PART IV

Department of
Obstetrics and Gynecology

Interns and Residents

2020 – 2021

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Policies and Procedures Manual

TABLE OF CONTENTS

General Residency Service Coverage

The resident service should at minimum have the following coverages:
Ob Days: 3 (with at least one chief or functional chief)
Clinic: 1 upper year & 1 lower year
Gyn: 4 residents (minimum 3)
Onc: 1 resident
Nights / week-ends: 3 (with at least one chief or functional chief)

The functional Chief can be a 3rd year.

OB Service

The labor floor team consists of a Chief Resident (or functional Chief), an upper-year resident (PGY2 or 3), and an intern. In addition, a Family Practice intern, Emergency Medicine resident and several medical students may rotate through the service. Also, the midwife team will have someone assigned to the labor team, or at minimum to assist when the floor gets busy and the residents need help. The midwife assigned to L&D will come to the floor before morning conference.

AM Rounds

All postpartum patients must be seen and examined each morning. Postpartum patients may be located on floors R1 or R2E. The Labor and Delivery Days Intern is responsible to ensure postpartum rounding is completed on R1; historically all interns available assist with the rounding early in the year as the number of postpartum patients to be seen is often more than one intern can accomplish. The Labor and Delivery Upper Year is responsible for rounding on R2E. The Nights intern is responsible for any postpartums present on R2S (Labor and Delivery). Medical students on the L&D team should be told what time and where to meet for rounding. The medical student notes should be "shared" with residents, so the appropriate resident can sign them.

Antepartum patients present on R2E are seen by the MFM resident BEFORE morning conference. Antepartum patients on Labor and Delivery (R2S) are to be seen by the night intern.

All postpartum notes are to be completed by 0645 hours; board sign-out occurs at 0645 hours sharp. The following residents are expected to be at board sign-out unless patient care requires otherwise: Nights Intern, Days Intern, Nights Upper Year, Days Upper Year, Nights and OB Chief.

Morning conference begins after board sign-out promptly at 0710 hours. Please be present. This is protected resident teaching time and **is mandatory** to help assure education is not superseded by service, (unless you have been excused by Dr. Schnatz or Terri Chervanick). Notify Terri (or the ObGyn Dept. / office) for absences – ahead of time if and whenever possible. For example, if a Cesarean Section starts at 0700, the DOD should scrub in to assist (instead of a resident). If the DOD is unavailable, the chief resident should scrub. If these two are unavailable, an available resident should scrub and the absence and reason should be reported after the completion of the Cesarean section to Dr. Schnatz or Terri Chervanick.

> *The reasons for an excused AM conference absence include: Vacation, Elective, being away at a conference/meeting, PTO/Leave, a doctor's appointment that cannot be scheduled at another time (i.e., this should be a rare event), or a Chief Resident providing emergent care for clinic patients (if another physician is needed, a faculty associate or other attending should excuse any junior residents). Before assisting with non-service elective cases or patient care, the private attending should discuss with the residency program. If valid reasons deter you from notifying the Department ahead of time, please notify the Dept. as soon as possible to avoid the perception of an absence or tardiness. Despite morning conference being of high priority, patient care should never be compromised.*

The Night Float is responsible for calls from the labor floor until 0710 hours.

Cesarean sections that start after 0700 hours may go to the day team.

Labor Floor Routine

Scheduled inductions will need to be admitted in a timely fashion following morning conference. Confirm vertex presentation on all inductions by ultrasound. Document should be placed in the admission H&P that presentation was confirmed by ultrasound.

The interns will spend time in Maternal Fetal Medicine while on their OBT/US rotation and as time allows during other rotations to learn the basics and to get signed off on BPP, AFI, presentation, and EFW. Please use downtime on L&D to find additional US opportunities. Ultrasounds performed on Labor and Delivery and in OB Triage (other than presentation) must be done or supervised by someone who is signed off (may be upper year or chief). These ultrasound images should be uploaded and transmitted to MFM for a formal report (an informal report should be entered in EPIC as a progress note until a formal report is available).

All clinic patient deliveries should be attended by a resident during the day.

All private deliveries, unless there is a more important educational opportunity or the private does not need assistance, should be attended by a resident.

