

Edition

19

Wright State University

Boonshoft School of Medicine

Department of Obstetrics and Gynecology

Resident Program Manual

Wright State University Program

Wright State University Boonshoft School of Medicine
in conjunction with
Miami Valley Hospital
Wright-Patterson Medical Center

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Section

1

Program Overview

In this section of the manual you will learn about the university and the hospitals that make this program an affiliated hospitals integrated program.

The Program

The Wright State University Program is the allopathic Obstetrics and Gynecology (OB/GYN) residency program in Dayton, Ohio. Dayton is the sixth largest city in Ohio and is located in southwest Ohio, 60 miles north of Cincinnati and 70 miles west of the capitol, Columbus. Our program has been sponsored by the Wright State University Boonshoft School of Medicine (WSU BSOM) since 1978, and the program utilizes the Miami Valley Hospital (MVH) in Dayton, Ohio as its primary institution; and the Wright-Patterson Medical Center (WPMC), located at the Wright-Patterson Air Force Base (WPAFB), Ohio as major participating institutions. Historically, the program existed as the Miami Valley Hospital OB/GYN Residency Program and graduated its first resident in 1963. The program joined with the Air Force Medical Corps in the late 1970's, and the first combined civilian and military class graduated in 1980.

Dayton has a population of approximately 800,000 including the surrounding smaller cities and towns. MVH is located just one mile south of downtown Dayton and is a 970-bed, state-of-the-art tertiary referral hospital, and has the only high-risk maternity center and neonatal intensive care unit in the same facility, serving 17 counties. The WPMC is located 12 miles north-east of downtown Dayton and is a 62-bed hospital and is one of the largest Air Force teaching and referral hospitals in the United States. The integration of military and civilian medicine has allowed our residents to develop into well rounded OB/GYN physicians over the past 25 plus years and promises to continue in this tradition for future residents.

The program is accredited to train six residents per year for a total of 24 residents. On average, three civilian residents are selected through the National Resident Matching Program. The other three residents are Air Force Medical Corps physicians and are chosen through the Department of Defense Military Selection Board. The civilian and military residents work well together and their education is completely integrated. Throughout the four years, approximately 75% of the residents' curriculum is at MVH, 20% at Wright-Patt Medical Center and 5% at Kettering Medical Center.

The Wright State University Program provides a unique educational setting for the residents. The faculty and hospitals are diverse and this allows for an outstanding opportunity for the residents. The chairman of the WSU OB/GYN department, the program director, the associate program directors, and the full-time and clinical faculty are all involved in the educational process and program. Of note, the full-time faculty is comprised of both OB/GYN physicians employed by WSU working at MVH and military OB/GYN physicians employed by the Air Force stationed at WPAFB at the WPMC. The goal of the program director, one associate director at MVH and one at the WPMC is to provide direction and guidance for the faculty and to facilitate their instruction of the six ACGME competencies in OB/GYN to produce graduates who possess the knowledge, technical skills, and attitudes required to function competently and independently as OB/GYN physicians in either civilian private practice, academic medicine, or military medicine. The faculty incorporates the Accreditation Council for Graduate Medical Education's (ACGME) six competencies into all of their teaching and instruction so that the residents may demonstrate the following: 1) Patient Care that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health; 2) Medical Knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as, the application of this knowledge to patient care; 3) Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care; 4) Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families and other health professionals; 5) Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds; and 6) Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as, the ability to call effectively on other resources in the system to provide optimal health care. These six competencies are discussed in more detail beginning on page 14 of this manual.

To accomplish the above goals, the Wright State University Program oversees the resident educational process from the new R1 to the graduating resident so that they have satisfactory exposure to the necessary basic clinical knowledge as well as an adequate volume of supervised patient visits and surgical procedures to become proficient in both the cognitive and technical aspects of the specialty. The program uses as its plumb line the CREOG "A Design for Resident Education in Obstetrics and Gynecology" along with the 11th edition of "Educational Objectives: Core Curriculum in Obstetrics and Gynecology." With the aide of these materials, our program developed its own goals and objectives which we are provided to the residents at the beginning of each rotation on-line (New Innovations) and reviewed with the residents by at least one faculty member at the end of every rotation to ensure that the residents meet these objectives. The Wright State residents progress through a structured educational environment from total supervision to essentially independent function although faculty is available to residents even after graduation for input.

