

RESIDENT HANDBOOK

***Department of Obstetrics, Gynecology
& Reproductive Sciences***

2006-07

TABLE OF CONTENTS

FORWARD	3
GENERAL CONSIDERATIONS	4-5
PAGERS	5
SCHEDULE FOR CONFERENCES	6-7
Daily Conference	
Committees	
Important Dates for Residency	
National Conferences	
CREOG Exam	
DUTY HOURS – 80 Work Week	8
DAILY RESIDENT SCHEDULE	9-10
CONTINUITY CLINIC	11
SERVICE OUTLINE	
Gynecology	12-13
Obstetrics	14-16
Maternal Fetal Medicine (MFM)	16
Gynecologic Oncology	16-17
Reproductive Endocrine & Infertility	17-18
Urogynecology	18
Elective	18-19
Night Float	19-20
LISTS	21
RECORD KEEPING	21
ABORTION/TERMINATION OF PREGNANCY	21
LEAVE OF ABSENCE	22
CALL SWITCHES	22
GUIDELINES FOR MORBIDITY AND MORTALITY CONFERENCES	
Obstetrics	23-24
Gynecology	25-26
COMMUNICATION IS KEY	27

Forward

Dear fellow residents,

We are looking forward to working with you this upcoming year. As you may recognize, the advent of the new work hours and restrictions has led to a comprehensive restructuring of the individual services and our schedules. Please keep in mind that this is actually a work in progress. We have worked hard to try to incorporate your suggestions and make them work within the confines of the new “rules.” Phase 3 of the ACGME Outcomes Project needs to be implemented by July 1, 2007, so we will continue to rely on resident input as to how we can continually improve the training program.

Only with continued, open communication and cooperation can we re-shape our residency to make it fall within the rules and regulations of the Residency Review Committee, while making it one of the best residencies in OB/GYN in the country. We look forward to hearing your comments and suggestions. Let’s make this year successful, and most importantly, enjoyable.

Sincerely,

Ryan and Elena

General Considerations

1. You'll notice multiple reminders in the following text, but let us re-emphasize the need ***to show up to clinic on time!*** Simply make it your priority to come to clinic on-time, no matter what you are doing before your clinic. Verbal warnings followed by letters in your file can be expected.

2. **Given that we are thinly spread out across several busy services it should be understood that there is no time allotted for days "off." If you need a day off outside of vacation, for example, to take the boards, interviews, doctor's appointments, you will need pre-approval, at least one month in advance, and additionally will be required to find coverage for that day if you're on service. You will find a copy of the "Unscheduled Days Off" Request form in the Appendix Section. If you are sick, it is your duty to notify the Chief Resident on your service or one of the Administrative Chief Residents, AND the Residency Coordinator, Patti Johnson (ext. 5-4004) on the day you are absent. An "Unscheduled Days Off" Request form will need to be submitted by you upon your return. Any absences due to medical reasons will require a doctor's note upon your return to duties stating that you are well enough to resume clinical duties.**

3. **Discharge summaries - If you discharge a patient from the floor, it is your responsibility to dictate that chart prior to it leaving the floor, regardless of whether the patient is "yours" or whether you are cross-covering the service, for example, on the weekend. This is a matter of common courtesy to your fellow residents and attendings. If your note is the last in the chart on the day of the patient's discharge, you will be tracked down by an attending anyway, so do the dictation while you remember the patient, not weeks after when you do not have time to do it and do not remember anything about the patient. Also remember, it is not necessary to dictate vaginal delivery patients unless they are non-routine cases, e.g. admitted with antepartum complications, operative deliveries, tubals, etc. Poor medical record keeping skills will be noted in your permanent record.**

4. This year, we are phasing in the concept of the **TEAM Continuity Clinic** in the Women's Center (WC). The PGY-3 and PGY-4 residents have all been assigned to a "private practice" team in the WC: Red Team, Yellow Team, and Blue Team. They are the "senior partners" and permanent members of each team. PGY-1 and PGY-2 residents are the "junior partners" in the 3 practices and will be rotating in and out of the 3 teams based on their rotation schedules. Each team will have their own cluster of patients to be shared among the PGY-3 and PGY-4 members. Once a patient has been assigned to a Red, Yellow, or Blue team, the patient needs to be seen by a member of that team—even for follow-up visits or to be scheduled for surgery. The pre-op clinic is now being absorbed into each of the Team Continuity Clinics; each team needs to schedule and pre-op their own patients. **The goal is to schedule elective surgeries for any of the "Senior Partners" during the time they will be on the GYN Service.** The "Senior Partner" can then supervise one of the "Junior Partners" through the surgery. **The WC patients are YOUR patients.** If you have booked a surgery for yourself, no

matter how small (including D&C's or tubal ligations), it is YOUR responsibility to show up for surgery and supervise or perform the surgery on YOUR patient—regardless of the distractions of “better cases” on the schedule that day. **Do not expect the WC attending to do the case for you or take one of the junior residents through the case for you.** Professional responsibility is an ACGME requirement.