Cesarean Section Deliveries:

- Intern: primary, vertex presentation
- Upper year: repeat, breech, STAT, or multiple gestations

In general:

- Fetal heart tracing/contraction monitoring should be reviewed, with cervical exams as indicated, and documented every two to three hours. Residents need to document their own cervical examinations.
- If any abnormalities or concerns arise, or during the second stage of labor, notes should be written more frequently, and as indicated. Notes should clearly document what the thought process is, as well as the indication for interventions (for example, “terbutaline administered for uterine tachysystole with prolonged deceleration”).
- The upper-year resident is responsible for the labor floor and needs to know everything that is happening on the floor. At all times (except for conference), a PGYII or above must be responsible for the labor floor and immediately available. If the Upper Year will be unavailable (as may happen on nights with need for emergency GYN surgeries), the upper year must call the chief and notify them of their inability to be responsible for the labor floor for that period. Whether it is the PGY II, III, IV, midwife, or attending who is functioning as the “responsible resident”, they must be signed in to vocera as the “L&D resident”. The intern should be signed in as “OB intern”. Both the intern and the upper year answer to the attending staff and get approval for management decisions from the attending staff.
- The charge nurse should know the upper year “in-charge” resident’s whereabouts at all times. During the day, there should always be at least an upper year resident, a non-physician provider, a Chief resident, or the DOD present and/or responsible. An intern should never be left in a position of making independent decisions or interpretations of strips/care (The upper year resident is responsible for making sure the responsible person is properly identified and that this information is communicated).

Antepartum transfers off the labor floor:

- Ultrasound evaluation must be completed as indicated: EFW, AFI, fetal presentation, etc.
- Write a transfer note outlining the patient’s admission and L&D course thus far.
- Notify the MFM resident of the transfer if occurring during the day or the Upper Year on Nights if occurring at night. This notification should happen at the time of transfer.
- Add the patient to the antepartum sign-out list.

Transfers and consults to the WHC service can be accepted ONLY by the DOD (communication between the DOD and Ob Chief Resident is imperative). All calls regarding obstetrical patients in the Emergency Room must be deferred to either the Chief Resident (if a clinic patient) who will discuss with the DOD or to the attending (if it is a private patient or the Chief is unavailable for some reason). Please be helpful to the Emergency Room staff by providing the pager number of the appropriate person for them to speak with if the need is non-urgent or address the need immediately if it is of an urgent nature. The only calls interns or Upper Years are permitted to address are “tracing review” calls (i.e., you may determine whether a tracing is Category 1 or otherwise). No management plans in regard to ED patients are to be determined by an intern or an upper year without consulting the chief resident / DOD (i.e. all chief plans are to be reviewed with the DOD, or with the DOD directly) or the private attending.

Board Sign-out (L&D huddle):

- An OB Multidisciplinary hand-off / huddle to improve communication among all the staff caring for our patients occurs daily during 15-minute sessions at 8:00 am and 7:15 pm. Those present include: 8AM: the entire Ob and MFM covering team (including both chief residents), the daytime DOD, the PM DOD, NICU, Anesthesia, and the charge nurse. 715PM: The OB day and night teams (including intern, upper year, and chief residents), the night team, the PM DOD, NICU, Anesthesia, and the charge nurse.

The following chain of command should be followed for all questions regarding routine or complicated patient care.

WHC: Intern → Upper Year → Chief → DOD → Residency Director / Assoc. Chair and/or the Dept Chair, and/or Designee (The Chief Resident is responsible for overseeing the management of the OB Service in general and knowing the details of all WHC patients). Private: Intern → Upper Year and/or Chief resident [The Upper Year, Chief Resident, and DOD should all be aware of any sick &/or complicated private patients on L&D] → Private Attending ->DOD → Residency Director / Assoc. Chair / Dept Chair, and/or Designee(s).

Dr. Schnatz and the Dept Chair should be notified regarding any significantly high-risk patients, unusual complications, or severely ill patients.

Call & Duty Hours

The following is a summary of the ACGME Duty hours and must be maintained in service coverage:

ACGME's common duty hour standards acknowledge scientific evidence that long hours and sleep loss have a negative effect on resident performance, learning and well-being. The duty hour standards include:
• An 80-hour weekly limit, averaged over four weeks;
• An adequate rest period, which should consist of 10 hours of rest between duty periods;
• A 24-hour limit on continuous duty, and up to six added hours for continuity of care and education;
• One day in seven free from patient care and educational obligations, averaged over four weeks;
• In-house call no more than once every three nights, averaged over four weeks;
• The option for programs in some specialties to request an increase of up to 8 hours in the weekly hours, if this benefits resident education, with approval by their sponsoring institution and the Residency Review Committee (RRC) in the given specialty.

- Rounds are completed by both the resident coming off-call and the resident coming on-call for all OB/GYN patients in house: GYN, Oncology, and Antepartum. Typically, the outgoing resident rounds on GYN and Antepartum. The incoming resident rounds on Oncology. Patients in the ICU should be seen twice a day, and more frequently as needed, by a resident with notes placed in the chart accordingly.
- You must always carry the GYN pager . Please remember to sign onto Vocera as Antepartum resident, GYN resident, and L&D resident (aka "labor and delivery resident" or "Ob resident").
- Strategic napping is permitted if the floor is **unusually** quiet. If a resident is fatigued, they should notify the team and/or the PD to facilitate necessary napping. However, the upper year is still expected to know the details of each patient's presentation and labor course; this will preclude significant periods of sleep most nights. At no point should an intern be left to make management or independent decisions or interpretations of strips/care without appropriate support from an upper year or attending.

