV. Usually only 4 patients are scheduled and this is supervised by Dr. Hueppchen. Occasionally these slots will be filled by consults and you will have to dictate a formal consult note in EPR.

JHH-your contact is Cathy Maiolatesi. Call clinic at the beginning of the week and get the schedule for Friday. The clinic number is 955-5850. Make sure if there are new patients that you obtain their records usually sent over to clinic ahead of time. Dr. Bienstock, Henderson, or Aina usually run this clinic and you will also have a first year fellow, and 2 PGY-2s (one from L&D, one from GBMC).

Conferences:

You must attend the MFM conferences on Wednesday. This starts at 1pm with a genetics conference followed by either journal club, sono conference, M&M, etc.

Call:

You will take call approximately every other weekend on L&D at JHH.

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**GBMC ONC**

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<td>OR</td>
<td>Resident school</td>
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Responsibilities:

1. Run the oncology service with the oncology fellow and Dr. Grumbine
2. Pre-rounding on all patients daily
3. Present pts to fellow (and sometimes Dr. Grumbine) and verify plan of care for day
4. Floorwork, dictating discharge summaries
5. Cover all OR cases
6. Carry gyn onc pager and respond to calls from floor and ED

Floor:

You are responsible for pre-rounding on all patients. You will set up time the day before with the fellow that you will meet them for rounds. You will sign out to fellow before the OR or clinic starts. After cases, you should check in on patients, dictate dc summaries, and respond to any consults. You will hold the onc pager until the nightfloat resident comes on and then you will sign out to them. Occasionally, you will have no patients in house and the in house resident will hold the pager for you until the nightfloat comes on.

OR:

Cover all OR cases with fellow and Dr. Grumbine. Dr. Grumbine operates every other Monday, all day Tuesday and Thursday. In addition, you are responsible for covering Dr. Dillon’s cases. If 2 cases overlap, work out with the fellow who will cover which case. All cases are in the GOR. You can get the OR schedule the week before from Dr. Grumbine’s office staff and can verify cases when the benign team picks up the final schedule the previous afternoon.

Clinic:

Dr. Grumbine has clinic on wed and fri. The fellow will go to clinic with him, but you do not. During that time, you can take care of floorwork, catch up on dictating, or read. Sometimes you will be asked to cover a benign case if nothing else is going on and the benign team is short staffed. You will have your continuity clinic one half day per week.

Call:

The week that you take nightfloat call, the gyn residents will cover the onc cases. When you are on call on the weekend, you are responsible for both the benign and onc services. If you are not on call, you do not need to come in to round on the onc patients.

Conferences:

The benign service has teaching rounds mon-thurs am at 6:45. You are welcome to go to this if you aren’t rounding with onc fellow but you are not expected to be there. Grand rounds is every Friday at 7 am.
Responsibilities:

1. Attend all major OR cases
2. Round on all patients you operate on
3. Keep record of all cases you participated in

On the first day of the rotation, meet with Dr. Campbell, the chairwoman of the department and your contact while there. She will orient you. You will also receive a brief computer training, be given a locker and parking pass and id badge. The ORs at Howard County start at 8am. At the beginning of the week, you can get both the main OR and ambulatory care center OR (TCAS) schedules. Plan to attend all major cases unless there is overlap. You can also attend any minor cases you want. Ask the attendings whether they want you to dictate the operative note and write orders (some attendings use the computer order system which we do not have access to). Also, dictate discharge summaries on patients you operate on. Most post op patients go to the MCU (maternal child unit) or 3 South (a surgical floor). Dr. Campbell wants you to keep a list of all patients you operate on and the procedure performed and any complications. Give this to her at the end of the rotation. In general, you will take call every other week at BV or JHH L&D. You have one week of vacation during this rotation.

BV Nights

Responsibilities:

You are responsible for running L&D as well as caring for post op gyn patients, the postpartum and antepartum service, and seeing ED consults. You oversee and delegate tasks to the PGY-1. Discuss any complicated patients with attending. In general, plan to do pelvic exam with PGY-1 and “lay eyes” on ED consults. All triage patients should be run by you after being seen by PGY-1. During deliveries and C-sections, you will scrub with the PGY-1 with backup support from attending. Only the intern will scrub for deliveries and C-sections with BGLM patients. Be there at 5:30pm for signout from the day team and am rounds are at 7, except on thursdays when there is grand rounds and signout is at 6:30. Also, once a month, at 8am is M&M conference. You are expected to stay for the conference; however, you do not need to report back to work until 6:30pm that night. Your week is from Sunday-Thursday night with Friday and Saturday nights off. You will have clinic on Friday am after you leave L&D.

JHH ONC

Responsibilities:

1. Pre-round on assigned patients.
2. The PGY 1 and 3 form one “team” and the PGY 2 and 4 form a second “team”. Each week the teams will switch from being responsible for the OR to covering the floor and clinic. On OR weeks, the PGY-3 makes the OR schedule (with the help of PGY-4) for the week. All cases must be covered. In general, the intern will go to minor cases, otherwise, come to cases with you. Also, if 2 cases are happening at same time, the intern can go with fellow to one case and you go to the other case. Also, if not busy, you
can have the other team help out as long as clinic is also covered. On non OR weeks, the
PGY-3 will share both clinic responsibilities and floor work with the PGY-1. The PGY-1
or 2 carries the onc pager and responds to calls from floor and ED with back up from
you.
3. M&M conference every other week. You will present all your cases from the
previous week. You will only have about 15 minutes. Prepare a list of all cases,
including history, indications, procedure, complications, etc. Put only patient initials on
list, except for Dr. Bristow’s list put patient names.
4. You will share rounding responsibilities on the weekends with the PGY-4. In general,
you will each be “chief” one day of the weekend and round with the attending and junior
residents on call. After rounds, help out the on call resident with floorwork and orders
before going home. Also, make sure to sign out to the chief on L&D.
5. There is no in-house call on this rotation.

REI

Responsibilities:

The fellow will make the weekly schedule and in general you will spend your days either
in clinic with the attendings or in the OR at JHH. In addition, you will participate in egg
retrievals and transfers at Greenspring Station. You are responsible for rounding on all
patients you operate on, and signing out these patients to the Weinberg night float. Every
Thursday afternoon the REI department has their weekly meeting which you attend from
1-5 at GSS. You will have to present an assigned article for journal club during one of
these meetings. In general, you will take call every other week at either BV or JHH
L&D. You have one week of vacation during this rotation.

ELECTIVE

You can spend your elective however you choose as long as it is educational and
approved by the department. You have no call responsibilities during these 4 weeks so
you do not have to stay in Baltimore. Your proposal to the department must include your
learning objectives and at the end of the rotation you must complete an evaluation on
your experience. You will have 2 weeks of vacation during this rotation.
Rotation Responsibilities PGY-4

JHH OB Rotation: PGY-4

Weekday schedule:

Daily weekday rounds at 7am; weekend rounds at 8am. The night float chief will stay for board rounds.

Intern schedule: the first two weeks of the month, the ER intern works 7a-7p and the ob intern works 7p-7a; they switch for the second half of the month. The intern schedule is posted on L&D. They both preround in the mornings. If the suite is busy, the day intern covers the suite during rounds while the night intern rounds with the team; if not busy, the day intern comes to rounds too. The night intern then signs out to the day intern and goes home immediately. The ED interns are required to attend their departmental lectures on Fridays, 7-11am, so plan accordingly. The ED interns are to preround on their patients prior to their Friday am lectures.

Mondays: 8:30a conference – alternates Journal club and Strip Rounds.

Tuesdays: 8:10a - Ob interdisciplinary case conference

Wednesday: 8:30a –Ob anesthesia conference
   1:00 pm – prenatal diagnostic conference.
   3:00 pm - MFM conference (Phipps lecture hall); includes OB M&M conference and stats (Dr. Witter will provide data). You and the day pgy-2 should attend this conference every week whenever possible.

Thursdays: 7:30a Grand Rounds (Phipps lecture hall)

Fridays: 8:00 am – NICU rounds in the NICU.
   8:30 am – High Risk Clinic Rounds (JHOC 8th Floor, Pod C). The day PGY-2 is required to attend. The night PGY-2 goes home. L&D will be covered by the OB Chief, Intern, and a CNM.
   1:00p Fox lunch

   2:00-4:00p: school (Phipps lecture hall)

Responsibilities:

1. Supervise L&D.
2. Make decisions for housestaff and housestaff/transport patients (not for Group, JHMSc, private patients; the pgy-2 communicates directly with the physician on call for those groups). The fellow/attending will also have a role in decision-making for housestaff patients. Note: though you don’t make decisions for
Group, JHMSC, or private patients, you should be aware of their presence and have a general idea of what’s going on.

3. Leave admitting note on charts of all admitted antepartum patients (housestaff and housestaff/transport). This note doesn’t have to be a full H&P, which is the pgy-2’s responsibility. Read the pgy-2 note and critique plan as necessary.

4. Supervise care of antepartum and postpartum patients by pgy-2’s and interns.

5. Chief all housestaff and housestaff/transport deliveries and Csxsns. If suite’s very busy, occasionally may do Csxn with attending without pgy-2, or pgy-2 may be in Csxn while you watch the suite.

6. Run morning floor rounds with attending and junior residents. Includes reviewing resident notes, making sure all paperwork has been filled out and labs charted, and discussing plan with team. A note on paperwork: to make sure the juniors are keeping up with it, the ob chief traditionally does “spot checks” during rounds. Alternatively, you can go back later for spot checks. The important paperwork:
   a. The delivery record (located in pink section). All blanks should be filled in, including the cord gas.
   b. The history and physical. Is it complete? Was it signed?
   c. Are labs charted in the diagnostics section? (H8, STS, urox. For Csxsns, postop H8 should also be charted).

7. Floor consults should be delegated to pgy-2. Once that person has evaluated the patient, he/she will call you and the attending to staff the patient. If the suite’s busy, you should either cover the suite for the pgy-2 or see the consult yourself.

8. Ob mortality and morbidity conference and stats. Held once monthly on Wednesday afternoon. See below.

9. Prepare Monday and Tuesday am conferences (see below) – journal club, strip rounds, OB interdisciplinary case conferences.

10. Make sure the High Risk Chief provides you with an updated copy of the high risk list.

11. Maintain list of antepartums/complicated postpartums to sign out to night call chiefs.

12. Weekends: Chief coverage of weekend OB rounds will be determined by the post-call and on-coming chiefs on a weekly basis.

13. Quality Assurance (AKA Problem Based Learning and Improvement Conference) - labeled “Privileged and Confidential” - OB chief and Night Float Chief will keep a running daily list and description of all patients who do not have an uncomplicated SVD. All c-sections, operative vaginal deliveries, shoulder dystocias, deliveries that result in Apgars < 7 at 5 min, and all patients with negative outcomes or questionable management should be listed in the Quality Assurance list. This list will be discussed every morning before rounds.

Conferences:

1. Monday 8:30a conference – Journal Club and Strip rounds. The OB Chief should review an interesting journal article for this conference on an every other week basis. The article should be distributed to the juniors and the attending beforehand. Strip rounds is every other week and the OB Chief will select an interesting tracing to be reviewed by Dr. Blakemore. Know the patient’s history
and labor course. Dr. Blakemore will ask the intern or a pgy-2 to interpret the strip. She will then add editorial comments on the management of the patient.

2. Tuesday 8:10a OB interdisciplinary case conference. Topic to be picked and presented by the OB Chief. Goal is to discuss and interesting case.

3. Wednesday 8:30a OB anesthesia conference. Given on alternate weeks by ob pgy-2. Anesthesiology residents are responsible for the other weeks. You assign the day PGY-2 to a date at the beginning of the block. They should choose a paper about an ob anesthesiology-related topic, present it and discuss it. Conference attended by ob team, anesthesiology residents and attending.

4. Wednesday prenatal diagnosis conference (1:00p). Discussion by PDC counselors, attendings.

5. Wednesday MFM conference (3:00p). Interesting cases presented along with relevant imaging (usually ultrasound, but occasionally MRI).

6. Ob mortality and morbidity conference. You prepare once monthly. Given at Wednesday afternoon conference. Involves presenting interesting cases (usually assigned by Dr. Witter). Dr. Witter will prepare the departmental stats from the last month and present them prior to your presentation.

7. Thursday 7:30a Grand Rounds: September through June.

8. Friday 8:00a NICU conference. Given by NICU fellow. No preparation necessary by ob team; just be ready to ask about particular babies you’ve delivered.

9. Friday 8:30a High Risk Clinic Rounds – PGY2 Days and PGY2 from GBMC are required to attend.

10. Friday 1:00p Fox lunch. Friday school (2:00-4:00p). MANDATORY for PGY2 (days), ob intern, and you. The suite is covered by the fellow/attending while the residents go to lecture. If there’s a busy spell and a resident needs to stay back, make sure everyone gets to go sometimes.

The Kelly Gynecologic Oncology Service: CHIEF

ORGANIZING YOUR TIME ON GONC:

Day prior to first day on svc:

- Get signout from off-coming chief.
- Keep an onc notebook for yourself (separate from team’s notebook) for scut lists, M&M, familiarize yourself with the patients on service (review charts and meet patients).
- tumor board, etc.
First day:

- Meet with Bristow to review expectations.
- Meet with your team to review expectations/duties (set the tone the first week).
- Review schedule with your team (including OR, clinic, conferences).
- Give your team a copy of the weekly schedule.

First week:

- At the end of the first week, meet with team to review performance, give feedback, etc.

Team One Notebook (kept in Weinberg 4B for access by all team members)

- Has weekly schedule (Alternate weeks with the 3rd year on Onc)
- Has OR schedule (Alternate weeks with the 3rd year on Onc)
- Completed H&Ps for upcoming cases (Done by the senior who has the OR schedule that week)
- Has tumor board (4th year every week)
- Has M&M (Alternate weeks with GYN service, also you share time with the 3rd year on service)
- Useful articles

Reminders

- Try to complete your own daily pre-rounds 15-30 minutes before rounds so you can help juniors or answer any questions.
- Remind on-call person to page you with any admissions or big overnight events with inpatients.
- Remind juniors/Nurse that patients should have f/u appts in 7-10 days postop.

Your weekly schedule:

Monday:

- prepare for tumor board
- print out path
- Tuesday:
- Wednesday: complete M&M
- Thursday: prepare M&M
- Friday:
  - H&P’s for next week
  - M&M/tumor board
Important Numbers

<table>
<thead>
<tr>
<th>ONC office: 5-8240 fax 4-6718</th>
<th>ONC pager: 3-2540</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Jo Lamberson (schedule)</td>
<td>Weinberg 4B: 2-1136; 2-1140</td>
</tr>
<tr>
<td>Sharon Thompson 3-0876</td>
<td>fax: 2-1142</td>
</tr>
<tr>
<td>Bristow direct: 4-6546</td>
<td>call rm code 5088</td>
</tr>
<tr>
<td>pager 3-0911; 1-800-617-5965</td>
<td>supply rms 4300</td>
</tr>
<tr>
<td>(Bristow is reachable by text-pager @ <a href="http://www.pagerbox.com">www.pagerbox.com</a> - if on outside computer, login is Hopkins and password is Osler)</td>
<td>Weinberg radiology: 2-1020</td>
</tr>
<tr>
<td>Deborah Armstrong (med onc): 3-2532</td>
<td>Operating Rooms</td>
</tr>
<tr>
<td>JHOC POD A: 5-9504/office 5-1432</td>
<td>Josie 2-1223</td>
</tr>
<tr>
<td>appts 4-6814</td>
<td>OR #12: 2-1200</td>
</tr>
<tr>
<td></td>
<td>WICU 2-1048</td>
</tr>
<tr>
<td></td>
<td>ORCIS 2000 (press caps lock)</td>
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</table>

Rounds **KEEP MOVING** Always think ahead, and encourage team to do so as well.

- Be sure attending sheets are stamped for the next day and organized in order of rounding (PGY2 should do, but double check). If running low on sheets, make sure PGY2 picks up copies in onc office (call ahead!).
- If there’s a new admission, stamp an Attending Admission Note and prepare to present from H&P.
- Write orders as you go.
- Teach juniors to prepare the chart for the next patient presentation after the previous one’s complete.
- Go into each patient’s room with the attending so you will know if the plan changes.

OR

- After morning rounds and after each case, ask attending when they want to be called for the next case.

  Bristow: when patient is ready to be intubated. He will want to do an EUA.

Professorial Rounds

- Coordinate with gyn chief regarding who will present. Try to alternate. Try not to present an onc case. OB cases are welcome.

Clinic

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- Send one resident to clinic. Check with Bristow if you’d like to send more.
- Dictating: use attending’s # for dictation (Bristow J8519, Giuntoli T3945); work type #30; code 206A. (Recently attendings have been doing their own dictations.)

### Attending Preferences:

- Chemo patients: keep Hgb > 10; hold chemo for ANC < 1500 (ANC = WBC x (%bands + %PMNs))
- Rad patients: keep Hgb > 11.5
- No bowel resection and has bowel sounds: clears (Bristow).
- Bowel resection: advance diet only w/flatus.
- Bristow: likes hematocrit, not hemoglobin; wants to hear about his patients even if not attending of the week. Consult him prior to pulling drains.
- DON’T FORGET: preop antibiotics
- DO NOT CLEAR a patient for chemo prior to checking labs (esp ANC!)

### TUMOR BOARD

Friday 7:30 am Weinberg 2nd floor Path Dept

- Comprises all cases done from Monday to Sunday of the previous week, clinic patients requested by Bristow (list these at the end), AND cases left over from the previous week.
- Initialize all names for confidentiality (except one copy for you and for Marsha Potler) and make 12 copies.
- Prepare a skeleton list as you are making the OR schedule for the week, then complete the final list each prior Thursday night – most of the path should be available by that time.
- Fax or email the list to GYN path fellow (pager 3-3580; fax 4-1287) by each prior Monday morning. You can also ask previous Onc chief who they have been most recently emailing the list to as this can change throughout the year. Good idea to call the GYN path fellow to make sure the list has been received. Also fax or email a copy to Richard C. Zellars (rad onc) phone 410-502-1421 fax 410-502-1419
- Helpful to print out all path from EPR before tumor board so you’re not busy writing the path down and can concentrate on the discussion and recommendations. You can use the path printouts for M&M also.
- During tumor board:
  - arrive 5 minutes early and have a copy of staging for gyn cancers available
  - write down names of all faculty attending.
  - write down all recommendations – many times the Onc Fellow on service will do this because they are now in charge of creating the Tumor Board EPR notes.
- After tumor board:
  - Dictate or create unstructured note (#39) in EPR (cut and paste title, date, attendees, pt’s name, history #, history, and pathology, and add recommendations). See above – most likely the Fellow will handle this but ask in case the fellow is going to be off service.
• Note the dictation job number at the top of the yellow sheets, which then go to Diane in ONC office. (I don’t think that these yellow sheets are in use anymore.)

**MORBIDITY AND MORTALITY CONFERENCE**

Friday 7am Weinberg 4th Floor conference room (alternating weeks with the Gyn Chief)

• List ALL admissions and OR cases (Weinberg and JHOC) that occur from Monday to Sunday of the previous week.
• Use tumor board or your OR schedule as a template (cut and paste).
• Update your M&M list daily (i.e. history, procedure, findings, OR time, EBL, hospital course, pathology). Keep a copy of the H&P Include date, initials of patient, brief history, procedure, findings, pathology and hospital course.

**CHIEF TO DO LIST**

**Daily:**

Evening rounds:

- Update and run list w/team.
- Get the OR times, EBL of cases you didn’t scrub on for M&M.
- Check the OR schedule for the following day to confirm cases/times.
- Remind juniors about cases/clinic and in general, coordinate the next day.
- Be sure H&P’s are ready (keep them in Onc notebook).
- Confirm that attending sheets are stamped (if a new admission, make sure it’s an admit note).
- Confirm that discharge summaries have been dictated.

After evening rounds:

- Check in with attending of the week to update them and find out time to round next morning.
- Sign out to night chief (L&D fax 4-7720).
- Update M&M and tumor board lists for the week.

**Each Friday:**

- Obtain most of OR schedule from Onc office including attending clinic schedules. They will fax to you and PA.
- Work on H&P’s and place in Onc notebook.
- Assign cases for the upcoming week and place in Onc notebook.
- Check with Sharon Thompson RE any chemo admissions for the following week.

