

**Department of Obstetrics and Gynecology
Resident Manual**

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360 Focused Assessment of Competency
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Residents Evaluate Faculty
Residents Evaluate Program at the End of the Year
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Department of Obstetrics and Gynecology
Residency Program

Mission Statement

The Obstetrics and Gynecology residency program of the Medical College of Georgia is an institutional leader in resident education. It provides the environment in which residents will master the principles of Obstetrics and Gynecology. The residency program will prepare its graduates to practice independently, act as expert consultants in their medical community, enter subspecialty training or academic medicine. The residents act as teachers of, and role models for, the physicians of the future.

Manuals on the World Wide Web

The MCG Graduate Medical Education House staff Manual is posted to the World Wide Web, and can be found at <http://www.mcg.edu/resident/HSPolicies/documents/Manual080706.doc> . You will find information on benefits and services available to residents, as well as various departmental protocols.

The Department of OB/Gyn Housestaff manual is also posted to the World Wide Web, and can be found at:

<http://www.mcg.edu/SOM/OBGYN/PDF/2005-06%20HS%20Manual2005.pdf>

The Department of OB/Gyn has a website:

<http://www.mcg.edu/SOM/OBGYN/INDEX.HTML>. This website has many links to sites that are of importance to residents in our training program.

ACGME Competencies

Identification of general competencies is the first step in a long-term *effort* designed to emphasize educational outcome assessment in residency programs and in the accreditation process. The American College of Graduate Medical Education's (ACGME) Residency Review (RRC) and Institutional Review Committees (IRC) have incorporated the general competencies into their requirements. The following statements are used as a basis for future Requirements language. If you have any questions, comments and other requests for assistance, please address them to <http://www.acgme.org/outcome/comp/compMin.asp>

Evaluation of all competencies is performed in the department's current methods of resident evaluations.

ACGME GENERAL COMPETENCIES Vers. 1.3 (9.28.99)

The residency program must require its residents to develop the competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

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. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans counsel and educate patients and their families
- use information technology to support patient care decisions and patient education

- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE

Residents must demonstrate 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. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

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. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

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. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory , questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM

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

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities. Speak to and treat respectfully patients and their families, ancillary and nursing staff, medical students, attending physicians, and fellow residents

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. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

INTRODUCTION

It is necessary to monitor and track each resident's experiences. This is needed to ensure quality of education, to ensure an adequate case experience volume, and to allow the ACGME to review and audit this information. Additionally, this data will be used in regular evaluation of residents for promotion and credentialing. The fact that one is credentialed in a procedure indicates that such resident has been taught the principles and technique, observed in performing that procedure, and deemed competent in performing that procedure independently. **Thus, when entering practice, credentials are required in each procedure in order to practice medicine. It is therefore imperative that each resident is given credit for every procedure they perform.**

The Resident Case Log System is an Internet-based data collection system utilizing CPT codes. The system was designed to permit residents to enter procedures on a regular basis at their convenience. Data may be entered from any PC connected to the World Wide Web. The site is secured by an encryption certificate obtained through the Verisign Corporation.

The RRC office provides each program director with a "Username" and "Password" to access the collection. The program enters program specific information such as residents, attending physicians, institutions, and users. Access to the system is available through most commonly used Internet browsers and providers, such as Microsoft Internet Explorer 4.01, Netscape 4.0, AOL, and Prodigy. No special download is required.

COMPLETION

Residents are expected to maintain their case logs on a daily basis. It requires a minimal amount of time to record a case into the system. Ambulatory lists are recorded as numbers of encounters per day (ie number of visits for hypertension, breast problems or abnormal uterine bleeding). It is strongly encouraged to enter your ambulatory numbers at the end of each respective clinic. To locate the web site log onto <https://www.acgme.org/residentdatacollection/>

COMPLIANCE

All of the resident's case logs will be monitored on a weekly basis. Residents who are delinquent may be subject to dismissal from operative duties or all clinical duties until such

records are updated.

HELP

The on-line “Help” menu is easy to understand and quite helpful.

For additional questions or trouble-shooting, contact:

Kathy Kline – Residency Coordinator, 1-2541

ACGME Help Desk (312-755-7125)

Departmental Compliance Overview

Professional conduct as a resident physician includes various record keeping and data tracking requirements. These requirements are outlined below. These requirements serve multiple purposes including and not limited to efficiency in patient care, procedure credentialing, hospital revenue, resident funding, and residency program development.

- Medical records completion
- Timely dictation of operative/discharge notes
- Regular completion of logged time
- Regular updates to the ACGME Case Log
- Timely completion of required evaluations.

Medical Records

It is essential to complete medical records at the time of the patient encounter (for example, dictating the discharge summary at the time the patient is discharged). Powerchart office allows for completion of medical records online. Powerchart Office instruction is available at orientation for the GME and on an individualized basis with additional need. Powerchart Office allows for notification of pending documentation, such as discharge summaries or operative reports, and records requiring signature for completion. Health Information Management Services (HIMS) is located on the Mezzanine level of the Ambulatory Care Center. For questions or concerns regarding medical record completion or assistance, contact HIMS staff by calling **1-3050**.

Deserving of emphasis is the expectation that operative dictations need to be completed immediately after the completion of the procedure. Please refer to the GME manual, section M 4.0, for a basic policy on Medical Records for MCG residents.

<http://www.mcg.edu/Resident/HSPolicies/m40.htm>

The department chairman receives a weekly report of who is on the delinquent list of medical records. Residents who repeatedly are on this list will face recourse as outlined at the bottom of this section.

Time Logged

Logged time needs to be completed on a weekly basis. The Program Director and Program Coordinator review these weekly. Furthermore, the hospital Director of Graduate Medical

Education reviews these on a regular basis. These reports are also an important part of the hospital compliance reports. Please refer to One45 to report your time at <https://www.one45.ca/georgia/index.php>. Residents who fail to maintain their time will face recourse as outlined at the bottom of this section.

ACGME Case Log

Regular updates to the online case log should be done on essentially a daily basis. Residents can sign on from any computer to enter cases at <http://www.acgme.org/acWebsite/home/home.asp>. This data is used by the RRC to verify your training experience and is being utilized more commonly by hospitals after your graduation to determine your credentialing status. Residents who fail to maintain their case logs will face recourse as outlined at the bottom of this section.

Evaluation Completion

Feedback about your rotations, the faculty, and the program are very important to the development of the curriculum. Automated email reminders are sent out when you have evaluations that are due. Please refer to One45 to complete your evaluations at <https://www.one45.ca/georgia/index.php>. Failure to complete these evaluations will result in recourse as outlined at the bottom of this section.

Non-Compliance with Departmental Tasks

Delinquency in the above tasks will not be allowed. Completion of these tasks is a part of your duty to the Competency of Professionalism as well as to the Competencies of Patient Care and Systems Based Practice. Additionally, your completion of these tasks is a testament to your dedication. Residents who are repeatedly delinquent will be subject to disciplinary measures which may be one or more of the following:

- Verbal or written reprimand from the Program Director or Department Chairman.
- Written reprimand which will become part of your permanent file.
- Removal from clinical duties until completion of given task.
- Loss of annual leave time.
- Academic remediation, the time and terms of determined by the Medical Education Committee
- Possible dismissal from the program for non-compliance after placement on

academic remediation.

Please refer to the GME manual, section HS 3.0, for a basic policy on Non-Renewal of Contract for MCG residents. <http://www.mcg.edu/Resident/HSPolicies/policy3.htm>

Professional Conduct

As a member of the health care team, your interaction with the patients and their families will often exceed that of more senior members of your team. Accordingly, you are required to meet certain standards of professional decorum.

Dress

Residents are expected to wear clean white coats with name tags at all times. Failure to wear your name tag may result in lack of admission to the hospital, or various secured areas within the hospital. Without exception, dress in patient care areas should be in a professional manner. Surgical scrubs should only be worn on the Labor and Delivery deck and Operating Rooms. If you must leave one of these areas briefly, a white coat should be worn over the scrubs. Tee-shirts, sweat tops or other such clothing is not appropriate. Scrubs should not be worn to the ACC. Please refer to the GME manual, section HS, for a basic policy on Personal Appearance for MCG residents.

Punctuality

Residents are expected to be present and on time for all rounds, conferences, didactics and other scheduled activities. If a resident must be absent from or late to your usual activities for any reason (illness, car trouble, family emergency, jury duty, etc.), it is their responsibility to contact their Chief Resident, the Administrative Chief Resident and the Program Coordinator at ext. 2541.

Failure to present and conduct yourself in a professional manner may result in:

- Dismissal from the clinic/operating room
- Loss of annual leave time
- Documentation of such in evaluations
- Academic remediation for repeated problems
- Dismissal from the program

Resident Promotion and Tenure

The Departmental Resident Education Committee meets on a regular basis at which time various aspects of resident education are discussed. The committee members are as follows:

- Program Director
- Associate Program Director
- Undergraduate Clerkship Director
- Associate Undergraduate Clerkship Director
- Faculty Advisors to the Residents
- Research Advisor to the Residents
- Administrative Chief Resident
- A 3rd year resident nominated by the residents

The committee affords a venue to review resident performance, the educational curriculum, or any other feature of residency program that may affect the residents' daily activities. Suggestions are constructed by the members and then proposed to the Department Chair for approval. The committee gives high consideration to input from both faculty and residents prior to recommending any changes to the resident curriculum.

The committee also reviews resident progress on a semi-annual basis. This is done to ensure both satisfactory progression in achieving their educational goals and to identify areas that may need improvement. Based on those reviews, the committee will recommend promotion (at the end of a given academic year), or academic remediation. Additionally, at any time during the year the committee has the responsibility to review the performance of residents who receive substandard ratings or about whom significant concerns have been raised by faculty or by other residents.

Each resident will have approximately four formal reviews during the academic year. Reviewed during these meeting are the rotation evaluations and the resident's progress towards completion of residency. The resident will have the opportunity to discuss the evaluations, case logs, the CREOG In-Service Exam results, oral examination results, career plans, and recommendations. The schedule for formal resident review is as follows:

Semi-annual review with yearly advisor (1st and 3rd quarters)

Semi-annual review with program director (2nd and 4th quarters)

A resident may be placed on academic remediation if that individual fails to correct deficiencies noted during formal reviews and/or demonstrates substandard performance on the CREOG In-service exam and/or Oral examination. The CREOG exam may not be used solely as a basis for resident dismissal or promotion. Scores on the CREOG exam below 2SD compared to that resident's year are considered significantly low scores and may merit the recommendation of a specific remediation program from the Medical Education Committee. Documented matters of continued unprofessional behavior are subject to consideration for remediation by the Medical Education Committee. A resident undergoing academic remediation will be assigned a mentor who will outline and monitor a remediation program. This is expected to be assigned reading about which the mentor will formally test the resident or administer a second comparable examination. The mentor will then advise the Program Director when this remediation has been satisfactorily completed.

A resident on remediation who receives a second unsatisfactory evaluation is subject to dismissal. The Medical Education Committee will decide whether the resident should continue in the program, be suspended, or be dismissed. Before action is taken against a resident, the resident will be advised in writing of the contemplated action. An appeal may be made to the Department within 10 days of formal notification. An ad hoc committee consisting of chosen members of the Education Committee will hear the appeal and make a recommendation to the full Medical Education Committee. The resident will be advised in writing of the right to appeal any adverse decision to the Dean or DIO of the School of Medicine.

Upon successful completion of the year, academic remediation is automatically lifted. The Medical Education Committee may recommend removal of remediation based on review of that resident's successful progress during the period of remediation.

Disciplinary action may also be taken for unnecessarily endangering the life or health of a patient, chronic failure to complete assigned duties, tardiness, unexcused absence from official

duties, substance abuse, morally objectionable behavior, or behavior detrimental to the residency, the Department, or the Medical College of Georgia. The Medical Education Committee bases action recommended and taken on individual review of the circumstances. Remediation, dismissal or recommendation to repeat a year of training may result. Appeal of this action follows the same procedure as noted above for academic remediation.

Please refer to the GME manual, section HS 13.0

<http://www.mcg.edu/Resident/HSPolicies/policy13.htm> for a basic policy on housestaff grievance for MCG residents.

House staff Grievance

Purpose

To establish guidelines for departmental decisions concerning evaluation and advancement, disciplinary action, or grievance issues.

Policy

This policy describes the Institution's involvement concerning Departmental policies and decisions taken with respect to academic evaluation and advancement, disciplinary actions, and/or grievances issues on the part of House staff and outlines an appeals process which may be used by House staff in case of Departmental decisions adversely affecting their training or professional standing. For the purposes of this policy, "House staff" refers to the interns, residents or fellows enrolled in an MCG Graduate Medical Education Program. The "Department" refers to the clinical Department in which the House staff's training program resides. The "Institution" refers to the Medical College of Georgia. Please refer to the GME manual, section HS 13.0

<http://www.mcg.edu/Resident/HSPolicies/policy13.htm> for a basic policy on housestaff grievance for MCG residents.

Oversight

Oversight refers to the Institution's review of Departmental policies and procedures. Each Department will be required to furnish the Dean of the School of Medicine with a current copy of the Resident's Manual. This manual must contain statements of the department's evaluation, promotion, due process and grievance policies. The Dean, through the Assistant Dean for Graduate Medical Education and the Graduate Medical Education Committee, will review these documents to determine that they are appropriate, and that they provide clear guidance to the House staff as to how matters of advancement, non-renewal of contract, disciplinary action, and grievances are to be handled. The GMEC may recommend acceptance or modification of these Departmental statements. When disciplinary action is considered for House Officers on duty away from the Department, the responsibility for disciplinary action is with the department where the House Office performs the rotation.

Appeals Procedure

After a Departmental decision has been made, the House Officer may appeal decisions to the Dean of the School of Medicine within 10 working days after being notified of the Chairperson's final decision and the reason the House Officer is asking that the decision be reversed or modified. The House Officer may or may not remain on duty during the appeals procedure depending on the nature of the issue involved. The Department, upon becoming aware that an appeal is being made, will advise Hospital Administration, through the appropriate Assistant Hospital Director, of such appeal.

Within 5 working days after receiving the written appeal, the Dean shall refer the matter to an ad hoc faculty committee of 3 persons who shall review the appeal and make recommendations to the Dean within 10 working days. The Dean shall review the recommendation of the committee, render a final decision and notify the House Officer and the Chairperson of his/her Department in writing within 5 working days of receiving the committee's recommendation. Within 10 working days of the date of the Dean's written decision, the House Officer may submit an appeal in writing to the President of the Medical College of Georgia. Within 10 working days the President shall advise the House Officer in writing of his/her final decision. The President's decision may be appealed to the Board of Regents under Article IX of the Bylaws of the Board.