5. Please understand that your administrative chiefs are trying very hard to ensure everyone has an equal experience (i.e. calls) throughout the year. Obviously, everyone won't have the *exact* same experience, e.g. someone may do Onco during a 9 wk vs. an 8 wk block. Additionally, there are little nuances involved with scheduling, the details of which do not need to be exhaustively explained in the handbook. All said, please do not harass your administrative chiefs with needless whining and requests for “equaling” out the call schedule, etc. Your administrative chiefs long ago realized it is both in your and their best interests to keep everything as equal as possible (and thus “fair”).
6. That being said, please feel free to get in touch with us with any questions or comments. We would like to think of ourselves as your representatives and advocates.

*** PAGERS:**

Please make every attempt to answer pages within 5 minutes of beep...if delayed, please apologize to the caller. The subject may seem trivial to you, but the inexperienced nurse looking for a Tylenol order is hanging on your every word! The ACGME is now requiring Nurses, fellow residents, and other allied professionals to perform 360° evaluations of individual residents. Courtesy, Professionalism, and Respect, and timeliness of responding to a page are all being evaluated. Team pagers (eg. ED pager, L&D pager) are your responsibility to pass on from shift to shift. Any lost pagers or pagers left at home should be brought to the Residency Coordinator's attention immediately so that we can arrange alternate forms of communication.

Schedule for daily conferences

All attempts are made to provide a broad coverage of CREOG topics as well as the requirements dictated by the RRC. It takes a tremendous amount of effort to schedule the speakers as well as an immense commitment on the part of the speakers to prepare the presentations and appear on time; it is therefore appropriately expected of all residents in the program to make all effort to attend the scheduled talks; conferences marked with an asterix* are mandatory and occupy protected time slot. Attendance will be maintained and absences will be recorded; consistent absentees will be reported to the program director and run risk of imposition of extra calls and **a note being made in your permanent record. Attendance at the Thursday afternoon Resident Lecture Series is an ACGME requirement.**

* Protected teaching time is currently 12 noon – 4 pm each Thursday. You will be provided a schedule of topics approximately one week prior to each session.

Important dates for the Residency

Holidays:

Independence Day July 4 th	Tuesday - July 4, 2006
Labor Day	Monday - September 4, 2006
Thanksgiving	Thursday - November 23, 2006
Christmas	Monday - December 25, 2006
New Year's Day	Monday - January 1, 2007
Good Friday	Friday - April 6, 2007
Memorial Day	Monday - May 28, 2007

Conferences:

- ❖ **SGI/SMFM:** The Interns **may be** sponsored by a pharmaceutical company to attend either the SMFM (early February) or SGI (early March) - from Wednesday to Saturday. The Administrative Chief Residents have already **ASSIGNED** the Interns to attend one of these 2 national conferences based on rotation schedule. Do not expect to attend BOTH conferences. They are expected to take their week day calls until the day of departure as well the Sunday call for the week-end.
- ❖ PGY-2, 3, and 4 residents will be allowed to attend **ONE** national conference each year within the Continental United States if they are presenting a poster or oral presentation.
- ❖ Each PGY-4 resident may be allowed to attend a conference of choice, pending approval of program director and adequate completion of clinical/administrative responsibilities, and **ONLY** if they are not already attending and presenting at another conference during the PGY-4 year.
- ❖ Other conferences available: ASRM, SGO, SMFM, ACOG, SGI .
- ❖ Conference leave must be scheduled 2 months in advance with the Administrative Chief Residents and the Program Director to determine coverage and application fees. Any fees posted over the discounted “Early Bird” rates for the national conferences must be charged to the Resident Book Fund.

- ❖ The Ella Grasso Conference is a locally organized conference to discuss cutting edge advancements in the management of Ovarian Cancer that is held annually. The Administrative Chief Residents will be arranging a special coverage schedule to maximize attendance from the Residency.

Other Special Days:

- ❖ **CREOG Exam** Friday, Saturday - January 19 & 20 ,2007. **Satisfactory performance (Score > 200 for your year of training) is required for maintaining your elective, travel privileges, and possible advancement in the program. Residents with CREOG scores < 200 will be subject to academic remediation.**

All residents/interns should confirm with the administrative Chief Residents regarding the choice of the day to take the examination. Residents on call on Friday will be taking the exam on Saturday and vice-versa. The rest of the residents will be allocated by Administrative Chiefs to assure appropriate service coverage.

The remaining dates should be noted in your calendar as important days to block out on your calendar so that you can attend these important events.