**Each weekend:**
- Make a skeleton M&M and tumor board for the following week based on the OR schedule.
- Be sure H&P’s are complete. Make sure pt has had appropriate pre-op. If not, discuss w/attending.
- Complete any outstanding tumor board dictations.
- Check if any outstanding discharge summaries or other patient issues.
- Relax!!
JHH Night Float – PGY4
& Chief weekend call – PGY3 & PGY4

NIGHT FLOAT

Schedule: Sunday-Thursday, 5:45P-7a

*note: the rotation starts the Sunday night before the official Monday start date, so everyone finishes the night float block with a full weekend off.

Responsibilities:

Sleeping is not acceptable while working night float. If you have free time, you should do catch up on your reading.

Ob:

1. supervise L&D.
2. make decisions for housestaff and housestaff/transport patients (not for Group, JHMSC, private patients; the pgy-2 communicates directly with the physician on call for those groups). The fellow/attending will also have a role in decision-making for housestaff patients; some are better at giving you autonomy than others. Note: though you don’t make decisions for Group, JHMSC, or private patients, you should be aware of their presence and have a general idea of what’s going on.
3. Leave admitting note on charts of all admitted antepartum patients (housestaff and housestaff/transport). This note doesn’t have to be a full H&P, which is the pgy-2’s responsibility. Read the pgy-2 note and critique plan as necessary.
4. Chief all housestaff and housestaff/transport deliveries and Csxns. If suite’s very busy, occasionally may do Csxn with attending without pgy-2, or pgy-2 may be in Csxn while you watch the suite. Make sure you let the attending know where you are if you don’t scrub in a housestaff Csxn and make sure he/she is OK with that.
5. Ob chief will sign out all antepartums/complicated postpartums on the floor to you in the evening.
6. Occasionally, floor consults on ob patients will be requested in the evening. If the suite is busy and the call is non-emergent, the consult may wait until things calm down. Use reason: it’s nice to have consults done ASAP, but if your first opportunity is at 3am, wait until morning. Floor consults generally are delegated to the pgy-2.
7. Go home in the morning after staying for L&D Board Rounds. You don’t have to stay for floor rounds.
Gyn/gyn onc:

***Remember to find out which attending is on call for GYN and Onc***

1. The Weinberg call resident will carry gyn and gyn onc beepers and answer all floor/ER/patient calls.
2. Gyn and gyn onc chiefs will sign out to you before they go home. You are responsible making sure that the Weinberg resident has taken care of any evening scut on their patients. Gyn and Gyn onc teams are responsible for tucking things in as much as possible (within reason) before their teams go home for the evening. Members of the gyn and gyn onc teams are responsible for relieving the Weinberg call resident of their team’s beeper no later than 7am.
3. Gyn ER calls: Weinberg call resident will do the consult and then call you. You may need to see the patient yourself, use your discretion. Dr. Anderson requests that all consults be run by the on call GYN attending. You must also call the attending for any gyn admission. You don’t need to call the day gyn chief unless that person asks you to.
4. Gyn onc ER calls: Weinberg call resident will initially evaluate the patient. You will most likely then evaluate patient, then call whomever is on call for the onc service (Bristow, Giuntoli or Diaz-Montes). Many times the first call will be to the fellow except on Sunday nights when the fellow is off. Inform the gyn onc chief of all admissions.
5. Direct admissions: occasionally, you’ll get called with direct admits, usually to the gyn onc service. Sometimes, the gyn onc team will sign out that a clinic patient is being admitted who hasn’t arrived yet. In general, the Weinberg call resident will need to complete an H&P. You should review the H&P and critique as necessary, then write a brief addendum. Make sure admission labs (almost always H8 plus manual diff; comprehensive panel, U/A, any necessary cultures) and radiologic studies are ordered. Make sure the Weinberg call resident has followed up on all labs/studies and chart results that night. Again, inform gyn onc chief of all admissions.
6. Floor consults: occasionally, there will be gyn floor consults at night. If the Weinberg call person is not busy, they should see the consult. If s/he is busy and the consult is not emergent, defer it to the gyn or gyn onc team the next day (pass along patient info to the team).
7. Night of surgery notes: the gyn and gyn onc teams will sign out any night of surgery notes (NOSN) to Weinberg call resident.

**CHIEF WEEKEND CALL**

Schedule – Rounds start at 8am on L&D on Sat and Sun. Coverage of Gyn Rounds on Sat and Sun – every Sat and Sun, one of the Chiefs on call (either the Sat or the Fri/Sun call person) will round with Benign Gyn and the other will round on L&D. This should
be decided on a weekend-by-weekend basis. Hopefully, this will allow people who have the weekend off to not have to come in to round on GYN over their off weekend.

Coverage of Onc Rounds on Sat and Sun – The Onc 3rd and 4th years will alternate who rounds on the weekends. The most senior Weinberg call resident will also round with the Onc Chief over the weekend.

Same OB/Gyn/Onc responsibilities as the Night Float Chief (see earlier descriptions).

Practices (L&D):

Housestaff. Attended by group attending.

1. High risk ob (housestaff).
3. JHCP (Johns Hopkins community Physicians, an HMO): Drs. Nikita Levy, Deborah Martin, Wanda Nicholson, Courtney Rhoades, James Russell, Marilyn Short, Yue-cheng Yang; Jean McCarten, CNM; Deb Doerfer, CNM
4. Halo clinic (HIV+): Drs Edie Gurewitsch, rarely Jean Anderson. (There is a call schedule for HALO on L&D).
5. JHH general gyn practice (occasional ob patients): Drs Jean Anderson
6. Dr Milagros Atienza
7. Dr Kamil Hamod

Practices (gyn):

1. housestaff: attended by JHH general gyn and urogyn attendings and fellows.
2. JHCP
3. JHH general gyn practice: attendings as above
4. REI: Drs Jairo Garcia, Edward Wallach, Howard Zacur, Lisa Kolp
5. Dr Kamil Hamod
6. Dr Rene Genadry
7. Dr Milagros Atienza
8. Occasionally, Group attendings will have private patients undergoing gyn cases, usually in the outpatient center.
9. Gyn onc: Drs Rob Bristow, Rob Giuntoli, Teresa Diaz-Montes
10. Dr Dwight Im (private gyn onc; from Mercy)
11. Dr Michael Dillon (private gyn onc; from York)

**GBMC Chief-GYN**

**Schedule**

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<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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- Rounding on patients should occur before formal team rounds in the morning. Check the patient roster on unit 46 and make sure that all gyn patients who the residents operated on or admitted are being seen by a resident. Residents should see all patients on whom they operated; the remainder of the patients should be assigned by you to various members of the team. Try to keep the numbers of patients fairly even between residents.
- Residents should contact attendings about problems with their patients before scrubbing in the morning if possible.
- You are responsible for following inpatient house patients.
- Formal team rounds: assign your team days on which to present an article or a topic. Review the daily OR schedule before the team breaks up for the day.
- Pick up the weekly OR schedule in advance from the posting office (ready after 3pm on Friday of the week before) and assign cases. Check the daily schedule (available after 3pm the day before) as well as cases may be added or cancelled at the last minute. Make assignments the night before. You may occasionally ask the urogyn pgy-4 or onc pgy-3 to cover a case. In the morning, call PPW and the GOR and give them the resident case assignments, along with beeper numbers. It’s especially important for the OR to know if a resident will not be scrubbing. If you are unable to cover a major case, talk to the attending in advance. Sometimes a scrub tech will fill in. Sometimes you will need to mediate between attendings competing for a resident. Sometimes you will need to ask your floor attending to help you cover a case. Minor cases often go uncovered; you do not need to call the attending for these. On Friday afternoon, attendings know they do not get residents after noon. Nonetheless, cases will often be posted. You may call the attending in advance or the call person for the weekend may choose to scrub on the case.
- Make sure your juniors get some good cases. Even an intern should occasionally be assigned an abdominal case. Choose that case carefully, though, since certain attendings are more appropriate for interns than others. Good choices include the Kaiser attendings (Dowling, Wu, but not Manley), faculty (Blomquist, Ellerkmann,);
- Poor choices for green juniors are Bottaglieri, Khouzami, and Supplee. Let the attending know in advance that you are sending a relatively inexperienced resident to make sure the case isn’t a difficult one. It’s also nice to hand down some vaginal cases to the pgy-3. Scopes should be shared by the team, including you and the pgy-3. In general, scrubbing in on a major, then asking a junior to scrub you out after the uterus is out so you can go to the next case is poor form.
- When Gyn PGY4 is on vacation, the Urogyn PGY4 will be Gyn chief and distribute/assign case coverage. However, when the Urogyn PGY4 is Gyn chief, the Urogyn 4 is still responsible for covering Urogyn cases first (ie- Urogyn 4 cannot chose to do a TVH with a private attending instead of doing the abd

<table>
<thead>
<tr>
<th>6:45am rounds</th>
<th>6:45am rounds</th>
<th>6:45am Urogyn lecture in PPW Conf Room</th>
<th>6:45am rounds</th>
<th>7:30am Grand Rounds</th>
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<tbody>
<tr>
<td>(attending presents)</td>
<td>(res presents)</td>
<td>(Unit 46 Lounge)</td>
<td>(res presents)</td>
<td>1:00pm Fox lunch</td>
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<td>(Unit 46 Lounge)</td>
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<td></td>
<td></td>
<td>2:00pm school</td>
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sacroculpopexy with Dr. Blomquist, so the TVH must be handed down; however, if there are no Urogyn cases, the Urogyn 4 can pick which ever cases they want. If both the Gyn PGY4 and the Urogyn PGY4 are both on vacation, the Gyn PGY4 Float will become the Gyn chief and assign the cases.

- **IF YOU KNOW THAT THERE WILL BE NO COVERAGE FOR AN OR CASE, YOU MUST INFORM THE ATTENDING AHEAD OF TIME (PREFERABLE A DAY AHEAD OF TIME).**

- Encourage team members to get to the OR in a timely fashion (by 7:20am for 7:30 am cases). Patients should be seen preoperatively when possible, and missing paperwork should be filled out. All postop paperwork should be filled out. Residents should ask attendings whether they want them to dictate the case.

- Coordinate with the Onc pgy-3 regarding coverage of Grumbine cases on the day that they have continuity clinic.

- The Urogyn pgy-4 is responsible for letting you know if he/she needs help covering cases.

- ER and floor consults will be called in to you during the day. You may assign a junior or see the patient yourself, then discuss the case with the attending of the week if a house patient, or with the appropriate private attending.

- Residents are expected to check on their patients before going home for the day (a second progress note unnecessary unless significant events have occurred), and to update the sign-out with the on-call resident. Only complicated patients need a NOSN.

- The fourth Wednesday of odd months a resident needs to attend the afternoon colpo clinic at the Hannah More Office in Reisterstown. Contact Carolyn Brice for more details.
  - Scheduled on the 4th Wednesday of every odd month only. Clinic is from 1-4pm.

- Attending: usually the urogyn fellow will attend that clinic.

- Address/directions: Hannah More Academy Center, 12035 Reisterstown Road 21136
  
  Phone 410-887-1152/FAX# 410-887-1157. Take Baltimore Beltway (695) to Exit 19 marked Route 795. Get off Route 795 at Exit 7A, Franklin Boulevard (East). Follow to second light which is Reisterstown Road. Turn left and go to second traffic light marked Caraway Road. Turn right into health center.
  
  o FYI: the clinic is a service provided for free for qualified women by the Baltimore County Department of Health.
  
  o The day before the clinic, call Nancy Miller RN (the clinic’s nurse; office phone 410-887-2705) and make sure that patients have been scheduled (occasionally sessions are cancelled for one reason or another).
  
  o Up to ten patients are scheduled per session. No shows are common but you will usually see at least five patients.

  o While you are there, review charts and path from the previous session and make plans for follow-up (i.e. repeat Pap in 3 months, etc).

- **Conferences:**
1. Formal morning rounds (as above).
2. Friday Grand Rounds. You are expected to attend even if you have Friday morning clinic, just leave early if necessary.
3. All residents not on call should attend Fox lunch/school.
Colposcopy Chief Responsibilities

- Colposcopy clinic is every Tuesday morning 8:30-12 pm in JHOC 8th floor pod C. Attending: Connie Trimble.
- Colpo Correlation Clinic (CCC) is every other Thursday @ 4pm. Check with Dr Trimble to see when it is happening because it often gets postponed.
- Gyn Onc intern also attends colpo clinic.
- Ask previous chief for list of patients for the upcoming colpo clinic and about anyone who may need additional follow-up.
- During clinic, keep note of who shows up for their appointments and note what path is pending. Also keep track of no-shows because at the end of clinic, you need to fill out a form letter stating that the patient needs to reschedule. These go to Betty Sauter, who will send them out. (Many times Katie Chang will handle this).
- The colpo form has 3 copies: white, yellow and pink. White goes to you, yellow goes to the patient’s chart, and pink goes to pathology whether or not you’ve done colpo & biopsy with your Pap.
- Keep your pile of white sheets together during clinic, alphabetize them for each clinic session and then attach them to your schedule for that day. When Dr Ronnett reviews the slides in CCC, she will go by each clinic day and in alphabetical order.
- At CCC, your job is to read the clinical history on each patient. Dr Ronnett will show all the interesting features of each slide. A diagnosis and plan are made there at CCC. Note at the bottom of each sheet what the plan is and then write “discussed at CCC.”
- Create a CCC note in EPR under Dr. Trimble’s name discussing the history, exam, path and plan of care for each patient discussed.
- Patients are normally scheduled for follow-up 3-4 weeks after their biopsy.
Resident Research Program

**Purpose:** to expose residents to the research process in an effort to train residents to be scientists and knowledgeable consumers of scientific information in addition to being clinicians

**Requirement:**
Beginning with the intern class of 2008-2009, residents will be required to complete **TWO** research projects over the course of residency:
1. a clinical case report
2. an original scientific study
Each of these projects will be supervised by a faculty mentor.

Residents are expected to present their research, in abbreviated form, at Resident Research Day to be held annually in the Spring. *Cash prizes will be awarded for the best presentations.* Residents are also encouraged to present their research at regional or national conferences.

**Administrative Oversight:**
Dr. Connie Trimble will serve as the director of the resident research program. She will meet with each resident on an on-going basis to help facilitate a productive research experience.

**Educational Courses:**
Lecture series regarding study design and statistical analysis will be a mandatory part of Friday “school” to help residents best create their own research projects.

**Timeline:**
PGY-1: Identify an area of interest for scientific study and a faculty mentor
Present a case report at Resident Research Day

PGY-2: Generate a research question and design an appropriate study
Obtain IRB approval
Begin data collection

PGY-3: Analyze data
Submit an abstract to a regional/national conference
Present preliminary data at Resident Research Day

PGY-4: Complete manuscript
Present (optional) completed project at Grand Rounds
Description of Administrative Chief Resident Position

The duties, roles, and expectations of the department’s Administrative Chief Resident will include, but not be limited to, the following:

1. Represent the residents as needed on department or hospital committees as deemed appropriate by the departmental chairman/program director
2. Responsible for developing the academic year resident rotation calendar, including non-department rotations and rotations for residents from other departments
3. Responsible for call schedules, vacation and educational leave schedules and for settling conflicts pertinent to such schedules
4. Assist director with new resident orientations
5. Assist the faculty/chairman/director as needed in planning educational and patient care conferences
6. Serve as liaison between the residents and attending staff and assist in resolving conflicts/issues between them as needed
7. Assist the director in keeping residents informed of events, conferences, resident responsibilities, duties, etc.
8. In general, serve as a representative of all residents in the administration of the residency program; serve as a resident advocate; serve as a leader in the finest sense of the work in all matters involving resident issues and welfare in the program.

Administrative Chief Resident Selection Criteria

The principle criteria upon which the Administrative Chief Resident will be selected are as follows, in approximate descending order of importance:

1. Leadership skills – demonstrated and potential
2. Rapport/relationship with residents, both peer level and junior level
3. Rapport/relationship with attending staff, nurses, paramedical personnel, secretaries, etc.
4. Rapport/relationship with department chairman/program director
5. Organizational skills
6. Support and enthusiasm for program
7. Ideas and plans expressed during interview for position
8. Teaching interest and abilities
9. Extracurricular academic activities
10. General clinical and academic capabilities

Administrative Chief Resident Selection Process

The Administrative Chief Resident will ultimately be selected by the department chairman and program director, but only after considering input from all residents, the fulltime faculty and private attending staff, and, when appropriate, from paramedical personnel (secretaries, nurses, unit managers, etc.) associated with the department.
Section Four

Didactics
Educational Conferences

Johns Hopkins Hospital

Monday
Practice based Learning & Improvement Daily
Tracing Conference 8:10am biweekly
Professorial Rounds 5:30pm weekly

Tuesday
Practice based Learning & Improvement Daily
Gyn Onc Tumor Board 4:30pm weekly

Wednesday
Practice based Learning & Improvement Daily
Prenatal Diagnosis Conference 1:00pm weekly
Ob Morbidity and Mortality Conference 3:00pm monthly
Ob Ultrasound Conference 4:00pm weekly
Pelvic Floor Multidisciplinary Conference 5:30pm biweekly
MFM Conference 3:10pm weekly

Thursday
Practice based Learning & Improvement Daily
Grand Rounds 7:30am (Sept-June) weekly
PGY-1 Conference with Dept. Chair weekly
REI Conferences 2:00pm weekly
Colposcopy Correlation Conference 4:00pm biweekly

Friday
Practice based Learning & Improvement Daily
Gyn/Gyn Onc Morbidity and Mortality Conference 7:00am weekly
High Risk Ob Clinic Conference 8:20am weekly
Fox Lunch 1:00pm weekly
School 2:00-4:00pm weekly
Gyn Preop Conference 5:00pm weekly
Johns Hopkins Bayview Medical Center (please see Bayview Rotation Guidelines)

Monday
OB Practice based Learning & Improvement Daily
REI Conference 8:00am weekly

Tuesday
OB Practice based Learning & Improvement Daily
NICU Conference 12:00pm monthly

Wednesday
OB Practice based Learning & Improvement Daily
Conference 8:00am
Ob/Gyn Morbidity and Mortality Conference monthly
Gyn Radiology Conference monthly
Perinatal Conference 12:00pm biweekly

Thursday
OB Practice based Learning & Improvement Daily
Grand Rounds (at JHH, Sept-June) 7:30am weekly

Friday
OB Practice based Learning & Improvement Daily
Journal Club 8:00am biweekly
NICU Rounds 8:00am biweekly
Fox lunch (JHH) 1:00pm weekly
School (JHH) 2:00pm weekly
Greater Baltimore Medical Center

Monday
Gyn Attending rounds 6:45am Daily

Tuesday
Gyn Attending rounds 6:45am Daily

Wednesday
Gyn Attending rounds 6:45am Daily
Urogyn Conference biweekly

Thursday
Gyn Attending rounds 6:45am Daily
Gyn Onc Tumor Board 4:30pm biweekly

Friday
Gyn Attending rounds 6:45am Daily
Grand Rounds 7:30am weekly
Fox Lunch (JHH) 1:00pm weekly
School (JHH) 2:00pm weekly
**Attendance Policy for Scheduled Didactic Conferences**

The ‘core’ didactic series of conferences is being maintained for the benefit of resident education. Residents are excused from routine clinical activities, except for those on call at GBMC or the chief covering Bayview L&D, at all three hospitals during Grand Rounds and resident didactics. Therefore, absences from these conferences will be excused only for post-call or night float residents, illness, vacations, out of town rotations or for coverage of high acuity emergency cases. In order to be promoted residents must attend a minimum of 70% of the resident didactic lectures from which they were not excused. In addition, approval of department funding for educational materials ($1000 book fund) is contingent upon satisfactory (70+%) attendance at scheduled didactic sessions.
Resident Presentations and Conferences

Grand Rounds

Sometime during the PGY-4 year, each resident will be asked to present the Departmental Grand Rounds. Typically, topics have been clinical, addressing issues of interest or controversy, but basic research based presentations, or topics dealing with adult education are also options.

Presentations should be carefully prepared and based on an exhaustive review of the current literature. AV materials should be legible. Presentations should be about 45 minutes in duration.

Journal Club

Journal Club meetings will occur on each service on a regular basis. A suggested format for presentation is detailed below to aid you when it is your turn to present.