Medical Liability Cases/Quality Assurance

Sometime during the residency you may be notified that an attorney has requested the chart on a patient that you have taken care of. You may be named as a party in a professional liability suit.

The best solution is prevention:

1. Work within your sphere of competency.
2. Consult freely and as required with more senior colleagues and assigned faculty.
3. Document the chart well with appropriate, timely, progress notes.
4. Notify the Program Director of all requests for charts or legal complaints (notices of suits) or subpoenas.
5. Request that a copy of this notification be sent to:
 - a. Mr. Andrew Newton, Senior Legal Advisor
 - b. Executive Director, Physician's Practice Group
 - c. Hospital Administrator

It is imperative that all of these offices be notified so that your legal rights can be protected and the insurance carrier notified.

6. Under no circumstances should you discuss the care with the plaintiff's attorney without the explicit permission of your MCG attorney. It is best not to discuss the circumstances of the care with anyone except your assigned attorney.

On occasion an attorney will want you to write a letter or call requesting information regarding a particular patient. Consult with your attending in all cases. Requests for non-routine information on a patient should be referred to Mr. Newton, Senior Legal Advisor.

Once a suit has been filed, it may last for a considerable length of time. During that period you may have to answer a lot of questions (interrogatories) and give a deposition. Your attorney will help you. Please keep us informed of the progress of the suit. We need to know, if we are to help.

7. The professional liability insurance provided for you during the residency only covers you for official residency duties related to professional liability. It does not cover other civil or criminal actions. Coverage continues after the end of the residency for claims arising from incidents that occurred during your residency. The insurance carriers are "The Medical Association of Georgia Mutual Insurance Company", and the "Georgia Department of Administrative Services"

Resident Advisors

The resident advisor is an MD faculty member who serves as a mentor to Obstetric and Gynecologic residents. The Ob/Gyn chair of the department will serve as the advisor to all first year residents.

The intent is to provide guidance, discipline, inspiration and to develop a sense of class cohesiveness and loyalty resulting in a mature, fully-trained Obstetrics and Gynecologic physician.

The advisor will be selected by the resident class, with the approval of the program director, during the PGY-2. The program director can not be selected as an advisor, he/she must be available to all the residents.

Advisor Responsibilities

The advisor may use any resource necessary to meet the listed objectives.

1. The advisor will review each resident's monthly clinical activities report and faculty and section evaluations. The department resident manual, CREOG Education Objectives, the CREOG In-Service Examination report, ACGME procedure log, One45 site for resident evaluations, and the weekly incomplete/delinquent medical records reports are potential information sources for expected performance standards and deficiencies. Formal reviews are to be held every six months with a completed evaluation form to be kept in the resident's training folder.
2. The advisor serves not only as an advisor, but also mentor, and should recognize excellence as well as areas for improvement therefore encouraging the maximum potential for education and preparation for post-residency achievement.
3. While the advisor has the responsibility of identifying academic deficiencies, he or she will also aid in the identification of other problems of a non-academic nature. The advisor will offer counsel and if necessary, provide alternatives for dealing with these problems directing the resident to other resources.

4. The advisor reports to the program director areas of concern regarding the progress of individuals. The program director will also report to the advisor areas of concern. Potential solutions and management plans should be jointly established and monitored.
5. Both formal and informal group sessions between the advisor and the resident class are encouraged.
6. The advisor may represent the resident in any department disciplinary action.

Resident Awards

In order to promote excellence in residency education and as a reward for academic and personal achievements during the residency in Obstetrics and Gynecology at the Medical College of Georgia, five awards will be given according to established guidelines. Certificates will be given for each award and all award values may vary from year to year. These awards are: 1) Virginia Zachert, Ph.D. Award 2) The Donald M. Sherline Award 3) The Professor C. Iverson Bryans, Jr., Award, CREOG 4) The O. Eduardo Talledo Executive Committee Award and 5) The Richard Torpin Faculty Award.

1. Intern of the Year This award is given annually to a first year resident (PGY-1). This award is given to the resident with the highest % on their yearly evaluations.
2. Resident of the Year Award. This award is given annually to the resident exemplifying the spirit of the Obstetric and Gynecologic Residency Program at the Medical College of Georgia. Nominations are made by the MCG Students.
3. CREOG Award. An award will be given to the resident who obtains the highest score equal to or greater than two standard deviations above the mean for their year on the CREOG In-Training Examination.
4. Administrative Chief Resident Award: This award is given annually in recognition of the work and dedication of the administrative Chief Resident.

5. Faculty Teacher of the Year Award: This award is given annually in recognition of excellent resident teaching in Obstetrics and Gynecology. Nominations are made by the Residents.

These awards will be announced at the Annual Resident's Day Dinner in June, or at another suitable time as determined by the Residency Program Director.

Chart Dictation

The following information is provided during first year resident orientation concerning what charts need dictating.

OB - antepartum admissions, stillbirths, multiple births, deliveries enroute or admission for postpartum care only, complicated deliveries, mothers who transferred from or to another in-hospital service, hospital stays greater than 6 days or maternal deaths.

GYN - complicated admissions, patients who transferred from or to another in-hospital service, hospital stays greater than 6 days or patient death.

The timely completion of medical records is an integral and required component of health care. Residents are expected to complete charts in a timely manner. Procedure dictations should be performed as soon as possible after the completion of a procedure, and certainly within 24 hours. Discharge summaries should be done on the day of discharge. Residents are expected to complete all medical records prior to annual leave. If a resident is unable to complete outstanding medical records (sick leave, maternity leave, etc.), this should be done immediately upon return to the hospital.

Operative notes are to be dictated immediately following a surgical procedure. Under no circumstances should more than 24 hours elapse for dictation of an operative note; therefore, no resident should be on the delinquent list for undictated operative notes.

Delinquency of medical records affects the resident as well as the responsible attending. Non-

compliance with chart completion by the resident or the attending may result in loss of admitting and operating privileges for that attending. Loss of privileges may appear on one's permanent record.

Non-compliance with medical records by the resident staff is a serious offense and will not be tolerated by the department or the hospital. Consequences may include:

Loss of operating privileges until completion of records, and subsequent effect on evaluation

Dismissal from clinical duties (and subsequent loss of vacation days) until completion of medical records

Placement on academic remediation

Statements in their permanent records reporting poor compliance

In compliance with MCG's House staff Delinquent Records Policy M.4.0, a resident's salary may be withheld if-

- Any operative report is more than 30 days delinquent
- More than one discharge summary is more than 30 days delinquent
- 5 or more incomplete records for more than 30 days

Lack of endorsement from the department when seeking privileges in practice

Dismissal from the program

See GME House staff Delinquent Records Policy M.4.0 for complete policy at

<http://www.mcg.edu/Resident/HSPolicies/m40.htm>

How do I send a page?

The new pagers are simple to operate. Some basic user information follows:

To send an Internal Page: campus/hospital

1. Dial 1-PAGE (1-7243).
2. The system's automated attendant will ask you to enter the 4-digit pager number (person you are paging).
3. You will then be asked to enter your call back number (your pager number or dept.)

To send an External Page: outside of campus/hospital

1. For local calls, dial 721-PAGE (721-7243).
2. For long distance, dial (706) 721-7243 or
3. The system's automated attendant will ask you to enter the 4-digit pager number (person you are paging).
4. You will then be asked to enter your call back number (you pager number or dept. phone number).

How do I change my pager options?

Dial 1-7243, listen to recording, then enter your individual 4-digit PIN (pager ID) followed by (# * 1#). This will put you into the setup mode for your pager, where you can choose from the following options, you also will be asked to enter your password. Generally your password will be your four digit PIN.

- a. Press (1) to change pager status
- b. Press (2) to retrieve messages
- c. Press (3) to change personal greeting:

Personal greeting: If there is a long pause after taking out your name or message, go back to the menu, press 3 to change greeting. Press the #key immediately to get rid of the pause. To delete greeting: press 3 and immediately the #key, then add new greeting.

- d. Press (4) to add/change security code (your PIN is your security code)
- e. Press (5) to repeat menu options

Options-

- Press 1** **available**
- Press 2 available wide page
- Press 3** **not available**
- Press 4 not available, message stored
- Press 5 in meeting until
- Press 6 not available but can be reached at xxx-xxxx
- Press 7** **not available, covered by 1-xxxx**

It is strongly encouraged that you sign out your pager when you are not on duty (ie vacation, not on call, etc.). This prevents other physicians, staff, and ancillary services from trying to reach you when your pager is still signed in. When returning don't forget to sign your pager back in.

Code Pages

Code pages will still be sent through the Code Paging Operator (1-2222)

Additional information:

All pager numbers share the first seven digits: 721-7243. The following four numbers reflect your PIN or personal paging number.

It is critical that the pager list at the nursing stations reflect your **nine-digit** pager number. (i.e. 1-7243-xxxx)

To reach the paging operator, dial 721-3893.

Alpha instructions from Groupwise

Step 1: In the To: (Box) – Type: 1Pagexxxx (x's indicate page number)

Step 2: Go to text area and type message (message can contain only 120 characters).

Fringe Benefits

1. **Insurance:** Medical and malpractice insurance.
2. **Lab Coats:** Housestaff will receive two (2) lab coats at the beginning of the residency and one additional coat each year. This is not to exceed \$50.00 per coat.
3. **Graduation:** A graduation event will be held every June. The graduating chiefs will be invited to bring 3 guests. The remaining housestaff will be invited to bring one guest to this event. Anyone wishing to bring additional guests is strongly encouraged to do so with the understanding that each additional guest will be charged the cost of the meal. This payment will need to be remitted prior to the date of the event. Guests slots are nontransferable (housestaff who are not using all allotted guest slots may not reserve a slot for anyone else).
4. **Senior Resident (Chief) time off at the end of June:** The business week prior to the OB/Gyn Boards (last Monday of the month) may be used as study time. The chiefs will be available for team emergencies, but no call or clinic responsibilities will be scheduled (i.e. they will maintain pager contact and be in the vicinity of the hospital during that week). Any days following the Boards will be used to update stats and complete exit responsibilities prior to departure. Residency Certificates (diploma), as well as paychecks, will be held until the last day of June and/or when all paperwork is complete.

For residents entering fellowships programs beginning on July 1 following graduation. Permission may be granted for leave in the final week of June for travel. This provision is subject to approval by the Program Director. Residents wishing to utilize this provision should maintain either annual leave or educational leave time to accommodate the absence.

5. **Educational Leave:** During the third year each resident will be encouraged to attend a post-graduate course or meeting in the continental United States. Third year residents are

encouraged to take up to three (3) days of education leave to attend a meeting or course, or to interview for jobs or fellowship. No reimbursement is available for this travel. Unused leave does not carry over to the forth year.

Each fourth year resident may take up to five (5) educational days to attend a major meeting or educational course. PGY-4 residents receive a total of \$1500 in educational allowance. This may be used for attending meetings or courses, purchasing books, or paying for board examinations (see below under #9).

Additional travel and funds will be available to residents who present a research paper at a medical meeting. This must be negotiated in advance with the Program Director. The total leave for a meeting or course is limited to five (5) working days per meeting, regardless of whether attending or presenting at the meeting. All travel is subject to approval by the department chair. Travel must be by the most expedient method. In general, auto travel, as a substitute for commercial air to meetings more than 200 miles distant from Augusta will not be approved.

Residents may chose to use their educational leave for job or fellowship interviews in lieu of attending a meeting or course. No reimbursement is available for this travel. Total educational leave is limited to three (3) days at the PGY-3 level and five (5) days at the PGY-4 level, regardless of number of interviews scheduled. Additional time may be taken as Annual Leave. All such leave must be at the approval of the Program Director.

6. **Annual Leave:** Annual Leave (vacation) is three (3) weeks per year (15 working days). Requests must be made at least **60 days in advance**. This advance notice is imperative to allow adequate time for cancellation of clinics, clinical coverage, notification of operative scheduling, and overall courtesy to both your colleagues and patients. You are advised to spread your annual leave throughout the year. It is recommended that vacation requests be completed for the entire year by July 15th annually. Changes may be made in circumstances when vacation dates require rescheduling on an individual basis. Invariably some residents will wait until the end of the year to schedule vacation and unfortunately

lose part of that vacation time if educational/clinical services will not support the request. Vacation requests are not accepted for the first two weeks of July or the last two weeks of June in any calendar year. Residents should take vacation in one week blocks (as opposed to single vacation days).

All requested leave must be in writing to the administrative chief resident. Clinic personnel will not accept any requests for leave unless they receive notification from the Program Director or Program Coordinator. The Program Coordinator will not forward any requests for cancellation of clinics until the Administrative Chief Resident has indicated approval. Also, all delinquent medical records must be completed the day prior to your scheduled leave. Failure to complete medical records prior to annual leave is equivalent to unapproved leave and can result in disciplinary action.

Restrictions to leave:

- Only one person off from a rotation team at one time
- No scheduled leave during Night Float
- No leave during the CREOG Exam
- No leave during Mock Orals
- No leave during the first two weeks of July or last two weeks of June
- Not more than two residents from any single year off at one time

7. **Sick and Other Leave:** Please refer to the section Policy on Leave for information about this type of leave.

8. **Book Allowance:** Each PGY-1, PGY-2 and PGY-3 resident receives a yearly book or journal allowance of \$125. It must be spent in the academic year allotted. It is recommended that you purchase Williams Textbook of Obstetrics and/or Comprehensive Gynecology. Receipts must be turned in to the Department's Business Office prior to close of the academic year, June 30. Drug Representatives also supply additional books throughout the year.

9. **Licensure:** The Composite State Board of Medical Examiners has issued new guidelines requiring **all** interns, residents, fellows to have a temporary postgraduate training permit to participate in postgraduate medical training program in the state of Georgia (House Bill 1265). This permit must be renewed every year. Please refer to the GME manual, section HS 6.0, for a basic policy on licensure for MCG residents.
- <http://www.mcg.edu/Resident/HSPolicies/policy6.htm>

A \$100.00 fee and the renewal fee of \$50.00 are paid by the Graduate Medical Education office. Refer to the GME website at:
for more information regarding the Georgia medical training permit requirements.

You must have an unrestricted, Degree of Doctor of Medicine or an equivalent degree to practice before applying to the American Board of Obstetrics and Gynecology to take the written examination. This application is due November 30th of the last year of your training.

- 10 **American College of Obstetricians and Gynecologists:** The Department pays for junior fellow membership in ACOG. Membership includes a subscription to "Obstetrics and Gynecology" as well as other benefits. Residents are encouraged to join and to become active in the junior fellow's Georgia Section. Applications are available during resident orientation. All residents are expected to join the local Ob/Gyn organization (Augusta OB/Gyn Society) at no expense to them.