Chiefs

Each chief will be responsible for covering equal amount of night float. The hours of call run from Sunday-Friday 1915-0815. The chiefs are an involved member of the team.

GYN Service

The GYN team consists of at least 3 residents [ideally 4 residents] (A GYN Chief [or functional chief] and at least 2 additional residents.

<u>Responsibilities of the Team</u>

Scheduling of OR cases: Any and all clinic cases that are scheduled for surgical procedures are the responsibility of the Gyn service Chief resident, under the supervision of the Faculty Associates. A junior resident can do the procedure with an attending, at the discretion of the Faculty Associates. The Chief, however, is still responsible for being involved in the patients care. Before any surgery is scheduled, the booking form should be reviewed with the faculty associate [after the faculty associate has examined the patient, agrees with the plan, and assures the checklist has been properly addressed]. All surgeries should be scheduled with a Faculty Associate, unless the patient needs to be referred to a subspecialty service. In the latter scenario, a faculty associate should communicate with the subspecialty service. It will be the responsibility of the clinic resident to sign out/present the patient to the resident on that service. Similarly, it will be the responsibility of the faculty to communicate with each other. The resident on that service will take over care of the patient along with the subspecialty attending. This discussion and communication (from resident to resident and attending to attending) will help assure proper hand-off and patient safety. The case will obviously need to be discussed with any covering physician, but they do not necessarily need to sign the booking slip.

All first scheduled Women's Health Center patients need to have an interval H&P updated by the resident before morning conference. If this cannot be completed prior to conference (Ex. patient is late), chief resident or GYN DOD must be notified prior to conference to avoid delay in the case. All other WHC interval H&P's should be updated by the GYN residents in a timely manner as the patients arrive.

Postoperative coverage: All GYN patients will be followed by the resident who scrubbed for the case, under the supervision of the GYN team, the GYN Chief resident, and ultimately the attending physician until they are discharged to go home, with the exception of weekend coverage as outlined above. The primary resident surgeon for the case is expected to complete the post-operative rounds that day prior to sign-out (unless the case finished after 2pm in which case the post-op check may be completed by the night team), as well as rounding the following am.

AM rounds and notes should be completed by 0645 hours. The GYN team will meet at 6:45 AM for GYN chief rounds for an update and brief review of all GYN patients.

The GYN team will also be responsible for presenting any GYN cases at morning report, when cases are presented. The GYN Chief should give the GYN attending a list of the on-service patients and discuss rounding.

Patient Coverage: All major GYN surgeries at the main hospital and the Spring Ridge Surgical center must have resident coverage. If there will **NOT** be resident coverage for a major GYN case, this must be discussed with the attending at least one day prior (unless the case is added on after the OR list is distributed the morning of the case) as well as giving notification to the OR scheduling coordinator (ext 8278). The chief resident will assign GYN cases and have responsibility for all WHC GYN cases. Case will be distributed to residents on the Gyn team. Exceptions may be made (i.e. case covered by non-GYN resident) if a case is above a resident's competence level (i.e., striving for level appropriate experience) AND if approved (or required) by Dr. Schnatz due to the need for surgical numbers, volume, or experience. The GYN Chief will notify the OR who will be covering which cases. Patients who do not have resident coverage (no residents available to scrub for case or overnight non-operative admissions) need to be brought to the attention of the GYN Chief and added to the GYN Sign-Out List (the gyn team should communicate with the attending of note to determine what, if any, involvement from a resident is expected. Any minor cases at the main hospital and the Spring Ridge Surgical center can also have resident involvement.

Inpatient management: Discuss more significant management decisions with the attending staff. This varies per attending, but generally it is a good idea to check with the attending before initiating any of the following:

- Adding new medications
- Removing packing, sutures, or staples
- Pulling lines or drains
- Ordering imaging studies
- Placing consults to other services

Death Pronouncement and Death Certificates

Historically, residents have provided this function, however, they have not been able to sign the death certificate. According to the current PA law, resident physicians can both pronounce death and sign the death certificate. While this may occasionally involve private patients, if residents were intimately involved in the care

of the patient, it will mostly involve service patients. Signing the death certificates should be done by senior level residents, with oversight by an attending.