General:
1. When discussing an article, please limit your presentation to 15-20 minutes. Residents and faculty will then have 10-15 minutes for open discussion.
2. Consider asking a faculty member to serve as your “mentor”. This individual can help you review pertinent literature, identify strengths and weaknesses of your article, and guide your presentation. They may even know why the article was selected for review.

Experimental Design Outline-Format for Presentation
1. Reference (author, title, journal and site of research)
2. Introduction (brief background of information)
3. Hypothesis (brief background of information)
4. Methods (experimental design – concise)
   a. Type of study
   b. Subjects (sample population and number)
   c. Inclusion and exclusion criteria for study group
   d. Controls
   e. Descriptive variables of the sample population
   f. Outcome variables to be measured and analyzed
   g. Types of measurements used in the study
5. Statistical Analysis (methods of analysis and levels of significance to be accepted – concise)
   a. Descriptive statistics (graphs, tables, etc)
   b. Inferential statistics (type of statistical analysis used to test the hypothesis)
6. Results (analysis and interpretation of the descriptive and outcome variables – this is the most important part of the entire presentation)
7. Conclusions (relative significance of the study as it applies to the hypothesis attested and the study data presented)
8. Comments (literature discussion and how this study contributes to the medical literature – it is an optional section and should be omitted if the comments section does not contribute to the impact of the presentation.

Outline for the Critique of a Medical Report

1. Objective or Hypothesis
   a. What are the questions to be answered? (study objectives)
   b. What is the population to which the investigators intend to apply their findings?

2. Design of the Investigation
   a. Was the study an experiment, planned observations or a retrospective analysis of records?
   b. Are there possible sources of sample selection bias?
   c. What is the nature of the control group?

3. Observations
   a. Are there clear definitions of the terms used? (i.e., diagnostic criteria, measurements made and outcome variables)
   b. Was the method of either classification or measurement consistent for all the subjects and relevant to the objectives of the investigation?
   c. Are the observations reliable and reproducible?

4. Presentation of Findings
   a. Are the findings presented clearly, objectively, and in sufficient detail to enable the reader to judge them?
   b. Are the findings internally consistent? (i.e., do the numbers add up properly and can the different tables be reconciled, etc.?)

5. Analysis
   a. Are the data worthy of statistical analysis? If so, are the methods of analysis appropriate to the source and nature of the data?
   b. Is the analysis correctly performed and interpreted?
   c. Is there sufficient analysis to determine whether “significant differences” may in fact be due to a lack of comparability of the groups? (i.e., age, sex, clinical characteristics, or in other relevant variables)

6. Conclusions
   a. Which conclusions are justified by the findings?
   b. Which are not justified by the findings?
   c. Are the conclusions relevant to the questions posed by the investigators?

7. Constructive Suggestions
   If the study could be improved, the reviewer should suggest a revised experimental design that would provide reliable and valid information relevant to the questions under study.

Types of Errors in Medical Literature – Most Frequent Errors

1. Conclusions are applied to a population without testing an adequate sample
2. No use of statistical test when needed and appropriate
3. Design of the study is not appropriate for solving the stated problem
4. Too much confidence attached to negative results from small samples
5. Improper use of statistical techniques
6. No mention of the type of test used or the significance level
7. Absence of a control group
8. Improper manipulation of data
9. Misleading charts or tables
10. Use of measured sensitivity without specificity
11. Improper conclusions drawn although analysis was proper
12. Multiple comparisons are made, yet importance is attached to statistical significance
Residents as Teachers

Residents are entitled to expect effective teaching efforts made on their learning behalf, from faculty physicians, from private (volunteer faculty) attending physicians, from experienced nurses and from all other health care providers who may have worthwhile information of educational merit to pass on to residents. Very importantly, however, residents are also entitled to expect quality-teaching efforts from within their own ranks. In fact, upper level, more experienced residents teaching junior residents is a fundamental concept upon which quality residency program education is based.

Being an effective physician requires one to constantly teach and as eventual practitioners, residents will find teaching opportunities in each and every patient encounter they have. The effective delivery of quality health care also requires that all members of a health care team benefit from physicians’ teaching efforts – nurses, nurses aids, surgical technicians, etc. And, importantly, physicians have an obligation to teach successive generations of medical students, nursing students and others eager to learn the science, art and practice of medicine. Quite simply, when it comes to teaching and much else, practicing physicians should never forget what it was like to be a resident and residents should never forget what it was like to be a student.

Teaching is and should be fun! It is an important part of the fabric of being a physician and should be provided willingly, effectively, fairly, frequently and without prejudice to all who seek to learn. Residents should never sell themselves short when it comes to their teaching offerings and, accordingly, are expected to be teachers throughout their residency years and beyond. Part of your didactic ‘school’ sessions will be dedicated to teaching you to be excellent teachers.
Core Objectives for Residents Teaching Medical Students
Obstetrics

1. Be able to diagnose pregnancy by history, physical exam, and laboratory tests.
2. Be able to take and appropriately record a complete obstetrical history.
3. Be able to outline the multi-system physiologic changes that occur in the pregnancy woman.
4. Become familiar with the basic concepts of fetal-placental physiology and function.
5. Become familiar with routine antepartum and postpartum care in an uncomplicated pregnancy.
6. Know how to clinically monitor the three stages of labor and manage a normal vaginal delivery.
7. Know the various techniques of antepartum fetal assessment and their indications.
8. Be able to identify high-risk circumstances in pregnancy based on history, examination or laboratory studies.
9. Understand the implications of the following conditions for the mother and fetus:
   a) chronic hypertension         d) multiple gestation
   b) preeclampsia/eclampsia       e) Rh isoimmunization
   c) diabetes mellitus            f) substance abuse
10. Be able to construct appropriate differential diagnoses for patients presenting with a) first trimester bleeding, b) third trimester bleeding, c) postpartum hemorrhage.
11. Know how to identify and manage premature labor and premature rupture of membranes; know possible etiologies.
12. Know how to identify and manage fetal distress.
13. Understand the effects of chronic diseases, genetic disorders and commonly used medications on the developing fetus.
Core Objectives for Residents Teaching Medical Students
Gynecology

1. Be able to take and appropriately record and complete gynecologic history.

2. Learn and be able to perform and appropriately record the essentials of a breast, abdominal and pelvic examination (including speculum and bi-manual portions of the pelvic exam).

3. Know how to obtain a PAP smear, perform cervical cultures and interpret KOH and wet smears of vaginal secretions.

4. Consider the possibility of pregnancy occurring in any woman within the reproductive age range who presents for medical evaluation and care. Understand that pregnancy, both intrauterine and extrauterine can present in many ways and must be considered in terms of differential diagnosis and treatment decisions.

5. Understand the hormonal relationships of the menstrual cycle and how they relate to normal and abnormal uterine bleeding.

6. Develop an appreciation for the differing gynecologic issues and problems encountered in the different stages of a woman’s life.

7. Become familiar with the anatomy of the external genitalia and pelvic viscera of women.

8. Become familiar with the common gynecologic neoplasms, including the presentation, diagnosis and treatment; understand the general principles of staging.

9. Be able to construct appropriate differential diagnoses for patients presenting with (1) abnormal bleeding and/or (2) pelvic pain and/or (3) vaginal discharge and/or (4) menopausal symptoms and/or (5) acute abdomen.

10. Be able to outline appropriate measures of prevention and/or early detection of cervical dysplasia and sexually transmitted diseases.

11. Be able to outline the different contraceptive techniques with their advantages/disadvantages, risks and benefits.

12. Assess a patient for possible perimenopausal symptoms and be able to construct a differential diagnosis, evaluation and management plan for those women. In addition, the student should be able to counsel women regarding hormone replacement therapy.
Section Five

Evaluation
Evaluation Methodology

Resident Performance Evaluation
In accordance with the ACGME special requirements for Ob-Gyn training programs, resident performance evaluations will be conducted as follows:

- Face to face end of rotation verbal performance evaluations will be performed by the chief of service of each major rotation (While this is strongly encouraged, it is not required, but residents should request it whenever feasible).
- Online (through E-Value) evaluations by attending physicians and faculty at the conclusion of every rotation will be solicited, using the appropriate Resident Evaluation Forms. Residents will also be evaluated by Professional Associates and by patients.
- The resident education committee (REC) reviews the written evaluations for the preceding calendar year on at least an annual basis and conducts more frequent evaluation of residents in need of remediation.
- The program director or associate director reviews all written evaluations, verbal feedback and REC actions, as well as performance on the in-training examination at least semi-annually. The outcome of this review is communicated to the resident in a face-to-face meeting, which is documented on the semiannual resident progress review form. A final written evaluation using the final resident progress review form will be prepared by the program director for each resident who completes the program. It will verify that the resident has sufficient professional ability to practice competently and independently. This record will be maintained in the institution’s permanent files.

Program Evaluation
The design of the residency program must be flexible enough to respond to changing RRC requirements, modification in faculty composition and other changes in the medical marketplace. The ability of the existing program to meet the residents ongoing training needs must be continuously evaluated. To this end, resident input will be solicited for each major component of the program.

- The full-time faculty will be evaluated by each resident at the end of each applicable rotation using the resident evaluation of attending physician form.
- Evaluation of the overall quality of a clinical rotation will be solicited at its conclusion using the resident evaluation of rotation form.
- All resident-submitted written evaluations are collected anonymously, pooled, whenever possible, and shared with the faculty member, chair and chief of service annually or on an as needed basis if a problematic pattern is identified. Resident teaching evaluations figure prominently in faculty performance reviews and decisions about faculty promotion and retention.
- Residents are encouraged to share their concerns and suggestions for program improvement with the respective chiefs of service, the administrative chief resident for presentation at REC meetings, or with the program director. The latter will use the semiannual meeting with the resident to solicit constructive feedback.
Semi-annual Resident Review
Department of Gynecology and Obstetrics
Johns Hopkins University

Resident’s Name: ___________________________ PGY- __ Date of Review: ________________

Faculty Reviewer: _______________________________________

Rotations Completed: _______________________________________

Patient Care (clinical judgment and technical skills):

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Specific strengths and weaknesses; action plan for improvement:

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Medical Knowledge:

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Specific strengths and weaknesses; action plan for improvement:

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Practice Based Learning and Improvement:

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Specific strengths and weaknesses; action plan for improvement:

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### Interpersonal Communication Skills:

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Specific strengths and weaknesses; action plan for improvement:

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### Professionalism:

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Specific strengths and weaknesses; action plan for improvement:

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### Systems-based Practice:

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Specific strengths and weaknesses; action plan for improvement:

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### Overall Performance Level:

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Status:  In good standing:_____________  Probation:_____________

Resident’s Observations Regarding Program:

______________________________________________________________________________

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______________________________________________________________________________

Signature of Evaluator/Date

______________________________________________________________________________

Signature of Resident/Date
Johns Hopkins University
Gynecology and Obstetrics Training Program

Resident Evaluation of Rotation

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**Rotation Objectives** *(Question 1 of 8 - Mandatory)*

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**Competency Skills Gained** *(Question 2 of 8 - Mandatory)*

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**Rounds** *(Question 3 of 8 - Mandatory)*

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**Conferences** *(Question 4 of 8 - Mandatory)*

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**Patient Care** *(Question 5 of 8 - Mandatory)*

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<td>Patient Volume/Cases  (Question 6 of 8 - Mandatory)</td>
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<td>Value  (Question 7 of 8 - Mandatory)</td>
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<td>Is this rotation valuable?</td>
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| Changes  (Question 8 of 8 - Mandatory) |
| What changes in the rotation would you suggest? |
Competencies Evaluation

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### Patient Care - Clinical Skills (Question 1 of 21 - Mandatory)

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### Clinical Skills Comments (Question 2 of 21)

Specific comments recognizing excellent performance or areas for improvement

### Patient Care - Surgical Skills (Question 3 of 21 - Mandatory)

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### Surgical Skills Comments (Question 4 of 21)

Specific comments recognizing excellent performance or areas for improvement
### Medical Knowledge (Question 5 of 21 - Mandatory)

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#### Medical Knowledge Comments (Question 6 of 21)

Specific comments recognizing excellent performance or areas for improvement

### Communications and Interpersonal Skills (Question 7 of 21 - Mandatory)

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#### Communications and Interpersonal Skills Comments (Question 8 of 21)

Specific comments recognizing excellent performance or areas for improvement

### Professionalism (Question 9 of 21 - Mandatory)

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#### Professionalism Comments (Question 9 of 21)

Specific comments recognizing excellent performance or areas for improvement
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Specific comments recognizing excellent performance or areas for improvement |

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Never analyzes effectiveness of own practice; Fails to perform self-evaluation; does not use information technology to enhance patient care or pursue self improvement; poor understanding and application of principles of evidence-based medicine |

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Specific comments recognizing excellent performance or areas for improvement |

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<th>System-Based Practice (Question 13 of 21 - Mandatory)</th>
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Unable to access/mobilize outside resources independently; actively resists efforts to improve systems of care; does not use systematic approaches to reduce error and improve patient care |

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Specific comments recognizing excellent performance or areas for improvement |

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### System-Based Practice Comments  (Question 14 of 21)
Specific comments recognizing excellent performance or areas for improvement

### Teaching Skills  (Question 15 of 21 - Mandatory)

1

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### Teaching Skills Comments  (Question 16 of 21)
Specific comments recognizing excellent performance or areas for improvement

### Comments  (Question 17 of 21 - Mandatory)
Based on the above ratings of each component skill, please provide any additional comments about the trainee's clinical performance.

### Competence  (Question 18 of 21 - Mandatory)
Overall competence.

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240
**Face to Face Discussion** *(Question 19 of 21 - Mandatory)*

I have discussed this evaluation with the resident.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
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**System Ease of use** *(Question 20 of 21)*

E*Value was easy to use.

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<tr>
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</table>

**E*Value Comments** *(Question 21 of 21)*

Comments entered here will be forwarded to E*Value technical support.
Sample of Resident Evaluation- OB

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<tbody>
<tr>
<td>Evaluator:</td>
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<td>Site:</td>
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<td>Period:</td>
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**Spontaneous Delivery (Question 1 of 15 - Mandatory)**

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<tr>
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**Vacuum Delivery (Question 2 of 15 - Mandatory)**

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**Forceps Delivery (Question 3 of 15 - Mandatory)**

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**Cesarean Section (Question 4 of 15 – Mandatory)**

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**Vaginal Breech (Question 5 of 15 - Mandatory)**

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**Episiotomy Repair (Question 6 of 15 - Mandatory)**

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**Management of Shoulder Dystocia (Question 7 of 15 - Mandatory)**

<table>
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### Cervical Cerclage (Question 8 of 15 – Mandatory)

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### External Cephalic Version (Question 9 of 15 - Mandatory)

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### Amniocentesis in 3rd Trimester (Question 10 of 15 - Mandatory)

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### Postpartum Tubal Ligation (Question 11 of 15 - Mandatory)

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### Care of Medically Complicated Antepartum Patients (Question 12 of 15 - Mandatory)

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### Comments (Question 13 of 15)


### System Ease of use (Question 14 of 15)

E*Value was easy to use.

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<th>Strongly Disagree</th>
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Johns Hopkins University
Gynecology and Obstetrics Training Program

Sample of Resident Evaluation- GYN

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<td>--------------</td>
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<td><strong>LEEP</strong> (Question 11 of 15 - Mandatory)</td>
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**System Ease of use** (Question 14 of 15)  
E*Value was easy to use.

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Professional Associates Evaluation

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**Clinical Setting** *(Question 1 of 15 - Mandatory)*

Please indicate the clinical setting you have interacted with the resident.

**Clinical Observations** *(Question 2 of 15 - Mandatory)*

On average how many clinical observations did you have of the resident?

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<th>&lt;4</th>
<th>5 - 10</th>
<th>10 - 20</th>
<th>&gt;20</th>
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**Professional Role** *(Question 3 of 15 - Mandatory)*

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<th>Med Student</th>
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<td>3.0</td>
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</table>

**Professional Role - Other** *(Question 4 of 15 )*

Please define.

**Communication - Patients/Families** *(Question 5 of 15 - Mandatory)*

Communicates clearly, is willing to answer questions and provide explanations, willing to listen to patients and families.

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<tr>
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<td>6.0</td>
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</table>

**Communication - Nursing/Allied Staff** *(Question 6 of 15 - Mandatory)*

Consistently demonstrates willingness to listen to nursing and allied staff.

<table>
<thead>
<tr>
<th>Unable to Assess</th>
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<th>Unsatisfactory</th>
<th>Unsatisfactory</th>
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<td>7.0</td>
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**Respectfulness - Patients** *(Question 7 of 15 - Mandatory)*

Treats others with respect; does not demean or make others feel inferior; provides equitable care to patients, uses respectful language when discussing patients; is sensitive to cultural needs of patients.
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Rating Options</th>
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<tr>
<td>8</td>
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<td>9</td>
<td>Compassion</td>
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<td>10</td>
<td>Reliability</td>
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<td>11</td>
<td>Honesty/Integrity</td>
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<tr>
<td>12</td>
<td>Responsibility</td>
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<tr>
<td>13</td>
<td>Altruism</td>
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<td>14</td>
<td>Advocate</td>
<td>Unsatisfactory Unsatisfactory Satisfactory Satisfactory Excellent Excellent Excellent</td>
</tr>
<tr>
<td>15</td>
<td>Comments</td>
<td>Please provide comments concerning the resident's relationships with patients, families and other healthcare professionals.</td>
</tr>
</tbody>
</table>

Comments: Please provide comments concerning the resident's relationships with patients, families and other healthcare professionals.
Patient Satisfaction Questionnaire

This questionnaire is completely anonymous. Please do not sign your name. Your doctor will only see the results grouped with other results and will not know that you filled out this form.

<table>
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<th>M.D.</th>
<th>Date</th>
<th>Rating Scale</th>
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<td>Inpatient</td>
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<table>
<thead>
<tr>
<th>HOW IS THIS DOCTOR AT...</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greeting you warmly; being friendly, never crabby or rude</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Letting you tell your story while listening carefully; asking thoughtful questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Informing you during the physical exam about what he/she is going to do and why; telling you what he/she finds</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Using words you can understand when explaining your problems and treatment; explaining any technical medical terms in plain language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encouraging you to ask questions; answering them clearly; never avoiding your questions or lecturing you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Final Resident Evaluation  
Gynecology and Obstetrics Residency Program  
Johns Hopkins University

Resident Name: __________________________  Graduation Year: __________________________

Did the resident complete the program in Gyn/Ob?  Yes ☐  No ☐

Patient Care-Clinical Skills

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

Patient Care-Surgical Skills

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

Medical Knowledge

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<td>basic and clinical sciences; minimal interest in learning; does not understand complex relations, mechanisms of disease</td>
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Exceptional knowledge of basic and clinical sciences; highly resourceful development of knowledge; comprehensive understanding of complex relationships, mechanisms of disease

Communication and Interpersonal Skills

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<th>Superior</th>
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<td>relationships with patients, families, and colleagues through listening, narrative or nonverbal skills; does not provide education or counseling to patients, families, or colleagues; poor oral presentations, written records inaccurate or incomplete</td>
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Demonstrates excellent relationship building with patients, families, and colleagues through listening, narrative and nonverbal skills; excellent education and counseling of patients, families, and colleagues; always “interpersonally” engaged; excellent oral presentations; records complete and accurate
Professionalism

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

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

Practice-Based Learning

Never analyzes effectiveness of own practice; Fails to perform self-evaluation; does not use information technology to enhance patient care or pursue self improvement; poor understanding and application of principles of evidence-based medicine

Constantly evaluates effectiveness of own practice; effectively uses technology to manage information for patient care and self-improvement; excellent understanding and application of principles of evidence-based medicine

System-Based Practice

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

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

Teaching Skills

Fails to educate students and other health care professionals; Avoids teaching responsibilities

Excellent educator of students and other health care professionals; seeks out opportunities to teach

Overall Competence
Does this resident demonstrate sufficient competence to practice without direct supervision?  
Yes ☐ No ☐

Recommendation:

☐ Do not Recommend  ☐ Recommend

Residency Program
Director________________________________Date:_____________

Resident:_______________________________________________Date:_____________

Residents Name______________________________
Evaluation of Chief Resident by Junior Resident

Subject:

<table>
<thead>
<tr>
<th>Evaluation Area</th>
<th>Rating Options</th>
<th>Score</th>
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<tbody>
<tr>
<td>1) Teaching Skills, Communication of Knowledge</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<tr>
<td>Effectively communicated medical knowledge, e.g. in presentations and in articulation of clinical reasoning processes.</td>
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<tr>
<td>2) Teaching Skills, Learning Environment</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<td>Demonstrated a commitment to teaching.</td>
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<td>3) Teaching Skills, Autonomy</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<td>Provided an appropriate balance between independence and supervision.</td>
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<td>4) Relationship with Juniors, Supportive</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<td>Was supportive, e.g., approachable, patient, empathetic.</td>
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<td>5) Feedback</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<td>Provided effective feedback, e.g., clear, timely, specific.</td>
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<td>6) Humanistic Qualities, Attitude</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<td>Demonstrated a caring attitude towards patients and families.</td>
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<td>7) Organization, Punctuality</td>
<td>Not Applicable</td>
<td>Strongly Disagree</td>
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<td>Arrived on time for rounds/clinic.</td>
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8) Role Modeling
The Resident Physician is a good role model.
Not Applicable  Strongly Disagree  Disagree  Neutral/Undecided  Agree  Strongly Agree
0  1  2  3  4  5

9) Leadership, Overall
Overall leadership effectiveness.
Not Applicable  Strongly Disagree  Disagree  Neutral/Undecided  Agree  Strongly Agree
0  1  2  3  4  5

10) Resident Physician Strengths
These comments will be viewed by the Resident physician, but will be anonymous and aggregated. For comments to be effective feedback, please be direct, specific, and constructive, avoiding general statements that are too nonspecific to be useful.
Comments:

11) Areas for Growth
Comments:
Resident Skills Evaluation

PGY I:

General

- Demonstrate the ability to perform a comprehensive history and physical examination in a timely manner. In doing so, the resident will elicit salient information and differentiate normal from abnormal states.