American Board of Obstetrics and Gynecology: Termination of four years of residency ends with the written examination of the American Board of Obstetrics and Gynecology. **Responsibility for initiating contact with, applying for, and taking the examination rests with the individual resident.** The department will allow the reimbursement for the application cost as well as the examination fee for the written examination to be taken out of the PGY-4 educational allowance. This examination is given the last Monday in June. **The deadline for application is November 15th of the senior or fourth year of residency. The deadline for payment of all fees is the following May 1.** **NOTE:** A valid unrestricted license to practice

medicine in a state is a requirement for application. The department is to be notified by you of pass/fail results from the board.

The address of the American Board is:

Norman F. Gant, M.D.
Executive Director
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, Texas 75204

See <http://www.abog.org/> for important information, including deadlines.

Parking

The Parking Services Office is a Bureau of the Public Safety Division. The Parking Office is open Monday through Friday, 8:00 A.M. to 5:00 P.m., and located on 15th Street, (HT Building) Annex II,

All persons that park on campus must register their vehicle. Registration may be done by returning a completed parking registration form (PS 226) to the Parking Office.

Members requiring disabled parking should make a request to the Parking Office. Temporary handicapped parking will be provided to cover emergency or temporary situations.

Dining

Meals on Call

The House staff Dining program is a hospital sponsored meal allowance granted to MCG residents and students taking overnight call. Residents and students participating in this program will be required to use their I.D. Badge to access hospital provided dining funds.

Call rotation dining allowances are determined by the GME office from the departmental call schedule (\$10 week night & \$15 weekend or holiday). Funds are given only for MCG hospital in-house overnight call.

- § House staff Dining funds may only be used in the hospital cafeteria Terrace Dining Room and the CMC McDonald's.
- § Food is available at no cost on the 9th floor housestaff lounge when the hospital cafeteria Terrace Dining Room is closed.
- § Funds are available by the first day of the rotation and any unused balances are purged the 15th of the following month. Funds remain valid a minimum of 2 weeks after the end of the rotation.
- § Funding for each month's call rotation is a separate 'plan' and each plan balance is reported individually. When two (or more) plans are valid, the 'first' plan is used until it expires or reaches a \$0 balance - THEN the 'next' plan is automatically accessed.
- § Personal funds on the card (Express \$ or Dining \$) are accessed ONLY when house staff funds are depleted or when House staff daily limits have been reached. Personal funds on the card DO NOT EXPIRE.

Lost or misplaced cards should be reported immediately to the MCG Express Office at 721-9939 to prevent misuse. Please contact the MCG EXPRESS CARD office with questions concerning your account or plan balance. The manger is paged by any voice mail messages and all pages are answered if/when received.

How can I sign up?

It's easy to open an MCG Express or Dining Dollars account. Just visit the MCG Express Debit Card Office located in the Student Center Bookstore and complete an application. Your ID must be activated in person at the MCG Express Office. There is a one time \$10.00 activation fee to open an account.

Hours of Operation

Monday - Friday 9:00 a.m. - 5:30 p.m.

Phone: (706) 721-9939

The amount of initial deposit depends on your needs. The minimum initial deposit to open an MCG Express account is \$25. The minimum deposit thereafter is \$5. Dining Dollars are deposited in increments from \$100 to \$500 which earn Bonus Dollars from 6 percent to 10 percent of your deposit amount. Bonus Dollars are accessed when your Dining Dollars balance is reaches zero.

Personal Copying

The MCG EXPRESS Copy card is a generic (non-photo) debit card used to access pre-deposited funds designated for photo-copies.

Copy machines with MCG EXPRESS Copy Card access are located in the MCG Library, the Satellite Copy Center (1' floor R&E Building) and the Dental School.

MCG EXPRESS Copy Cards do not use PIN numbers or access codes. A valid card, when swiped through a copy card reader, will credit the maximum number of 99 copies. The copy machines operate as usual and will make any number of copies up to the maximum number. When finished, the user should CLEAR any unused copy quantity remaining. To produce more than 99 copies, simply swipe the card again. (The copiers retain any special settings, i.e., SORT, GROUP, etc.)

Each MCG EXPRESS Copy card is registered to an individual user. To obtain a copy card,

complete a request form and return it to the MCG EXPRESS DEBIT CARD office at DA-102.
There is a one time activation fee of \$5.00

Lost or misplaced cards should be reported immediately to the MCG Express Office (19939/3-8093) to prevent misuse. Cards can be deactivated (and reactivated, if found) by phone. **CARDHOLDERS ARE RESPONSIBLE FOR ALL CHARGES MADE TO A LOST OR MISSING CARD - MAKE SURE YOU REPORT A LOST OR MISSING CARD IMMEDIATELY.**

Replacement cards may be obtained from the MCG EXPRESS office at DA-102. Current cost for a replacement card is \$5.00.

MCG EXPRESS CARD
MEDICAL COLLEGE OF GEORGIA
STUDENT CENTER DA-102
AUGUSTA, GA 30912
(706)721-9939
(706)723-8093

Malpractice Insurance

The following information is provided to you as a brief summary of your medical malpractice insurance coverage. The coverage described below is for *activities that are within the scope of your MCG resident training program* and cover you regardless of whether your activities occur at MCG Hospital and Clinics or at an affiliated hospital. Please note that “moonlighting” activities are not covered under these insurance plans because such activities are outside the scope of your residency.

As a Medical College of Georgia House staff member, you are protected under the Georgia Tort Claims Act (O.C.G.A. 50-21-20 et seq.) from personal liability for medical malpractice claims arising out of the performance of duties within the scope of your MCG employment when such claims are made in the courts of the State of Georgia.

For medical malpractice claims *not* covered by the Georgia Tort Claims Act, House staff are covered by the Georgia Department of Administration Services, with limits of \$1,000,000 per person bringing a claim and \$3,000,000 per occurrence with no annual aggregate.

The Medical College of Georgia and the Physicians Practice Group (AMCG/PPG@) administer a self-insurance plan which provides medical malpractice liability coverage for MCG House staff up to \$250,000 per occurrence. Additionally, the Georgia Department of Administrative Services (ADOAS@) administers a self-insurance plan which provides excess medical malpractice liability coverage for MCG House staff with limits of at least \$1,000,000 per occurrence and \$3,000,000 annual aggregate.

For information regarding your medical malpractice insurance coverage, see the website at: <http://www.mcg.edu/Resident/malinsurance.pdf> or contact:

Mr. Andrew Newton, Vice President for Legal Affairs
MCG Hospital & Clinics
1120 15th Street
Augusta, GA 30912

Policy on Resident Work Hours

The Department of Obstetrics and Gynecology recognizes that education and patient care are integrally related. All graduate medical education programs have a responsibility to the resident to provide training in continuity of patient care. Continuity of patient care addresses all of the core competencies on some level. Please refer to the GME manual, section HS 10.0, for a basic policy on work hours for MCG residents.

<http://www.mcg.edu/Resident/HSPolicies/policy10.htm> The Obstetrics and Gynecology Residency Training Program provides, through its duty hours and call schedules, an appropriate balance between patient care and teaching, in an environment conducive to both. This environment ensures wherever possible that undue stress and fatigue among residents is avoided. The Department of Obstetrics and Gynecology fully supports the Resident Work/hours policy established by the ACGME with the following requirements:

- **A maximum of 80 hours per week averaged over 4 weeks, inclusive of all in-house activities.**
- **Ten hour period of rest must be provided between all duty periods and after in-house call.**
- **One day in 7 free from all educational and clinical responsibilities, averaged over 4 weeks, inclusive of call. One day is defined as a continuous 24 hour period free from all clinical, educational and administrative duties.**
- **Twenty-four hours maximum continuous on-site duty with up to 6 additional hours permitted for patient transfer and other activities.**
- **No new patients after 24 hours of continuous duty.**
- **House officer's time spent in the hospital during at-home call is to be counted toward the 80 hour maximum.**
- **In-house moonlighting is counted toward the maximum 80 hours.**
- **Call is to be no more frequent than every 3rd night, averaged over 4 weeks.**

Adequate backup through resident physicians or supervising faculty physicians will be available and utilized as needed to assure that patient care is not jeopardized by resident stress or fatigue.

Please refer to our Program Level Policy on Resident Supervision and Policy on Resident Fatigue.

Resident training is a full-time responsibility. It encompasses the formal curriculum, the individual learning opportunity through independent study time, and clinical exposure including the service component of patient care. It is MCG Institutional Policy (HS 16.0) <http://www.mcg.edu/Resident/HSPolicies/policy16.htm> that the Program Director must be informed, and approve of activities outside the educational program (i.e., moonlighting). Please refer to our Program Level Policy on Moonlighting.

The facilities afforded the residents are there to ensure an appropriate environment for learning and providing patient care. This shall include food service capabilities during assigned duty hours and on-call rooms suitable for each resident on night duty in the hospital.

Policy on Resident Supervision

The Department of Obstetrics and Gynecology residency training program will provide for appropriate supervision for all residents in accordance with the GME manual, section HS 9.0. <http://www.mcg.edu/Resident/HSPolicies/policy9.htm> The attending physician has both an ethical and legal responsibility for the overall care of the individual patient and for the supervision of the resident involved in the patient's care.

The attending staff, based on direct observation and knowledge of each resident's skills and ability, must determine the level of responsibility accorded to each resident and this may vary with the clinical circumstances.

Faculty schedules must be structured so that they are immediately available for consultation and support. Constructive feedback is a vital element of supervision and serves to highlight areas believed by the teaching staff to be important. The department encourages timely, specific feedback by faculty. This may take verbal or written form. A Focused Assessment of Competency is available for faculty to utilize the competencies in evaluating a specific issue. End of rotation and clinical evaluations also utilize the competencies to assess resident performance. Operative performance is supervised and evaluated.

Evidence of resident supervision must be documented in the form of signed notes in patients' charts and other records such as indication of the level of attending presence in procedure notes.

In a supervisory role, faculty and residents are asked to recognize the signs of fatigue or impairment, in themselves, or others. Please refer to the department's Resident Fatigue Policy, located on pages 32 of this manual.

Sub-optimal performance in any of the competencies by residents will be met with appropriate counseling by the faculty involved, faculty advisers and/or the Program Director. The development of specific competency-based remediation programs, or other measures designed to assist each resident in achieving the goals and objectives of the Department of Obstetrics and

Gynecology residency program, may occur. These measures will include additional supervision of the resident by faculty in several possible venues.

Policy on Resident Fatigue, Stress and Impairment

The goal of this policy is to assist the Department of Obstetrics and Gynecology in its support of high quality education and safe and effective patient care. Please refer to the GME manual, section HS 10.0, for a basic policy on fatigue for MCG residents.

<http://www.mcg.edu/Resident/HSPolicies/policy10.htm> The Department of Obstetrics and Gynecology is committed to meeting the requirements of patient safety and resident well being. Excessive sleep loss, fatigue and resident stress are serious matters. In the event that any resident experiences fatigue, impairment, and/or stress that is interfering with his/her ability to safely perform duties, they are strongly encouraged and obligated to report this to his/her senior resident or attending on service.

Appropriate backup support will be provided when needs create resident fatigue or stress sufficient to jeopardize patient care, the resident, or the general public's safety. Residents must not be allowed to continue patient care activities, or perform potentially dangerous tasks, such as operating a motor vehicle, when overly fatigued or impaired.

All faculty and residents are instructed to closely observe other residents for any signs of undue stress, impairment and/or fatigue. Faculty and other residents are to report such concerns of sleepiness, tardiness, resident absences, inattentiveness, or other indicators of possible fatigue, impairment and /or excessive stress to the supervising faculty and/or Program Director. The resident will be relieved of his/her duties until the effects of fatigue, impairment and/or stress are no longer present.

There are three levels at which a resident can obtain counseling and help for diverse conditions such as psychiatric disturbances (anxiety disorders, depression), marital problems, substance abuse, stress, and other work related problems. These three levels are the OB/Gyn Department, the Medical College of Georgia Hospital and Clinics, and a variety of community programs in the city of Augusta.

1. Obstetrics and Gynecology Department:

There is a faculty advisor for each residency year. Please refer to the section on Faculty

Advisors for a complete listing of advisor duties. The advisor will offer counsel and if necessary, provide alternatives for dealing with problems by directing the resident to other resources.

2. Medical College of Georgia Hospital and Clinics:

a. MCG has available to all of its employees a crisis intervention program named "Employee/Faculty Assistance Program" (EFAP). This is a free program provided to all employees, faculty, and residents of the Medical College of Georgia and their immediate family members.

They provide counseling and appropriate referral for problems such as personal stress, marital problems, substance abuse, or emotional difficulties. The program is totally confidential for those who self-refer. Supervisors who make referrals to the program receive only feedback regarding attendance.

The EFAP facilities are located at 844 Chaffee Ave., Telephone 721-2599, office hours are 8AM-5PM Monday through Friday. Their web site is: www.mcg.edu/campus/efap

b. The Psychiatry Department, through its outpatient clinic, is available for those residents who need specialized attention. After an initial evaluation of the case a referral is made within that department. If a resident desires to see a psychiatrist outside of the hospital an appropriate referral may also be made. MCG Outpatient Psychiatry Services – Peter Buckley, M.D., Chairman and Director – 1-6597 new referrals, 1-3141 return appointments.

3. Community Programs are available for residents for various support issues. Any resident desiring more information on current available programs is encouraged to contact the Program Coordinator, consult the local telephone book, or request information through the EFAP, as mentioned above.

All residents will acknowledge the Policy on Resident Fatigue, Stress, and Impairment annually. The program coordinator will notify all residents of the policy via <https://system.one45.com/georgia/>.

Policy on Resident Moonlighting

While not strictly forbidden, moonlighting is not encouraged for our resident staff. The requirements of patient care and learning during residency training demand significant time commitment from the residents. In addition, time away from patient activities for rest and rejuvenation is recognized as necessary for maximizing patient care, learning, and resident well being. Please refer to the GME Housestaff Manual, section HS 16.0, <http://www.mcg.edu/Resident/HSPolicies/policy16.htm> for a general policy on resident moonlighting.

Any resident wishing to moonlight outside of the parent institution must meet the following requirements:

- 1) All logged time must be up to date
- 2) All ACGME surgical logs must be up to date
- 3) All medical records must be complete and up to date
- 4) All clinical responsibilities pertaining to the residency program must be met and in compliance with the ACGME Work Hour Requirements
- 5) All educational responsibilities pertaining to the residency program must be maintained and performed as scheduled

The Program Director must approve all moonlighting activities, in compliance with the MCG Institutional Policy (HS 16.0). Any resident approved for moonlighting will be closely monitored for signs of fatigue, stress, or impairment as listed in the Policy on Resident Fatigue. No resident will be allowed to continue moonlighting activities if any evidence of his/her residency training appears to be compromised.

Policy on Leave

Please refer to the Fringe Benefits section for information on vacation (annual) and educational leave (page 23 of this manual).