- | | |
|------------------------------------|------------------|
| ❖ Resident Christmas Party | TBA |
| ❖ Resident Retreat | TBA |
| ❖ Stump the Professor Day | June 7, 2007 |
| ❖ Resident Research Day and Dinner | June 8, 2007 |
| ❖ Residency Interviews | December 9, 2006 |
| | January 6, 2007 |
| | January 13, 2007 |

WORK/DUTY HOURS
(80 Hour Work Week)

Compliance of 80 work week is outlined below:

- Duty hours must be limited to 80 hours per week, averaged over a 4-week period inclusive of all in-house call activities. (Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care - both inpatient and outpatient, administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences).
- Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one **continuous** 24 hour period free from all clinical, educational, and administrative activities.
- Adequate time for rest and personal activities must be provided. This should consist of 10 hour time period provided between all daily duty periods and after in-house call.
- In-house call must not occur more frequently than every third night, averaged over a four-week period.
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.
- No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as “any patient for whom the resident has not previously provided care”.
- At home call is defined as call taken from outside the assigned institution. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
- * **To remain in good standing each resident must be current in recording their duty hours in the E*Value system.**

Daily Resident Schedule

All residents on service are expected to pre-round on their assigned patients prior to Morning Report. GYN Morning Report begins at 7:00am and consists of the Night Float Residents signing out to the Daytime GYN team. OB Morning Report begins at 7:30am and consists of the Night Float Residents signing out to the Daytime L&B team and MFM team. The interns on Internal Medicine, resident on elective, GYN Oncology teams round at their other predetermined times. The Urogynecology Resident and REI Resident will be expected to attend GYN Morning Report to present any In-patient GYN patients to the GYN Morning Report attending.

Morning Rounds

- ❖ All patients on the Gyn and OB services should be seen, progress notes written and orders updated before sign out. You may not have time to go back and catch up until later in the day.
- ❖ All members of the OB and Gyn teams are expected to be present on time for sign out and morning report and prepared to present any of their patients.
- ❖ All members of the OB team are expected to stay for perinatal rounds and teaching activities except with direct approval of the OB Chief. This is not a time to catch up on rounding.
- ❖ On weekends, although there is no morning report, often there will be active patients on L+B and we therefore ask that rounding and progress notes be completed by sign out at 8:00 AM, with incoming and outgoing residents sharing the responsibility.

Sign Out

- ❖ Sign out time is 5:30 PM Monday through Thursday by all teams at Yale. All the night float team members (except for the resident covering Onco at night, who will take sign out from the day Onco team directly) are expected to be in the conference room on L&B at 5:30 pm SHARP to take sign out from day teams: OB, HR, GYN, Urogyn. The YOCA will be present, and the GYN call attending as indicated
- ❖ Everyone not on call signs out at **5pm on FRIDAYS**.
- ❖ Sign out for Night Float is at 6:30am Monday through Friday. NF hours are 7 pm -7:30 am Sunday - Monday, 5:30 pm – 7:30 am Monday through Thursday.
- ❖ All junior members of teams are expected to sign out with service Chiefs.

Conferences (also see conference schedule page)

- ❖ All residents are expected to attend the Thursday afternoon Resident Lecture Series promptly at 12:00 noon, with service coverage provided by designated fellows and faculty.
- ❖ Attendance at conferences will be recorded; lecture evaluations must be filled out
- ❖ All residents are expected to present at Debate Club to review journal articles several times during the year while on GYN and OB rotations. Topics will be chosen by faculty or Residency Program Director and the articles will be assigned to various members of the 2 teams. If particular team members are on vacation, the Program Director will assign participation to additional residents on other subspecialty rotations.

Admissions from Women's Center (WC)

- ❖ All patient admissions from WC clinic should be brought to the attention of the respective Chief resident (OB or Gyn), after 5:30 pm – Chief Resident on NF or on-call Chief Resident (on Fridays)
- ❖ It is the responsibility of the resident Chief of the service to notify the covering attending regarding the admission.
- ❖ It is the responsibility of a member of the in-patient team (OB or GYN) as designated by the Chief to perform the history, physical, admission note and orders for the patient. Of note all private patients admitted from offices or through ER should also be admitted by corresponding team members in a timely fashion (except during protected teaching time, attendings should provide H&P's and admission orders). Surgical patients from WC are the primary responsibility of the Chief Residents on the respective services.

Morbidity and Mortality Conference

- ❖ All M+M cases should be presented by the Chief or Senior resident most involved with the case. Interns and juniors are exempt from presenting.
- ❖ Possible cases for M+M should be discussed with Drs. Simon/Bercik (Gyn) or Dr. Buhimschi (OB) weekly and a draft of the write up should be submitted to them a week prior to the conference to .
- ❖ It is the responsibility of the presenting resident to make each M+M case presented interesting and educational for all attendants at the conference.

Surgical Experience

- ❖ All attempts are made to make the surgical experience balanced and fair for every resident.
- ❖ The chiefs and so on in order of level of experience have the first choice et cetera for choosing in which cases he or she may participate. There are certain cases that are appropriate for certain level residents – for example vaginal hysterectomy – PGY3 /4; Urogyn cases (excluding AP repairs) – PGY-4, abdominal hysterectomy – PGY-2, D&C – PGY-1, etc.