- Demonstrate the ability to perform a focused history and physical examination appropriately tailoring the type of historical information elicited and the components of the examination to the presenting complaint and symptoms. Can then outline and initiate an appropriate management plan.

- Demonstrates the ability to write succinct admission notes and progress notes as well as verbally present a patient concisely and coherently. All notes must include the date and signature as well as time for inpatient notes.

- Demonstrates accuracy in the collection, documentation and reporting of clinical data regarding patients in his or her care.

- The resident will be able to recognize situations that are beyond the scope of his or her expertise and appropriately consult senior level residents and attendings.

- When working in an environment demanding attention to more than one problem or patient at a time, he or she will be able to effectively assign priorities to tasks and implement plans accordingly.

- Can provide supervision and guidance to medical students in the content areas above.

Gynecology

The resident will be able to diagnose and develop a management plan for patients with

- upper and lower genital tract infections
- threatened, incomplete, inevitable and missed abortion
- ectopic pregnancy
- dysfunctional uterine bleeding
- contraceptive needs

Demonstrate the ability to perform:

- Incision & Drainage of a Bartholin’s abscess with placement of a Word catheter
- Endometrial aspiration biopsy
- Vulvar biopsy
- Hysteroscopy
- Dilation and Curettage
- Suction Curettage
- Diagnostic laparoscopy
- Laparoscopic sterilization
- Surgical management of ectopic pregnancy

- The resident will be able to recognize and initiate management of common post-operative problems such as infection, ileus, hemorrhage, and fluid and electrolyte imbalances.

**Obstetrics**

- Demonstrates the ability to provide antenatal care to an uncomplicated patient. Can recognize when a pregnancy becomes complicated and initiates appropriate management and referral as necessary.

- The resident will be able to diagnose and develop a management plan for patients with preterm labor, premature rupture of membranes, preeclampsia, post-datism, chorioamnionitis, postpartum endomyometritis, and IUGR. This includes the ability to perform a level I sonogram.

- The resident will be able to effectively manage an uncomplicated labor. This will include the recognition of both normal and abnormal labor patterns and fetal heart rate tracings and being able to outline appropriate management plans.

Demonstrates the ability to perform a safe and expeditious vaginal delivery including:

- Management of the second stage of labor
- Provision of local or pudendal anesthesia
- Cutting and repairing a midline or mediolateral episiotomy extending up to the rectal sphincter.
- Management of the third stage of labor.
- Immediate care of the newborn including neonatal resuscitation.

- With assistance, can safely and expeditiously perform:
  - Primary cesarean section
  - Post-partum bilateral tubal ligation.

- Demonstrates the ability to perform elective neonatal circumcision for male infants.

**Primary Care**

- The resident will develop the ability to provide age appropriate screening for non-gynecologic diseases.
  - The resident will be able to initiate management for common medical conditions including

  - Upper and lower respiratory tract infection
  - Asthma
  - Conjunctivitis
  - Otitis media
  - Urinary tract infection
  - Chronic hypertension
- Hypercholesterolemia
- Acute and chronic gastrointestinal diseases
- Headache
- Uncomplicated inflammatory skin diseases
- Premalignant skin disorders
- Uncomplicated diabetes
- Thyroid dysfunction
- Nicotine addiction
- Alcoholism
- Weight management
- Immunizations
PGY II

In addition to the task outlined in the above learning objectives for the PGY I year, the PGY II resident will be expected to master the skills outlined below.

**Gynecology**

- The resident will demonstrate competence in performing
- Marsupialization of a Bartholin’s gland abcess
- Laparotomy
- Lysis of adhesions
- Total abdominal hysterectomy and bilateral salpingoophorectomy
- Myomectomy
- Ovarian cystectomy
- Colposcopy and cervical biopsy
- Cervical conization
- Breast cyst aspiration

- The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
- Dilation and curettage
- Diagnostic laparoscopy

**Obstetrics**

Demonstrates the ability to manage the ambulatory and inpatient care of patients with complicated pregnancies including
- diabetes
- hypertensive disorders
- multiple gestations
- thyroid disease
- seizure disorders
- hemoglobinopathies

- The resident will be able to provide appropriate counselling to patients with advanced maternal age or who are at risk for genetic disorders.

The resident will demonstrate competence in performing
- Amniocentesis in the third trimester
- Fetal scalp pH
- Operative vaginal delivery
- vacuum
- forceps
- Repair of episiotomies which extend through the anal sphincter and rectal mucosa
- Repeat cesarean section
The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures:
- Spontaneous vaginal delivery and episiotomy repair
PGY III

In addition to the task outlined in the above learning objectives for the PGY I & II years, the PGY III resident will be expected to master the skills outlined below.

Gynecology

The resident will demonstrate competence in performing

- Operative laparoscopy
- Complicated total abdominal hysterectomy
- Appendectomy
- Repair of bowel or bladder injuries
- Surgery for pelvic inflammatory disease

The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures

- Marsupialization of a Bartholin’s gland abscess
- Laparoscopic tubal ligation
- Ovarian cystectomy
- Colposcopy and cervical biopsy
- Breast cyst aspiration

Obstetrics

The resident will function in a supervisory capacity and assist junior residents in the care of high-risk obstetrical patients.

The resident will demonstrate competence in performing

- Management of fetal shoulder dystocia
- Complicated operative vaginal delivery
- Repair of cervical lacerations and vaginal sulcus tears
- Emergency cesarean section
- Uterine artery ligation
- External cephalic version
- Cervical cerclage

The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures

- Primary and repeat cesarean sections
- Postpartum tubal ligation
- Repair of episiotomies extending through the rectal sphincter and anal mucosa

Pathology

The resident will demonstrate the ability to process and evaluate surgical pathology specimens.
PGY IV

In addition to the task outlined in the above learning objectives for the PGY I, II, and III years, the PGY IV resident will be expected to master the skills outlined below.

**Gynecology**

The resident will demonstrate competence in performing
- Urodynamic evaluation
- Surgery for urogenital prolapse and urinary incontinence
- Cystoscopy
- Vaginal hysterectomy
- Anterior and posterior colporrhaphy
- Tubal reconstructive surgery

The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
- Incision & Drainage of a Bartholin’s abscess with placement of a Word catheter
- Marsupialization of a Bartholin’s gland abscess
- Endometrial aspiration biopsy
- Vulvar biopsy
- Hysteroscopy
- Dilation and Curettage
- Suction Curettage
- Diagnostic and operative laparoscopy
- Laparoscopic sterilization
- Surgical management of ectopic pregnancy
- Laparotomy
- Lysis of adhesions
- Total abdominal hysterectomy and bilateral salpingoophorectomy
- Myomectomy
- Ovarian cystectomy
- Colposcopy and cervical biopsy
- Cervical conization
- Breast cyst aspiration
- Appendectomy
- Repair of bowel or bladder injuries
- Surgery for pelvic inflammatory disease

The resident should become familiar with the indications for the following gynecologic procedures and how to perform them.
- Repair of vaginal fistulas
- Repair of ureteral injuries
- Radical hysterectomy
- Lymph node dissection and omentectomy
- Surgical correction of congenital uterine anomalies
- Brachytherapy
- Assisted reproductive techniques
Obstetrics

- The resident will function in a supervisory capacity and assist junior residents in the care of high-risk obstetrical inpatients.

The resident will demonstrate competence in performing
- Vaginal delivery of twin gestations
- Cesarean hysterectomy
- Level II obstetrical ultrasound examinations

The resident will develop a level of surgical expertise which will allow him/her to function as a senior resident responsible for guiding junior residents through a case for the following procedures
- Amniocentesis in the third trimester
- External cephalic version
- Cervical cerclage
- Management of labor and delivery
- Fetal scalp pH
- Provision of local or pudendal anesthesia
- Simple and complicated operative vaginal delivery
- vacuum
- forceps
- Management of fetal shoulder dystocia
- Repair of episiotomies which extend through the anal sphincter and rectal mucosa
- Repair of cervical lacerations and vaginal sulcus tears
- Primary and repeat cesarean section
- Emergency cesarean section
- Uterine artery ligation
- Immediate care of the newborn including neonatal resuscitation.
- Post-partum bilateral tubal ligation.

The resident should become familiar with the indications for the following obstetric procedures and how to perform them.
- Obstetric anesthesia
- Genetic amniocentesis
- Neonatal intubation
- Hypogastric artery ligation
- Vaginal breech delivery
Section Six

Resident Procedure Data
Guidelines for Tracking Resident Program Data

As of July 1, 2003, all Gyn/Ob residents report their procedures through the ACGME Resident Case Log System on the web. Each resident is responsible for keeping an accurate and up-to-date record of all procedures. Statistics are necessary for review of residents’ experience in connection with the Internal Residency Review, and the regular review by the Accrediting Council on Graduate Medical Education through the Residency Review Committee in Obstetrics and Gynecology. They are also needed for hospital credentialing after graduation.

In your personal statistical program, the categories of surgeon and assistant are used. The categories are those of the Residency Review Committee (composed of members of the AMA, ACOG, ABOG, and several other organizations.) These categories are defines as follows:

Surgeon: Resident see the patient preoperatively, writes orders, discusses care with the attending physician, and the resident performs \( \geq 50\% \) of the surgical procedure, if one is performed, and cares for the patient postoperatively under supervision. Also includes cases where the resident has little involvement in the pre and/or post operative care of the patient but performs \( \geq 50\% \) of the surgical operation under supervision.

Assistant: Resident serves as assistant at surgery performing less than 50% of the surgical procedure. Also includes cases where the resident (PGY-3 or PGY-4 level) is scrubbed on a surgical procedure to supervise, teach, and assist a more junior level resident in performing a case for which the junior resident will claim surgeon responsibility.

Protocol for Program Reporting:

1. An accurate record of procedures (by category) and of ambulatory encounters is kept for each rotation.
2. Resident must enter procedures often. YOU SHOULD NOT BE MORE THAN ONE MONTH BEHIND IN YOUR CASE LOG. This is monitored.
3. Complete and up-to-date statistics (surgical and ambulatory) are a prerequisite prior to leaving for any vacation or meeting.

For Post-Graduation Credentialing:

1. Privileges for cystoscopy, operative pelviscopy, laparoscopic assisted vaginal hysterectomy, and LASER almost always require a “set” number of procedures. Count them.

You will receive information on the Resident Case Log System during your orientation. Please refer any questions about the system to the Residency Program Coordinator at 410-955-6710. Your fellow residents will also provide help and instruction in using the system. Just ask!
IMPORTANT!!!! Your case log entries are monitored monthly. Please keep your log up to date. Do not forget to put in your Ambulatory Care cases. Use patient ID numbers.
Section Seven

Resident Recruitment and Selection
ACGME Institutional Requirements
Regarding Resident Recruitment and Selection
(Source: AMA Graduate Medical Education Directory)

Residents
1. Resident Eligibility and Selection
   The sponsoring institution must have written policies and procedures for the
   recruitment and appointment of residents and comply with the requirements
   listed below, and it must monitor the compliance of each program with these
   procedures.

   a. Resident Eligibility
      Applicants with one of the following qualifications are eligible for
      appointment to accredited residency programs:
      i. Graduated of medical schools in the United States and Canada
         accredited by the Liaison Committee on Medical Education
         (LCME)
      ii. Graduates of colleges of osteopathic medicine in the United
          States accredited by the American Osteopathic Association
          (AOA).
      iii. Graduates of medical schools outside the United States and
           Canada who meet one of the following qualifications:
            A. Have received a currently valid certificate from the
               educational Commission for Foreign Medical
               Graduates or
            B. Have a full and unrestricted license to practice medicine
               in a U.S. licensing jurisdiction
      iv. Graduates of medical schools outside the United States who
          have completed a Fifth Pathway program provided by an
          LCME-accredited medical school

   b. Resident Selection
      i. The sponsoring institution must ensure that programs select
         from among eligible applicants on the basis of their
         preparedness, ability, aptitude, academic credentials,
         communication skills and personal qualities such as motivation
         and integrity. Programs must not discriminate with regard to
         sex, race, age, color, national origin, disability, or veteran
         status.
      ii. In selecting from among qualified applicants, it is strongly
          suggested that institutions and all of their sponsored programs
          participate in an organized matching program, where available,
          such as the National Resident Matching Program (NRMP).
All PGY-1 residents entering the residency program will be selected through the National Residency Matching Program (NRMP) using the AAMC-sponsored Electronic Residency Application Service (ERAS) and abiding by the “Resident Eligibility and Selection” requirements detailed in the ACGME’s Institutional Requirements. The process to be employed is as follows:

2. applications received through ERAS will be reviewed by the program director
3. the decision to invite an applicant for a required interview will be based on a review of the following factors in combination:
   a. medical school reputation
   b. USMLE Step 1 and Step 2 (if available) scores – passing scores are required; generally the minimum score is 200, occasionally exceptions may be made to this criterion at the discretion of the program director
   c. election to Alpha Omega Alpha Medical Honor Society
   d. medical school transcript
   e. strength of Dean’s letter (MSPE) and three letters of recommendation (a chairman’s letter is required)
   f. research and other extracurricular academic achievements
   g. personal statement
4. interview invitations will be offered in a ‘rolling’ process (as opposed to a ‘batch’ process)
5. approximately 80 to 100 interview appointments will be offered each year
6. the interview process will consist of
   a. a detailed program review conducted by the program director
   b. two faculty interviews and an interview with a current resident
   c. a facility tour
   d. luncheon with resident group
   e. an informal social event with current residents
7. a standardized evaluation and scoring form will be used
8. the NRMP rank list will be determined by a group consisting of:
   a. the program director
   b. the chairman
   c. the administrative chief resident
   d. full time faculty persons and private attending physicians involved in the interview process
9. after a detailed review and discussion of each applicant’s submitted material and interview day evaluations, the final NRMP rank list will be determined by a voting process

Unexpected vacancies in the program will be advertised on the CREOG website.
Recruitment, Selection, Appointment, Evaluation, Promotion and Dismissal of House Staff

I. Recruitment and Selection
A. Application for appointment to an ACGME-accredited program may be made by:
1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   a. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or
   b. Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are in training.
4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
B. Appropriately selected international medical graduates from a medical school which is not on the Johns Hopkins University School of Medicine list of schools approved for reciprocity will be reviewed on a case by case basis.
C. Each program shall establish a system of recruitment and evaluation of applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.
D. No program shall discriminate with regard to sex, race, age, religion, color, national origin, disability, sexual orientation or veteran status.
E. The Johns Hopkins School of Medicine and its ACGME-accredited programs shall participate in an organized matching program, such as the National Resident Matching Program, where available.

II. Appointment
A. Appointments shall be made for a period specified by the program, up to a maximum of 12 months; reappointment shall be made annually for multi-year programs.
B. The offer of appointment shall be made by issuance of a Resident Agreement (attachment I); the specific program, the PGY level if a multi-year program, the stipend level and the vacation allotment shall be specified as part of the agreement.
C. Acceptance of the appointment shall be indicated by return of a signed copy of the Resident Agreement to the program director. The signed document shall be maintained in departmental files.
III. Evaluation
A. Each program shall maintain an effective plan for assessing resident performance throughout the period of appointment, including during periods of service at affiliated institutions. Assessment shall include competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, in addition to program specific standards.
B. Regular and timely feedback shall be provided; this shall include written semiannual evaluations which are accessible to the resident and which are used to achieve progressive improvement in competence and performance.
C. Each program shall collect anonymous evaluations by residents of the faculty and of the training program in accordance with the ACGME Common Requirements and program-specific requirements. Unless otherwise stated in the Common or Program-specific Requirements, these evaluations shall be performed at least annually, but preferably more frequently. In conducting these evaluations, the GMEC has mandated the use of a GMEC-approved electronic evaluation system to be implemented by July 1, 2003, unless the program has presented an alternative which is found acceptable by the GMEC. The program director and/or department chair should discuss individual faculty evaluations with the faculty member at least annually. The program director shall prepare a summary analysis and interpretation of the faculty and program evaluations. The summary analysis shall be provided to the department chair and the DIO at least annually. The GMEC Internal Review Team shall also receive and review the most recent summary analysis prior to its Internal Review of the program. The summary report and analysis by the program director shall include the specific performance improvement steps the program intends to make (or has made) based on these evaluations.

IV. Promotion
Departmental evaluation for promotion shall consider compliance with institutional policies and departmental policies, as well as progress in developing skills in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

V. Non-Renewal
On-going evaluation will be made. If performance is deemed unsatisfactory and attempts at correcting the problem have been unsuccessful, a written notice of non-renewal shall be provided no later than four months prior to the end of the current period of appointment. However, if the primary reason(s) for the nonrenewal occurs within the four months prior to the end of the agreement, the program shall provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow. A resident in receipt of a notice of non-renewal is entitled to utilize the "Grievance Procedure for Faculty, Fellows and the Student Body" of the School of Medicine.
VI. Probation, Suspension and Termination

In situations which may lead to the imposition of probation, suspension or dismissal, the Johns Hopkins University School of Medicine policy on "Probation, Suspension and Termination of Postdoctoral Students" will be followed.
Section Eight

Benefits and Policies
“Student Status” For Deferment of Resident Loans

On November 21, 1989, Congress completed action on the Omnibus Budget Reconciliation Act of 1989. A provision of that bill prohibits the use by medical residents of the “student status” deferment of loans, which are authorized by Title IV of the Higher Education Act. These loans include Stafford Student Loans, Supplemental Loans for Students, and Perkins Loans. The reconciliation provision does not affect residents’ eligibility for the two-year internship deferment. Since the Johns Hopkins University School of Medicine has not regarded residents as students, the House Staff Office procedure has been able to certify loan deferments only for the first two years of training. Therefore, the provisions to the Omnibus Budget Reconciliation Act will not affect the policies of our office. Residents can still defer loans for the first two years of training. After this time, the Omnibus Budget Reconciliation Act provides that lenders extend “forbearance on the payment of educational loans.”
VACATION POLICY

The vacation policy is 2 weeks to one month as determined by the training program director for Postgraduate year.

STIPEND POLICY

<table>
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<tr>
<th>Postdoctoral Year in Program*</th>
<th>2008-2009 Annual Stipend</th>
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</tbody>
</table>

*Not all prior postgraduate years of training count toward the year in program. Postgraduate year is determined by the Postdoctoral Office based on established criteria.

Complete descriptions of the dental insurance, health insurance, disability insurance, and life insurance plans are on the following website: [http://www.hopkinsmedicine.org/som/gme/residents/index.html](http://www.hopkinsmedicine.org/som/gme/residents/index.html). You may also access information regarding the Parents in a Pinch Program, Dependent Care Flexible Spending Account, 403(b) Retirement Program, and the Summary of Benefits and Description of the House Staff Ambulatory Care Program from this website.