The **American Board of Obstetrics and Gynecology**, Inc. has published guidelines in the BULLETIN under The Resident Program, #7: <http://www.abog.org/pdf/BAS2007.pdf>

1. Leaves of absence and vacation may be granted to residents at the discretion of the program director in accordance with local policy.

2. If, within the four years of graduate medical education, the total of such leaves and vacation, for any reason, (e.g., vacation, sick leave, maternity or paternity leave, or personal leave) exceeds eight (8) weeks in any of the first three years of graduate training, or six (6) weeks during the fourth graduate year, or a total of twenty (20) weeks over the four years of residency, the required four years of graduate medical education must be extended for the duration of time the individual was absent in excess of either eight (8) weeks in years one through 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.

The Institution and the Department may offer the additional training if resources and training allocation are available to do so.

This information may be found at: <http://www.abog.org/pdf/BAS2007DF>.

Medical Leave

In following the GME policy No. HS 4.0, <http://www.mcg.edu/Resident/HSPolicies/policy4.htm> any leave for medical reasons beyond 3 days must be requested of the Department Chairperson in writing by the House Officer along with a written statement from the House Officer's physician stating the reason for and expected length of leave. Any planned absences should be approved, in writing, in advance by the House Officer's Program Director or Department

Chairman. The Department is responsible for informing the Graduate Medical Education Office of the status of House staff in their Department who are on medical leave which exceeds #1 and #2 below.

Fourteen calendar days of medical leave per year are granted to each House Officer on July 1 of each academic year. Each House Officer may accrue a maximum of 21 calendar days of medical leave by carrying over unused medical leave from one year to the next.

Time taken as medical leave will be accounted for in this sequence:

1. Medical leave with full stipend and all benefits until exhausted, then
2. Annual leave until exhausted, then
3. Leave of absence without stipend or benefits.

Premiums for insurance coverage, provided as a benefit when on full pay status, become the responsibility of the House Officer when on leave of absence without stipend or benefits.

Other Types of Leave

All leave except sick leave requires prior approval of the department.

1. *Bereavement Leave*: Regular/full-time and regular/part-time employees may use accrued sick leave to attend the funeral of a member of the immediate family. **Three days is the maximum amount of sick leave** authorized for this purpose. Annual leave or leave without pay may be used for any additional time. Immediate family includes spouse, parent, parent-in-law, brother, sister, child, stepchild, son-in-law, daughter-in-law, grandparent, grandchild, foster parent or legal guardian. Employees who work less than half time may be excused for the above purpose but are not eligible for paid time off since they do not accrue sick leave.

2. *Court Leave*: Regular/full-time employees who are subpoenaed or otherwise directed by proper legal authority to appear as a witness in a jury trial or to serve as a juror in any court, or is mandated to serve on jury duty may be given court leave during scheduled working hours. Court leave is not charged against any other leave accrued and there is no deduction in pay for the absence even though a jury or witness fee may be paid to you. Court leave may not be given to

any employee summoned to a court as a defendant or plaintiff unless the summons is in connection with the employee's official duties with the Medical College. Court leave does not cover any period of absence other than your scheduled working hours. You are expected to return to work if the court excuses you during your scheduled workday.

3. *Military Leave With Pay*: Leave with pay will be granted to regular/full-time and regular/part-time employees who are members of the Georgia National Guard or a reserve component of the Armed Forces of the United States for periods specified by official orders. This type of leave does not cover drill periods and/or reserve training periods on “week-ends” or other scheduled days off. The amount of Military leave with pay is limited to eighteen workdays in any one federal fiscal year, October 1 - September 30, and may not exceed eighteen workdays in any one continuous period of such absence.

4. *Family Medical Leave*: In accordance with the Family Medical Leave Act, employees who have worked for MCG for a total of at least twelve months on a half-time basis or greater are eligible for twelve (12) work weeks of family medical leave during any consecutive 12-month period. This must be at the approval of the Program Director and may require additional training time at the end of your residency.

Policy on Unexpected Leave Notification Procedure

When unexpected circumstances, including illness prevent you from reporting to work, it will be necessary to follow **each** of the following steps.

1. Contact the senior resident on your service.

- a. If you are the senior resident, contact the next highest level resident (PGY-3 or 2 or 1) on your service. Have that resident make arrangements for the team, which may include contacting other team members, including the attending.
- b. If you are the only resident on your service, contact the attending you are to working with that day.

2. Leave a message on the Program Coordinator's answering machine at 721-2541.

3. If you visit a physician it is recommended that you bring in a work excuse.

Take it to the Program Coordinator's office and it will be placed in your file.

Policy on Sexual Harassment

Federal law provides that it shall be an unlawful discriminatory practice for any employee to discharge without just cause, refuse to hire, or otherwise discriminate directly or indirectly against any person with respect to any matter related to employment or academic standing on the basis of sex. Any such action taken against an employee or student would constitute sexual harassment. All students, staff and faculty should be aware that the Medical College of Georgia is committed to full compliance with this law and will take appropriate steps to ensure that our academic community remains free of sexual harassment and all other forms of sexual intimidation and exploitation.

The Medical College of Georgia defines sexual harassment as any unwelcome sexual advance, request for sexual favors or other verbal or physical conduct of a sexual nature when:

- Submission to such conduct is made explicitly or a term or condition of an individual's employment or academic standing; or
- Submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting an individual; or
- Such conduct unreasonably interferes with an individual's work or academic performance or creates an intimidating, hostile or offensive environment.

It is important that all faculty, staff and students are aware of the serious consequences of activity constituting sexual harassment. Such activity has a destructive effect on the academic community and creates serious potential liability for the institution, as well as for the individual employee. It is important that faculty, staff and students feel free to discuss complaints or allegations of sexual harassment with the appropriate administrative officials. Faculty members may contact the Vice President for Academic Affairs (EEO/AA Officer); classified employees may contact the Assistant EEO/AA Officer; and students may contact the Vice President for Student Affairs.

If requested, complaints will be held in confidence and counseling will be provided. No investigation or action against an accused can be taken, however, unless the complainant consents to be identified in connection with the investigation. Existing campus procedures, including appropriate procedural due process, will be utilized to impose sanctions or corrective measures as may be necessary against employees who violate this sexual harassment policy.

Examples of Sexually Harassing Behavior

The following examples illustrate the range of behavior that may be considered sexual harassment as described in the sexual harassment definition. These examples are intended as illustrations only; they are by no means inclusive.

1. Part 1 of the Definition: Certain behavior constitutes sexual harassment when “submission to such conduct is made explicitly or implicitly a term or condition of an individual’s employment or academic standing.”

A graduate student was very impressed by the interest a famous member of her department showed in her program. Because of his encouragement she chose to specialize in his area of expertise. When she later realized that his interest had been only sexual, she was astonished and angry. She felt humiliated and foolish for having believed he respected her academic work. She has taken a job outside her field and wonders if she will ever finish her dissertation.

An instructor for a large introductory course uses sex-stereotyped references and depictions and often makes jokes about sex. He has suggested that the better looking a woman is, the more help she will get. A female student in his class needs extra help. She is deeply offended by the instructor’s attitude and refuses to see him outside of class.

Since the first week of class a male student has been uncomfortable with the way the male teaching assistant (TA) for composition looks at him. Now the student must make an appointment with the TA to discuss his writing. The TA told the student the only time

he could see him was at his apartment in the evening.

2. Part 2 of the Definition: Certain behavior constitutes sexual harassment when “submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting an individual.”

A secretary for a large research project was recently laid off. She had been involved with her boss for several months, but broke off the relationship just before she got the layoff notice. She was told the layoff was due to budget cuts, but she handled the budget and know this was not the reason.

A graduate student was invited by one of her instructors to share a hotel room when they attended a professional meeting. When she refused, he accused her of being immature. He told her he doubted that she could handle future professional situations.

3. Part 3 of the Definition: Certain behavior constitutes sexual harassment when such conduct unreasonably interferes with an individual’s work or academic performance or creates an intimidating, hostile, or offensive environment.

A newly-hired female electrician is uncomfortable because her coworkers regularly leave pornographic pictures where she will find them. She dreads going to work and is finding it harder and harder to keep herself motivated because of the situation.

A student depends on a work-study job to stay in school. One Saturday while she was alone with her boss, he put his arms around her and invited her to go home with him that night. She ran from him and did not go back to work. Now she can’t pay tuition.

CONSENTING RELATIONSHIPS

A relationship between a faculty member and a student should be considered one of professional and client in which sexual relationships are inappropriate. The power

differential inherent in such relationships, as well as those between a supervisor and an employee, compromise the subordinate's ability to freely decide.

The Medical College of Georgia does not specifically forbid sexual relationships between individuals where a professional power differential exists, but it does actively discourage even apparently consenting sexual relationships between faculty and student or supervisor and employee. A faculty member who enters into a sexual relationship with a student or a supervisor with an employee where a professional power differential exists, must realize that if a charge of sexual harassment is subsequently lodged, it will be exceedingly difficult to prove immunity on grounds of mutual consent.

Relationships between a graduate student and an undergraduate when the graduate student has some supervisory responsibility for the undergraduate are included in this category. Among other relationships included are those between a student or employee and an administrator, advisor, program director, counselor, or residential staff member who has supervisor responsibility for that student or employee.

RESPONSIBILITIES OF SUPERVISORS IN SEXUAL HARASSMENT SITUATIONS

The Medical College of Georgia encourages all members of its community to report instances of possible sexual harassment to the appropriate person as described in the policy. Supervisory personnel, however, have special responsibilities regarding sexual harassment.

MCG policy provides for resolving sexual harassment situations at the lowest appropriate level. Ideally, complaints are made directly to the person involved. If this is not feasible, or the person does not heed the complaint, it may be brought to the person's supervisor. If the supervisor can handle the situation without further assistance, he or she should take appropriate actions and report the incident to the EEO/AA office. The report should explain the nature of the situation and the action taken, but names need not be revealed. If the supervisor feels unable to handle the situation, the complaint should be referred to the EEO/AA Office. Appropriate line officers will be informed of sexual harassment

complaints made directly to the EEO/AA Office, and will be involved in the complaint resolution process.

In addition to responsibility for resolving known sexual harassment problems, all supervisory personnel are charged with promoting and maintaining an atmosphere that properly deters sexual harassment. Supervisors are expected to actively discourage all behavior that might be construed as sexual harassment as defined by the policy.

WHAT TO DO IF YOU ARE HARASSED

If you find yourself feeling uncomfortable about someone's behavior related to a sexual issue, you may be experiencing sexual harassment. As illustrated in the examples, sexual harassment includes a range of behaviors, some more harmful than others, but none acceptable. If you are uncertain about whether something happening to you is sexual harassment, talk to someone you trust about the situation.

If the person harassing you has power over your education or employment, it is understandable that you might fear reprisal if you take steps to end the harassment. You have a right to pursue your education and conduct your job in an environment free of this kind of interference. The college's policies are intended to protect you against reprisals.

A. Informal Resolution

Early efforts to control a potentially harassing situation are very important. Sometimes you can stop sexual harassment by telling the person directly that you are uncomfortable with his or her behavior and would like it to stop. Writing a letter to the person or talking to the person's supervisor can also be effective. You may also consider discussing the matter with a friend. Talk to others who might also be victimized by the harasser, since harassment often involves more than one victim.

The EEO/AA Office staff can advise you in the most appropriate course of action and can assist you with your complaint if you choose an informal approach.

1. Formal Resolution

If you decide to file a formal complaint, it will be resolved according to established Medical College of Georgia Appeal procedures. For the most part, the procedure depends on the status of the person against whom the complaint is being filed, not the status of the person bringing the complaint.

PREVENTING SEXUAL HARASSMENT

All faculty, supervisors, and administrators employed by the Medical College of Georgia are obligated to take appropriate action to prevent sexual harassment. Any behavior that might be construed as sexual harassment, including apparently consenting sexual relationships with subordinates, is to be avoided.

It is all too common for someone accused of sexual harassment to say, "I didn't realize that he/she would be offended by that." Whatever the intent, however, the effect of harassment can be devastating. Sensitivity to the impact of one's action on others is essential. In addition, all members of the College community should educate themselves about the range of behavior included within the definition. Departments are urged to hold their own discussions of the policy, paying particular attention to how it applies to their situations. Supervisors may elect to participate in training programs by the EEO/AA Office.

Discrimination and Harassment

It is the firm policy of the Medical College of Georgia (MCG) that no one be subjected to discrimination or harassment. The purpose of these guidelines is to outline the procedure by which students and faculty members in the School of Medicine who have a complaint or who is accused of discrimination or harassment may be heard. It is hoped that this procedure will result in settlement of the complaint at the school level. If not, the complaint progresses to the Faculty Grievance Committee of the Medical College of Georgia Faculty Organization.

Although these guidelines deal with the procedure at the school level, the complaint may be initiated directly through the Vice President for Academic Affairs (EEO/AA Officer). Also, if the complainant and the accused are both classified employees, the procedure follows that described in the MCG Employees Handbook.

These guidelines are authorized and subject to the provisions of the Policies and Procedures of the MCG General Faculty Assembly, Part II.

Definitions of the terms grievance, discrimination, and harassment have been excerpted from the Policies and Procedures of the MCG Faculty Assembly. They are:

1. Grievance is defined as a complaint arising from the work situation/learning environment and shall include complaints arising from dismissal and suspension procedures.
2. Discrimination and Harassment: Federal laws provide that it is an unlawful practice for any employer or institution of higher education to discriminate against an individual, i.e. employee (including house staff), student, or faculty on the basis of that individual's race, gender, age, disability status, religion or national origin. For the School of Medicine, the term harassment may include any discriminatory conduct or practice when:
3. Employment hiring, discharge, promotion or discipline or any other decision

related, directly or indirectly, to employment is based upon discriminatory factors.

4. Submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment or academic standing.

5. Submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting an individual.

6. Such conduct unreasonably interferes with an individual's work or academic performance.

7. In the case of sexual harassment only, such conduct or practice creates an intimidating, hostile or offensive working or academic environment.

Before registering a formal complaint, the complainant is encouraged to inform the person(s) whose behavior is in question that the behavior is discriminatory and/or harassing. This may be done directly to the person(s) or through an appropriate administrator, via., the supervisor of the accused, chairperson, an associate dean, a dean, the Vice President for Student Affairs or the Vice President for Academic Affairs (EEO/AA Officer). If the complaint cannot be settled informally, a formal Letter of Complaint may be registered according to the following procedure:

1a. Complainant writes a Letter of Complaint describing to the best of their ability:

- the date(s), time(s), and place(s) of events in question;
- the names of any witnesses;
- a description of the grievance and action requested;
- a description of any efforts or actions taken already to gain redress.