Continuity Clinic

- ❖ Every PGY2-PGY4 resident must attend weekly continuity clinic except when on vacation, when on the PGY3 elective, or on night float. PGY1 residents have clinic during their outpatient OB rotation. The clinic sessions are 8am-12pm; 1pm-5pm; no residents are assigned to clinic during protected teaching time.
- ❖ YOU MUST **BE ON TIME** TO YOUR ASSIGNED CLINIC---**NO EXCEPTIONS!!** If you change your schedule you must notify the Administrative Chief Residents. If the Administrative Chief Residents are unavailable, Dr. Bercik should be notified.
- ❖ All *cancellations* and *switches* of clinic must be made through the Administrative Chief Residents or Dr. Richard Bercik and submitted on the Resident Vacation/Meeting Request form 4 weeks in advance. Forms are located in the Women's Center and Patti Johnson's office (338B FMB)
- ❖ At the beginning of each new rotation, every effort must be made by the chiefs/senior residents of the rotations to remind their team of their clinic schedule. This is a professional responsibility!!!!!!
- ❖ Every attempt to dress professionally should be made. If you have no choice, then scrubs must be clean and a white coat should be worn over them.
- ❖ For every morning session starting at 8am, there will be a 15 minute teaching session from 8 to 8:15 regarding any topic the residents wish. From 8:15-8:30am patients will be discussed- including those on the ectopic pregnancy list.
- ❖ **Patient Load:** Chiefs are expected to see 1 patient every 15 minutes. PGY3's are expected to see 1 patient every 15- 20 minutes. (PGY2's are expected to see 1 patient every 20-25 minutes. Every effort during the first few months of the year will be made to limit the number of patients given to the PGY2's until they are more comfortable in clinic. Every effort will be made to have 2 residents from the same Clinic team (Red, Yellow, and Blue) will be assigned to see patients together. The template will be limited to approximately 20 patients for the team to see together. The clinic session does not end until all of the patients in the combined template is seen—so it behooves the team partners to work together to assure that they both finish at the same time.
- ❖ **Your clinic schedule will change depending on your service assignment. It is your responsibility to check the schedule and be present.**

Obstetrics and Gynecology Residency Program
Yale University School of Medicine
Yale-New Haven Hospital

Service Outline

Gynecology Service:

The gynecology service is centered on benign gynecological operative experience at Yale-New Haven Hospital and the Women's Surgical Center (Yale-New Haven Ambulatory Services). This service will provide experience (commensurate with training level) in vaginal, advanced laparoscopic, abdominal, and minor laparoscopic/vaginal procedures. In addition to operative technique, residents become aware of pre-operative evaluation and intimately involved with post-operative care. Duties include coverage of the Community OB/GYN service as well as the University/Women's Center Service

In addition to operative experience, PGY-1 residents may be asked to investigate the acuity of the patients in the ED. The PGY-1 must evaluate an ED patient under the direct supervision of PGY-2 resident or higher level. PGY-2 residents or higher are responsible for initial GYN consultations to the Yale-New Haven Hospital Emergency Room. Initial consultations are handled by the PGY2 in concert (as needed) with the GYN Chief Resident/Night Float Chief Resident. A 24-hour/7 days-a-week attending coverage insures proper supervision. All patients seen in the ED must be reported to a fellow, community attending, GYN attending on-call, or YOCA. This schedule is updated by the residency coordinator and forwarded to the Emergency Room staff.

*Residents are expected to dictate all operative reports immediately following the procedure. Discharge summaries are to be dictated by the resident at the time the patient is discharged. Delinquent dictations will result in loss of resident privileges (elective rotation, conference time & possible promotion) – **This requirement applies to all rotations.***

Resident Staff and Duties:

Chief Resident (CR)

- Responsible for all in-house Women's Center GYN patients and be prepared to present them at *morning report* (although they may request a more junior make the actual presentation). Every effort will be made for the GYN cases to be presented by the resident who was actually scrubbed in the case.
- Responsible for assigning residents to operative cases
 - o in an effort to provide appropriate operative assistance, the CR should contact each attending physician the week prior to their scheduled OR case to determine the complexity of the case.
 - o rough outline of appropriate OR coverage:

- CR – TVH, advanced laparoscopic, urogynecologic procedures (not covered by the Urogyn CR)
 - PGY3 – complicated TAH or abdominal procedures, uncomplicated TVH, urogynecologic procedures (not covered by UroGyn, advanced laproscopic)
 - PGY2 – basic abdominal procedures, uncomplicated TAH, ER coverage
 - PGY1 – simple laparoscopic procedures, clinic tubal ligations, D&C’s
 - Women’s Surgical Center (WSC) PGY1 – see below
- Responsible for collecting cases for the monthly *Morbidity & Mortality* conference
 - CR are to meet with Drs Bercik and Simon on a regular basis.
 - Failure to meet this obligation will result in an “insufficient” mark during this rotation
 - It is anticipated that at least three clinically relevant cases will be presented each month
 - If cases are not forth-coming, it will be the responsibility of the GYN CR to prepare a PowerPoint presentation of educational value for this conference
- Responsible for medical student operative a clinical oversight
- Ultimately, the GYN CR is *responsible for all aspects* of the GYN service outlined below.