"Beta List"

This is an EPIC list of abnormal βHcG's during first trimester pregnancies which may include ectopics, pregnancies of undetermined location, miscarriages (when a pathology report confirming normal chorionic villi is not available), and follow-up for molar gestations. This is not a list for following known intrauterine pregnancies until prenatal care is established.

It is to be maintained by the most junior resident on the GYN team. Interns should be taught how to manage the beta list during their first rotation on GYN.

It should be reviewed at least two times weekly. Please make sure to place appropriate orders and update the WHC nurse managing the abnormal betas as needed. There are guidelines regarding how to manage these patients, specifically regarding the appropriate frequency of obtaining labs and sending certified letters.
Call the GYN Chief if there are any questions.

"Tubal Days"

Tubals should preferentially be done during minor block time. Tubals can be done on other block days if our operative schedule is not full. In addition, if there is a back-log of tubal patients, they can be done on other non-block days after confirming with Dr. Schnatz that GYN attending coverage is available.

All charts and cases will be reviewed with the Chief Resident and the attending staff in the pre-op clinic.

Always check pre-op labs, including beta hcg or pregnancy test. No patient is permitted to undergo anesthesia for a tubal without first confirming a negative beta hcg.

Case Assignments and "Down" Time

Print the following day's OR list and deliver it to the GYN Chief each afternoon. All cases for the next day will be assigned by the GYN Chief. The Chief will post the OR list in the Resident Lounge and confirm everyone, including the medical students, know where they are assigned for the day.
Review and be prepared for assigned operative procedures. Attending staff will expect that you have read about and are aware of the risks, complications, and basic technical aspects of the surgery for which you are scrubbing. They will also expect that you know the patient's history, pre-operative evaluation, indications for the procedure, and results of any testing that was ordered (beta hcg, CBC, Pap, GC/Chlamydia, etc).

If an opportunity arises to leave early, before leaving the Hospital, always clear it with the GYN Chief and the ObGyn Residency, and only if all services are well covered. Dr. Schnatz and the residency assume you are here at the hospital if you are needed, or need to be reached for any reason, unless you have an approved absence. Also, no one is permitted to leave the hospital without signing out to the covering resident. At no time should the late stay or nights resident be asked to assume care of a patient without first receiving sign-out from the off-going resident. This sign-out should occur in person.

Morning GYN Rounds

This computer-generated list must be updated daily. New patients, consults, re-admission, etc. should be added to the list. It should be confirmed at morning rounds, and prior to morning report or conference, that the list is updated and accurate.

You should always sign out in person to the late stay or night resident; the sign-out lists should be printed out and used to optimize the sign-out. Sign-out lists are expected to be up-to-date and complete (for example, EBL for gynecologic surgeries should be listed). Try to complete as much information as possible (meds, medical history, abnormal labs, etc).

Post-op Checks

Mandatory Progress Notes should be completed four to six hours after each surgery. They should include assessment of patient complaints, vital signs, urine output, physical exam, pertinent labs, etc.
Should be completed prior to 1900 hours if possible, or else posted on the Sign-Out List for the Night float to complete. The post-op check should be done by the resident logging "surgeon" for the case.

Research

By January 1st of the intern year the research title should be reported to the OB/GYN department.

By February 15th of the second year, a solid plan, methodology, and IRB approval should be completed. Whether you must acquire new IRB approval or not, please hand in a written proposal ("Research Proposal") according to the Research Proposal Template.

By August 1st of the third year, it is required that all data be ready for analysis, or before planning / scheduling any elective other than research.

By February 15th of the third year, it is required that the data be analyzed and ready to prepare presentation, abstract and manuscript.

A write up (in manuscript format) must be handed into the department by March 18th of the chief year and will be submitted for the S. Leon Israel Award.

Each resident will have 3 weeks of research/gyn during their 3rd year, assuming this time is not needed for other program requirements, clinical experience, make-up time, remediation, etc.

The OB/GYN Resident Research Night will be in April. The components include:

- Brief presentation of research question, background and plan by the PGY-2 class.
- Formal Research Presentation by PGY-3 class.
- Poster allowing residents to highlight research accomplishments by PGY-4 class. This includes the front page of manuscripts (peer & non-peer reviewed), abstracts, posters, etc.

All above presentation and poster materials should be completed and turned into the department two weeks before the event.

A write up (in manuscript format) should be handed into the department by the deadline of March 18th for the S. Leon Israel award [of chief year]. These two components are required for program completion (i.e.-The oral presentation and the manuscript preparation).

If the research project components are not completed by each above deadline, the resident will be removed from service until it is completed.

Residents who have an abstract accepted to a National Meeting (either as a poster, oral, or video presentation) and approved by the Program Director, will be supported by the department (up to $2000) to present their work at the meeting. The standard hospital & departmental travel policies apply.