Resident's progression is evaluated by the Clinical Competency Committee and documented on the ACGME Milestones. They complete certification in Fundamentals of Laparoscopic Skills administered by SAGES which is now a requirement to be eligible for ABOG Qualifying (Written) Exam. Completing our program will qualify the graduate to sit for the Qualifying Exam from the American Board of Obstetrics and Gynecology.

Another goal of the Wright State Program is to introduce residents to basic sciences and clinical research and to introduce our residents to academic medicine. To that goal, each resident is required to design and implement a research project suitable for submission for publication. The research process is designed to begin the first year of residency and continue through all four year of residency. A completed project is expected to be presented in May of the Residency year three.

The education of the resident is integrated with the participating institution's clinical experience utilizing patient clinics, supervised surgery, daily teaching rounds and multi-disciplinary attending rounds. In-depth experience is provided in high-risk obstetrics, basic and level II ultrasound, colposcopy, advanced laparoscopy and hysteroscopy, laser applications for both intra-abdominal and external applications, laparotomy, gynecologic oncology, reproductive endocrinology and infertility, *in-vitro* fertilization (IVF), microsurgery, minimally invasive surgical techniques and urogynecology.

Didactic conferences by the full-time and clinical faculty (private OB/GYN physicians in the community) are presented in general obstetrics, maternal-fetal medicine, genetics, ultrasound, general gynecology, pathology, gynecologic oncology, endocrinology, and urogynecology, and multiple primary care topics. Additional conferences include gynecologic pre-op conferences, Morbidity, Mortality & Improvement (MMI) conferences, fetal monitor strip reviews, tumor conferences, patient safety conferences, quality improvement conferences, as well as peer review presentations and journal club conferences. A twice monthly Ob/Gyn Grand Rounds schedule utilizes visiting speaker presentations on a wide range of topics. Didactic conference attendance by residents is mandatory, and the residents are exempt from clinical responsibilities during this time.

The Hospitals

Miami Valley Hospital

Miami Valley Hospital (MVH) is a 970-bed community hospital and a principal teaching affiliate of Wright State University Boonshoft School of Medicine. Reverend Carl Mueller of the German-Lutheran Church founded the hospital in 1890. MVH is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and MVH ranks in size among the nation's top 100 hospitals with a staff of more than 1,200 physicians representing 34 primary, medical and surgical specialties.

Miami Valley Hospital's regional services include a high-risk maternity center serving 17 counties; a recently redesigned and expanded Neonatal Intensive Care Unit with our family-centered maternity program; MVH is a Level I Emergency and Trauma Center; CareFlight, the area's air ambulance service; the Regional Adult Burn Center; and the Regional Chronic Kidney Dialysis Center. Other services offered include a senior program, health information center, cardiovascular laboratory and intensive care unit, medical/surgical intensive care unit with an expanded advanced care unit, cancer treatment and research, alcohol and chemical dependency unit, sports medicine and physical rehabilitation, and a neuroscience center that offers diagnosis and treatment for hearing and balance disorders, chronic pain and sleep disorders.

MVH nurses and other health professionals care for patients at the bedside and work closely with physicians and residents to develop and implement individualized care programs.

The MVH Craig Memorial Medical Library is one of the largest of its kind in Ohio. It has more than 30,600 bound volumes, monographs, and 600 journal subscriptions. Additional material through interlibrary loan and computerized, bibliographic searching tools are available to physicians and residents. Shared services with all the Dayton hospital libraries and WSU School of Medicine's Fordham Health Sciences Library are maintained via the OhioLINK computer system.

Berry Women's Health Pavilion opened in July 1990 offering the most comprehensive maternity service available in a 17-county area. There are 36 private rooms with family-centered maternity care and offers the birthing room concept for those expecting uncomplicated vaginal births. MVH also offers 16 specialized postpartum care private rooms for cesarean births, a nursery and a solarium.