PGY3:

- The PGY3 is assigned to appropriate operating room cases as designated above
- Act as a consultant to the PGY2 in the Emergency Room if the CR is occupied
- Urogynecology surgical cases and Urogynecology Faculty Practice experience with Dr. Connell are a priority

ER PGY2:

- Responsible as “first call” to the Emergency Room, but may take a PGY-1 with them
- Coverage of GYN floor issues

Ambulatory Surgery PGY2:

- Coverage of the Women’s Surgical Center out-patient cases
 - 3 days/week
 - Specifically, this resident will be available for uncovered cases at the WSC (laparoscopy, hysteroscopy, D&C, cone biopsy etc.)
- Planned Parenthood/Dr. Susan Richman
 - 2 days/week (Mondays and Wednesdays)

PGY1:

- Coverage of tubal ligations and D&C’s
 - WSC if no scheduled cases – as cases allow
- Coverage of cases as assigned by the CR

Obstetrics Service:

The in-patient obstetrical service is responsible for coverage of activities occurring in the ante-partum testing unit, Labor & Birth (L&B) unit, and the post-partum floors. These activities include (but may not be limited to) evaluation of non-stress tests/biophysical profiles, early labor lounge evaluation, admission and progress of university/clinic & community patients in labor, delivery (vaginal and cesarean section) of university/clinic & community, following all university/clinic post-partum patients, following all complicated ante and postpartum community patients.

The residents serve as primary-care providers to the resident-clinic patients on L&B. As such, they are responsible for adequate documentation of admission, labor progress, delivery, and postpartum care (with supervision of the Yale On-Call Attending/YOCA). Please refer to the Obstetrical Documentation Outline for specific requirements. Recognizing the substantial service provided (patient care and resident-teaching by the midwives) and the wonderful collaborative relationship with the Yale Nurse-Midwifery program, the CR on service will (in conjunction with the YOCA) act as a consultant for these patients. In accordance with the Yale-New Haven Midwifery guidelines, the CR will be immediately available for all clinic CNM deliveries (and document their attendance).

The Community Physicians also provide a substantial contribution to resident teaching during their service on L&B. In an effort to gain educational experience and provide superior patient care, the residency program will provide a resident that is dedicated to the community patients on L&B. This resident will provide evaluation of all community Early-Labor-Lounge patients (ELL). In addition, they will be constantly monitoring labor progress of these patients and be responsible for vaginal delivery assistance. If a cesarean section becomes necessary, the CR will assign an appropriate operative assistant. Although we recognize the limited availability of Night Float Residents, every effort will be made to maintain the continuity of this coverage 24hrs/7days.

50-75% of all community vaginal deliveries are being required to be turned to trainees (including residents) for your ACGME procedure logs. During walk rounds in L&B following OB Morning report, the residents should introduce themselves to all of the patients in L&B. Besides completing all of the "Green Sheets" (abbreviated H&P's) on all admitted patients, the residents should be writing progress notes at least **EVERY 2 HOURS** on every laboring patient on L&B, and even more frequently if the patient's condition changes. Once the resident is notified by clerical or nursing staff of an imminent delivery, the resident should be gowned and gloved to assist or perform the delivery. After being gowned and gloved for a delivery, the resident must remain in the room for the entire delivery (hands on the baby's head), delivery of placenta, perineal repair; and be responsible for writing the orders and delivery note. It is unprofessional to leave the room simply after delivery of the infant without completing all of the immediate post-partum tasks. The residents should make every effort to perform postpartum rounds on community patients in which the delivery was "turned" to a resident or a fellow resident.

Resident Staff and Duties:

Chief Resident:

- Responsible for all clinic patients (ante, intra & postpartum) and be prepared to present them at morning report
- Responsible for assigning appropriate level residents for obstetric operative procedures.
 - o Guideline of day-time OB OR assignments (see Night Float/NF below):
 - Primary C/S – PGY1
 - Repeat C/S – PGY2
- Responsible for all OB duties when assigned resident is unavailable
- CNM service
 - o Notified of all admissions
 - o Consultant (in conjunction with YOCA)
 - o Immediately available for all deliveries
- Ultimately, the OB CR is *responsible for all aspects* of the OB service (including MFM patients on L&B).
- Supervise Morning Rounds to assure that no resident is rounding on OB patients before 6:00am
- Assist PGY-3, PGY-2, and PGY-1's in completing their morning rounds
- Supervise PGY-1's and medical students in writing postpartum notes

PGY3:

- responsible for all in-patient activities on the MFM service if MFM PGY2 is on vacation
 - o Assist MFM PGY-2 on antepartum rounds
 - o Complicated C-sections
 - o Running L&B while PGY-4 is in WC
 - o Labor and Delivery duties
 - o Management of MFM patients in labor
 - o postpartum rounds & circumcisions

PGY2

- L&B coverage of clinic patients
- Repeat C/S
- Floor coverage of clinic patients
- Postpartum rounds on repeat C/S patients
- Supervise the PGY-1 on any complicated patient following vaginal delivery
- Assist the PGY-1 on any excess vaginal delivery patients

PGY1

- The PGY-1 residents should be responsible for no more than writing 10 postpartum patients each morning per PGY-1.
- Round on any primary C-sections that the PGY-1 performed
- ELL evaluations of community patients
- Postpartum rounds on any community patient that was delivered by a fellow resident
- Responsible for all community patients on L&B

- Green sheeting/admissions
- Following labor course
- Actively participating in deliveries

Maternal Fetal Medicine (MFM) Service:

The MFM service serves as consultant/primary care provider for local, regional and national referral of patients with complicated medical/obstetrical issues. In addition to providing superior patient care typical of any obstetric patient, residents on this service will be exposed to a multitude of complications ranging from chronic/acute medical maladies to issues unique to the obstetric population.