One PGY III resident will be selected each year for the best research award and will be presented at graduation. Residents who do not have the following completed by August 1st of their 3rd year will need to spend their elective (3rd year elective) time at the hospital, under the guidance of their mentor, accomplishing the research goals:

1 Research title, methods and approval
2 Data has been collected or a very strong and solid plan is in place for this to be completed soon.
3 The data is ready for analysis or a solid plan is in place for this to be completed soon.

ELECTIVE

The 3rd year elective form needs to be filled out, returned, and approval signed off by Dr. Schnatz prior to any plans being made.

There will be flexibility to spend time off site getting any desired clinical experience providing:

1. You can cover your expenses.

2. You have accomplished the necessary research goals, as described above under “Research”. If your research is not ready for analysis, your elective rotation must be utilized to get your research up to date.
3. This time is not needed for program requirements, clinical experience, remediation, or other make-up time.
   a. Your case volume is on track to attaining your minimum numbers and competencies
4. It is an educational experience &/or need that cannot be met here at the hospital.

Off-Service Rotations

Attendance at OB/GYN morning conference is not required, but strongly recommended if possible (when not pulling you from your off-service requirements or educational opportunities).

Internal Medicine

While on this rotation, you are responsible to their service. You will have no ObGyn coverage and are not expected at our conferences. You should attend their didactics, rounds, call duty, etc.

NICU Curriculum

The NICU / neonatology experience form needs to be completed by the end of your internship year. Certification in Neonatal Resuscitation (NRP) is a requirement to complete this curriculum.

Maternal-Fetal Medicine Rotation
(PGY2/PGY3)

Clinic duties: Diabetic clinic is held Tuesday morning followed by continuity clinic in the afternoon.
Thursdays: the MFM resident will see high risk OB clinic patients all day.
Monday/Wednesday/Friday will be spent all day in MFM office performing ultrasounds and genetic counseling (see the curriculum for further details).

MFM Resident:

- Rounds on all in-house MFM patients prior to conference.
- Takes care of all new admissions and consults to the Antepartum service.
- Responsible for OB Triage ultrasounds over 16 weeks.
- Responsible for keeping the MFM service list updated.
- Ultrasound with MFM attending when not in clinic.
- Clinic duties as above.
- Carry the antepartum pager.
- MFM consults on Monday and Friday for WHC patients.
- Responsible to work with Dr. DeVeaux to present OB portion of the OB/NICU Case Presentations.

Above all, communicate with each other through the week on inpatients, clinic patients, or any other questions/concerns you may have. Sign-out to MFM attending (together) at least once a week on all inpatients (even if not formally consulted). Good communication will make this a successful rotation. If paged for an admission or ultrasound during clinic hours on Tuesday or Thursday, please complete if able to do so. However, if unable to do so, the MFM resident must call the OB Chief to request assistance.

Triage/US Experience: Experience on the Ob Triage unit, and being signed off on the competencies, will take place on the Triage/US rotation during the intern year. Tuesdays & Thursdays, when the MFM resident is in clinic, the intern will be on MFM to 1) get signed off on fetal viability, position, and AFI. Rounds with the lactation consultants at least twice (for a total of 4 hours of lactation education).

Adolescent/Pediatric Gynecology

Residents gain pediatric and adolescent gynecology exposure through the Pediatric/Adolescent Gynecology

curriculum which is achieved longitudinally during residency training. The first requirement is to complete the Adolescent and Pediatric Gynecology ASRM modules. Each resident also attends a minimum of two pediatric/adolescent clinical care sessions (including either the pediatric/adolescent gynecology clinic &/or SANE examinations). Additionally, the department provides an educational core lecture series on Pediatric and Adolescent gynecology. Residents also obtain didactic learning in puberty, pubertal abnormalities, and disorders of the gonadal development during their REI rotations.

Philadelphia ObGyn Society Monthly Meetings

The REI & one of the Gyn residents should plan to attend the monthly Philadelphia ObGyn society meeting. They will be done with their duties by noon, so they can have some protected time to get to this meeting – for education, networking, etc.

Ambulatory Duties

Each resident will be scheduled for Continuity Clinic on dedicated blocks through their residency. There is a minimum of two residents scheduled in clinic per block. With at least six weeks' notice, vacation can be taken during this rotation if there are three residents on the service. No more than one of those three residents can be off at a given time. The resident must attend and have an active role in daily huddle.

The Ultrasound

Under no circumstances does the "Labor Floor" ultrasound ever leave the labor floor/Ob Triage area. If an ultrasound is needed in the OR/ED/Antepartum/other floors, the OB Triage machine is borrowed with appropriate notification of the OBT midwife.