Descriptions of the benefit plans will be distributed to you with membership cards and insurance certificates.

STUDENT HEALTH PROGRAM (SHP) (Effective date is determined by completion date of application)

For house officers, spouses, same-sex domestic partners and dependent children. Enrollment must take place within 30 days of appointment. Changes in enrollment can be made during the July open enrollment period or as a result of a "life event" provided application is made within 30 days of the qualifying event.

I. HOSPITALIZATION INSURANCE - STUDENT HEALTH PROGRAM (Through Johns Hopkins Employer Health Programs)

A. Hospitalization

All inpatient care - 30 day semi-private room at 100% of Reasonable & Customary charges; then 80% of Reasonable & Customary charges, after deductible

Outpatient Surgical Facility Charges – 100% of Reasonable & Customary charges

B. Out-of-Pocket Maximum - Calendar Year

| Individual | $3,000 |
| Family     | $9,000 |

The out-of-pocket limit includes the deductible and coinsurance but does not include: penalties, prescription drug coinsurance and expenses; Program maximums; any charges for services which are not covered, or mental health and substance abuse charges, including treatment of alcoholism.

C. Diagnostic Tests

For diagnostic tests performed in a physician's office or hospital outpatient department:

1. X-ray examinations, radioisotope studies (made by qualified X-ray specialist or radiologist upon referral from another physician or by a specialist qualified to make such examination in his own field), electrocardiograms, and electroencephalograms.

2. Pathology examinations including the study of surgically removed tissue, blood tests, analysis of urine, spinal fluids, etc.

D. Prescription Plan

Benefits are paid for most prescription drugs, injectable insulin, diabetic supplies and other medicines and supplies. You can receive a 30 day supply. The prescription plan is a three tier formulary with a $10, $20 and $35 co-pay for each 30 day supply.

When you go to a pharmacy, show your membership card and pay only your portion of the cost of a prescription. A cost saving 90 day supply of medication may be obtained by mail with a 2 co-pay payment. Details on the mail order program are included in the Student Health Program brochure. Prescribed oral contraceptives are covered under the Prescription Plan.

E. Maximum Lifetime Benefit - $1,000,000
Subject to a $100 deductible per member ($300 per family) per calendar year. The Program will pay 80% of Reasonable & Customary charges for all other covered expenses up to the $1,000,000 lifetime maximum. (Except substance abuse care which has a $250,000 lifetime maximum)

F. Outpatient Mental Health Services
The program provides benefits for outpatient mental health service when provided in a psychiatrist's office, or in a hospital outpatient department or clinic. These benefits are coordinated with the benefits available under the University Mental Health Program as discussed in the Summary of Health Benefits and Description of the House Staff Ambulatory Care Program.

G. Case Management Component
Elective (non-emergency) hospitalizations require certification by the Johns Hopkins Student Health Program prior to admission. Emergency care must be reported to the Johns Hopkins Student Health Program within 48 hours.

H. Pre-Existing Condition Exclusion (applies only to subscribers who have not presented a valid Certificate of Health Coverage from a prior health plan)
Benefits will be limited to $10,000 during the first year of the policy for any condition, except pregnancy, for which a new subscriber has received medical treatment in the 90 days preceding effective date of policy.

II. AMBULATORY CARE PROGRAM (Coverage is effective date of Student Health Program enrollment)
The House Staff Ambulatory Care Program (HSACP) is designed to provide payment for comprehensive ambulatory health services to house officers, spouses, same-sex domestic partners and dependent children. The Ambulatory Care Program covers professional fees and, within certain guidelines, medical expenses not covered by the Student Health Program. Outpatient pediatric care is also supplemented under this program. The entire brochure is available on line as noted above.

III. UNIVERSITY HEALTH SERVICES (UHS)
Adult ambulatory care services are provided by the University Health Services (UHS Health Center) to house staff, spouses and domestic partners. You may choose a pediatrician of your choice. Each house officer, spouse and domestic partner will be assigned a UHS Health Center primary care physician. House staff may choose a primary care physician of your choice under this plan. The UHS Health Center is located at 401 N. Caroline Street and their website is http://www.hopkinsmedicine.org/uhs/.

IV. UNIVERSITY MENTAL HEALTH SERVICES (UMHS)
University Mental Health offers a confidential source for house staff and their spouses/same-sex domestic partners seeking mental health help. Services are rendered by physicians and professional staff of the Johns Hopkins Psychiatry Department. The mental health benefit provides unlimited visits if care is received through UMHS. The Student Health Program is billed for mental health visits with the balance supplemented by UHS/UMHS.

V. FACULTY & STAFF ASSISTANCE PROGRAM (FASAP)
The FASAP program is available to house staff and their immediate families. Services include identification, assessment and diagnosis of personal problems, referral to appropriate service or treatment resources; brief counseling, preventive and educational sessions, and support and discussion groups. For a more complete description of services, see www.fasap.org.

VI. DENTAL PLAN - Coverage effective first of the month following month of appointment
For house officers, spouses, same-sex domestic partners and dependent children. This is a basic CareFirst BlueCross BlueShield dental plan with a co-payment requirement for services rendered.

VII. LONG TERM DISABILITY INSURANCE (House Officer Only)
Enrollment Form Required. Effective date is determined by completion date of application. Details of the plan will be mailed approximately 6 weeks after your enrollment form is received.

A. The policy is noncancellable and guaranteed renewable for your lifetime.
B. The monthly benefit of $2,750 per month applies to new appointments 7/01/05 and beyond.
C. Benefits are payable after the 90th day of your disability.
D. The policy can be maintained (and increased) by you after you leave Hopkins by the continuation of premium payments.

VIII. SUPPLEMENTAL DISABILITY BENEFITS
In addition to the above benefit a Supplemental Disability Insurance Plan may be purchased by the house officer on a direct pay basis. The plan provides a $1,000 additional monthly benefit at guaranteed rates. Enrollment information will be mailed to your home by UnumProvident.
IX. LIFE INSURANCE (House Officer only – Coverage is effective date of appointment. No enrollment form required; completion of beneficiary form required.)

$100,000 of group life coverage under a policy underwritten by Unum Life Insurance Company of America.

X. RETIREMENT PLAN 403(b)

The institutions provide 1.5% of your annual salary to a retirement plan. In addition, this plan allows you to voluntarily tax shelter a portion of your taxable income received as compensation for services (i.e. salary/wages). That portion of income received in the form of fellowships (stipends) is excluded from 403(b) eligibility. The minimum voluntary contribution is $15 per month and may not exceed $15,500 of your taxable income for the 2008 calendar year. The effective date of your voluntary participation will be the first day of the month after all appropriate enrollment forms are received by the Office of Benefits Administration.

XI. DEPENDENT CARE ACCOUNT

A dependent care reimbursement plan allows house staff to use pre-tax dollars to pay for eligible dependent care expenses for children or dependent adults. Details are available in the Registrar’s Office, Broadway Research Building, Suite 147. Internal Revenue Service regulations govern eligibility; you must receive a wage/salary to participate. Compensation received in the form of a fellowship stipend will be excluded from eligibility.

XII. PARENTS IN A PINCH

Parents in a Pinch is a program designed to provide Sick, Emergency & Back-up Care. The cost of care is partially subsidized by Johns Hopkins for up to 10 placements a year. Additional unsubsidized placements are available. See website http://www.hopkinsmedicine.org/som/gme/residents/index.html.

Office of the Registrar
April 14, 2008
H. **Pre-Existing Condition Exclusion** (applies only to subscribers who have not presented a valid Certificate of Health Coverage from a prior health plan)
   Benefit will be limited to $10,000 during the first year of the policy for any condition, except pregnancy, for which a new subscriber has received medical treatment in the 90 days preceding effective date of policy.

II. **AMBULATORY CARE PROGRAM** (Coverage is effective date of Student Health Program enrollment)
   The House Staff Ambulatory Care Program (HSACP) is designed to provide payment for comprehensive ambulatory health services to house officers, spouses, same-sex domestic partners and dependent children. The Ambulatory Care Program covers professional fees and, within certain guidelines, medical expenses not covered by the Student Health Program. Outpatient pediatric care is also supplemented under this program. The entire brochure is available online as noted above.

III. **UNIVERSITY HEALTH SERVICES**
   Adult ambulatory care services are provided by the University Health Services (UHS Health Centers) to house staff and their spouses. Each house officer and their spouse will be assigned a UHS Health Center primary care physician. The UHS Health Center is located at 401 N. Caroline Street and their website is [http://www.hopkinsmedicine.org/uhs/](http://www.hopkinsmedicine.org/uhs/).

IV. **STUDENT MENTAL HEALTH SERVICES**
   Student Mental Health offers a confidential source for house staff and their spouses/same sex domestic partners seeking mental health help. Services are rendered by physicians and professional staff of the Johns Hopkins Psychiatry Department. Co-payments are required after eight calendar year visits.

V. **FACULTY & STAFF ASSISTANCE PROGRAM (FASAP)**
   The FASAP program is available to house staff and their immediate families. Services include identification, assessment and diagnosis of personal problems, referral to appropriate service or treatment resources, brief counseling, preventive and educational sessions, and support and discussion groups.

VI. **DENTAL PLAN - Coverage effective first of the month following month of appointment**
   For house officers, spouses and same-sex domestic partners and dependent children. This is a basic CareFirst BlueCross BlueShield dental plan with a co-payment requirement for services rendered.

VII. **LONG TERM DISABILITY INSURANCE (House Officer Only)**
   Enrollment Form Required. Effective date is determined by completion date of application. Details of the plan will be mailed approximately 6 weeks after your enrollment form is received.
   
   A. The policy is noncancelable and guaranteed renewable for your lifetime.
   
   B. The monthly benefit of $2,750 per month applies to new appointments 7/01/05 and beyond. For appointments prior to 7/01/05, the monthly benefit is $2,250 per month.
   
   C. Benefits are payable after the 90th day of your disability.
   
   D. The policy can be maintained by you after you leave Hopkins by the continuation of premium payments.

VIII. **SUPPLEMENTAL DISABILITY BENEFITS**
   In addition to the above benefit, a Supplemental Disability Insurance Plan may be purchased by the house officer on a direct pay basis. The plan provides a $1,000 additional monthly benefit at guaranteed rates. Enrollment information will be mailed to your home by University.

IX. **LIFE INSURANCE (House Officer only – Coverage is effective date of appointment. No enrollment form required.**
   Completion of beneficiary form required.)
   $100,000 of group life coverage under a policy underwritten by Unum Life Insurance Company of America.

X. **RETIREE PLAN 403(b)**
   The retirement plan is a 403(b) plan. It allows house staff to save a portion of your monthly compensation into a retirement account. Contributions are tax deducible and may be made quarterly. The maximum contributions are 10% of your monthly compensation, up to $15,500. Contributions will be effective on the first day of the month following the retirement account enrollment form.

XI. **DEPENDENT CARE ACCOUNT**
   A dependent care reimbursement plan allows house staff to save pre-tax dollars to pay for eligible dependent care expenses for children or dependent adults. Details are available in the Registrar's Office, Broadstone Building, Suite 147, at orientation. Internal Revenue Service regulations govern eligibility; you must be on the policy to participate. Dependent care expenses are not eligible for reimbursement.

XII. **PARENTS IN A PINCH**
   Parents in a Pinch is a program designed to provide Sick, Emergency & Back-up Care. The cost of care is partially subsidized by Johns Hopkins for up to 5 placements a year. Additional unsubsidized placements are available. See website.

Office of the Registrar
April 20, 2007
The Johns Hopkins School of Medicine

Policy Number 111
GRADUATE MEDICAL EDUCATION COMMITTEE POLICY  Effective Date 1/8/04

SICK LEAVE for RESIDENTS and FELLOWS
in ACGME ACCREDITED PROGRAMS  Supersedes 10/00

I. POLICY:
It is the policy of The Johns Hopkins Hospital and University to provide a reasonable amount of paid sick leave to Residents who are unable to work because of their own illness or injury. This policy is administered in coordination with the requirements of the Family and Medical Leave Act.

II. SICK LEAVE
A. Reporting
All illnesses of Residents should be reported to the Training Program Director. Those illnesses which can be anticipated to last more than two weeks should be reported in writing to the Associate Dean for Postdoctoral Programs by the Training Program Director. Such illness requires evaluation by the attending physician.

B. Leave over two weeks
A Resident can be placed on sick leave in excess of two consecutive weeks only by the attending physician. Such leave also requires the approval of the Training Program Director.

C. Leave over six weeks
A sick leave request in excess of six consecutive weeks requires a special review by the Associate Dean for Postdoctoral Programs and the Director of the Training Program before an extension can occur. A letter stating the nature of the illness and the reason for the requested extension of sick leave must be provided by the attending physician.

D. Leave maximum
Leave of absence for medical reasons will be granted with pay for maximum of 13 weeks with the approval of the Program Director and the Associate Dean for Postdoctoral Programs. It may not exceed the termination date of the appointment. Such leave will be prorated appropriately for part-time Residents.

E. Disability Benefits
Residents who are totally disabled for an extended period of time are eligible for long-term disability benefits after 13 consecutive weeks of total disability.

III. DEPARTMENTAL DUTIES
A. Leave of absence
Each request for a leave of absence after 13 weeks of sick leave have been exhausted will be reviewed by the Training Program Director in consultation with the Associate Dean for Postdoctoral Programs and a decision made based upon the circumstances involved. The personnel needs of the department will be given primary consideration.
B. Record Keeping

It is the responsibility of the Program Director to keep accurate records of training status so as to have adequate information for Board Certification. The Hospital and University Registrars should also be informed so that certificates may be accurately prepared.

C. Board requirements

The Director of the Training Program will determine whether or not the Resident will be required to spend additional time in training to compensate for the leave period and be eligible for certification for a full training year. That decision will be based upon the requirements of the individual specialty boards.
Department Leave Policy for Residents

PGY 1 through 3: Vacation plus leave for any reason (maternity leave, interviews, sick leave, etc.) must not exceed 8 weeks.

PGY 4: Vacation plus leave for any reason (maternity leave, interviews, sick leave, etc.) must not exceed 6 weeks.

Total leave throughout the four years of residency must not exceed 20 weeks.

Please note that for PGY 4s, this means that beyond your 4 weeks of vacation, there are only 10 working days available for sick leave and fellowship or job interviews.

If you exceed these limits, your residency will need to be extended for a commensurate amount of time.

Educational leave, such as presenting at a conference, is not included in this calculation.

It is essential that the program administrator keeps accurate tract of resident leave (excluding scheduled vacations as published on the rotation schedule.) If you require leave, please complete the Resident Leave Time Request form and submit it to Dr. Bienstock’s office.
Resident Leave Time Request

Resident: Complete the following and have it signed by the senior resident and attending responsible for the service involved for the request time. Then submit to the Program Director’s office for signature.

Name: ________________________________

Service during Leave: ________________________________

Dates Requested: ________________________________

Reason: _____ Interview

 _____ Meeting

Location and title ________________________________

The following residents have been contacted and agree to cover the service and take call during my absence: (Must be signed by the senior resident)

__________________________________________  ________________________________________

__________________________________________  ________________________________________

☐ Continuity Clinic has been cancelled (Must attach Clinic Cancellation Form)

Attending: Please review the above request and sign below if approved. If not approved, please contact the resident as to the reason for disapproval.

I have reviewed the above interview/meeting request and by my signature approve of the resident’s request for time off the service and the arrangements for coverage as listed.

Signature of Attending ___________________________ Date _________________

Signature of Program Director ___________________________ Date _________________

Please return to the Residency Program Coordinator’s Office (Phipps 279)
Departmental Policy Regarding Resident Vacation Time, Personal Leave and Maternity/Parental Leave

The Department’s policy regarding the various types of vacation and leave time is guided by the Bulletin of the American Board of Obstetrics and Gynecology (ABOG), which, in conjunction with the Residency Review Committee (RRC) for Obstetrics and Gynecology, is responsible for the accreditation of training programs and the certification of individual competence in obstetrics and gynecology.

“Leaves of absence and vacation may be granted to the resident at the discretion of the program director in accordance with local policy. If, within the four years of graduate medical education, the total of such leaves and vacation, for any reason (e.g., vacation, sick leave, maternity leave or paternity leave, or personal leave) exceeds eight (8) weeks in any of the first three years of graduate training, or six (6) weeks during the fourth graduate year, or a total of twenty (20) weeks over four years of residency, the required four years of graduate medical education must be extended for the duration of the time the individual was absent in excess of either eight (8) weeks in years one-three (1-3), or six (6) weeks in the fourth year, or a total of twenty (20) weeks for the four years of graduate medical education.”

In keeping with the above, the Department’s policies with respect to this matter are:

**Total Leave Time**

The total of vacation, educational meeting, personal leave and maternity/parental days off cannot exceed 20 weeks during the four year program. If the 20 weeks total is exceeded for whatever reason(s), one’s training must be extended accordingly into a fifth year. Such training extensions must be approved by the RRC and are not guaranteed.

**Vacation Time**

Arrangements for vacation time are to be made according to specific established guidelines. We allow three weeks of vacation for PGY1s and four weeks for PGY2s, 3s, and 4s. All requests require the approval of the Administrative Chief House Officer and Program Director.

**Maternity Leave**

If desired, a resident will be granted up to eight weeks for maternity leave during the first, second, and third program years, and up to six weeks during the fourth year. It should be remembered, however, that maternity leave must be factored into the 20 week total leave, which obviously means that vacation, educational meeting, or personal discretionary leave may be lost in current or subsequent training years.

**Parental Leave**

After a partner’s delivery, a resident may have a maximum of seven days off during the postpartum period. Such leave must be approved by the program director. Call nights will be expected to be kept, unless exchange coverage is arranged. The seven days allowed are inclusive of weekend days/holidays.
**Personal/Discretionary Leave**

This category includes leaves for the following possible reasons:

a. job/practice interviews for PGY-3s and 4s  
b. fellowship interviews for PGY-3s and 4s  
c. religious holidays  
d. short term illness of dependent children

A total maximum of ten workdays will be allowed per year for any combination of the above and must be approved by the program director. PGY-4s terminal leave in June (one week) may also be given up for additional interview time. PGY-3s interviewing for fellowships will be expected to use third-year discretionary time for such activities or count it against fourth-year vacation/discretionary/terminal leave time.

Time away for examinations, e.g., Step 3 USMLE, or to present papers/posters at sanctioned scientific meetings will be considered workdays and not count against leave time. Attendance at funerals of close relatives will also not be considered leave time. It is obviously hoped that personal or family illness will not occur. Recognizing that such may occur, however, it is the department’s intention to be as reasonable as possible in considering personal leave for illness. If needed for legitimate reasons, up to two days per year, in addition to the ten days of personal leave discussed above, may be taken without loss of vacation time. In the event of a major illness, loss of subsequent vacation or personal/discretionary leave or program extension may have to be considered.

The Program Director will serve as the final arbiter in all questions arising form this policy. Working within the guidelines of ABOG/RRC, it is the department’s desire to be both liberal and fair to all concerned when considering the above issues. Residents must also accept the responsibility they have to the ABOG/RRC, to their training, to the program, and to their peers. With such a spirit of cooperation and responsibility, major problems are unlikely to develop with this policy.
Resident Vacation and Educational Meeting Scheduling

1. Vacation per year for residents is as follows:
   a. PGY-1: 3 weeks vacation and additional 4-6 days around the Christmas and New Years Holidays
   b. PGY-2, 3, and 4: 4 weeks vacation and additional 4-6 days around the Christmas and New Years Holidays

2. All meeting and vacation scheduling will be coordinated by the Administrative Chief Resident. Any conflicts are to be settled by the Administrative Chief Resident and involved resident(s), and, if necessary, by the program director.

3. A seniority system will be used for requesting vacation and meeting time. The specific dates during which requests will be taken from each resident group will be indicated by the Administrative Chief Resident at the appropriate time.