The resident program structure is designed to capture basic skills of obstetrical patient management (PGY1 year), apply them to outpatient care (PGY2) and finally manage these issues in an acute care venue (PGY3). Oversight on this rotation is provided by the MFM unit (attendings and fellows).

Resident Staff and Duties:

Chief Resident:

- Out-patient experience in MFM management issues
 - MFM Admissions from EP4
 - EP4 Outpatient Clinics -- Tuesday, Wednesday, Fridays
 - EP4 Ultrasound – Monday and Thursday mornings
 - At least one Tuesday afternoon per month with Dr. Lockwood at the Long Wharf office

PGY2 (MFM)

- MFM -
 - MFM antepartum in-patients
 - MFM Admissions from EP4
 - EP4 Outpatient Clinics -- Tuesday, Wednesday, Fridays
 - EP4 Ultrasound – Monday and Thursday mornings
- Responsible for notes on antepartum MFM patients
- Priority is to complete MSCU (10th floor WP) in-patient care before coming to EP4

PGY1:

- Out-patient
 - antenatal testing unit (NST/BPP)
 - basic ultrasound training
 - ½ day clinic session per week in Women’s Center

Gynecologic Oncology:

The Gyn Oncology service provides for extensive inpatient and outpatient experience dealing with patients plagued by gynecologic cancers. The PGY2 & PGY3 residents, along with oversight from fellows and attendings, provide comprehensive patient care for these individuals. Experience in complicated admissions, extensive operative experience (including exposure to radical surgery and lymph node dissections) and

the management of these patients postoperatively provide a management foundation for our residents. Residents not only gain operative experience, but are involved with chemotherapy and radiation therapy options. A comprehensive and collaborative pathology conference (tumor board) occurs weekly.

The CR serves on the out-patient GYN oncology service. They are involved with “first-visit” consultations, pre-operative evaluations and life management decisions (including end of life discussions). Extensive exposure to outpatient procedures (colposcopy, office LEEPs) is expected. In addition, this resident will spend 1 day per week in the Breast Clinic at Yale-New Haven Hospital under the direction of Dr. Donald Lannin (Professor of Surgical Oncology)

Because many of the women diagnosed with gynecologic cancers are post-menopausal, residents will be cognizant and receive instruction of special issues concerning menopause and geriatric patients.

Resident Staff and Duties:

Chief resident:

- “Endometrial Chief” or Oncology Surgery Chief
 - o GYN Onco clinic – 3 days per week
 - o Breast Clinic – 1 day per week
 - o Available for GYN Oncology surgical cases 5 days per week
 - o Must round on any GYN Oncology post-surgical cases by 7:30am before OR day starts.

PGY3

- Inpatient GYN Oncology service
- If time permitting, attend 1 half-day of GYN Oncology Clinic per week
- In-charge of service assignments
 - o PGY2
 - o Visiting residents
 - o Sub-interns

PGY2

- inpatient GYN oncology service
- If time permitting, attend 1 half-day of GYN Oncology Clinic per week

Reproductive Endocrine & Infertility:

The Reproductive Endocrine and Infertility division provides a 2 month rotation block for PGY3 residents. In addition to gaining knowledge of human reproductive endocrine function, residents are introduced to disruptions in physiology and function leading to endocrine and infertility problems.

Exposure to Advanced Reproductive Technologies (ART) is integrated into this rotation. In addition the out-patient clinic/surgery and the in-patient service, the PGY3 will have the opportunity to attend division specific conferences and journal clubs. Residents will also gain considerable experience in vaginal ultrasound for the diagnosis of vaginal bleeding, fetal viability, and ovarian stimulation.

Resident Staff and Duties:**PGY3**

- Outpatient clinic
 - o ultrasound/ART
 - o patient clinic visits
- In-patient service
 - o Present all in-patients to GYN Morning Report Team during the week at 7:00am

Urogynecology:

The division of Urogynecology and Reconstructive Pelvic Surgery provides a 2 month rotation for chief residents. During this rotation, they will learn the complete evaluation and treatment of pelvic organ prolapse, urinary and fecal incontinence, voiding disorders and interstitial cystitis. The CR will participate as a team member in both inpatient and outpatient settings. In the office setting, they will learn to take a detailed Urogynecological history, perform a physical examination pertinent to this field, and be instructed in the conduct of office procedures including urodynamic testing, office cystoscopy and pelvic floor rehabilitation. In the operating room, they will gain experience with incontinence procedures and reconstructive pelvic surgery, and will be involved in the post-operative care of these patients. There is a divisional journal club twice a month discussing the latest advances in the field where they may sharpen their evidenced- based analytical skills. By the very nature of this specialty, much of the specialty deals with issues of post-menopausal women. Whenever possible, residents will receive instruction of this discipline within the context of this specialty.