Maternity 1, Berry Center 1, and Newborn Nurseries

Each inpatient unit cares for postpartum vaginally - delivered patients, post-operative Cesarean, tubal ligation patients, and healthy newborns. Maternity 1 (M1) provides capacity for 22 mothers and 22 babies. Birthing Center 1 (BC1) has capacity for 18 mothers and 12 babies. Services provided include nursing care during recovery from birth, infant care, care coordination, and discharge instructions. Length of stay varies according to patient condition, with an average of 2 days for vaginal deliveries, 3 days for Cesareans, and 2 days for newborns. Average daily census is 25 mothers and babies per floor.

Berry Center 2

Labor & Delivery (L&D) provides care to mothers and neonates of all risk categories. L&D incorporates perinatal care including: antepartum, intrapartum, neonatal and postpartum services. All pregnant patients, unless a scheduled admission (i.e. induction of labor or Cesarean) with anticipated on going pregnancies are seen in the triage area for diverse chief complaints (i.e. rule out labor and/or ruptured membranes, antepartum testing, evaluation of vaginal bleeding, monitoring blood pressure, lab testing). Patients are seen in one of the nine triage rooms, prior to being admitted, transferred, or discharged. Newborns are assessed at birth and are transitioned at the bedside or at the Transitional Nursery.

Medical and nursing staff assesses the patients' needs. Care is determined based on the physical, social, and historical data as well as other diagnostic data and patient preference. All patients are assessed by an RN upon arrival. We are a Level III Center, patients and referring agencies have access to maternal-fetal, neonatal physicians, and anesthesia services 24 hours/day seven days a week. In addition, through our affiliation with Wright State University Boonshoft School of Medicine, there is in-house resident and attending coverage 24hours/day.

Maternity 2 and Newborn Nursery

Maternity 2 (M2) is 16 bed inpatient unit that cares for antepartum patients with medical, surgical, or obstetrical complications; postpartum cesarean and vaginally-delivered patients, healthy newborns, and postoperative gynecology patients. Patient ages range from newborn to women from menarche to menopause. At any given time, censes may range from as few as 5 antepartum patients to as many as 15.

Neonatal Intensive Care Unit

The Berry Women's Health Pavilion supports MVH as the Region II Perinatal Referral Center. Nurses and physicians are prepared to assist with care for both high-risk mothers and infants before, during, and after birth. The Pavilion also includes an expanded Neonatal Intensive Care Unit (NICU), a Level III newborn nursery with 60 newborn beds and 2 infant isolation rooms. This inpatient unit cares for healthy neonates from birth through the transitional period, and those neonates with a variety of medical and surgical conditions. The patients' ages range from the neonate at birth (encompassing all stages of prematurity to term) up to 28 days of age, and infants beyond the neonatal period but less than one year of age.

The NICU provides 24 hour, 7 days per week comprehensive care through a multidisciplinary team approach. Care of the patient is based upon physical, developmental, social, and historical data, as well as other diagnostic and family preferences. There are 60 private rooms located in the Berry Women's Health Pavilion. Admission to the nursery is determined by physician protocol criteria.

Diagnostic and consultative services are readily available. The NICU provides care for patients with a variety of medical diagnoses and surgical conditions. Extracorporeal Membrane Oxygenation (ECMO) is available onsite. We are the only facility in 17 counties who has this capability. A collaborative relationship exists between Miami Valley Hospital and the Children's Medical Center of Dayton for specialty coverage and transport. Home care service is contractually provided through an agreement with Fidelity Home Care. Graduate nursery beds for infants no longer requiring the intensive care of NICU are included in the nursery.

The Perinatal Ultrasound and Diagnostic Center offers routine and advanced perinatal diagnostic services with the most advanced ultrasound equipment to help determine the fetal well-being. Through CareFlight, MVH also provides patients and physicians with on-site, high-risk maternity air ambulance service.

Due to continued community growth, an addition to the Berry Women's Health Pavilion was completed in 1996 containing private offices and the Family Birthing Center which offers alternative birthing plans.

Birth and Family Education

The Birth and Family Education (BFE) department consists of an all-RN staff that provides a wide variety of education and support to childbearing women, their families, and support systems in the classroom setting or in the inpatient antepartum setting. Individuals may register for any of the classes by calling 208-BABY. Certified Lactation Consultants provide lactation education and support to women (and their families and support systems) that state the intent to breastfeed or provide human milk to their infants. Postpartum follow-up is provided as needed with phone consults or lactation clinic visits. Other in-patients with medical care needs who are lactating are also seen for consults by the lactation consultants.