2a. If the accused is a *faculty member or employee (including House staff)*, the Letter of

Complaint is directed to the chairperson of the department of the accused. The chairperson may consult the institution's legal advisor in dealing with the complaint. The time for action at this level shall not exceed 10 working days from the receipt of the letter.

- 2b. If the complaint can be settled at the level of the chairperson, the chairperson writes a letter describing the terms of agreement, has it signed by the complainant and the accused and files it, with the Letter of Complaint, in his/her office.
- 2c. If the complaint cannot be settled at the level of the chairperson, the chairperson forwards the Letter of Complaint to the Dean with a letter describing the actions taken at his/her level.
- 3a. If the accused is a *medical student*, the Letter of Complaint is directed to either the Associate Dean for Student Affairs in the School of Medicine or the Vice President for Student Affairs. The administrator may consult the institution's legal advisor in dealing with the complaint. The time for action at this level shall not exceed 10 working days from the receipt of the letter.
- 3b. If the complaint can be settled at this level, the respective administrator writes a letter describing the terms of agreement, has it signed by the complainant and the accused and files it, with the Letter of Complaint, in his/her office.
- 3c. If the complaint cannot be settled at this level, the respective administrator forwards the Letter of Complaint to the Dean with a letter describing the action taken at his/her level.
- 4a. If the accused is a *chairperson* or an *associate dean*, the Letter of Complaint is directed to the Dean. The Dean may consult the institution's legal advisor in dealing with the complaint. The time for action at this level shall not exceed 10 working days from the receipt of the letter.
- 4b. If the complaint can be settled at this level, the Dean writes a letter describing the terms of agreement, has it signed by the complainant and the accused and files it, with the Letter of

Complaint, in his/her office.

5a. In the event a complaint cannot be resolved within the School of Medicine, the matter shall be heard by the Faculty Grievance Committee of the Academic Council whose functions are:

- to review all appeals from school or administrative unit decisions regarding discrimination and harassment complaints;
- to determine if a hearing of such appeals shall be granted;
- to appoint a Hearing Subcommittee;
- to make recommendations to the President regarding the appeal;
- to make an annual review of its rules and procedures and to make recommendations to the Academic Council for appropriate revision.

(If the two parties are both classified employees, the complainant should appeal to the Vice President of Academic Affairs (EEO/AA Officer). Procedures to be followed are outlined in the MCG Employees Handbook.)

5b. **All requests for appeal must be made to the Committee Chair of the Faculty Grievance Committee within 10 days of receipt by the applicant of written notice of final action by the Dean. Further procedures are outlined in policies approved and published by the Academic Council.**

Curriculum: Expectations and General Overview of the Program

INTRODUCTION

Residency is a four year period of intense study and patient care. We expect, providing that the resident's interests do not change and that satisfactory progress is made through the residency, that the residents we match in the first year will complete the residency. That is our goal, and our duty. The Resident Manual is intended to acquaint residents in obstetrics and gynecology with general expectations and guidelines. It does not cover all of the expectations nor situations that may arise over the course of the four years of residency.

When there are questions relating to patient care it is important that the chief resident assigned to the service, and the assigned faculty be notified immediately. When there are questions relating to your education, discuss these first with your faculty advisor and if appropriate with the program director.

Every residency program has the same basic resident physician expectations or responsibilities which include¹:

- 1) Develop a personal program of self study and professional growth with guidance from the teaching staff.
- 2) Participate in safe, effective and compassionate patient care under supervision, commensurate with their level of advancement and responsibility.
- 3) Participate fully in the educational activities of their program and, as required, assume responsibility for teaching and supervising other residents and students.
- 4) Participate in institutional program and activities involving the medical staff and adhere to established practices, procedures, and policies of the institutions.
- 5) Participate in institutional committees and councils, especially those that relate to patient care review activities, and apply cost containment measures in the provision of patient care.

American Medical Assoc. 1991-1992 Directory of Residency Training Programs, Chicago, Illinois

The Resident Manual treats these responsibilities as the backdrop to describing the progressive assumption of duties and responsibilities through your four years of training in Obstetrics and Gynecology. The faculty intends to make this training program the most educationally profitable experience possible and for it to lay the foundation for your practice. Each resident is responsible throughout the residency for extensive individual reading and studying to supplement daily experience. At the completion of the four years each resident should have the ability to meet all the General and Special Requirements for Obstetric and Gynecologic Residencies specified by the Accrediting Council for Graduate Medical Education (ACGME).

More specifically, the objectives set forth by CREOG are delineated by rotation and year of training here at MCG and are found in a binder in the resident's library and with the Residency Training Coordinator.

The following description of curriculum expectations for the residency training in Obstetrics and Gynecology represents the minimum expected performance. The objectives presented here are stated in general terms to encompass the variation in individual accomplishments and to keep pace with advances in the field. Specific examples are best obtained by referring to the CREOG objectives by year and rotation. Resident or incident-specific objectives may be obtained by contacting the chief resident or the faculty physician assigned to the service.

GENERAL OVERVIEW OF THE CURRICULUM

The program director, associate program director, department chair, and education committee are committed to the continued quality improvement in resident education. The core curriculum emphasizes obstetric delivery skills, management of inpatient and ambulatory antepartum and postpartum patients, preoperative and postpartum gynecology, operative skills in gynecologic surgery, and ambulatory primary care for women. Subspecialties in obstetrics and gynecology are required and are available for further elective rotation experience.

FIRST YEAR

Obstetrics 12 wks

Gynecology 6 wks

Gynecologic Oncology 12 wks

Ultrasound 4 wks

Family Medicine 4 wks

Emergency Medicine 4 wks

Night Float 6 wks

The first year of training signifies the start of the educational curriculum essential to mastering the specialty. Faculty and upper level resident guidance and supervision to help structure the learning process, will be most intense during this year. The first year resident should master certain skills, and perceive, in this secure environment, what future training will accomplish as reflected in the CREOG objectives. The first year resident must learn to recognize his or her limitations and use these as avenues for consultation with others. The first year resident will help with teaching medical students. The GME at the Medical College of Georgia requires direct supervision, by upper level residents or attending physicians, of all interns performing patient examinations for at least the first six months of training.

* Please refer to the objectives at the back of the manual for a complete list of knowledge and skills expected by rotation.

SECOND YEAR

Obstetrics 12 wks

Gynecologic Oncology 6 wks

Night Float 6 wks

Reproductive Medicine and Infertility 12 wks

Gynecology 6 wks

Elective / Research 6 wks

The second year resident will show commensurate improvement in individual decision making and surgical skills as well as abnormal obstetrics and gynecology management. He/she will continue to recognize personal limitations, using them as stimuli for consultations, with upper level residents and staff. The second year resident will assume more responsibilities for teaching medical students as well as first year residents.

* Please refer to the objectives at the back of the manual for a complete list of knowledge and skills expected by rotation.

THIRD YEAR

Maternal-Fetal Medicine 12 wks

Gynecology 6 wks

Night Float 6 wks

Urogynecology / Pelvic Reconstructive Surgery 12 wks

University Hospital 12 wks

The third year resident should have appropriate confidence in his/her care rendered to most obstetrics and gynecology patients. While relying upon the chief resident and staff for supervision, the third year residents should have a total, relatively flawless management plan. This resident should be able to provide guidance, counseling, and instruction to the more junior residents and students in all the competencies. Third year residents may participate in

departmental committees.

* Please refer to the objectives at the back of the manual for a complete list of knowledge and skills expected by rotation.

FOURTH YEAR

Obstetrics 12 wks

Gynecologic Oncology 12 wks

Night Float 6 wks

Gynecology 6 wks

University Hospital 12 wks

The fourth year of residency is the culmination of the residency program. The fourth year resident not only assumes responsibility for individual patients, but the management of the assigned service utilizing attending physicians as consults. Management duties include patients, more junior residents, students, and other assigned personnel.

This resident must be competent to diagnose and treat all general obstetric and gynecologic problems, act as a consultant to non-obstetric and gynecologic services, and effectively teach all the competencies to students, residents and ancillary persons, and function as a member of assigned department committees. Lectures, didactic, small group discussions, formal student lectures, patient care rounds, as well as Grand Round presentations all are a part of this resident's teaching responsibilities.

* Please refer to the objectives at the back of the manual for a complete list of knowledge and skills expected by rotation.

Learning Objectives

The obstetrics service accounts for more than 10,000 visits and 1,800+ deliveries each year. In addition to the MCG obstetrics service, Dwight David Eisenhower Army Medical Center (DDEAMC) conducts its obstetric practice at MCG. This provides 400+ deliveries per year and is staffed by military physicians in the Departments of Family Medicine and Obstetrics and Gynecology. The General Obstetrics and Gynecology and Maternal-Fetal Medicine (MFM) sections at MCG provide support for the DDEAMC providers when needed for consultation. A protocol exists for necessary transfer of care in matters of complicated obstetric patients.

CREOG obstetric objectives for all levels of residents may be obtained at the back of this manual.

Educational Program – Clinical Work

The obstetrics service consists of an attending physician, chief resident, mid-level resident, and intern provider. In addition, Emergency Medicine and Family Practice interns participate as off-service rotators on the obstetrics service.

The coverage areas involved are the following:

LABOR/DELIVERY:	Attending, Chief, PGY-2, and PGY-1(s)
NIGHT CALL/WEEKENDS:	Attending, Nightfloat or On-Call Residents
CONSULTATIONS:	MFM Attending, MFM Resident (PGY-3)
POSTPARTUM:	Attending, PGY-1(s)

Coverage contingencies:

1. Chief off-campus: responsibility shifts to **MFM resident**.
2. MFM Resident off-campus: responsibility shifts to **chief resident**.
3. L&D resident off-campus: responsibility shifts to **chief resident**.
4. **The chief is to oversee all duties of the service.**

The chief and MFM residents cannot be off campus at the same time. Cross-coverage, if needed, from other services must be explicit and provide an equivalent or more senior level resident if it is to be approved for purposes of travel or vacation.

CLINICS:

Administrative Director of Womens Health Services: Linda Wildey

Administrative Manager: Teresa Stovall

Clinical Nurse Manager: Lorraine Stephens, RN

Obstetric Clinical Testing

All patients will receive the following tests at their first visit unless they have prior documentation that they have been done elsewhere by a reputable laboratory:

- | | |
|--|------------------------------------|
| a. Complete Blood Count | g. RPR/VDRL |
| b. Urinalysis with Microanalysis | h. Rubella screen |
| c. Urine Culture (Uricult ⁷) | i. Gonorrhea and Chlamydia Culture |
| d. Blood Type/Antibody Screen | j. Pap Smear |
| e. Hemoglobin Electrophoresis | k. Hepatitis B Antigen |
| f. HIV testing (opt out) | l. Cystic fibrosis mutation panel |

- At 15 - 20 weeks: QuadScreen (optional)
- At 28 weeks:
- a. Repeat CBC
 - b. Repeat Antibody Screen in Rh negative patients and administer Rho-D immune globulin if screen negative
 - c. Glucose screening test - 1 hr post 50 gm glucose load
- At 35 - 37 weeks:
- a. Group B streptococcus lower 1/3 vagina and anal skin culture (1 specimen)
 - b. Repeat GC and Chlamydia cultures

Fetal assessment tests (ultrasound evaluation, fetal heart rate testing, biophysical profile tests must be scheduled through current OrderComm forms. Contact numbers for these tests are:

- a. Ultrasound (721-2382)
- b. NST/Biophysical (721-3594)

Obstetric Medical Records

Outpatient Records (Prenatal Flowsheets) are maintained in Labor and Delivery. Records are scanned into Powerchart Office following all outpatient encounters and the Prenatal Flowsheets are returned to L&D. All records must be signed out and accounted for to prevent losses. FAX transmission is available between L&D and the ACC. All records may be viewed on PowerChart as well.

MATERNAL and INFANT PROGRAM

Mary Jane Barrentine, RN, Program Coordinator

The M&I Project is funded through an MCH Block Grant. Its purpose is to help reduce poor outcomes through the provision of comprehensive health care to high risk pregnant women and their families. This consists of medical care, patient education, and nutritionists. MCG-M&I staff see the patient as indicated for various related services.

Assistance with WIC and Medicaid enrollment, is provided. All patients are assessed for high risk status whether of economic, social or medical nature. Close liaison with local health department staff regarding patient's care and follow up is available. A transportation system is provided from twelve of the outlying counties. The staff is available to assist all obstetrical patients with pregnancy related needs. These activities are supervised by the Maternal Fetal Medicine Section. Patients are also seen at the Jefferson County Prenatal Clinic (JCPC) by an MCG nurse practitioner under supervision of the MCGM&I medical director. These patients are registered as MCG patients with active charts as with the in-clinic population. The record maintained in powerchart is copy of the JCPC record. These patients do not need a new patient work up when transferred to MCG for subsequent care.

INPATIENT SERVICES:

1) 7-WEST

Currently, antepartum and postpartum patients are admitted to 7-West. 7-West also houses routine term and intermediate care nurseries. 7-West also contains 3 birthing rooms (7022, 7024, and 7026).

Circumcisions should be completed at least one day prior to discharge on day of life one. All newborns are medically cleared by the newborn nursery attending prior to circumcision. This is documented in the medical record, along with the timeout procedure notation. Circumcision duties are share with Pediatrics. Schedules are posted in the resident office and in the newborn nursery. The postpartum intern is responsible for completion of circumcisions and notification of those on-call with regard to weekend coverage.

Obstetrics service rounds are held daily by the responsible services.

2) L&D/ 7-West Birthing Rooms

These are limited access areas requiring approved badge-swipe entry. Labor and Delivery is the typical point of entry into the health care system for laboring, acutely ill or transferred patients. Admission, Discharge, and Transfer regulations are covered in the L&D Policy/Procedure Manual. This area also contains our operating rooms for cesarean sections, tubal ligations, cerclage and D&C's. There is a separate set of governing policies and is intended for evaluation of non-laboring, less acute patients as well as for assessment of patients with gestational age > 20 weeks who present with non-obstetric complaints. The 7-West birthing rooms also have a separate set of policies and are intended primarily for patients requiring minimal intervention during normal labor. They may be used for overflow labor rooms should the need arise.

3) Obstetric Consultation

The L&D resident **must**:

1. Notify the responsible attending physician for all deliveries, referrals, transfers and triage patients.
2. Consult with the chief resident assigned to L&D for:
 - a. Obstetric complications:
 1. Preterm labor/rupture of membranes
 2. Breech presentation, regardless of gestational age
 3. Transverse lie/compound presentation
 4. Multiple gestation
 5. Third trimester bleeding
 6. Persistent abnormal FHR patterns
 7. Slow progress or failure to progress in labor
 8. Prior cesarean delivery
 9. Fetuses with known or suspected major malformations

b. Delivery room complications:

1. Operative vaginal deliveries
2. Breech, twin or preterm deliveries
3. Fourth degree or extensive cervical/vaginal tears
4. Retained placenta
5. Postpartum hemorrhage

c. Antepartum complications:

1. Preeclampsia, regardless of severity
2. Diabetes mellitus
3. Abnormal labor pattern
4. Premature rupture of membranes
5. Abnormal FHR tracing on admission
6. Intrauterine Growth Restriction
7. Fetal anomalies

SURGERY:

Operating Schedules are also covered in a separate policy.