4. The following scheduling guidelines/rules are to be followed throughout the year; exceptions will be considered for special circumstances and must be approved by the Administrative Chief Resident and program Director:
   a. Residents will be allowed educational meeting time if they are the presenting author of a paper. Up to one week (five work days) per year is allowed for educational leave.
   b. For PGY1s, 2s, and 3s, days not used cannot be used for vacation or other purposes. For PGY4s, unused days may be used for practice searching or fellowship interviewing. Call make-up may be expected.
GRADUATE MEDICAL EDUCATION COMMITTEE POLICY  
Effective Date  
1/8/04

PARENTAL, MATERNITY AND ADOPTION LEAVE  
FOR RESIDENTS AND FELLOWS  
Supersedes 10/00

Please note: The policies below are to run concurrently with the Family Medical Leave Policy

I. PARENTAL LEAVE
Up to one week of **PAID** leave will be granted following the birth or adoption of a child. Residents who plan to utilize parental leave are expected to notify their program director or department director as soon as they know they will need to use parental leave to facilitate appropriate scheduling. The period of time allocated for parental leave is in addition to allotted vacation and sick time.

II. MATERNITY LEAVE

A. Length of leave
Total of eight (8) weeks, typically taken two weeks prenatal and six weeks postpartum, maternity leave for uncomplicated pregnancy. *(Seven weeks will be allocated to sick leave and one week is paid parental leave.)*

B. Procedure for requesting leave
Early (1st trimester) written notification will be given to Training Program Director or designee

C. Procedure for alteration of leave due to an unanticipated event or complicated delivery
Complicated pregnancy or delivery will be handled through sick leave and disability policies

D. Continuation of salary and benefits during maternity leave
Salary and benefits will be provided and paid by usual source of salary.

E. Continuation of salary and benefits if additional months of training are necessary to complete program requirements.
If required by certifying board, an extended appointment period with salary and benefits will be granted provided trainee has not exceeded usual maternity leave and approved family medical leave and trainee has utilized all available vacation time.

F. Continuation of leave beyond eight weeks
If trainee wishes to extend maternity or parental leave for up to twelve weeks for family medical leave, this leave will be charged to vacation and then to leave without pay. Health benefits will be maintained under the same condition as if the trainee continued to work. If both parents are employed by the University, only the parent who is the primary caregiver will be eligible for the full twelve weeks of family and medical leave following the birth of a child.
III. ADOPTION LEAVE

Following the adoption of a child, a parent who is the primary care giver for the child will be given a six week leave with pay. (Five weeks are allocated to adoption leave and one week is parental leave.) If both parents are employed by the University, only the parent who is the primary caregiver will be given the six week paid leave. The other parent is eligible for one week of paid parental leave. Residents who plan to utilize adoption leave are expected to notify their program director or department director as soon as possible to facilitate scheduling. If a trainee wishes to extend adoption leave for up to twelve weeks for family medical leave, this leave will be charged to vacation and then to leave without pay. Health benefits will be maintained under the same condition as if the trainee continued to work. If both parents are employed by the University, only the parent who is the primary caregiver will be eligible for the full twelve weeks of family and medical leave following the adoption of a child.
FAMILY & MEDICAL LEAVE
PROVISIONAL NOTIFICATION
FOR RESIDENTS
(INCLUDING CLINICAL FELLOWS IN ACGME ACCREDITED PROGRAMS)

TO: _________________________________________ DATE:
______________________
(Name)
______________________
(Home Address)

FROM: _______________________________________ PHONE:
______________________
(Name of Training Program Director)

On __________________, we became aware of your need to take family/medical leave due to:

(Date)

☐ the birth of your child, or the placement of a child with you for adoption or foster care
  (Within twelve (12) months following birth, adoption, or placement for foster care); or

NOTE: Absences for prenatal visits may qualify toward Family/Medical Leave

NOTE: For the placement of a child, you must provide written documentation of the adoption or foster care (i.e., court order, etc.). This documentation must be submitted to the Office of Occupational Health, 600 N. Wolfe Street, Phipps 3, Baltimore, Maryland 21287, Attention: Geraldine Moler

☐ a serious health condition that makes you unable to perform the essential functions of your job; or

☐ a serious health condition affecting your spouse, same sex domestic partner, child or parent for which you are needed to provide care.

Name: ______________________  Date of Birth: ________
Relationship: ________________
You notified us that you need this leave beginning on ________________ and that you expect leave to continue until on or about _________________.

You have a right under the Family and Medical Leave Act (AFMLA®) for up to twelve (12) weeks of unpaid leave in a twelve (12) month period (July 1st through June 30) for the reasons stated above, if eligible. The university requires that you substitute accrued paid leave for unpaid FMLA leave. Your health benefits will be maintained during any period of unpaid leave and you will be reinstated to the same position with the same pay, benefits, and terms and conditions of appointment on your return from leave. These points are discussed in more detail below.

Based on the information available, it appears that the leave provisionally qualifies as Family and Medical Leave effective ________________ (date). Should you have any questions concerning your obligations or rights under the university’s Family and Medical Leave Policy, please contact (Training Program Director or Administrator.) If you fail to meet the obligations, the taking of Family and Medical Leave may be delayed or denied.

**CERTIFICATION:**

You will be required to furnish medical certification of a serious health condition or the serious health condition of a family member. Enclosed is a Certification of Health Care Provider to be completed by you or your family member’s health care provider. This initial Certification must be submitted to the Office of Occupational Health Services, Houck 3 East, 600 N. Wolfe Street, Baltimore, MD 21205 within 15 days of this request, or by ________________. Upon receipt of the requested documentation, a final determination will be made. If the documentation you submit does not support Family and Medical Leave, or if you fail to provide the requested documentation, the leave will not be approved as Family and Medical Leave and university policies and procedures covering absences will be applied.

The university may require subsequent Certifications during your leave at 30 day intervals or other reasonable times. A new Certification may be requested if the circumstances of your leave change. If you are taking leave on an intermittent or reduced leave schedule, Certification will be required every 12 months.

**LEAVE BALANCES:**

As of the date your leave commenced, you had _______ sick days and ________ vacation days remaining.

If you are taking leave due to your own serious health condition, for prenatal care or birth of a child, leave will be charged first to any sick time you may have, then to vacation, then to leave without pay. In the event leave is for the birth of a child, once released by your physician, leave will be charged to vacation then to leave without pay. Please refer to Parental, Maternity and Adoption Leave Policy for Residents for information regarding paid leave.

If you are taking leave due to the serious health condition of a family member (spouse, same sex domestic partner, child or parent), leave will be charged to not more than 12 sick days, then to vacation, then to leave without pay.

If you are taking leave due to the adoption of a child, or placement of a child with you for foster care, you will be eligible for six weeks of leave with pay (5 weeks adoption and 1 week parental), then vacation leave, and finally leave without pay. If both parents are members of the house staff or fellows, only the parent who is the primary caregiver is eligible for the six week paid leave.

For postdoctoral fellows who are not paid through JHU, reference to paid leave, including sick time, vacation leave, parental leave and adoption leave refer to the time allotment only and do not confer any right for paid leave unless provided by another source.
MAINTENANCE OF BENEFITS:

Your health benefits will be maintained under the same condition as if you continued to work.

RETURN TO WORK:
During leave, you may be required to report periodically on your status and intention to return to work. If the circumstances of your leave change and you are able to return to work earlier than the date indicated above, we ask that you notify us at least two work days prior to the date you intend to report for work.
As stated above, you should notify the appropriate authority at least two weeks prior to the expiration of the leave of your intent to return to work and, in any event, must provide a minimum of two days notice of readiness to return to work. If the reason is due to your own serious health condition you must provide a written release from your Health Care Provider stating that you are fit to return to work. This release must be taken to the Occupational Health Services Office in the Phipps Building, 3rd Floor, (410) 955-6211. The Occupational Health Office will give you clearance to return to your job. If a release to return is not submitted, your return to work may be delayed until the release is provided.

IMPORTANT NOTICE:
Trainees should be aware that the amount of leave taken may affect their ability to meet the requirements of a certifying board, if applicable, and should be discussed with the training program director.
If you engage in other employment during this leave, you may be considered to have violated the terms of the leave and have voluntarily terminated your appointment with the university.
Please keep this letter as part of your records. You will receive an FML Determination confirming approval or denial of your request for leave. Also, please refer to the attachment outlining your rights and obligations under Family and Medical Leave.
If you have any questions about this policy, please contact me or the department administrator, (NAME).

Sincerely,
(Training Program Director)
cc: Levi Watkins, Jr., M.D., Office of Postdoctoral Programs
Geraldine Moler, Occupational Health Services
Attachments:
Certification of Health Care Provider
U. S. Department of Labor Program Highlights - The Family and Medical Leave Act of 1993
NON-MEDICAL LEAVE OF ABSENCE FOR
HOUSE STAFF AND POSTDOCTORAL FELLOWS Superseded 11/8/95

I. LEAVE OF ABSENCE
If a trainee wishes to take a leave of absence for non-medical reasons, this must be negotiated with the program director and would require an interruption in appointment, without pay. Except in unusual circumstances, a leave of absence may not extend beyond the trainee's period of appointment. During the leave of absence, benefits may be purchased through the School of Medicine Registrar's Office and are the responsibility of the trainee.

II. REINSTATEMENT
Reinstatement in the training program is dependent upon the availability of training positions. Where appropriate, program directors are encouraged to reinstate trainees in good standing in the next available training position. However, position, salary and benefits cannot be guaranteed for voluntary interruption in appointment. Adjustment in quota positions will be negotiated through the University and Hospital administration through the Office of Postdoctoral Programs.
Department of Gynecology and Obstetrics
Resident Duty Hours Policy
Effective July 1, 2003

1. The scheduled work week shall not exceed 80 hours per week, averaged over a four-week period, inclusive of in-house call activities. Hours worked at any institution participating in the resident’s educational program are aggregated in this total.

2. Residents are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period inclusive of call.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between consecutive daily duty periods, and after in-house call.

4. In-house will occur no more frequently than every third night, averaged over a 4-week period.

5. Continuous on-site duty will not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer of care of patients, conduct outpatient continuity clinics, and maintain continuity of medical and surgical care. No new patient may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care.
Grievance Procedure for Faculty, Fellows, and the Student Body

INTRODUCTION

Since the founding of this Medical School, disputes among faculty, administration, or students have been very successfully settled through a series of informal procedures. Typically a complaint or dispute by a faculty member is brought to the attention of the grievant's department director and is resolved through informal discussion. Where a medical student or graduate student has a complaint, he or she may bring it to the associate dean for student affairs. Postdoctoral students normally appeal to the associate dean for postdoctoral programs. In some circumstances, the dean is asked to help in the informal resolution of grievances. The formal procedure set forth below is not meant to supplant attempts at resolving complaints through informal means. When at all possible, complaints and disputes should be settled through informal discussion. The procedures presented here are to be applied only after every effort has been made to settle disputes informally.

Nothing in this document shall be construed to impinge upon the managerial responsibilities of any regularly constituted body of the University. Moreover, no action may be taken with respect to the grievance that would conflict with or modify a policy approved by the board of trustees of the University, any policy of The Johns Hopkins Hospital, any federal, state, or local law or regulation, or any contract to which the University or School is a party.

PURPOSE

The purpose of this procedure is to provide a formal mechanism to resolve grievances of faculty, fellows, housestaff, or students of the School of Medicine; this formal mechanism is to be used in any particular case only if the usual informal processes have failed to resolve it.

DEFINITIONS

A. A grievance is a complaint by a faculty member, post-doctoral fellow, member of the housestaff, or student that he or she has been adversely affected in his or her professional activities as a result of an arbitrary and capricious act or failure to act or a violation of a University or School of Medicine procedure or regulation by the grievant's supervisor, department director, or other school administrator or body.

Excluded from consideration under this grievance procedure are:
1. Complaints alleging discrimination or harassment on the basis of race, color, sex, age, religion, homosexuality, national origin or ethnic origin, or handicap. These complaints are to be referred to the University’s Affirmative Action Officer.
2. Complaints pertaining to general levels of salary, fringe benefits, or other broad areas of financial management and staffing.
3. Disputes that are personal in nature or that do not involve the grievant’s professional activities.
4. A complaint, the resolution or remedy of which would conflict with a policy approved by the board of trustees of the University, a policy of The Johns Hopkins Hospital, federal, state, or local law or regulation, or any contract to which the University or the School is a party.
5. A complaint pertaining to a subject matter within the purview of any other standing committee of the University or School, unless the complaint arises from a committee's alleged failure to act or to follow the policies or procedures of the University or School. For example, disputes involving grades, student promotions, or other evaluation of the grievant's academic work could only be considered under these procedures if the normal procedures for handling these matters were found not to have been followed.

B. A grievant is a faculty member, post-doctoral fellow, member of the housestaff, or a student currently enrolled in the School of Medicine who brings a grievance pursuant to this procedure.

C. As used in this grievance procedure, the term "faculty member" means any person holding a full- or part-time appointment to the faculty of the School of Medicine.

D. As used in this grievance procedure, the term "dean" means the Dean of the Medical Faculty or his or her designee.

COMPOSITION OF THE GRIEVANCE COMMITTEE

Each year, the dean shall appoint a Grievance Committee. The Grievance Committee shall have a chairman and ten additional members. At least one full professor, one associate professor, one assistant professor, one medical student, one graduate student, and one postdoctoral fellow or member of the housestaff shall be members of the Committee.

INITIATION OF A FORMAL GRIEVANCE AND SUBSEQUENT PROCEDURE

A. In the event that informal discussion fails to resolve a dispute involving a faculty member, fellow, member of the housestaff, or student, a formal grievance may be initiated. Grievances except those brought by a student or fellow must be initiated through the grievant's department director, whether the grievance involves members of the grievant's own or other departments. In the case of a grievance against the grievant's department director, senior school administrator, or any committee of the School, the grievant may submit a statement directly to the Grievance Committee chairman. A grievance brought by a student or fellow may be initiated either through the appropriate department director or through the associate dean for student affairs (in the case of medical students or graduate students) or the assistant dean for postdoctoral programs (in
the case of fellows). All grievants must submit a written, signed, and dated statement of the grievance. This statement should include (1) a factual description of the complaint or dispute resulting in the grievance, (2) the name of the person(s) against whom the grievance is initiated, (3) a brief description of all informal attempts at resolution, and (4) any other information that the grievant believes to be relevant or helpful. The grievant should attach to the written complaint any documentation in his or her possession bearing on the subject matter of the complaint. The grievant should be aware that initiation of a formal grievance is a serious matter and must not be undertaken over trivial matters or out of malice.

B. Within three days of receipt, the department director, associate dean for student affairs, or assistant dean for postdoctoral programs shall forward the statement of grievance to the chairman of the Grievance Committee of the School of Medicine. The department director, associate dean, or assistant dean shall include his or her own statement that an informal resolution of the grievance has been unsuccessful. Upon receipt of the statement of grievance, the chairman of the Grievance Committee shall send to the grievant a written statement that the grievance is under consideration. The Grievance Committee chairman, in consultation with other members of the Grievance Committee, shall decide whether the grievance presents a grievable issue. If it does not present a grievable issue, the Grievance Committee chairman shall notify the grievant, stating the reasons for the Committee’s decision. Otherwise, the Grievance Committee chairman shall notify the person(s) against whom the grievance is filed, and shall provide a copy of the grievant's statement. The Grievance Committee chairman or the chairman's designee shall assemble all relevant documentation and facts. A report of this information shall be forwarded to the parties involved. On the basis of the assembled information, the Grievance Committee chairman or a designee shall attempt to achieve a resolution of the grievance in a manner appropriate to the circumstances. Such a resolution shall be subject to the approval of the dean.

In cases where the Grievance Committee chairman requests that the grievant consult another body within the University, the grievant may resubmit the grievance to the Grievance Committee chairman for action should the other University body decline to consider the matter.

C. If the Grievance Committee chairman or a designee is unable to resolve the grievance to the satisfaction of the parties involved, a subcommittee shall be convened of at least three members of the Grievance Committee acting as a Grievance Panel. No member of the Grievance Committee who has an interest in the matter giving rise to the grievance shall participate in the work of the Grievance Panel; if possible, however, the Panel should include a medical student if the grievant is a medical student or a graduate or postdoctoral student if the grievant is a graduate or postdoctoral student. All pertinent assembled information bearing on the grievance shall be provided to the panel. The Panel shall establish a date at which time the grievant and all others involved shall have the opportunity to appear personally for an airing of the matter. Within a reasonable time after the conclusion of the meeting(s), the Panel shall submit to the dean a recommendation for the resolution the grievance. This statement should include (1) a factual description of the complaint or dispute resulting in the grievance, (2) the name of the person(s) against whom the grievance is initiated, (3) a brief description of all informal attempts at
resolution, and (4) any other information that the grievant believes to be relevant or helpful. The grievant should attach to the written complaint any documentation in his or her possession bearing on the subject matter of the complaint. The grievant should be aware that initiation of a formal grievance is a serious matter and must not be undertaken over trivial matters or out of malice.

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D. The dean (or provost) shall issue a written determination of the grievance within two weeks of receipt of a recommendation from the Grievance Panel. The decision of the dean, or of the provost in the case of a grievance against the dean, shall be the final University action in this matter. If the decision of the dean or provost is to grant remedial relief in favor of the grievant, the grievant, in consideration of the relief being granted, shall execute a complete release of all claims against the University and the School of Medicine, its officers, agents, and employees arising out of the matter giving rise to the grievance.
Department of Gynecology and Obstetrics

Due Process for Residents

The Program Director reviews the written evaluations of the resident’s performance that were submitted to the Director of the residency program after each service rotation, the CREOG in-training examination scores, and patient case logs. The residency program and service rotation are discussed with the resident and his/her review of teaching and other deficiencies and suggestions for improvement of the program are requested. The resident’s difficulties, if any, are discussed. After the meeting a written report of the resident’s progress is submitted and placed in the resident’s personnel file. Residents who receive substandard ratings or about whom significant concerns have been registered by other faculty members are referred to the Resident Education Committee for further discussion.

The resident Education Committee, composed of members of the full time faculty of each institution in the program, the Administrative Chief Resident, the Director of the Residency Program, and the Department Head, has the responsibility to evaluate the performance of residents referred by the faculty for consideration because of alleged below-standard performance. This committee meets at least quarterly and as needed to provide a mechanism of evaluation and to provide educational recommendations to the faculty of the Department.

Residents referred to the committee because of below-standard performance or other problems may be interviewed by the committee and faculty evaluations of performance on service rotations and other assessments, medical student comments, and CREOG scores may be reviewed. Additional documented information from affiliated or integrated hospital staff members who have worked with the resident may be requested and reviewed.

After a review of the aforementioned evaluations with the resident, she/he may be asked to submit a written response to the committee or meet with the program director. When this response is received and reviewed, the committee again meets and may make recommendations to improve his/her performance. If family, marital, psychiatric, or goal problems are identified as being pertinent to performance these are also discussed, if appropriate, and professional counseling or other solutions are sought.

If the resident’s performance has been sufficiently poor to merit consideration for dismissal, a defined period of probation may be recommended. During probation the resident endeavors to improve his/her performance by methods recommended by the Committee, and is monitored by the faculty as a whole and Program Director. More detailed supervision and observation by faculty members may be sought, and written evaluations at the end of the probationary period will be submitted to the committee for consideration. One of the following courses of action may be followed.
• Immediate dismissal from the program by the Associate Dean or Director of Clinical Affairs in consultation with the chief of service as provided by institutional guidelines.

• Probation for a defined period of time. During the probationary period the resident’s performance is carefully evaluated. Written evaluations of that performance will be submitted to the Program Director from those individuals responsible for supervision. These evaluations will be considered prior to further action.

• After the period of probation the resident may be dismissed from the program or asked to submit a resignation if his/her performance continues to be unsatisfactory. If performance has improved and has been maintained at a satisfactory level, the probation may be rescinded.

• A grievance procedure (see next page) is available to review actions taken by the Department if the resident believes that s/he has been unfairly treated.

• If the resident is dissatisfied with the Department’s review, s/he may contact the hospital grievance officer for appeal according to institutional guidelines.
Resident Dismissal

In the event that a remedial action or counseling is unsuccessful and temporary suspension or termination is deemed appropriate, the resident and the Associate Dean of Graduate Medical Education must be apprised of the circumstances in writing. A hearing must convene within 14 days, if requested by the resident.