Ultrasound upkeep and maintenance is an intern responsibility. The machine should be cleaned and stocked (paper, gel, condoms, lube, etc) on a weekly basis. If servicing is needed, Dr. Schnatz or the Chair should be informed immediately. In-house maintenance of the machine (electronics, hardware support, software) is available through the Biomed Department.

Ultrasound Experience:

The interns will spend time in Maternal Fetal Medicine during their triage rotation (when the MFM resident is in clinic) and during other rotations as time allows to learn the basics and to get signed off on BPP, AFI, EFW as well as determination of 1st trimester viability, as able and as resident progresses.

Required SonoSim Modules will be completed during the MFM rotation.

The 2nd and 3rd years will receive hands-on training in the MFM office during their MFM rotation.

The lowest level available resident on the GYN service will cover the clinic GYN ultrasound schedule Thursday afternoon every other week.

Residents should do their own scans in the ER before sending the patients to radiology. Even if radiology has done a scan before seeing the patient, there may be benefit to repeating an ultrasound in real-time. Residents should do their own ultrasounds in clinic or, if necessary, send them to the clinic GYN schedule.

The GYN resident with the pager will cover ultrasounds in OBT for <16weeks EGA. The MFM resident will cover ultrasounds in OBT ≥16 weeks EGA.

Vacations and Conferences

Vacation

There are fifteen weekdays allotted for PGY 2, 3, 4's and ten weekdays allotted for PGY 1's. Five additional days are allotted per year for job or fellowship interviews (PGY III &/or PGY IV years). Any PTO days not used by the end of the academic year will not carry over to the next academic year and will not be reimbursed. Please plan early, making appropriate coverage arrangements, and follow the steps outlined below and on the PTO approval form (located on-line or in the Dept). Half of your vacation days should be scheduled by December 31st. Half of your vacation days should be scheduled from January 1st to June 23rd.

The resident may **request** off weekends before and/or after his/her week of vacation. Requests are granted on a first come basis and cannot be guaranteed.

Vacation requests must be submitted to the department for approval. While there a multiple people that must be notified, official approval is made by the Program Director. No plans should be made until official approval by the Program Director. Please plan well in advance, i.e. before the next eight-week call schedule has been finalized. You must also notify clinic to block your schedule and your rotation commitments **at least 6 weeks in advance**. All requests for vacation will be given on a first-come first-served basis. Vacation requests cannot be guaranteed and will depend on keeping appropriate coverage. You must notify the service you will be on of your proposed vacation. You will also need to consider any other coverage responsibilities you would have while out and assure proper coverage &/or notification has been given (i.e. diabetic, oncology, ultrasound, pediatric, etc).

The Department must be notified of vacation time, or time off service, even when a resident is on an off-service rotation.

The Department must be notified of sick time that is taken even when a resident is on an off-service rotation.

Do not make <u>any</u> travel arrangements/deposits/commitments until written approval has been granted.

Conference

Conferences can be taken during each of the PGY 2, 3, and 4 years for a total of 5 weekdays.

Residents are recommended to attend a course with material relevant to the practice of general OB/GYN or a board prep conference. Those with CREOG scores ≤ 190 [overall or by PGY year] will need to select board review courses for their conference selections.

Conference requests must be submitted well in advance, i.e. before the next eight-week call schedule has been finalized.

Days of the conference plus one extra day of travel = number of days of requested leave permitted (not to exceed 5 weekdays)

Conference tuition, as well as modest travel, lodging, and meal expenses will be subtracted from each resident's educational fund.

All appropriate hospital and departmental travel policies and procedures must be followed. Failure to so will jeopardize reimbursement.

Leave Request Approval Protocol

A vacation or conference request form must first be submitted to the Department (sign offs will be obtained from the services you will be on, Clinic, the Chiefs, and then finally by Dr. Schnatz). Dates of leave are allotted on a first-come-first-served basis. You must obtain and confirm coverage for your appropriate clinics, i.e. diabetic, oncology, ultrasound, etc.

You must contact the clinic and inform them of your time off at least 6 weeks in advance.

Approvals are not complete until signatures from a Chief, the service attending, the Clinic scheduling staff, and Dr. Schnatz are affixed on the leave request form. The completed leave request form will reside in the residency program files. Once approval is complete, the time off will be added to the New Innovations time off calendar and to the outlook calendar, which will notify the resident that their request is officially approved.

The American Board of Obstetrics and Gynecology requires that any time away from the Residency (maternity, health, vacation, etc.) in excess of 12 weeks in any of the four PGY I-IV years be made up , thereby extending that resident's training program (length of residency program). (Maximum of 24 weeks total over the four years).