Resident Staff and Duties:**Chief Resident**

- Inpatient surgery
- Outpatient surgery
- Out-patient Urogynecology clinic (Dr. Bercik)
-

PGY3 (GYN)

- One out-patient Urogynecology session per week (Dr. Connell)
- Inpatient surgery (Dr. Connell)

Elective:

A PGY3 resident is eligible for elective participation if they are in good standing within the residency program prior to their scheduled rotation. Examples of non-qualifying performance include (but are not limited to):

- Performance on CREOG exams <190
- Experience logs indicate a deficiency in recording or operative/obstetric experience
- Unsatisfactory performance on specific rotations as revealed by evaluations
- Delinquency or continued lack of compliance with hospital/residency requirements (examples – dictation, compliance workshops etc.)

A resident applying for elective time must submit to the program director a written outline of the proposed activity and designate a mentor with a research project at least one month prior to the start of the rotation, and have the proper legal documents in place prior to beginning the rotation. Residents failing to comply with the requirements will forfeit the elective rotation and be assigned to one of the clinical services outlined in this document (as directed by the program director and the chairman of the department). **The PGY-3 elective time is an earned privilege, not an expectation.**

Resident Staff and Duties:

PGY3:

- Provide written outline of research focus
- Designate a mentor for elective and schedule regular meetings to assess progress
- If performing an off-site rotation, the legal documents must be in-place at least 1 month before the start of the rotation through the Program Director's office

Night Float (NF):

The night float service provides seamless coverage at YNHH on a Sunday-Thursday schedule. The coverage provides coverage of obstetrical services, GYN emergency surgery, emergency room consults, and the GYN Oncology service. Attending coverage for obstetrical services is provided via the YOCA. A separate GYN on-call schedule covers emergency room and clinic surgery during these hours. The Oncology fellows and attendings provide supervision for their service.

By nature, the NF rotation is a shift-based service (as opposed to an on-call service). Thus, residents are expected to be awake at all times. Prudent use of slow clinical activity during this rotation would include preparation for in-service exams and reading current journals.

The following is considered a guideline for resident coverage during night float:

PGY1

- L&B coverage
- All C/S at the discretion of the CR and YOCA

PGY2

- emergency room coverage
- AM rounds on clinic patients

PGY3

- GYN inpatients
- GYN Oncology coverage
- Cover L&B as needed
- AM rounds on private C/S

PGY-4

- responsible for all services in house
 - o may require the participation of the YOCA, GYN Oncology fellow or GYN on-call attending if the volume prohibits safe administration and oversight of other residents

- primary responsibility is to cover L&B with the intern
- primarily responsible for clinic and MFM patients

Lists, Lists, Lists

- ❖ Although obvious, we would like to remind everybody to place patients on the appropriate residents' list whenever a patient is admitted or operated on. If there is a question, consult a Chief resident. This will keep patients from being unintentionally neglected.
- ❖ If another team will follow the patient, this should be complemented by verbal sign-out.

Record Keeping

*One of the **most important** responsibilities of each resident is to document ALL surgical as well as relevant non-surgical/in-patient/ambulatory experience in the RRC online procedure recorder.*

PLEASE ENSURE THAT EACH SURGERY-OB/GYN IS DOCUMENTED/EACH OB ANTE NATAL IN-PATENT MANAGEMENT IS APPROPRIATELY RECORDED/EACH NEONATAL INTUBATION RECORDED (this includes laryngeal suction for meconium, utilizing laryngoscopic exposure)/AND ALL AMBULATORY CASES ARE RECORDED. The latter includes cases seen in the ED by the interns rotating through the ED as well as cases seen in ambulatory services.

See Appendix for Expectations for Record Keeping

Abortion/termination of pregnancy

Please inform the executive CR's if performance of abortions is against your religious/personal beliefs. An opt-out form will need to be signed and placed in your permanent record. Residents can not opt out of performing uterine evacuations of intrauterine fetal demises (IUID). However, ALL resident/interns must learn to manage complications related to abortions and can not discriminate against patients who are seeking care following a termination of pregnancy. Experience will be gained as intern on GYN service and during your Ambulatory Surgery/Family Planning rotation (PGY2).

Leave of Absence

Each resident is allowed 4 weeks of vacation time per year. ALL VACATIONS NEED TO BE APPROVED BY THE EXECUTIVE CRs. Any leave from work in excess of the above, including maternity leave, has to be in accordance with the ABOG statement.

The allotted vacation time for each resident is 4 weeks/year.

As stated by the American Board of Obstetrics and Gynecology, residents are allowed to take up to a maximum period of 20 weeks time off from work (over the duration of the residency) at the discretion of the Program Director. This applies to a leave of absence for any reason. Leave should not exceed 8 weeks in PGY1-3. For the Chief Resident's the maximum total time allowable is 6 weeks. The Board mandates that time in excess of this stated total must be made up at the end of the residency.