If the Program Director plans denial of reappointment or advancement, the resident should be notified as early in the year as possible to allow remedial action or counseling to be undertaken. The resident should be alerted to this possibility no later than the sixth month of the contract year with appropriate notification and documentation to the Associate Dean of Graduate Medical Education. If, at the end of the eight-month of the contract year there is no significant improvement, the Program Director must make the final determination. A hearing will be offered to the resident, as outlined above. All variances to this policy must be explained in writing to the Associate Dean of Graduate Medical Education and the Education Committee.
PHYSICIAN IMPAIRMENT AND COUNSELING

Members of the Medical Staff who exhibit a physical or behavioral impairment such as alcoholism, drug abuse, or a mental or emotional problem which may affect their skill, attitude or judgment, may refer themselves on a voluntary basis to the Professional Assistance Committee (PAC) and/or the Faculty and Staff Assistance Program (FASAP) for an assessment and possible treatment. The policies and procedures of the PAC and FASAP shall guide the management of these voluntary referrals.

The PAC and FASAP may be used either for voluntary referrals or for involuntary referrals in addition to, or as an alternative to, disciplinary action.

The duties and responsibilities of the PAC are as follows:

1. Develop through training and education of Medical Staff members an enhanced recognition of impairment and an awareness of conditions that may lead to impairment.

2. Assist Medical Staff in dealing with any physical and/or behavioral impairments that may affect a staff member’s skill, attitude or judgement.

3. Receive information and/or complaints concerning physicians who may be disabled, impaired, or distressed, and investigate the information and/or complaint.

4. Evaluate individual cases and make recommendations for action, including treatment and monitoring.

5. Communicate with Hospital Administration or other appropriate official bodies when necessary to ensure quality of patient care and staff well being.

The Faculty and Staff Assistance Program (FASAP) is available to house staff and their immediate families. Services include identification, assessment and diagnosis of personal problems, referral to appropriate service or treatment resources, follow-up on referrals, education, consultation and training on issues relevant to personal problems and prevention programs.

A physician, in accepting appointment or reappointment to the Medical Staff agrees to immediate testing of blood and/or urine for controlled substances and/or alcohol upon appropriate request. An appropriate request is based upon suspicion of disability and/or impairment from alcohol and/or drug abuse and may be made by a Chief of Service, his designated representative(s) or the Vice President for Medical Affairs. Medical Staff members who suspect another Medical Staff member of have a disability and/or impairment have a responsibility to notify immediately the appropriate Chief of Service, his designated representative(s), the Professional Assistance Committee or the Vice President for Medical Affairs of their concerns.
Any physician who refuses such testing will be treated administratively as though testing positive for alcohol and/or controlled substances. Administrative procedures to be followed in such instances will be those defined for the involuntary detection of the disabled or impaired physician.

Mandatory periodic drug and/or alcohol testing shall be required of a physician identified as impaired and/or disabled from drug and/or alcohol abuse disorder as part of ongoing treatment and monitoring of recovery as defined by procedures for the care, treatment and monitoring of the disabled/impaired physician.
The Johns Hopkins University recognizes that alcoholism and other drug addiction are illnesses that are not easily resolved by personal effort and may require professional assistance and treatment. Faculty, staff and students with alcohol or other drug problems are encouraged to take advantage of the diagnostic, referral, counseling and preventive services available through the University. Procedures have been developed to assure confidentiality of participation, program files and medical records generated in the course of these services.

Substance or alcohol abuse does not excuse faculty, staff or students from neglect of their employment or academic responsibilities. Individuals whose work or academic performance is impaired as the result of the use or abuse of alcohol or other drugs may be required to participate in an appropriate diagnostic evaluation and treatment plan. Further, use of alcohol or other drugs in situations off campus or removed from University activities that in any way impairs work performance is treated as misconduct on campus. Students are prohibited from engaging in the unlawful possession, use or distribution of alcohol or other drugs on University property or as a part of University activities.

It is the policy of The Johns Hopkins University that the unlawful manufacture, distribution, dispensation, possession or use of controlled substances is prohibited on the University's property or as a part of University activities. Individuals who possess, use, manufacture or illegally distribute drugs or controlled dangerous substances are subject to University disciplinary action, as
well as possible referral for criminal prosecution. Such disciplinary action of faculty and staff may, in accordance with this policy, range from a minimum of a three day suspension without pay to termination of University employment. Disciplinary action against students may include expulsion from school.

As a condition of employment, each faculty and staff member and student employee must agree to abide by this policy, and to notify the divisional Human Resources Director of any criminal conviction related to drug activity in the workplace (which includes any location where one is in the performance of duties) within five (5) days after such conviction. If the individual is supported by a federal grant or contract, the University will notify the supporting government agency within ten (10) days after receiving notice.
The Johns Hopkins School of Medicine
Policy Number 102

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY Effective Date 1/8/04

RESIDENCY TRAINING PROGRAM CLOSURE/REDUCTION POLICY

I. PURPOSE
The purpose of this policy is to protect the residents and provide for a smooth and orderly transition in accordance with ACGME recommended guidelines should closure or reduction of a program be required.

II. CLOSURE
The decision to close a program must be approved by the Advisory Board of the Medical School and the Medical Board of the Hospital. Only after careful consideration by the Department Director, Training Program Director, Associate Dean of Postdoctoral Programs, Vice President for Medical Affairs and the Joint Committee on House Staff and Postdoctoral Programs will a recommendation to close an ACGME accredited training program be made.

Every effort will be made to allow residents in the program to complete their training at Johns Hopkins and primary consideration will be given to the training requirements of those remaining for the final year(s). Assistance in the form of letters and/or phone calls will be offered to those residents wishing to transfer to another program. In addition, if termination of residents in good academic standing is unavoidable, financial assistance through support of stipend and benefits for one year of training as well as limited help with relocation expenses will be extended where needed in accordance with AAMC recommendations. All residents, as well as the Residency Review Committee for the specialty, will be notified in writing as soon as possible regarding the closure in accordance with ACGME Institutional and Program requirements.

III. REDUCTION
The decision to reduce the number of trainees will usually be accomplished by decreasing the number of new trainees entering the program. For major reductions, particularly those that may impact trainees in other programs in the institution, the review process for closure will be invoked. The Department Director and Training Program Director, after discussion with the Associate Dean for Postdoctoral Programs, may implement minor reductions in a program without the formal review process. If an immediate reduction is necessary, assistance to the affected resident will be provided. All residents, as well as the Residency Review Committee for the specialty, will be notified in writing as soon as possible regarding the planned reduction according to ACGME Institutional and Program requirements.
Institutional Statement of Responsibilities

The goal of the residency program is to provide trainees with an extensive training experience in the art and science of medicine in order to achieve excellence in the diagnosis, care and treatment of patients. To achieve this goal, the trainee agrees to:

1. Under supervision of the chief of service assume responsibilities for the safe, effective and compassionate care of patients on the inpatient service, the outpatient facilities and in out-of-hospital medical care activities administered by the Hospital, consistent with the trainee's level of training and experience.

2. Participate fully in the educational and scholarly activities of the training program and, as required, assume responsibility for teaching and supervising other residency trainees and medical students.

3. Develop and participate in a personal program of self-study and professional growth with guidance from the chief of service and the teaching staff.

4. Participate in institutional programs and activities involving the medical staff, adhere to established policies, procedures and practices of the Johns Hopkins Hospital and its affiliated institutions, as assigned by the training program director.

5. Participate in institutional committees and councils, especially those which relate to patient care review activities, as determined by the program director.

6. Participate in the evaluation of education provided by the program and its teaching staff.

7. Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education.

8. Apply cost containment measures in the provision of patient care.
Medical Professional Liability Protection

The Hospital and University provide coverage for liability exposure for all house staff and clinical fellows for those clinical activities which they perform within The Johns Hopkins Medical Institutions which are within the scope of their training program. Coverage includes legal defense and payment of loss to the extent of maximum judgment within insurance policy limits and also requires participation in the Hospital’s Risk Management Program.

Coverage is provided through MCIC Vermont, Inc. It is a claims made policy and provides the insured with "tail" coverage for future unreported claims. Coverage is in the amount of $5,000,000 per claim and unlimited aggregate limits.

Insofar as extracurricular employment is not an extension of postdoctoral training at the JHMI or an approved activity under any residency or clinical training and educational program of the JHMI, medical professional liability insurance coverage is not provided to any trainee for such activities.
Maryland Registration/Licensure

A Maryland license to practice medicine is not required for trainees in the performance of postdoctoral training duties as assigned by the Chief of Service of the training program.

The Maryland Board of Physician Quality Assurance (BPQA) does require unlicensed medical practitioners (trainees) enrolled in postgraduate training program to register with the BPQA annually. The registration form is to be completed during the appointment process. The Hospital will pay the annual $100.00 fee for this registration and will submit the completed forms to the Board.

Upon the expiration of your registration, you are not authorized to practice as an unlicensed practitioner in Maryland. Any person who practices medicine in Maryland without a license or registration is subject to a civil fine of not more than $50,000.00 according to the Health Occupations Article, Annotated Code of Maryland.
Equal Opportunity

Equal opportunity is a fundamental principle governing all University activities for faculty, students, and staff. The Johns Hopkins University welcomes and encourages qualified individuals to enter and progress within all University programs and activities on the basis of demonstrated ability, performance, and merit, without regard to race, color, religion, gender, age, sexual orientation, national or ethnic origin, disability, marital status or veteran status. The complete policy can be found at:

www.jhu.edu/~hr1/pol-man/appdxa.htm.
University Policy on Sexual Harassment

Sexual harassment will not be tolerated. Sexual favors may not be required either explicitly or implicitly as a term or condition of an individual's academic progress or employment. Sexual conduct or conduct with sexual overtones which have an effect of unreasonably interfering with an individual's academic or work performance or which creates an intimidating, hostile, or offensive learning or working environment is prohibited. The University will promptly investigate complaints of sexual harassment and, when necessary, will institute disciplinary proceedings against the offending individual. Complaints about sexual harassment or questions about University policy can be brought to Department Directors, the Dean, or any member of the Sexual Harassment Prevention and Resolution System. All problems of this nature will be treated confidentially. The complete policy can be found at www.jhu.edu/~hr1/pol-man/appdxc.htm.
Guidelines for Department Directors for Managing Performance Issues of Fellows and House Officers

ACADEMIC PERFORMANCE ISSUES

DISCIPLINARY ISSUES

IMPAIRMENT ISSUES

ACADEMIC PERFORMANCE ISSUES

Description:

Performance in terms of skills, judgment or conduct is deficient but does not represent imminent risk of harm to patients or others.

Review Process:

Department Director or Preceptor addresses deficiencies with fellow or house office in the presence of a third party.

Record of discussions is maintained.

If deficiencies are not corrected, disciplinary review process applies.

Actions:

- Repeat of rotations
- Additional supervision
- Mentoring
- Warning of possible disciplinary action if deficiencies are uncorrected

Board of Physician Quality Assurance Notification (clinical fellows and house officers only):

No

Other Policies:

Certification of completion of programs is awarded only on satisfactory completion of all program requirements and is not guaranteed.

Contacts:

- Associate Dean for Postdoctoral Programs
- Vice President for Medical Affairs (clinical fellows and house officers only)

DISCIPLINARY ISSUES

Description:
• Violations of standards of conduct
• Repeated errors in professional judgment
• Failure to correct deficiencies in performance which has or could lead to imminent risk of harm to patients or others

Review Process:
If immediate and serious danger to patients and/or institutions, Department Director suspends clinical fellow or house officer from responsibilities.
Department Director notifies Associate Dean for Postdoctoral Programs, and Vice President for Medical Affairs, if applicable, in writing describing deficiencies, prior warnings, if any, and proposed action.
Department Director meets with fellow or house officer, and Associate Dean (and Vice President for Medical Affairs, if applicable) before taking final action.
Department Director notifies fellow or house officer in writing of decision, including effect on salary and fringe benefits, training certification and reporting to BPQA.

Actions:

• Probation
• Suspension
• Termination*

Board of Physician Quality Assurance Notification (clinical fellows and house officers only):
Yes

Other Policies:

• Notify risk management if there are patient care concerns
• Notify JCCI of research protocol violations
• Notify safety office of any safety violations

* In the event of probation, suspension, or termination, or resignation in lieu thereof, the Department Director prepares a summary of the matter, including complaints, prior disciplinary action and a report sufficient to apprise any successor of the events leading up to the action.

Contacts:

• Associate Dean for Postdoctoral Programs
• Vice President for Medical Affairs (clinical fellows and house officers only)
• JHHS

IMPAIRMENT ISSUES
Description:
Performance deficiencies, including poor attendance due to physical or mental illness or alcohol or substance abuse -- no injury to patients or others.

Review Process:
Department Director refers fellow or house officer to Occupational Health Services (OHS), Faculty and Staff Assistance Program (FASAP) or Physician's Assistance Committee (PAC) for evaluation and recommendations for treatment, as a condition of continued employment.

If the fellow or house officer fails to comply with recommended treatment, matter is handled as a disciplinary issue.
If the fellow or house officer requires time off, Department Director with the approval of the Associate Dean for Postdoctoral Programs, may grant paid sick leave for up to 13 weeks per year (July - June).

**Actions:**
- Leave of absence
- Release from patient care responsibilities

**Board of Physician Quality Assurance Notification (clinical fellows and house officers only):**
No, as long as fellow or house officer is complying with recommended treatment, treatment is effective, and there has been no injury to patients or others.

**Other Policies:**
Family and Medical Leave runs concurrently with paid sick leave for serious health conditions of fellows and house officers after twelve months of service at Johns Hopkins. REQUIRES SPECIAL LETTER -- contact Postdoctoral Office or General Counsel's Office of the Johns Hopkins University.
If the fellow or house officer is disabled within meaning of Americans with Disabilities Act, reasonable accommodations must be considered.

**Contacts:**
- Associate Dean for Postdoctoral Programs
- Vice President for Medical Affairs (clinical fellows and house officers only)
- General Counsel for JHU and JHHS
- Occupational Health Services
- Faculty and Staff Assistance
- Physicians Assistance Committee
GMEC SUPERVISION POLICY AND PROCEDURES

I. POLICY
Faculty are expected to provide an appropriate level of clinical supervision required of all residents during clinically relevant educational activities. The GMEC subscribes to a philosophy that the most effective learning environment for post-graduate medical trainees is one that provides (a) sufficient freedom and graded responsibility for housestaff to share responsibility for decision-making in patient care under adequate faculty supervision, (b) supervising faculty feedback to housestaff concerning their diagnostic and management decisions, and (c) an appropriate balance of education with the patient’s right to expect a healthy, alert, responsible and responsive physician dedicated to delivering effective and appropriate care. In order to create this type of learning environment, ensure appropriate levels of housestaff supervision, and compliance with the Essentials of Accredited Residencies, the GMEC strives to ensure that the principles set forth in this policy and these procedures are followed by the residency training programs sponsored by The Johns Hopkins University School of Medicine.

II. PROCEDURES
1. Clinical responsibilities must be conducted in a carefully supervised and graduated manner, allowing housestaff to assume progressively increasing responsibility in accordance with their level of education, ability, and experience.
2. Faculty supervision must include timely and appropriate feedback and housestaff must be provided with rapid, reliable systems for communicating with supervising faculty.
3. Faculty supervision of housestaff must support each program’s written educational curriculum.
4. Faculty supervision of housestaff should foster humanistic values by demonstrating a concern for each housestaff member’s wellbeing and professional development.
5. All housestaff activities are supervised by faculty members who have overall responsibility for patient care rendered and the ultimate authority for final decision-making. The particular housestaff-faculty relationship and the structure of faculty supervision will vary according to patient care setting.
6. Faculty schedules must be structured to provide housestaff with continuous supervision and consultation. Faculty call schedules are structured to ensure that support and supervision are readily available to housestaff on duty.
7. The program director and the faculty must determine the level of responsibility accorded to each housestaff member.
8. Faculty and housestaff shall be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects. The program director and faculty must monitor housestaff for the effects of sleep loss and fatigue and respond in instances when fatigue may be detrimental to housestaff performance and well-being.

9. Duty hour assignments in teaching settings must recognize that faculty and housestaff collectively have responsibility for the safety and welfare patients.

III. PROGRAM AND GENERAL (SITE-SPECIFIC) HOUSESTAFF SUPERVISION

1. Program Specific Housestaff Supervision:
   • Each Program sponsored by The Johns Hopkins University School of Medicine shall develop and maintain appropriate supervision policies, compliant with ACGME Program Requirements.

2. General – The following Supervision requirements are applicable to the site specified in subsections a – e.
   a. Housestaff Supervision on Inpatient Services:
      • A patient care team that may include medical students, interns, residents and fellows, under the direct supervision of a faculty physician will care for patients admitted to the service.
      • Decisions regarding diagnostic tests and therapeutics, although initiated by housestaff, will be reviewed with the responsible faculty during patient care rounds.
      • Patients will be seen by the responsible attending and their care will be reviewed with the faculty at appropriate intervals. The attending will document his/her involvement in the care of the patient in the medical record.
      • Housestaff are required to promptly notify the patient’s faculty physician in the event of any controversy regarding patient care or any serious change in the patient’s condition.
      • Faculty or their designees (covering physicians) are expected to be available, by telephone or pager, for housestaff consultation 24 hours per day for their term on service, on-call day or for their specific patients.
   b. Supervision of Housestaff in Adult and Pediatric Emergency Departments:
      In the Adult and Pediatric Emergency Departments, faculty must be on-site 24 hours per day.
   c. Supervision of Housestaff in Clinics and Consultation Services:
      In clinics and consultation services, faculty must review overall patient care rendered by housestaff.
   d. Supervision of Housestaff in Intensive Care Units:
      In intensive care units, housestaff decisions regarding patient care, including admission, discharge, treatment decisions, performance
of invasive procedures and end-of-life decisions are to be discussed and reviewed by faculty.

e. Supervision of Housestaff in Operating Suites:
In the operating suites, surgical faculty are responsible for the supervision of all operative cases. Surgical faculty are present in the operating room with housestaff during critical parts of the procedure. For less critical parts of the procedure, surgical faculty must be immediately available for direct participation.

IV. MONITORING COMPLIANCE
1. The quality of housestaff supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the housestaff’s evaluations of their faculty and rotations and the GMEC’s internal reviews of programs. During the Internal Reviews of programs, the GMEC shall request that each program provide information regarding a description of the procedures to ensure supervision in the program’s clinical settings (including nights and weekends), an explanation as to how the program monitors compliance with its supervision policies, a description as to how the program becomes aware of and responds to exceptions or critical instances of breakdown of supervision and the mechanisms the program has in place to ensure accessibility and availability of faculty.

2. For any significant concerns regarding housestaff supervision, the respective program director shall submit a plan for its remediation to the GMEC for approval and the program director may be required to submit progress reports to the GMEC until the issue is resolved.
Patient Privacy Letter

January 26, 2004

Dear Colleagues:

Recently enacted federal privacy regulations require faculty to exercise increased vigilance in protecting the confidentiality of all our patients and research participants at Johns Hopkins Medicine. This is extremely important when employees are also patients. Unfortunately, there have been several recent instances where School of Medicine and Health System personnel have inappropriately accessed the private medical information of other Hopkins’ personnel. In these instances, the patients have been very angry and upset. As a result, it is likely that these patients will complain to federal authorities and bring legal actions against Johns Hopkins University and the person at Johns Hopkins who inappropriately accessed their medical records. Hopkins insurance will not provide coverage for faculty in instances where a faculty member has acted intentionally outside his or her authorized employment relationship and has inappropriately accessed a patient’s medical record. In addition, access of medical information by faculty for a non-professional reason constitutes professional misconduct, and, as explained in this letter, likely will result in termination.

Faculty must provide the leadership in insuring the confidentiality of patient information. This letter explains the background for JHM confidentiality policies, the possible consequences for faculty non-observance and steps that faculty must take to assure, to the extent possible, that patient confidentiality is respected.

Both Maryland and federal law and regulations protect the identifiable health information of individuals.

- Providers must keep medical information confidential and may disclose it only upon the authorization of the individual or for specific operational, clinical or educational purposes.
- Federal law allows the imposition of monetary fines and criminal penalties against covered entities and the individuals working at those entities for violations of these privacy provisions.
- State law also allows for the recovery of damages for breaches of patient confidentiality.