Labor inductions will be scheduled through the Labor and Delivery Charge Nurse with a nominal limit of 2 inductions per day. Any additional cases will need to be cleared with the supervising attending for that day.

Minimal work up for surgery should include:

CBC, UA, Type and Screen (as indicated).

Admission history and physical examination.

Appropriate nursing orders.

Verification that pre-certification forms have been completed.

(Note: this may be done after the fact in emergencies)

Monitoring of Laboring Patients. It is currently our policy to monitor all laboring patients for a minimum of 30 minutes upon entry to a labor/delivery room. Continuous electronic monitoring is indicated for:

1. All high risk patients being observed in labor.
2. Patients requiring tocolytic therapy.
3. Trauma patients (> 20 weeks gestational age).
4. Patients undergoing pre-induction cervical ripening.
5. Patients receiving epidural blockage.
6. Induction/Augmentation of labor with oxytocin.

Intravenous Infusions must be given via controlled infusion pumps.

Surgical Cases. All elective cases should be scheduled through the OR scheduling office (Mary Maddox, coordinator). Tubal ligations are considered as add-on cases and, depending on time of day, may need to be booked through the central OR schedule, to follow the regularly scheduled cases for the day. All emergency cases must be posted as soon as the decision for surgery is made. Appropriate consultation and consent must be obtained and nursing, anesthesia services and when appropriate, neonatology services notified. All surgical cases must have handwritten pre- and post-op notes in the record and be dictated within 24 hours.

By agreement with Anesthesia and Nursing services, all patients desiring postpartum tubal ligation will have their surgery either (1) within 2-4 hours after delivery, if they have a functional regional block and sufficient NPO period (>8h) and adequate staffing is available or (2) within 24 hours of delivery. Any patient who cannot have the procedures performed within this time frame will need to be scheduled for ambulatory surgery at a later date.

Ambulatory (Day of Service) Admission is required for all patients undergoing elective primary or repeat cesarean section, cervical cerclage, and dilatation and curettage, unless medical complications make this practice unfeasible. Patients for ambulatory admission require that preoperative work up must be completed on an outpatient basis and be available when the patient arrives for surgery. All such scheduled cases should be approved by the responsible attending physician before admission.

Evaluation

See under Evaluation Section.

MFM Research Resources

1. Diagnostic Ultrasound Laboratory (Harriet Isabel, RDMS)

The laboratory has multimode imaging capability, capable of targeted high-resolution scanning, cardiac Doppler evaluation, color flow Doppler and standard biometry. The ultrasound laboratory has acquired a significant file of unusual cases for teaching and research purposes.

2. Clinical Research Studies

Each year, the MFM section has an ongoing number of clinical research projects many of which involve fellow and/or resident participation. The list of current active studies are in the section offices.

Basic Research Studies

The Perinatal Research Laboratory (Drs. Prasad and Ganapathy) are conducting a variety of investigations into placental transport models and other basic areas of perinatal medicine. The list of active studies is maintained in the laboratory.

Learning Objectives

The goal of the Night Float rotation is to provide an intensive experience in the management of Labor and Delivery. You are also on call for the other services and will attend to in-hospital patients and/or emergency room consultations. This rotation occurs for 6 weeks during all years of your training.

Educational Program – Clinical Work

The Night Float team consists of a float “chief,” which could either be a PGY-3 or PGY-4, and a PGY-2 or intern.

The chief resident’s duties include:

- supervision of the PGY-2/intern in the management of all patients on labor and delivery.
- direct management of such patients deemed high risk and assistance in the direct management of patients that the PGY-2/intern is not yet confident in managing.
- teaching and assisting the junior residents in vaginal and cesarean deliveries
- communication with the attending physician regarding patient admissions or critical changes in patient conditions
- teaching the medical students pertinent objectives in OB/Gyn

The PGY-2/intern’s duties include:

- management of all patients on labor and delivery
- performance of cesarean deliveries with the chief resident
- respond to in-house/ER consultations
- supervision of the interns duties.
- communication with the chief resident regarding any admissions, triage patients, or change in status of patients on the unit

- teaching the medical students pertinent objectives in OB/Gyn

Evaluation

See under Evaluation Section.

Curriculum - Rotations

Benign Gynecology

Learning Objectives

The goal of the benign gynecology rotation is to expand and reinforce the resident's knowledge of general gynecology. This includes expanding the resident's surgical experience and understanding of surgical technique and instrumentation. Also, the resident should have a thorough understanding of the evaluation and medical/surgical management of gynecologic conditions.

The curriculum objectives for the senior residents (PGY-3/PGY-4) are as follows:

- Assume responsibility of the primary surgeon and ensure that all cases are covered.
- Mentor and guide the junior residents in surgical techniques.
- Provide, coordinate, and participate in the care of postoperative patients and other gynecologic admissions with the junior resident and students.
- Monitor for and manage postoperative complications.
- Provide consultation services with the junior residents for the emergency room and patient wards.
- Provide and coordinate the care of the high risk preoperative patient.
- Instruct the junior residents and medical students on obtaining a thorough informed consent for preoperative patients.
- Ensure the presence of a continuing care plan for each postoperative patient.
- Provide a topic and patient list for Gynecology Conference, distributed to all residents and faculty. Presentations should be done by both senior and junior level residents.

- Complete the specific CREOG gynecology objectives located at the back of this manual.

The objectives of the junior residents (PGY-1/PGY-2) are as follows:

- Become a competent first assistant in surgery.
- Perform minor operating room cases with the assistance of the senior resident.
- Become efficient in completing pertinent history, exam and management of consultations in the emergency room and patient wards under the supervision.
- Perform a pertinent history and focused exam as needed to complete the preoperative evaluation.
- Teach and guide medical students on rotation.
- Learn the assessment of risk factors that may affect the patient's perioperative care.
- Become comfortable with counseling the patient and obtaining informed consent for the planned surgical procedure.
- Complete the specific CROEG gynecology objectives located at the back of this manual.

Educational Program - Clinical Work

The benign gynecology team consists of the “on service” attending physician, senior resident, and junior resident. There will be one to two junior medical students rotating through the service as well. The team is responsible for coverage of all surgical cases. In the event of a conflict in scheduling such that a case may not be covered by a team member, it is the responsibility of the senior resident to arrange for coverage of that particular case. Additionally, if the senior resident will be unavailable to cover a case which may not be appropriate for the first year resident, the senior should discuss with the respective attending if an upper level resident is requested. The senior should then arrange for such coverage.

The benign team is also responsible for coverage of attending rounds, participation in gynecology conference, and timely response to consults from the emergency room or hospital wards.

Surgery: Surgical cases are scheduled for Monday, Tuesday, Thursday, and Friday. Cases may be in the main OR or L&D. Naturally, emergent cases can occur anytime. Residents are required to see the patient in pre-op holding to confirm the informed consent and verify completion of pre-op labs. One of the residents should be present when the patient arrives in the OR. The chief resident should act as the primary surgeon and has responsibility that all cases are covered. The first year resident will become proficient in all aspects of becoming a first assistant. The chief resident is expected to mentor and guide the first year in aspects of surgery. The role of the first year should be appropriate to their experience and is at the discretion of the chief resident and attending physician. Both residents are expected to be present for operative cases with the exceptions of Continuity Clinic coverage, hospital consultations or at the approval of the attending.

Those patients who were scheduled and routed through the private attending clinics will have the H&P available through the OR scheduling coordinator. The residents are expected to review the information and be familiar with it prior to entering the OR.

Scheduling of cases is coordinated through the Patient Education Specialist, Mary Maddox at ext. 8577, or pager # 5470. The proposed procedure should be cleared through an attending. The resident should then complete the admissions directive and posting slip and give those materials with pertinent supportive documents (progress notes, pathology, or imaging study results) to Ms. Maddox. Any changes to the gynecologic surgical schedule should be verified through Ms. Maddox.

Rounds: Resident inpatient rounds are to be completed prior to any surgical cases or clinics. It is expected that both residents act as a team in completing work rounds. The residents should instruct and supervise the students in assisting in inpatient duties, writing progress notes, night of surgery notes, and presenting in attending rounds. Attending rounds should take place daily. The attending should be notified of any admission or change in inpatient status.

Evaluation

See under Evaluation Section.

Curriculum – Rotations

Gynecologic Oncology

Learning Objectives

Administrative responsibilities are listed on a day-by-day basis. It is important that all meetings are attended on time and all paperwork is submitted in a timely fashion.

The chief resident must be in the O.R. by 0730 a.m. on operating days (0830 Monday). The chief resident is responsible for coordinating surgical cases with the surgery scheduling coordinator.

CREOG gynecology oncology objectives for all levels of residents may be obtained in the Objective Manual.

Educational Program – Clinical Work

In addition to the day-by-day responsibilities listed above, these are general rules while on service.

- The chief resident is responsible for rounding on all ICU patients and all critically ill patients
- The chief resident is expected to review the charts of all surgery patients prior to surgery to insure appropriate data is available.

- The chief resident will write in the chart when treatment decisions or plans have been made on inpatients.
- The chief resident is responsible to check out all patients on the service to the call team.
- The attending will be notified in a timely manner of all admissions or significant changes in a patient's condition.
- It is expected that all meetings, rounds, surgeries and clinics will be attended on time.
- It is expected any resident scrubbing on a case will know the patient's history, have read about the surgical procedure, and have reviewed the pertinent anatomy.
- All student notes will be followed by a resident note.

Weekly Schedule:

Monday - Section Meeting at 7:45. This is an operating day for Dr. Ghamande. The chief resident is assigned to the operating room unless at the attending discretion a more junior resident is appropriate for the planned surgery.

Tuesday - Tumor board is at 0700 in the pathology conference room. Residents should be prepared to present the cases. MCG Gyn Onc Clinic follows rounds and starts at 0830. All residents assigned to the service are expected to attend.

Wednesday - MCG Gyn Onc Clinic follows rounds and starts at 0830. All residents are expected to attend.

Thursday - This is Dr. Macfee's operating day. The chief resident is assigned to the operating room unless at the attending discretion a more junior resident is appropriate for the planned surgery. Dr. Ferris's preinvasive clinic should be attended by the junior resident if available.

Friday – This is the RCC day for the Gyn Onc chief resident and junior residents will cover the service accordingly.

Rounds - Rounds will be made on a daily basis. All notes must be completed prior to rounds. On weekend days a resident on the service is expected to make rounds if they are on-call. Otherwise, an upper level on call resident will make rounds. The time of rounds is at the discretion of the attending and will be communicated to the residents the day prior.

Evaluation

See under Evaluation Section.

Curriculum – Rotations **Reproductive Endocrine**

Learning Objectives

PGY-2 residents rotate on this service.

CREOG REI objectives for PGY-2 residents may be obtained in the Objective Manual.

I. PATIENT CARE

A. Outpatient

1. REI patients are seen daily at the Reproductive Medicine and Infertility Associates (RMIA) office located on Chafee Street, across 15th Street from MCG. Residents are expected to participate in all RMIA clinics as well as participate in patient ultrasounds and Artificial Reproductive Techniques (ART). This may

include weekend participation in IVF cycles.

2. Residents assist with hysterosalpingograms (HSG's) when scheduled. Monday and/or Friday are commonly operating room days for REI patients.
3. Residents will present assigned patients at the REI/Genetics Conference held Thursday 1:30-3:30 PM. The resident is expected to be thoroughly familiar with all of the information on these patients (particularly exact laboratory data and units) and should present a complete past work-up, present evaluation and planned therapeutic regime. All results of studies ordered on patients must be available at this conference. If a radiology study is performed on a subject, then a copy of this study should be available for review

The resident should also gain a basic understanding of the disease entities involved in the particular situation. A literature review is expected to provide as much information as possible on the presented diseases. These presentations should be considered formal. Outlines constructed on overheads or PowerPoint presentations, and handouts for use during the discussion are expected. These presentations should be placed in the resident's Educational Portfolio after each conference.

4. Residents may also present an interesting case at Dysmorphology and Genetics Conference, held monthly the first Tuesday of the month at 12 noon. These are also formal, PowerPoint presentations that should be placed in the resident's Educational Portfolio after each presentation.

B. Inpatient

1. The resident is responsible for ALL admissions on REI patients, follow-up notes, and discharge summaries. Initial evaluation, progress, and any complication should be reviewed as soon as possible with the attending on service.

2. The resident is responsible to check out the REI service at rounds to the night float, or on-call weekend team.
3. The resident should assist the fellow and attending in the care of all REI patients admitted to the hospital.

II. SURGERY

1. All patients who are evaluated and felt to be surgical candidates should have an admission directive and OR scheduling sheet filled out and turned in to Mary Maddox.
2. The resident is expected to be on time and present at ALL surgeries.
3. If the resident expects to be unable to attend or be delayed, the attending involved in the case must be informed.
4. The resident is expected to be familiar with the planned operative procedure, conduct, and potential complications.
5. It is the resident's duty to ensure that a preoperative and operative note are written, and operative note dictated, that orders are consistent with the attending's desires and that all dictations and computer entries are done. A letter to the referring physician should be generated.
6. As operative laparoscopy becomes more complex, hospitals are requiring physicians to demonstrate competency in these special areas before granting them privileges.

Evaluation

See under Evaluation Section.

Curriculum – Rotations

Urogynecology

Learning Objectives

PGY-3 residents rotate on this service.

The goal of the rotation in Urogynecology is to introduce, expand, and reinforce the residents' knowledge of Pelvic Floor Medicine. Residents on this rotation will become proficient in evaluating patients with urinary incontinence, pelvic organ prolapse and related disorders of the lower genital urinary tract. They will learn how to perform basic and complex urodynamic testing and become familiar with surgical and non-surgical methods for treating incontinence and prolapse. Additionally, the principles and practice of both minimally invasive and advanced laparoscopic surgery will be experienced in this rotation. The fundamental skills of laparoscopy can be reinforced through use of the pelvic surgical trainer available in the Urogynecology office.

CREOG urogynecology objectives for PGY-3 residents may be obtained in the Objectives Manual.

Educational Program – Clinical Work

The Section Chief in the Division of Urogynecology is Dr. Sean Francis. Additionally, Dr. O. Eduardo Talledo is in this division as Professor Emeritus.