Additional Leave and PTO Considerations

DO NOT make travel arrangements until ANY time away (conference, PTO/vacation, leave, interview, etc) has been approved. Vacations or conferences **are not permitted** during the following times:

- Vacation permissible during Ambulatory Rotation if three residents are assigned to ambulatory, one may be off at a given time. Must give at least six weeks' notice, and the third clinic resident, or another resident, must be available to cover.
- Vacation is permissible during OB rotation for 1-2 days at a time.
- All other vacation requests will be considered if coverage is available.
- No more than 1 Chief is permitted to be away at a time, unless for approved conference or board review courses or other unusual circumstances approved by the Program Director.
- While the end of June, July, December, and the 1st week back in January in general are more difficult times, requests will be considered, but guarantees cannot be made. (The end of June and during the Holiday Schedules are generally not possible).
- No more than 1/3 of the weeks off any subspecialty can be taken off over the 4 years.

Sick Days or Other Unplanned Time Away

Any resident who feels ill enough to stay home or has another urgent matter must contact ASAP:

- Terri Chervanick and/or Dr. Schnatz by cell phone (call or text) is best if after business hours. Make sure you get a reply.
- The Chief Resident on call also needs to be notified, either by Dr. Schnatz/Terri or the resident after discussion with the department.
- These calls should be made as quickly as possible. Please do not wait until the next day to make this call as it delays arrangement of appropriate coverage.

Please refer to Hospital Policy for further information.

Journal Club

Journal club occurs monthly during morning conference. One research journal article is selected by the resident(s) assigned to Journal Club that month (usually 2 per month). The article(s) presented should be a research article selected from the ABOG MOC list. The current ABOG MOC list can be found on the medical library webpage. Please select and send your article to Terri Chervanick for approval and distribution to the department one month prior to your scheduled session. If not selected in a timely manner, the department will select an article for you. The journal club schedule is sent out at the beginning of the academic year which notates which month you will be presenting. For your exact presentation date, please contact Terri.

The journal club review forms and a sample article can be found on the Q: drive under "Residency Program" > "Journal Club". Please follow this format for the presentation. The articles should be read and interpreted thoroughly by all participants. Residents should be prepared to discuss the study design, results, significance of conclusion, etc.

Dictations, Procedure Documentation, and Credentialing

Operative notes should be dictated within one hour of procedure completion. Procedures need to be entered in the ACGME website on a weekly basis (ideally daily, but at least weekly).

Levels of involvement:

- >50% involvement in the case qualifies as COMPLETE MANAGEMENT – Surgeon.
  30-50% involvement qualifies as OPERATIVE MANAGEMENT – Assistant.
  <30% involvement qualifies as SURGICAL ASSISTANT – Assistant.

- TEACHING assistant involvement includes a case where a higher-level resident did a significant portion of the case, was helping provide guidance and instruction, and is more proficient in the case than the lower level resident.

ORANGE cards: It is the resident's responsibility to submit to the attending physician for purposes of procedure scoring and credentialing of surgical skill sets. You should make sure to get as many orange cards as possible and at least some (or as many as possible) of all the procedures on the cards – even the "simple" procedures. The cards should NOT be handed back to a resident, but the attending should submit them to one of many orange card boxes.

The numbers needed for certification is listed in a separate document. Each resident, however, must at least attain the minimum number of cases as surgeon to graduate.

The following "simple procedures" must be signed off by an attending, an upper year resident that is signed off, or a non-physician provider via intern "pink card", before this procedure can be done without supervision. These include: IUPC insertion, Fetal Scalp Electrode Placement, Cervical Exam, Artificial Rupture of Membranes, Foley Bulb Placement, Pelvic Exam, Breast exam, IUD insertion, and Endometrial biopsy

Scheduling

Conference

Second and Fourth Wednesday of every month is Tumor Conference.

Chiefs meeting and Director's Meeting are held monthly.

OB stats occur monthly and GYN Stats occur on alternate months, usually a Monday. During the "STATS" presentation, a brief overview of the stats will be presented, and then approximately 3 cases will be presented by the resident involved in the cases (5-minute presentation and 10-minute discussion). The individual cases will ideally be presented by the resident involved in the case.

Simulation sessions will be done one day each month and according to the by year schedule.

Each resident is responsible for one departmental talk along with OB and GYN cases as assigned by the chief residents.

Call Scheduling Considerations

Complete in twelve-week intervals. The schedule must be completed and finalized one month before the next block. The call/scheduling Chief must approve the schedule prior to distribution.