As the persons involved in making up the schedules, it is the responsibility of the executive chief residents to notify the Program Director if any resident is at risk of exceeding the allotted vacation time of 4 weeks/year.

See Appendix for Unscheduled Time Off form.

Call Switches

Call switches can only be made between residents of equivalent levels and should not compromise adequate coverage of our duties. Call switches can not violate the work-hour regulations. All call switches MUST be coordinated with the administrative chiefs in written form one-week prior, and communicated to the program coordinator.

GUIDELINES FOR OBSTETRIC AND GYNECOLOGY MORBIDITY AND MORTALITY CONFERENCES

Obstetric Morbidity and Mortality Conference

Cases to be reviewed include all cases of mortality and significant morbidity:

1. Maternal mortality
2. Blood loss requiring replacement >5 units packed RBC's
3. Cesarean hysterectomy
4. Uterine / rupture
5. Placenta accreta / peruretia
6. Eclampsia
7. Pulmonary edema
8. Generalized sepsis
9. Ph at birth <7.0
10. Fetal mortality
11. Significant fetal morbidity, related to forceps, vacuum, shoulder dystocia
12. Obstructed labor with outcome of fetal Apgar score <4, 1 minute
13. Amniotic fluid embolism
14. Pulmonary embolism
15. Any case of maternal or neonatal morbidity which residents, attendings or midwives feel was attended by substandard care and needs to be reviewed

OBSTETRIC MORBIDITY AND MORTALITY REPORTS

The senior residents on MFM and L&B rotations are responsible for reporting all the Morbidity and Mortalities on those services to Dr. Stephen Thung on a weekly basis. This is part of your responsibility as the resident in charge of these services. This reporting should be done every Wednesday, face to face if possible.

You, or one of your colleagues, must write up the details of each event. All mortalities must be written up including the following details: patient's initials, admitting and discharge date, physician in charge, admitting diagnosis, operation, pathology obtained, complication and reason for the mortality. Expected mortalities should include a brief synopsis but unexpected mortalities will need more details.

Morbidities like returning to the OR, readmissions, massive transfusions, or unexpected intraperative or postoperative complications must be reported in detail. Any unusual or interesting cases should also be brought to Drs. Buhimschi or Sfakianaki's attention. The attending physician must be notified that their case is on the list to be presented. In addition, these cases must be submitted to Lynn one week prior to the conference.

This responsibility is **NOT ELECTIVE, IT IS REQUIRED** and has the overwhelming support of our department. Our M&M conference should be a learning experience for you and your audience. Let's make it that!

GYNECOLOGIC MORBIDITY AND MORTALITY REPORTS

The senior residents on Benign Gyn and Reproductive Endocrine are responsible for reporting all the Morbidity and Mortalities on those services to Dr. Howard Simon on a **weekly** basis. This is part of your responsibility as the resident in charge of these services. This reporting must be done **every Wednesday**, face to face if possible. The chief residents in charge of benign Gyn Oncology and Urogynecology must report their cases in a similar fashion with Dr. Richard Bercik.

You, or the resident involved in the case, must write up the details of each event. All mortalities must be written up including the following details: patient's initials, admitting and discharge date, physician in charge, admitting diagnosis, operation, pathology obtained, complication and reason for the mortality. Expected mortalities should include a brief synopsis but unexpected mortalities will need more details.

The following morbidities must be reported in detail:

- a. Post-operative mortality, cardiac arrest, or new central neurologic
- b. Unexpected return to the operating room
- c. Unplanned procedure to correct operative injury
- d. Unplanned re admission within 30 days of surgery/discharge
- e. Transfusion of a non-oncology patient
- f. Sensory or motor impairment unresolved at discharge
- g. Impairment of limb unresolved at discharge
- h. Post-operative wound infection requiring drainage, re-operation, repair, or admission
- i. Medication error resulting in permanent harm to patient, death, or near death event
- j. All unplanned conversions of Laparoscopy to open procedure due to bleeding organ injury
- k. Wrong patient or wrong surgical site procedure.
- l. All unexpected **readmissions** to the hospital related to a recent **hospitalization**.
- m. All transfers, from Women's Surgical at Temple Street

Any unusual or interesting cases should also be brought to Drs. Simon or Bercik's attention. The attending physician must be notified by the resident at least one week in advance that their case is on the list to be presented. **In addition, the case summaries must be submitted to Leslie Radcliff 10 days prior to the conference.**

This responsibility is **NOT ELECTIVE, IT IS REQUIRED** and will be considered as part of your evaluation for the rotation. It is also a new **ACGME COMPETENCY requirement** so the paperwork and a copy of your final slide presentation must be submitted as a part of your required educational portfolio, a requirement for graduation.

Communication is Key

- ❖ Please inform the Administrative Chief Residents as soon as possible regarding any conflicts in the schedule and emergency and/or illness situations, which require excuse, from clinical duties so that coverage can be arranged.
- ❖ Thanks to everyone. Let's all work together towards an educational and productive year

Elena Ratner
Page #5049
E-mail: elena.ratner@yale.edu

Ryan Martin
Page #5030
E-mail: ryan.martin@yale.edu