Applying these principles at Hopkins is a challenge in light of the open architecture of the electronic patient record (EPR). These records may be accessed for legitimate reasons such as: the physician/patient relationship; consultations; research approved by an IRB; quality assurance; billing; malpractice inquiries; peer review; accreditation, etc. However, these records may not be accessed for any non-professional reason, such as: checking on a famous person’s medical condition; investigating whether a resident or intern has medical problems; "surfing" the EPR to see who among staff may have a particular disease or condition (unless part of an
approved IRB study); checking on the health of a friend, ex-boyfriend or girlfriend or staff member, etc.

The University and Health System have established a process for investigating suspected breaches of patient confidentiality, i.e., intentionally assessing an individual’s patient or research record for no legitimate professional reason. If a breach is suspected:

- The University/Health System HIPAA Privacy Officer will investigate the matter, involving other personnel as needed.
- In the case of faculty, the Privacy Officer’s investigation report will be submitted to the Vice Dean for Faculty and the appropriate Department Director.
- The Department Director will consider the reported situation and base his/her recommended action on all the circumstances involved. However, except in extraordinary circumstances, (e.g., confusion as to whether a consulting relationship existed or a mistake as to which records were to be included for research, etc.), the recommended action for a breach will likely be termination.
- As set forth in the Policies and Guidelines Governing Appointments, Promotions, and Professional Activities of the Full-Time Faculty, if the matter involves a recommendation of termination, the matter would be referred to the Advisory Board of the Medical Faculty.

It is essential that all faculty, including residents and interns under their supervision, understand the Maryland law and HIPAA requirements.

- Training Courses are available at https://secure.lwservers.net. Everyone should have taken or should take General Patient Privacy. In addition, anyone involved in research should have taken or should take Privacy Issues Relating to Research.
- If you are credentialed or re-credentialed at one of the Hopkins’ hospitals, you will be asked to complete Tracking and Accounting Disclosures of Health Information and Release of Patient Information courses as well.
- All faculty will be asked to sign an agreement to respect the confidentiality of medical information throughout JHM.

We expect the faculty of Johns Hopkins Medicine to maintain the highest standard of professionalism in assuring patient confidentiality personally as well as by anyone under their supervision. Faculty must support a culture of compliance that includes protecting the rights of patients to the confidentiality of their medical information. Serious institutional, governmental and personal sanctions will follow if violations occur.

With your help and attention to Hopkins’ high standards, we expect to be a leader in the area of patient confidentiality.

Sincerely,

Edward D. Miller, M.D.  
Dean of the Medical Faculty  
CEO, Johns Hopkins Medicine

Janice E. Clements, M.D.  
Vice Dean for Faculty  
Professor & Director  
Comparative Medicine
HOUSESTAFF HARASSMENT POLICY

I. PREAMBLE
The Johns Hopkins University School of Medicine (the “Institution”) is committed to providing its, residents and fellows (“Housestaff) the opportunity to pursue excellence in their academic and professional endeavors. This can only exist when each member of our community is assured an atmosphere of mutual respect, one in which they are judged solely on criteria related to academic or job performance. The Institution is committed to providing such an environment, free from all forms of unlawful Harassment (“Harassment”) as defined below, including Harassment based on sex, age, ethnic or national origin, gender, race, color, religion, disability, sexual orientation or any other class protected by federal, state or local laws. The Institution prohibits such harassment whether it occurs on campus, in assignments off campus or at Institution-sponsored functions.

II. SCOPE
This policy applies to Housestaff who participate in training programs sponsored by The Johns Hopkins University School of Medicine.

III. DEFINITIONS
"Harassment" is a form of misconduct that undermines the integrity of the employment relationship. It includes communicating, sharing or displaying written or visual material or making verbal comments that are demeaning or derogatory to a person because of race, color, creed, religion, sex, sexual orientation, national origin, age, disability, marital status, citizenship or any other classification protected by federal, state or local law, including material or comments intended as humor. The use of the Institution’s facilities to disseminate, duplicate or display such materials is prohibited.

“Sexual Harassment” includes making unwelcome or unwanted sexual advances, requesting sexual favor in exchange for favorable treatment or continued employment or enrollment in an education program, engaging in verbal or physical conduct of a sexual nature which is made a term or condition of employment or of participation in an educational program, or which is used as a basis for decisions respecting an individual’s employment or for academic evaluation or advancement. “Sexual Harassment” also includes any type of sexually-oriented conduct, including conduct intended to be friendly or humorous, that is unwelcome and has the purpose or effect of unreasonably interfering with an individual’s performance at work or in an education program or creating an environment that is intimidating, hostile, offensive or coercive to a reasonable person. “Sexual Harassment” is not limited to male-female interaction but may be male-male or female-female interaction.
IV. POLICY

A. Fundamental to the Institution’s purpose is the free and open exchange of ideas. It is not, therefore, the Institution’s purpose, in promulgating this policy to inhibit free speech or the free communication of ideas by members of the academic community.

B. Harassment is unlawful and will not be tolerated. Any Housestaff member found to have engaged in Harassment will be subject to severe disciplinary action, up to and including discharge from the applicable training program.

C. All individuals associated with the Institution, including employees, faculty, Housestaff, trainees and students are responsible for ensuring a Harassment-free environment. Each member of the community is responsible for fostering mutual respect, for being familiar with this policy and for refraining from conduct that violates this policy.

D. The institution prohibits acts of reprisal against anyone involved in lodging a good faith complaint of Harassment. Conversely, the institution considers intentionally filing false reports of Harassment a violation of this policy.

The line between acceptable social conduct and Harassment is not always clear. For that reason, the Institution encourages individuals who feel they are being or may have been harassed to communicate politely, clearly and firmly to the offending party that the conduct is unwelcome, unwanted, offensive, intimidating or embarrassing; to explain how the offensive behavior affects the individual’s work or academic performance; and to ask that the conduct stop.

E. If the individual is uncomfortable with making a direct approach to the offending party or has done so, but the perceived harassment has not stopped, the individual may use the “Procedures for Resolution of Claims of Harassment”, which is set forth below. The Institution encourages reporting of incidents of Harassment regardless of the identity of the alleged offender. The Institution is committed to promptly responding to all complaints of Harassment made pursuant to this policy.

V. PROCEDURES FOR RESOLUTION OF CLAIMS OF HARASSMENT

There are several mechanisms for resolving a claim of harassment.

1. Claims of sexual harassment may be reported in compliance with The Johns Hopkins University Sexual Harassment Prevention and Resolution Program. The complete policy is available at http://www.jhuaa.org/shprp/index.html.

2. Claims of any form of harassment by a member of the medical staff may be submitted as a statement of concern to the Chairman of the Medical Board of the involved hospital to activate an investigation and possible fair hearing procedure in accordance with the hospital’s bylaws.

3. Claims of any form of harassment may be reported to the Associate Dean for Postgraduate Affairs or the Vice Dean for Education. A prompt investigation shall be carried out. The investigation will be conducted in an expeditious and discrete manner and will include an interview with the individual making the complaint and with any witnesses. The person alleged to have committed Harassment will also be interviewed. If it is determined that the
claim has merit, the claim and a report of the investigation will be submitted as appropriate for Institutional action. If the alleged harasser is a member of the faculty, the Dean shall be notified; if the alleged harasser is an employee or contractee of The Johns Hopkins University, the University’s Human Resources Office shall be notified. If the alleged harasser is an employee or contractee of an affiliated hospital or institution, the appropriate officer of that institution shall be notified.

VI. CONFIDENTIALITY
The name of the individual making the report of Harassment will be disclosed only to the extent necessary to conduct an investigation. However, absolute confidentiality cannot be guaranteed.

VII. DISCIPLINE
All employees, including Chiefs, Administrators, Directors and other management staff, will be subject to severe disciplinary action up to and including discharge for any Harassment or for retaliation for any individual’s pursuit of a Harassment complaint in accordance with this Policy.

VIII. CONTROL
The Designated Institutional Official shall assure conformance with the policy and shall establish such other policies or procedures necessary to effectuate its intent. This includes, but is not limited to, dissemination of this policy during new Housestaff orientation, training for all supervisory staff on the policy and how to maintain a work environment free of Harassment and communicating this policy to all non-employed medical staff, vendors, contractors and other business visitors interacting with Institution staff. The Vice Dean of Education and Designated Institutional Official shall notify the legal counsel of Harassment complaints for insurance reporting purposes.
The Johns Hopkins School of Medicine

Policy Number 107

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY  Effective Date 7/14/04

PROFESSIONAL FEE BILLING FOR RESIDENTS AND CLINICAL FELLOWS IN ACCREDITED PROGRAMS

BACKGROUND:
Federal regulations and the Medicare program have established rules governing the payment for services performed by residents who are in an approved training program based on the setting where the services are performed. (Medicare regulations include “fellow” in its definition of resident.) Approved training programs include those resident training programs approved by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). Johns Hopkins Medicine (JHM) will follow the Medicare billing rules and some additional Hopkins-specific requirements for all payers unless a specific exception is granted for a specific payor or payors by the Senior Director, Office of Billing Quality Assurance.

APPLICABILITY:
This policy applies to physicians who are residents and clinical fellows in Accredited Johns Hopkins Training Programs.

ADDITIONAL DEFINITIONS:
"Resident" means a physician who is enrolled in an Accredited Johns Hopkins Training Program for a clinical specialty.
“Clinical Fellow” means a physician who is enrolled in an Accredited Johns Hopkins Training Program for a clinical subspecialty.
“Accredited Johns Hopkins Training Program” refers to a Johns Hopkins Training Program that is accredited by the ACGME or ABMS and includes all years through the final required year of the Program, as designated by the Program Director; it does not include voluntary years of training in the same specialty/subspecialty subsequent to the final required year of the Program.
“JHMI” means The Johns Hopkins Hospital, The Johns Hopkins Bayview Medical Center, Johns Hopkins Community Physicians/Johns Hopkins Medical Services Corporation and Howard County General Hospital.
“Non-JHMI” means an institution other than one of the JHMI institutions.
“JHUSOM” means The Johns Hopkins University School of Medicine.
“Participating Institution” means an institution to which Training Program Physicians rotate in the Physicians’ Accredited Johns Hopkins Training Program.
“Training Program Physicians” or “Physicians” means residents and clinical fellows in an Accredited Johns Hopkins Training Program when referred to collectively.

INTRODUCTION:
Whether a Training Program Physician may bill for professional or patient care activities and what conditions apply to that billing activity depends on the location where the activities are rendered. Set forth below are the five relevant locations and the billing policies applicable for each. These rules are summarized on Attachment B-1 to this Policy.

BILLING LOCATIONS AND BILLING POLICIES FOR EACH LOCATION:
1. JHMI/Hospital Setting.
A Training Program Physician may bill for patient care activities in a JHMI hospital setting only if:
a. the activity is not in the same specialty or subspecialty as his/her Johns Hopkins Training Program,
b. the activity takes place only in the emergency department or in an outpatient setting,
c. the Physician does not admit patients,
d. the Physician complies with the requirements of Attachment B-2 to this policy, and
e. the Physician has an approved Moonlighting Request Form (Attachment M to the Moonlighting Policy), and has an approved Professional Fee Billing Request Form (Attachment B-3 to this policy).

2. JHMI/Non-Hospital Setting.
A Training Program Physician may bill for patient care activities in a JHMI non-hospital setting (such as a doctor’s office, nursing home or physician’s office) only if:
a. the activity is not in the same specialty or subspecialty as his/her Johns Hopkins Training Program.
b. the Physician complies with the requirements of Attachment B-2 to this policy, and
c. the Physician has an approved Moonlighting Request Form (Attachment M to the Moonlighting Policy) and an approved Professional Fee Billing Request Form (Attachment B-3 to this policy).

3. Non-JHMI/Participating Institution Hospital Setting.
A Training Program Physician may bill for patient care activities in a non-JHMI/Participating Institution hospital setting only if:
a. the activity is not in the same specialty or subspecialty as his/her Johns Hopkins Training Program,
b. the activity takes place only in the emergency department or in an outpatient setting,
c. the Physician does not admit patients, and
d. The Physician has an approved Moonlighting Request Form (Attachment M to the Moonlighting Policy) and an approved Professional Fee Billing Request Form (Attachment B-3 to this policy).

4. Non-JHMI/Participating Institution Non-Hospital Setting.
A Training Program Physician may bill for patient care activities in a non-JHMI/Participating Institution non-hospital setting only if:
a. the activity is not in the same specialty or subspecialty as his/her Johns Hopkins Training Program, and
b. the Physician has an approved Moonlighting Request Form (Attachment M to the Moonlighting Policy) and an approved Professional Fee Billing Request Form (Attachment B-3 to this policy).

5. Non-JHMI/Non-Participating Institution - Hospital or Non-Hospital Setting.
A Training Program Physician may bill for patient care activities in a non-JHMI/Non-Participating Institution hospital or non-hospital setting only if the Physician has an approved Moonlighting Request Form (Attachment M to the Moonlighting Policy).

For the complete policy, please follow this link:

Departmental Policy on Moonlighting

Residents in the Department of Gynecology and Obstetrics are expected to view their training as a full time commitment. As such, moonlighting is not permitted.
JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE

POLICY ON CRIMINAL BACKGROUND INVESTIGATIONS OF
STUDENTS, HOUSESTAFF, AND CLINICAL AND RESEARCH FELLOWS

I. Statement of Policy

It is the policy of the Johns Hopkins University School of Medicine that offers to prospective students in any professional or graduate program at the School of Medicine, interns, residents and clinical fellows in any Graduate Medical Education program sponsored by Johns Hopkins, and other clinical and research postdoctoral fellows at the School of Medicine are conditioned on a review of the prospective student’s, trainee’s or fellow’s criminal background. The University reserves the right to rescind an offer of admission or appointment to any educational or training program to any individual whose background investigation reveals a history of criminal conduct:

   a. that the University reasonably determines increases the risk of harm to patients or individuals on Johns Hopkins premises; or
   b. that was not accurately disclosed in response to a direct question regarding criminal history on any application for admission or appointment in connection with the program; or
   c. that is inconsistent with the high standard of ethical conduct required of all members of the academic community or is otherwise unbefitting a member of the academic community.

II. Procedure

   A. All offers of admission to professional or graduate programs, appointments to GME programs sponsored by Johns Hopkins or appointments to clinical or research fellowships will be specifically conditioned upon a criminal background investigation.

   B. Background investigations will be carried out by the University or an agency on its behalf. The Office of Admission in the case of prospective medical students and program directors in the case of graduate programs, GME programs and clinical and research fellowships will be responsible for obtaining written authorizations from individuals who have received conditional offers of appointment to their training programs in the form established by the University and/or the agency.

   C. The background investigation will consist of a verification of the name and social security number of the individual, confirmation of addresses in the United States in the past seven years, and disclosure of any felony and/or misdemeanor convictions for the seven year period immediately prior to the offer of appointment. Only convictions will be reported.

   D. If the report reveals a discrepancy in name, social security number or addresses or discloses a conviction for a felony and/or misdemeanor in the past seven years, the University will make a copy of the report available to the individual. The individual will be permitted to provide the University with any additional information s/he wishes the University to consider concerning the information disclosed prior to the
University’s making a decision whether to withdraw the offer of admission or appointment.

E. In the case of prospective medical students, the Associate Dean of Admission and the Associate Dean for Student Affairs, with advice from the Vice President and General Counsel of the University or his designee, will make the final decision as to whether the offer is to be withdrawn. In the case of prospective graduate students, the Program Director and Associate Dean for Graduate Education with advice from the Vice President and General Counsel of the University or his designee will make the final decision as to whether the offer is to be withdrawn. In the case of members of the housestaff and clinical fellows in GME programs, the Program Director, Department Chair and Designated Institutional Official, with advice from the Office of the Vice President and General Counsel of the University, will make the final decision as to whether the offer is to be withdrawn. In the case of clinical fellows in non GME programs and research fellows, the preceptor and Associate Dean for Postdoctoral Affairs, with advice from the Vice President and General Counsel of the University or his designee, will make the final decision as to whether the appointment is to be withdrawn.

F. In the case of members of the housestaff and clinical fellows, the information will also be shared with the Medical Staff Office of The Johns Hopkins Hospital, the Johns Hopkins Bayview Medical Center or other hospital at which the individual is to be appointed. If, following its credentialing process, the hospital declines to appoint the individual to its housestaff or to clinical fellowship, the offer of appointment to the program will be withdrawn.

G. Any individual whose offer of admission or appointment is withdrawn in accordance with this procedure may appeal the decision to the Vice Dean for Education. Appeals will be limited to review of whether this procedure was followed. An appeal must be in writing stating the grounds for the appeal and must be received by the Vice Dean within seven (7) days of the date of the decision appealed from.

Contact Information for Associate Deans:

Ph.D. Students:  Associate Dean for Graduate Education, Dr. Peter Maloney, pmaloney@bs.jhmi.edu

Residents/Fellows in ACGME Programs:  Associate Dean for Graduate Medical Education, Dr. Julia McMillan, jmcmill@jhmi.edu

Fellows in non-ACGME Programs:  Associate Dean for Postdoctoral Programs, Dr. Levi Watkins, Jr., lwatkins@jhmi.edu

Medical Students: Associate Dean for Admissions, Dr. James Weiss, jlweiss@jhmi.edu
Medical Records

The timely and accurate completion of medical records is among any resident’s most important responsibilities. Patient charts are medically and medico-legally vital documents that must be accessible at all times, and may never be removed from the hospital. The following rules apply to all institutions:

1. State Law requires that verbal orders must be countersigned within 24 hours. The MD signing does not have to be the MD giving the order – so sign, date, and time all verbal orders from your service when you see them.
2. H&Ps must be completed at the time of the patient’s admission. The referring and admitting attending MDs should be clearly identified to facilitate follow-up.
3. Medical student write-ups do NOT count as a completed H&P, and simple countersignature is NOT sufficient. A complete H&P or completion of an admission form by the resident is necessary.
4. Operative summaries must be dictated within 24 hours, no exceptions.
5. Discharge summaries are ideally dictated at the time of discharge by the resident most familiar with the patient’s care.
6. Clinic and procedure notes should clearly state the involvement of the attending physician.
7. Any delay or deficiency will become a medical records infraction for the attending physician of record, which may even result in suspension of hospital privileges for that physician. Attendings generally don’t like that!
**Junior Fellowship in the American College of Obstetrics and Gynecology**

The Department sponsors each of its residents as a junior fellow of the American College of Obstetrics and Gynecology. The department will pay both the application fee and annual dues during your residency. With this comes a subscription to Obstetrics & Gynecology (The green journal).
Board Examination, Part I

PLEASE NOTE: While your residency coordinator will assist you with the process and dates for application to take the written boards, YOU ARE RESPONSIBLE FOR COMPLETING ALL NEEDED STEPS. Please visit the ABOG website (www.abog.org) and read the bulletin describing the various steps, deadlines, and fees.

To apply to take the written examination, a formal application must be requested from the:

American Board of Obstetrics and Gynecology, Inc.
2915 Vine Street
Dallas, TX  75204-1069
Phone – (214) 871-1619
Fax – (214) 871-1943

Applications must be requested after September 1 of the PGY4 year of training. The deadline for return with application fee is late November of that same year. Deadlines, fees, and application procedures are posted on www.abog.org. The deadline for the examination fee is in early April.

The examination is taken the last Monday in June of the year of graduation.

The program director must sign your entrance card to the examination. To get the card signed, all resident data for surgical and obstetrical experience must be completed and logged.

Board Examination, Part II

To apply to take the oral examination, an application must be requested from the American Board of Obstetrics and Gynecology, Inc. (see address above). The completed application, fee, and two passport-type photographs, must be received during January or February of the same year you are to take the exam. The deadline date for receipt of applications in the board office will be posted in the Bulletin found on the www.abog.org website. Requests for the appropriate form must be made in writing.

The application is made in your second full year of full time, unsupervised practice. For example, if you graduated from the program June 30, 2002 and went into practice, you would be able to take the oral exam in December 2004. Therefore, your materials would need to be completed by February 28, 2004. Recently, the Board has offered a limited number of slots which allow candidates to take the examination immediately following their first year of full time unsupervised practice. Details of this program are outlined in the Bulletin of the ABOG.
Emergency Call Coverage

Illnesses and family emergencies can wreak havoc with the program’s fairly dense call schedules. It is therefore important that everyone recognize the need to be helpful and flexible. Ideally, vacancies in the call schedule will be covered by volunteers, who will be solicited by the senior resident on the affected rotations and the administrative chief resident. If no volunteers can be found, the Administrative Chief Resident will designate who will cover the call.