Outpatient:

The residents are expected to attend clinics on the 5th floor of the Ambulatory Care Center or at Hillcreek PPG site on the following days:

Monday – Dr. Francis (ACC)

Wednesday – Dr. Francis (Hillcreek)

Thursday – Dr. Francis (ACC)

In the clinic setting residents have the opportunity to evaluate all forms of pelvic organ prolapse and pelvic floor dysfunction. They also have the opportunity to perform histories and physicals on these patients under the supervision of the attending. Furthermore, they will assist and be able to perform diagnostic procedures such as multichannel urodynamics, cystoscopy, anal and bladder ultrasonography.

Surgery:

Surgical cases are scheduled every Tuesday and most Fridays. The general surgical objectives are as follows:

PGY-3:

- Develop a thorough understanding of patient preparation in the surgical theater (positioning, necessary equipment, etc.).
- Become proficient in the role as first assistant in surgical correction of pelvic organ prolapse.
- Be able to perform these procedures under the supervision of the attending physician.
- Learn and be able to perform the skills required in both minimally invasive surgery and advanced laparoscopic surgical technique.

Inpatient Rounds:

Residents are expected to make rounds on all in patients prior to the start of the scheduled daily duties. Attending rounds will be made daily at a time set by the attending physician.

Conference:

A weekly Urogynecology preoperative conference is scheduled every Monday at 1200 in the Chairman's Conference Room. At this meeting, the surgical cases for the following week are discussed focusing on preoperative evaluation and the determination of surgical approach. Subjects for literature are also discussed at these meetings. Attendance is mandatory.

Evaluation

See under evaluation section.

Curriculum – Rotations

University Hospital

Learning Objectives:

The University Hospital Preceptor-ship rotation for PGY-3 and PGY-4 residents is a concentrated gynecologic surgery rotation. The resident is expected to act as first assistant or primary surgeon, as appropriate, in a wide variety of operations for benign gynecologic conditions. The primary goal is to learn and refine various surgical techniques and gynecologic operative procedures including Cesarean sections. Clinical faculty, on the staff of University Hospital, and selected by the Chairman of the Department of Obstetrics and Gynecology at the Medical College of Georgia act as preceptors for the residents. There is a formal written agreement outlining the responsibilities of the clinical faculty.

Educational Activities:

The hours of the rotation are from 7am to 7pm weekdays. The residents will still attend their continuity clinics and Friday morning didactics. The residents are to review the next weeks surgical schedule of the Women's' operating room identify appropriate cases and communicate with the clinical faculty who scheduled the case. Arrangements will then be made to attend the surgery. Post operative rounds will be made at the discretion of the clinical faculty

Administrative Activities:

The residents are expected to communicate with the onsite clinical faculty designated as the education coordinator to include any vacations or absences from the rotation. The residents are responsible to ask clinical faculty to complete operative experience cards, and to complete ACGME logs in a timely fashion. The chief resident at University Hospital serves as the administrative liaison responsible for any issues regarding coverage, absences, or other areas of concern.

Evaluations:

The residents will be evaluated at the end of the rotation by the University Hospital Education Committee and the Program Director.

Curriculum- Rotations

Ultrasound

Learning Objectives

PGY-1 residents rotate on this service.

Upon completion of the prescribed OB ultrasound training sequence, residents will have mastered the skills described in the ACOG Technical Bulletin on Ultrasound in Pregnancy (# 187, 1993) and the “Practical Training Objectives” published by the International Society of Ultrasound in Obstetrics and Gynecology (Ultrasound Obstet Gynecol 1993;3:73-76) which have been adopted as minimum standards by the Council on Resident Education in Obstetrics and Gynecology. In addition, residents, through independent reading of appropriate textbook chapters (available in clinic), and through discussions with the attending ultrasound faculty, will familiarize her/himself with the fundamentals of ultrasound physics and the theoretical background behind the clinical skills to be acquired.

Specific ultrasound objectives for PGY-3 residents may be obtained in the Objectives Manual.

Educational Program – Clinical Work

The OB ultrasound diagnosis unit is located in the Ambulatory Care Center on the 5th floor. It features state-of-the-art scanning equipment and is staffed full-time by RDMS Sonographers. Generalists, perinatal specialists and reproductive-endocrinologists, are present daily to interpret the ultrasounds. Imaging support is provided for the full range of invasive prenatal diagnostic procedures, including amniocentesis, and fetal blood sampling.

PGY-3

The ultrasound experience for the PGY-3 consists of a four week experience working with the sonographers and reading the studies with the attendings. Residents become proficient in the areas of ultrasonography detailed in the attached objectives.

Evaluation

See under evaluation section. The Clinic Evaluation form is used as the global rotation form for this rotation.

Curriculum- Rotations **Emergency Medicine**

Learning Objectives

The OB/GYN service, particularly the Gynecology Service, is one of the principle consulting services to the Emergency Department (ED), in the care of patients with acute and subacute medical/surgical problems. Because the residents are the primary consultants from our service to the ED, it is essential that they not only learn emergency care management, but also become adept in “working through the system” in expeditiously evaluating and managing patients and, if needed, admitting patients to inpatient beds or to the operating room. Throughout their residency years, OB/GYN residents will be called to provide consultations for suspected gynecology problems while on-call and during the workday as the “GYN floor call” resident. Each PGY-1 resident will rotate through the ED for one month.

Principle features of the ED rotation are:

- Management of a wide variety of acute and subacute medical and surgical problems in the adult patient; rotating residents will be expected to function similarly to EM PGY-1 residents.
- Direct supervision will be provided by senior-level EM residents and full-time EM attending/faculty physicians; consultations will be provided by other services

as requested.

- Objectives are listed by year at the end of this manual.

CREOG primary care objectives for the PGY-1 resident may be obtained in the Objectives Manual.

Evaluation

Resident evaluations are performed by ED faculty utilizing their One45 global evaluation form.

Curriculum – Academics

Activity	Frequency per Month	Supervising Faculty
Perinatal Conference Monday 0730 - 0830 - Student Classroom (7th Floor)	4	Dr. Helfgott
Gyn Onc Tumor Board Tuesday 0700 - 0800 - Pathology Conference Room	4	Dr. Ghamande
REI Conference Thursday 1330 - 1530 - Chair's Conference Room	4	Dr. Layman
Urogynecology Conference Monday 1200 - 1300 - Student Classroom (7th Floor)	4	Dr. Francis
Gynecology Conference Wednesday 1630 - 1730 - Student Classroom (7th Floor)	4	Dr. Ray
Grand Rounds Wednesday 0730 - 0830 - Surgical Amphitheater (4th Floor)	2	Dr. Murphy
QA & I Conference Wednesday 0730 - 0830 - Surgical Amphitheater (4th Floor)	1	Dr. Francis
MFM-NICU Conference Wednesday 0730 - 0830 - Surgical Amphitheater (4th Floor)	1	Dr. Helfgott
Laparoscopy Lab Instruction Laparoscopy Lab	0.25	Dr. Francis
Core Lecture Series Friday 0700 - 0800 - Student Classroom (7th Floor)	4	Faculty
Fetal Monitoring/Ultrasound Conference Friday 0900 - 1100 - Student Classroom (7th Floor)	1	MFM Faculty
Journal Club Off-Campus	1	Dr. Macfee
Resident Research Conference Student Classroom (7th Floor)	0.25	Dr. McDonough
Noelle Simulation Friday 0900 - 1100 - Student Classroom (7th Floor)	1	Dr. Ray

Learning Objectives

The oral examination occurs annually and involves the PGY3 and PGY4's. This is a useful tool for both your education and the assessment of knowledge base. Additionally, it offers assessment of ability to formulate organized responses to questions and structured case scenarios, and to communicate those responses to the examiner in a cohesive, professional manner.

Format

The exam is divided into three equal sections: office practice, obstetrics, and gynecology. You will be asked to prepare a list of cases with which you were involved in the past year. More specifically, the respective lists will be 10 gynecologic cases, 10 obstetrics cases, and 10 office cases. During each 30-40 minute section of the exam, half of the time will be spent reviewing and defending your case list, the other half of the time will be spent discussing structured cases. No reference materials or electronic resources are allowed during the exam.

Evaluation

Three separate faculty will serve as your examiners. They each will fill out an evaluation form based on your performance. They will then meet together to discuss everyone's performance, offer critique in areas of strength and weakness, and to offer a final grade.

Passing the overall exam requires that you pass 2 of the 3 sections. The Program Director and/or Faculty Advisor will meet with each resident after the exam to review your scores. Failure will necessitate a remediation to be arranged by the Program Director. It is essential to note that failure may arise from inadequate presentation skills or non-professionalism during the exam.

Curriculum - CREOG In-Service Exams

Learning Objectives

The CREOG exam is the nationally administered exam given to all OB/Gyn residents. The exam is offered on Thursday and Friday or Friday and Saturday each year near the end of January. Residents that are post-call or on-call, will be scheduled on the alternative day. The exam is given in two sections, a morning session and an afternoon session, each approximately 180 questions and 2 ½ hours in length.

This comprehensive exam is a useful measure of your knowledge base. Scores are compared nationally to all residents taking the exam with the average score of 200. The score is also compared to peers in each residency year. Thus the average score of 200 reflects the average percentage correct for your year – 200 for chiefs may be an average correct of 72%; whereas 200 for the interns may be an average correct of 60%. It is designed as a tool to adapt self-learning programs to strengthen areas of weakness as well as broaden knowledge in areas in which a resident tested well.

The test results are not used as a sole measure of resident promotion or dismissal. However, poor performance (2SD below the mean or greater) will necessitate completion of a remediation program as arranged by the Program Director. If a resident performs poorly on both the CREOG examination and fails the oral exam, remedication status will be imposed and failure to abide by the expectations to repeal this status may lead to loss of clinical privileges or dismissal.

Curriculum – Resident Research

A resident research project is a required component of training. This project proposal will be presented as a PGY-3 and the completed research project will be presented at Research Day at year end. Multiple venues of research are available for resident participation. Partaking in research activity is an opportunity to expand knowledge of both basic and clinical science, research design, data analysis, and scientific writing. Involvement in research is highly encouraged for all residents. All faculty are receptive to resident participation.

If a research project is presented at a state or national level meeting, the department will pay for travel expenses as well as the meeting fee. Notable is the Georgia Obstetrics and Gynecology Society (GOGS) which has an annual meeting in mid-September. The majority of presentations at this meeting are by state residents. Other meetings commonly presenting resident research are the annual APGO (early March) and ACOG (May) meetings.

Time spent in active research (time spent in the actual laboratory or in the hospital) is included in the 80 hour work week guidelines. In general, time spent reading, preparing documents, or preparing presentations is considered educational and not counted toward the hourly guidelines. Pursuing additional research on your own time is supported and those hours are not included in the 80 hour work week guidelines.

Dr. Paul McDonough is currently the Director of Resident Research. He will assist you, along with your faculty sponsor, with project ideas, Human Assurance Committee (HAC) approval, writing and presentation skills, and with any other aspects of your research project.

Timeline for Required Research Project:

PGY-2

Identify research faculty mentor and project

Project proposal and necessary IRB documents complete

Begin project, including obtaining HAC approval

By 10/15 of each year – All PGY-2's need to submit their research project to Dr.

McDonough on the appropriate form. This form includes the research title, your faculty sponsor and a brief explanation of the project.

PGY-3

Continue ongoing project

Consider preparation for oral or poster presentation.

Present Research Proposal at Research Day (June)

PGY-4

Prepare final document

Consider submission to journal or regional/national meeting

(Meetings include the Georgia ObGyn Society, Southern Association, APGO, ACOG, subspecialty annual conferences, etc)

Prepare for presentation at the Resident Research Symposium at the end of chief year

By **3/15 of each year** – All PGY-4's need to submit their Project Abstract for publication in the Research Symposium pamphlet

Presentation (20 minutes) at the Resident Research Symposium (June)

RECOMMENDED READING LIST FOR RESIDENTS

(Available in Departmental Library)

• **PGY-1**

OB: Cunningham FG, et al: Williams Obstetrics

or

Gabbe S, et al: Obstetrics: Normal and Problem Pregnancies,

GYN: Stenchever, et al: Comprehensive Gynecology

ACOG Compendium of selected publications

Supplemental Reading List:

Thompson J, Rock J: TeLinde's Operative Gynecology

Berek J, Hacker N: Practical Gynecologic Oncology

Walters M, Karram M: Urogynecology and Reconstructive Pelvic Surgery

• **PGY-2**

Cunningham FG, et al: Williams Obstetrics

Thompson J, Rock J: TeLinde's Operative Gynecology

DiSaia P, Creasman: Clinical Gynecologic Oncology

Speroff L, Kase N, Glass R: Clinical Gynecologic Endocrinology and Infertility

ACOG Compendium of selected publications

- **PGY-3**

Speroff L, Kase N, Glass R: Clinical Gynecologic Endocrinology and Infertility

Kurman R: Blaustein's Pathology of the Female Genital Tract

Walters M, Karram M: Urogynecology and Reconstructive Pelvic Surgery

Bent A: Urogynecology and Urodynamics: Theory and Practice

Nichols D: Vaginal Surgery

ACOG Compendium of selected publications

- **PGY-4**

Sweet R and Gibbs R: Infectious Diseases of the Female Genital Tract

Soderstrom R: Operative Laparoscopy

Baggish M, et al: Diagnostic and Operative Hysteroscopy

Simpson, Golbus: Genetics in Obstetrics and Gynecology

ACOG Compendium of selected publications

Curriculum -How the Competencies Are Taught

Problem-Based Learning -

1. Clinical experience and teaching -

a. Daily rounds on services that have inpatients utilize application of evidence-based medicine. Upper level residents help teach junior residents, and all residents have a role in student education.

b. Weekly continuity and sub-specialty clinics use application of evidence-based medicine.

Participation - Residents at all levels on a service. Also, all level residents participate in continuity clinics.

Expectations – Residents are expected to increasingly incorporate evidence-based medicine into their inpatient and outpatient practices.

2. Conferences-

Conferences provide didactic and interactive discussions in practice performance, practice improvement, and the use of literature. Examples of conferences include:

- a. monthly Gyn Q/A
- b. monthly OB Q/A
- c. monthly Journal Club
- d. weekly MFM conference
- e. weekly Gyn conference
- f. weekly Didactics
- g. weekly GME conferences

Participation – Residents at all levels.

Expectations - Preparing/presenting at conferences increases over the four years of residency training. Participation in conferences begins early in training. Expectations include appropriate knowledge of literature, understanding how to access information from a variety of sources, and how a person's practice may change based on the literature.

3. Research project -

Participation – All residents must complete by the end of senior year.

Expectations – Residents should show working knowledge of the literature on their subject, including how to access and disseminate that information.