Five Rivers Health Center – Center for Women's Health

The Five Rivers Health Center – Center for Women's Health (FRHC - CWH) provides outpatient services for obstetrical and gynecologic care to patients from the age of 10 through the lifespan. A Registered Nurse, Nurse Practitioner, Certified Nurse Midwife, resident and/ or Attending physician, assesses patient care needs. Appropriate diagnostic services are available based on the physical or historical data collected. Social services and nutritional counseling are available to all patients. Childbirth classes are taught in English and Spanish. Teens may attend the Teens Learning and Caring (TLC) childbirth preparation classes.

Family Beginnings Birth Center (FBBC)

FBBC is a wellness model of care for low-risk women and their families, providing minimal intervention childbearing care. Services provided include care coordination, educational classes, nursing care during labor, tub (a.k.a. water) births, recovery, and infant care.

Maternal Fetal Medicine, Ultrasound and Genetics

The unit primarily provides antenatal services for diagnostic testing of low and high-risk pregnancies. These services include comprehensive obstetric and gynecologic ultrasound, neonatal ultrasound of the head and abdomen, antepartum testing, genetic counseling, and preconception counseling. The clinical staff consists of Board-certified Perinatologists, American Registered Diagnostic Medical Sonographers, Registered nurses, Board Certified Genetic Counselors, and Dietitians. Care is provided in a coordinated, multidisciplinary team approach. There is emphasis on patient education and choice of treatment options. Services are provided Monday through Friday with U/S and medical staff available after hours on an on-call basis.

Wright-Patterson Medical Center

The Wright-Patterson Medical Center (WPMC), is located northeast of Dayton on Wright-Patterson Air Force Base (WPAFB) and offers a rich, educational history linked closely to the city of Dayton, the “Birthplace of Aviation” and the home of Wilbur and Orville Wright. In the early 1990s, the 62-bed institution received a \$126 million renovation and expansion. It is one of five Air Force medical centers throughout the world and acts as a referral hub for military bases throughout the Northeast and Midwest regions of the country.

The Wright-Patterson Medical Center (WPMC) maintains accredited programs in internal medicine, surgery, obstetrics and gynecology, pediatrics, psychiatry, clinical psychology, nurse anesthesia and dentistry. Faculty members are board-certified or active candidates for certification and maintain an active interest in research.

Kettering Medical Center

Kettering Medical Center (KMC) is a 508-bed facility, employing 550 physicians in more than 35 primary, medical and surgical specialties. Our residents work with the clinical faculty at KMC for the purpose of increasing the residents’ GYN surgical experience. Our residents do not see their own patients at KMC, but work under the direct supervision of their clinical faculty with their patients.

The Faculty

General Obstetrics and Gynecology

Erya Agudu, M.D.
Sheela M. Barhan, M.D., Director Medical Student Clerkship (M4)
Amy Brown, M.D.
Josette D'Amato, D.O.
David Dhanraj, M.D., Department Chair
Janice Duke, M.D.
Amy Harris, M.D., WPAFB Medical Student Site Coordinator
Marilyn Kindig, D.O., Director Medical Student Clerkship (M3)
Jason Massengill, M.D.
Deborah Miller, M.D.
Kelly Nagy, M.D., Military Associate Program Director
Vivina Napier, M.D.
Keith Reisinger-Kindle, D.O., Associate Program Director
Tiffanie Tam, M.D.
Geoffrey Towers, M.D., Program Director
Halei Wong, M.D.
W. Roberts Wood, MD

The Division of General Obstetrics and Gynecology provides an active clinical teaching program at the two affiliated institutions. Board-certified faculty members are responsible for providing general obstetrics and gynecologic teaching and supervision for residents and students.

Outpatient clinics and surgical procedures, tubal and postpartum sterilizations, colposcopy, robotic surgery and pelviscopy procedures, plus laser surgery, provide the residents the hands-on experience needed to hone their techniques and surgical skills. Pelvic reconstructive surgery and urogynecology are special techniques also incorporated into the educational program.

Gynecologic Oncology

William A. Nahhas, M.D., Professor Emeritus
Michael Guy, M.D.
Thomas Reid, M.D.
Juliet Wolford, M.D.