Making the Call Schedule:

- Print out the calendar template for that block. Fill in holidays and long weekends.
- Check rotation schedule and previous call schedule.
    - Check previous call schedule for weekends and days on call so that nobody ends up doing five weekends in a row, or two or three days in a row.
    - Black out Night Float for the relevant block. Make sure that Night Float has the weekends BEFORE and AFTER off.
- Fill in as appropriate the APPROVED vacations and conferences.
    - Master schedule is available in Chief's office. Confirm with Chiefs if unsure. Never assume; make sure you have a copy of the APPROVAL.
- Consider and fill in requested off days and weekends as appropriate.
- Fill in weekends.
    - Avoid more than two or three consecutive weekends or all Friday/Sunday or Saturday; a much-appreciated courtesy whenever feasible.
- Fill in weekdays (1700-1900 hours Short Call).
- Assure that equal stats are maintained (as best as possible).

- Establish a single Stat sheet that is the responsibility of the person scheduling call to update.

Each resident is responsible for tracking their duty hours.
If you are approaching a violation of work hour requirements, you must notify Dr. Schnatz and/or Terri Chervanick. If you have hours worked from home, please report them to Terri.

Rotation Scheduling Considerations

OB Team includes: 3 residents (with at least one chief or functional chief), an MFM resident, and often a medical student.

GYN Team consists of at least 3 residents (A GYN Chief [or functional chief] and at least one additional resident.

UROGYN: PGY3 or 4.

Oncology: There is always at least a PGY3 or PGY4 on the Oncology service.

MFM: PGY 2 or 3.

ELECTIVE: one block for PGY3. (See description and requirements above)

REI: Check Dr. Minassian's office schedule for times.

Schedules and blocks turn over on Mondays.

The January block will start on the Monday closest to New Year's Day.

Holiday Weeks: last week of December block, first week of January.
Look at previous year's schedule if you need help.

Intern Off-Service Rotations: Have the department send memos to departments so they know when to expect a resident to rotate.

MEDICAL KNOWLEDGE AND SKILLS ASSESSMENT:

CREOG Scores (in conjunction with other testing, clinical knowledge, and skills assessment)

Residents are expected to be supplementing their on-service experience with at home regular reading and skills acquisition. CREOG scores less than 200 have been associated with a high likelihood of failing the written board exam. Your goal should be over a 210 on the CREOG in-service examination by year score:

1. Those with CREOG scores ≤ 190 [by PGY year], along with other metric assessments, will be put on academic remediation ("Remediation"). A repeat score in the same range (either on CREOG or a similar interim progress examination) will result in being placed on academic probation ("Academic Supervision"). A failure to remediate from academic probation could result in dismissal from the program.

Those with CREOG scores ≤ 210 [by PGY year] will need to select board review courses for their conference selections.

Fundamentals of Laparoscopic Surgery (FLS)

PGY1 residents are required to pass the FLS exam by February 28thin their first year of training. This is required to move onto the PGY2 year. If the exam is taken and passed within the first year of training, the department will cover the cost. It is recommended that you begin preparing for the exam early! Terri Chervanick will order a voucher for you at the start of the year, as there is some lag time to getting it. It is valid for the entire academic year. A voucher is required to sign up. Spots fill up quickly, so once you have the voucher, it is recommended you sign up immediately for a time slot. Pick a slot allowing you time to prepare, but early enough

to give you time to retake if needed and still complete on time. There will be simulation sessions throughout the year, but you will also need to be practicing on your own. If you do not have the appropriate supplies to practice in the simulation lab, please contact Terri to see if more supplies are in stock or if we need to order more. The skills assessment times (Form given to you by Terri & reviewed with a current PGY II) should be handed in by the end of July, Aug, and September.

Reading Hospital
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Resident Accountability Agreement

By signing this page of the attached Resident Manual:

_____ I agree to read and comply with the rules, protocols, and guidelines contained within the Resident Manual.

_____ I am accountable for my own compliance with such rules, protocols, and guidelines. Failure to do so may result in disciplinary action, probation, and/or suspension of privileges.

_____ I am responsible for responding to requests communicated through email and Hospital mail located on R2S.

_____ I must successfully complete Step 3 USMLE or COMLEX Level 3 by March 31st of my PGY1 year. I understand that successful completion is required to advance to PGY2. I am responsible for arranging plans to take this exam on time.

_____ I must complete a research project to be presented orally and submit a written version to successfully graduate.

_____ I understand my 3rd year elective will be used to complete my research if I have not kept up with the required timeline.

_____ I understand that I am required to complete a quality improvement project to successfully graduate.

_____ I agree to get approval for vacations, conferences and my elective before I make reservations.

_____ I am responsible for weekly submission of procedure stats (absolutely no more than two weeks between stat submissions to ACGME Website).

_____ I agree to address all medical records in a thorough and expedient fashion. All operative notes will be dictated immediately after the procedure. Discharge summaries will be dictated on the day of the patient's discharge. Delinquent medical records represent a medical liability and are unacceptable.

Print Name:_____

Signature: _____

PGY Year: _____ Date: _____