Interpersonal Communication Skills-

1. Clinical experience and teaching-

a. Weekly continuity and rotation-specific clinics help refine communication skills. In some clinics, residents have the opportunity to observe faculty role-model communication skills with patients, fellow physicians and staff.

b. Inpatient rounds as well as other patient care venues (such as Labor & Delivery) provide opportunities for residents to learn communication skills, and observe faculty and upper level residents role-model these skills with patients and their families, fellow physicians and staff. Upper level residents role-model and help teach lower level residents, and all residents help role-model for students.

c. Operative cases provide opportunities to effectively communicate with operative assistants, anesthesia teams, operating room staff, recovery room staff and patients and their families. Faculty and upper level residents role-model appropriate and effective communication skills

Participation- Residents at all levels.

Expectations- Residents will demonstrate efficient, thorough history taking, and patient/family counseling. They will also demonstrate efficient and effective interactions with all personnel.

2. Conferences –

Weekly MFM and Gynecology conferences, student and resident lectures and monthly Q/A, Dysmorphology and Journal Club presentations (each with unique discussion formats) provide opportunities for communication skills to be both assessed and refined. At these meetings residents can also observe (role-model) faculty interactions.

Participation– Residents at all levels, with participation increasing with training year.

Expectations– Residents are expected to have efficient, appropriate, professional presentations, and demonstrate effective communication with all colleagues and learners at various conferences and lectures.

Professionalism –

1. Clinical-

a. Resident professionalism development occurs daily in all venues. All members of the health care team are viewed as role models, whose professional behavior may influence the resident's education in both the inpatient and outpatient setting.

b. Any issues brought forth to the program concerning professional behavior are addressed in a timely and specific fashion. Specific instruction and discussions on appropriate behavior are given to the resident. The evaluative process allows faculty, peers, upper level residents, staff and patients to provide feedback on professional behaviors.

c. Ethical scenarios occur frequently during patient care. These issues are discussed and examined by the responsible faculty with the residents involved. An Ethics Committee is available for consultation, and may be used in difficult cases.

Participation– Residents at all levels.

Expectations– Appropriate dress, timely attendance to duties, leadership and teaching skills, integrity, caring, respectful, empathic and ethical interactions with diverse types of patients, family members, physicians, learners and staff. Upper level residents are expected to serve as role-models for lower level residents and all serve as role-models for students and staff.

2. Conferences –

Interactions and presentations during conferences provide opportunities for professional behavior, as well as faculty role-modeling. Some departmental and GME conferences cover professionalism topics.

Participation– Residents at all levels.

Expectations– Residents are expected to have timely attendance to meetings, appropriate participation, and respectful interactions with peers, faculty and learners during conferences.

3. Oral Examinations –

Oral examinations provide an opportunity for residents to demonstrate professional dress, demeanor, and behavior. Each resident is graded on their professionalism and this is shared with the resident through their faculty advisor. Any issues are discussed and recommendations on alterations in behavior are made.

Participation – Residents at the PGY-3 and PGY-4 levels.

Expectations – Residents will dress and carry themselves professionally, speak appropriately and respectfully to examiners.

4. Research –

The research project provides opportunities for professionalism.

Participation– All residents must complete by senior year.

Expectations– Discuss, plan, interact, and implement a research project with colleagues, faculty and researchers. Also, the resident must present their project to colleagues and researchers. Expectations are that the resident will dress appropriately, carry themselves professionally, present information appropriately, and respond to questions in a mature and respectful manner.

Systems-Based Practice –

1. Clinical teaching/experience –

a. On a daily basis each rotation's inpatient team is involved with the interaction of the various health care entities in order to facilitate comprehensive care, discharge planning, as well as outpatient coordination of care.

b. On a weekly basis each resident is involved in coordination of various health care services and outside resources to provide care in the outpatient setting.

Participation – Residents at all levels.

Expectations – Residents will learn and utilize hospital, local, regional, and even national resources to enable appropriate, cost-effective care.

2. Conferences-

Conferences such as weekly Resident Teaching Series, MFM and GME conferences, monthly Q/A, Grand Rounds, and Journal Clubs in which the residents often actively participate in discussions about their health care system and its best utilization.

Participation – Residents at all levels.

Expectations – Residents will be able to knowledgably discuss various resources at various levels to enable appropriate, cost-effective care.

3. Oral Examinations -

Oral examinations provide an opportunity for residents to demonstrate knowledge of care in our system. Each resident has graded their ability to utilize systems-based practice and this is shared with the resident through their faculty advisor. Any issues are discussed and recommendations are made to improve this competency.

Participation – Residents at the PGY-3 and PGY-4 levels.

Expectations – Residents will demonstrate, through their case list and the oral examination, appropriate use of ancillary and other systems-based resources in caring for patients.

Patient Care –

1. Clinical teaching/experience -

The majority of patient care teaching occurs in the inpatient and outpatient setting. Teaching rounds, L&D board rounds, continuity clinics and on call are particular venues in which patient care issues are addressed. Residents at all levels participate in teaching this competency to medical students, and upper level residents share the responsibility with faculty to teach junior level residents.

Participation – Residents at all levels.

Expectations – Residents will develop increasing responsibility for direct and indirect patient care issues over the four years of training. They will take appropriate care of patients and be competent surgeons. A continuum of this competency will be demonstrated through the evaluation process throughout the four years of training.

2. Conferences –

Weekly conferences in all sections: MFM, Gynecology, Gyn Onc, REI and Urogyn provide information on patient care issues. Other conferences, particularly monthly OB and Gyn Q/A provide presentation and participation opportunities for residents on direct patient care issues. The Resident Teaching Series provides 1-2 times a month laparoscopic skills and obstetric skills labs.

Participation – Residents at all levels, with increasing participation through the four years.

Expectations – Residents will demonstrate solid, appropriate, reproducible patient care skills during presentations and/or participation in conferences and skills labs.

3. Oral examination –

Oral examinations provide an opportunity for residents to demonstrate their methods of patient care. Each resident is graded on their responses to standardized patient scenarios, as well as their case list. Any issues with patient care are shared with the resident through their faculty advisor, and recommendations on patient care are made.

Participation – Residents at the PGY-3 and PGY-4 levels.

Expectations – Residents will compile a patient list as well as present patient care issues, and discuss standard patient care scenarios appropriately.

Medical Knowledge -

1. Clinical teaching/experience -

The majority of medical knowledge teaching occurs in the inpatient and outpatient setting. Teaching rounds, L&D board rounds, and continuity clinics are particular venues in which medical knowledge is queried and addressed. Residents at all levels participate in teaching this competency to medical students, and upper level residents share the responsibility with faculty to teach junior level residents.

If any concerns are expressed through the evaluative process, resident-specific remediation and/or educational processes are developed to ensure adequate training in this competency.

Participation – Residents at all levels.

Expectations – Residents are expected to demonstrate a continuum of medical knowledge throughout the four years of residency.

2. Conferences –

Weekly conferences in all sections: MFM, Gynecology, Gyn Onc, REI and Urogyn provide information on medical knowledge. Other conferences such as monthly OB and Gyn Q/A, monthly Journal Club and Grand Rounds provide presentation and participation opportunities for residents dealing with medical knowledge. The greatest conference for this is the Resident Teaching Series where standard OB and gyn textbooks are discussed and residents are quizzed on monthly. Resident-specific educational remediation will occur as needed.

Participation – Residents at all levels, with an increasing participation over the four years.

Expectations – Residents will demonstrate appropriate medical knowledge for their year of training during presentations and discussions.

3. Oral Examinations –

Oral examinations provide an opportunity for residents to demonstrate their medical knowledge. Each resident is graded on their responses to standardized scenarios, as well as their case list. Any issues with medical knowledge are shared with the resident through their faculty advisor, and recommendations on educational improvement are made.

Participation – Residents at the PGY-3 and PGY-4 levels.

Expectations – Residents will answer medical knowledge questions from their patient list as well as discuss standard medical knowledge questions appropriately.

4. CREOG Examination –

This examination is taking annually in January. Residents are given their scores and this is reviewed with both the Program Director and their advisor. Recommendations for increasing medical knowledge in any areas of concern are made.

Participation – Residents at all levels.

Expectations – Residents will demonstrate an improvement in scoring throughout their training. Residents will maintain scores above 2 standard deviations below the mean for each year of training. Any educational recommendations will be followed.

Resident Evaluation Process Utilizing the Competencies

Constructive feedback and evaluation is an integral part of resident education and training. A system has been established which offers assessments in each of the ACGME competencies:

- Patient Care

- Medical Knowledge
- Practice Based Learning and Initiative
- Systems Based Practice
- Interpersonal Skills and Communication
- Professionalism

Each competency is measured by using multiple evaluation tools by multiple evaluators (i.e. faculty, resident peers, patients and students). The table on the following pages outlines such tools and the competencies each addresses. Following the table is an expanded written list of the evaluations categorized by competency, with additional explanations. Examples of the evaluation forms are also included.

The formal evaluation process generally follows this scheme:

- Face to face mid-rotation verbal performance evaluations performed by the faculty of each service (while this is strongly encouraged, it is not required; but, residents should request it whenever feasible).
- Written summative evaluations by faculty will be solicited at the conclusion of every rotation. The chief residents are also requested to fill out such evaluations of their junior residents at the end of the rotations. For night float, all faculty who participate in call are encouraged to fill out evaluations.
- Junior residents complete evaluations of their senior residents at the end of rotations.
- At least one patient per quarter should be asked to fill out an evaluation of resident performance in his/her continuity clinic.
- Residents are evaluated by faculty in his/her continuity clinic quarterly using a summative Clinic Evaluation.
- Residents are evaluated on surgical skills using an Operative Performance evaluation. Residents are expected to assist faculty with obtaining this evaluation for each case he/she performs.
- Students are asked to fill out evaluations of the residents with whom they are rotated at the junior and/or senior level.

- Residents participate in Oral Examinations once a year at the PGY-3 and PGY-4 level. This is scored in a manner similar to the ABOG examination. Results are reviewed with the resident's advisor.
- Residents take 7 of 9 written quizzes on book chapters throughout the year. Significant and consistent poor performance may result in remediation.
- Residents will begin taking hands-on skills tests in both a laparoscopy and obstetric laboratory.
- Residents fill out Self-Evaluations on an annual basis.
- Faculty may fill out Focused Assessment of Competency (FAC) on particular encounters with residents.
- Resident Advisors meet with residents twice a year on a formal basis to review performance. This occurs in the fall and spring. Residents are welcome to meet with his/her advisor any time it is felt necessary.
- The Program Director reviews all, verbal feedback, case logs, operative performance evaluations, and oral/written exam results at least twice a year in December and June. The outcome of this review is communicated to the residents in a face-to-face meeting.

Program Evaluation

The design of the residency program must be flexible enough to respond to changing RRC requirements, modifications in faculty composition and other changes in the medical marketplace. The ability of the existing program to meet the resident's ongoing training needs must be continuously evaluated. To this end, resident input will be solicited for each major component of the program:

- Monthly: Residents have representatives on the Education Committee, which meets monthly
- Quarterly: Residents evaluate the faculty and rotations
- Annually: Residents evaluate the program as a whole, on paper and at a Resident Retreat

These evaluations are reviewed with the appropriate faculty member, Section Director, Chair and Program Director on an annual basis. Resident teaching evaluations figure prominently in faculty performance reviews.

Residents are encouraged to share their concerns or suggestions for program improvement with any or all of the following: the Administrative Chief Resident, the Program Coordinator, or the Program Director.

	Patient care	Med knowledge	Inter. Skills/Commun.	Professionalism	SBP	PBL
Global Evaluation every rotation except Ambulatory	X	X	X	X	X	X
Clinic Evaluation quarterly and with Ambulatory rotation	X	X	X	X	X	X
Operative Evaluation every case	X	X	X			
Peer Evaluation every rotation			X	X		
Patient Evaluation at least 1/quarter			X	X		
Student Evaluation every 6 weeks			X	X		
Quizzes Monthly		X				X
Surgical Simulators Monthly	X	X	X	X	X	
CREOG Exam Yearly	X	X				
Oral Exam Yearly	X	X	X	X	X	X
FAC as needed	X	X	X	X	X	X
Self Assessment Annually	X	X	X	X		
Written Evaluation by ancillary staff End of Rotations	X		X	X		
Education Portfolio Ongoing		X	X			X

Outcome Measures for the Competencies

Currently in place the Ob/Gyn Department Medical Education Committee uses several tools to evaluate outcomes in the various competencies. Many of these tools overlap to measure several competencies. We are also in process of developing additional outcomes measures that will be discussed under each section below. This list is to serve as an expansion of the table on the previous page.

Patient Care

1. The yearly in-service exam and the yearly oral exam are tools which provide objective measures.
2. Operative focused assessment evaluation cards were implemented in the fall of 2002 and provide direct evaluation of the residents' surgical skills. Presently they are used as immediate feedback but may be used in credentialing in the near future.
3. General focused assessment tools are in development of use to evaluate such patient care outcomes as performance of the history & physical exam as well as patient counseling.
4. Similarly, biannual Records Review will be implemented to assess outcomes in patient care (for example, preventative services).
5. We are early in the process of developing surgical simulators from which we can then measure outcomes in the operating room.

Medical Knowledge

1. The yearly in-service exam and yearly oral exams are considered to be the most objective outcomes measures of this competency.
2. We are developing Focused Assessment of Competency tools whereby this competency can be assessed on a periodic interval (such as the resident's presentation at a case conference and adequacy of medical knowledge demonstrated in such venues).

Interpersonal & Communication Skills

1. The Global Assessments provide a summative measure in this competency.
2. The residents are also evaluated by peers and patients providing a measure of their progress in communication skills.
3. We are also in process of developing Focused Assessments to provide a measure of the residents skills (will be done in all patient settings and for resident presentations at case conferences).

Professionalism

1. The Global Assessment provides a summative measure in this competency.
2. Peer and patient evaluations provide diverse outcomes in measuring the residents' professionalism. For example, we can measure patient satisfaction as well as student satisfaction.
3. We are in process of developing Focused Assessment tools for additional outcomes that can be assessed in the area of professionalism.
4. Also in development are self assessment tools to measure the residents' progress in self evaluation over the course of their residency.

Systems Based Practice

1. The Global Assessment provides a summative measure in this competency.
2. The oral exam also provides a measurable outcome in the residents' knowledge and application of the health care system.
3. The development of Records Reviews with the residents will also provide a measurable outcome in respect to the residents practice of cost effective medicine, patient advocacy, and healthcare delivery systems.

Practice Based Learning & Improvement

1. The Global Assessment completed after every rotation provides a summative measure of the resident's abilities in this competency.
2. The oral exam also provides an objective measure of the resident's knowledge and application of the literature, use of information technology, and evaluation of their own practices.

3. The tools in development including Records Review and Resident Portfolio will provide measurable outcomes (such as comparing their practice to benchmarks, journal clubs presentations, clinical topic reviews, etc).