The Division of Gynecologic Oncology includes board-certified and board eligible faculty who exhibit subspecialty credentials. Faculty is responsible for providing gynecologic oncology teaching to residents and medical students. They offer daily clinical teaching rounds, pre-op rounds and weekly tumor boards and case conferences that are attended by residents, students, nurses, and other medical support personnel. The division supports a heavy clinical practice and is actively involved in numerous research protocols and studies.

Maternal-Fetal Medicine

Christopher Croom, M.D., Director

Melanie Glover, M.D.
Adam Hiatt, MD
David McKenna, M.D.
Jiri D. Sonek, M.D.
Samantha Wiegand, M.D.

The Division of Maternal-Fetal Medicine includes board-certified faculty who develop obstetrics protocols for the PICU and the Center for Women's Healthcare as well as the obstetrics standards for obstetrical services at the USAF Medical Center, Wright-Patterson (in conjunction with the U.S. Air Force Operating Instructions). Residents and students are taught all aspects of obstetrical care: high-risk obstetrics patient care, labor and delivery, postpartum care, consultation, service and research.

The Division is a referral base for complicated, high-risk obstetrical patients and for its expertise in perinatal ultrasound diagnostic testing. Fetal heart rate monitoring, antepartum testing, biophysical profiles, amniocenteses, CVS, cordocentesis, Doppler flow studies and other ultrasound studies are performed on high-risk pregnancy patients.

Reproductive Endocrinology and Infertility

Amy Harris, M.D., Director

SpringCreek Fertility

Jeremy Groll, M.D.

Wright State Physicians

Stephen Karnitis, M.D.

The Division of Reproductive Endocrinology and Infertility consists of board-certified faculty who are responsible for training residents and students in reproductive endocrinology and infertility including all advanced pelviscopy procedures, laser, hysteroscopy, and microsurgery. Infertility treatments include intrauterine fertilization (IUI), in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), tubal embryo transfer (TET), and embryo cryopreservation. These techniques, as well as ultrasound-guided oocyte recovery, laser laparoscopic KTP surgery, and tubal reconstruction microsurgery are addressed with the residents in their endocrine rotations. Infertility therapy also includes ovulation induction with Clomid or Pergonal, and/or testing and treatment of the male factor.

Urogynecology and Reconstructive Pelvic Surgery

Jason Massengill, M.D.
Deborah Miller, M.D.
Geoffrey Towers, M.D., Program Director
Tiffanie Tam, M.D.

The Division of Urogynecology and Reconstructive Pelvic Surgery provides an active clinical teaching program at the two affiliated institutions. Fellowship trained faculty members (board certification is not available at this time) are responsible for providing teaching and supervision for residents and medical students in the care of women with urinary and fecal incontinence, pelvic organ prolapse, pelvic floor dysfunction and interstitial cystitis.

Diagnostic evaluation including history and physical examination techniques, pelvic floor testing (including simple and complex urodynamics) and cystoscopy, as well as medical and surgical management of pelvic floor problems are emphasized. Surgical training incorporates the full range of vaginal and abdominal techniques for the correction of pelvic floor disorders, with incorporation of office-based and minimally invasive techniques.

The Administration

Diana Charlino, BA ~ Residency Coordinator
Martie Blankenship ~ Residency Coordinator, WPAFB
Darla Todd, BA ~ Medical Student Education Coordinator
Joan Mangan-Boles, BA ~ Administrative Assistant to the Chair
David Hockman ~ Practice Manager
Rose Maxwell, Ph.D. ~ Director of Research
Kelly Rabah, MSW ~ Director Patient Safety & Quality Improvement
Helen Wyskiver ~ Administrative Assistant
Ben Edwards ~ Finance Assistant

Abbreviations and Acronyms

Abbreviations

Definitions

ABOG	American Board of Obstetrics and Gynecology
ACGME	Accreditation Council for Graduate Medical Education
ACOG	American College of Obstetricians and Gynecologists
APD	Associate Program Director
AF	Air Force
AFMC	Air Force Materiel Command
APGO	Association of Professor of Gynecology and Obstetrics
CHCS	Composite Health Care System
CCC	Clinical Competency Committee
DME	Director of Medical Education
EC	Education Committee
GYN	Gynecology
H&P	History and Physical
HROB	High Risk Obstetrics
KMC	Kettering Medical Center
MDGI	Medical Group Instruction
OB	Obstetrics
OI	Operating Instruction
PD	Program Director
PEC	Professional Education Committee
RRC	Residency Review Committee
RN	Registered Nurse
SOAP	Subjective, Objective, Assessment and Plan
WPMC	Wright-Patterson Medical Center

Section

2

Curriculum and Resident Experience

In this section you will learn details about your educational program and discover the daily life of an obstetrics and gynecology resident. All 6 competencies are included in these activities.

Clinical Rotations

The residency education program is designed to fulfill American Council on Graduate Medical Education (ACGME) Residency Review Committee (RRC) requirements of 48 months of obstetrics and gynecology rotations. Resident rotations are scheduled on week basis however some rotations due to rotation break are slightly longer than 8 weeks. The academic year is based on a 52-week year and residents are on rotations except for allotted vacation, conference time.

First Year

Residents become familiar with the core knowledge of obstetrics and gynecology. They will learn to evaluate gynecologic problems and about the decision-making process leading to surgical procedures. They will be taught minor gynecological surgical procedures and laparoscopy. The residents will learn management of normal labor and delivery in the labor suite. R1s will assist and/or perform approximately 75-100 vaginal deliveries and a similar number of cesarean sections in the first year. Some other procedures they will become proficient in include perineal laceration repairs and diagnostic laparoscopy/tubal ligations. They see patients for one-half day per week in a continuity clinic.

Rotation	Location
16 weeks Obstetrics	MVH
4 weeks Family Planning/Obstetrics and Gynecology Surgery	MVH
8 weeks Gynecology	MVH
4 weeks Well Women's Clinic	WPAFB
8 weeks Night Float	MVH
4 weeks Ultrasound/Genetics	MVH
4 weeks Emergency Medicine	MVH

Family Planning Training

The Accreditation Council for Graduate Medical Education (ACGME) requires that obstetrics and gynecology residency programs provide access to experience with induced abortion and this must be part of residency education. Here is their statement (Section 4.A.2.d.):

“No program or resident with a religious or moral objection shall be required to provide training in or to perform induced abortions. Otherwise, access to experience with induced abortion must be part of residency education. This education can be provided outside the institution. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral, or legal restriction that prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive satisfactory education and experience in managing the complications of abortion. Furthermore, such residency programs (1) must not impede residents in the programs who do not have religious or moral objections from receiving education and experience in performing abortions at another institution and (2) must publicize such policy to all applicants to those residency programs.”

The core educational curriculum at the Wright State University/Wright-Patterson AFB Integrated OB/GYN Residency Program includes didactic sessions on abortion and the techniques and management of its complications. The Family Planning rotation includes required learning modules and reading assignments; and can include in-person clinical experience to include options counseling, first and second trimester ultrasound, complex contraception counseling, medication abortion counseling and the performance of first and second trimester surgical abortions. In order to comply with the ACGME policy the Wright State University Department of OB/GYN Program’s policy is to ask each resident wishing to opt out of training for moral or religious reasons to complete and sign the form documenting their objection (Option OUT) to receiving procedural training in induced abortions. The “Opt Out” form must be submitted to the program Manager early in the residency. However, resident may change mind later and request to PD or PC to receive further training.

Second Year

Residents learn more complicated surgical procedures. They gain skills and knowledge necessary to care for the complicated obstetrical and gynecologic patient. Some procedures to become proficient in are operative hysteroscopy, OB ultrasound and Gyn ultrasound as well as multiple surgical procedures. They also see patients for one-half day per week in a continuity clinic.

Rotation	Location
8 weeks Obstetrics	MVH
8 weeks Gynecology	MVH
8 weeks Obstetrics	WPAFB
8 weeks Gynecology	WPAFB
8 weeks Gynecologic Oncology	MVH
8 weeks Night Float	MVH

Third Year

Residents perform more major surgical procedures including abdominal hysterectomy, and bladder suspensions and assist on vaginal surgery. Supervision of the Perinatal Unit and High-Risk Obstetric Clinic provides in-depth experience in management of high-risk obstetrical patients. Some procedures to become proficient in are abdominal hysterectomy, operative laparoscopy/ovarian cystectomy, IUD insertion in an office-based setting, and office-based hysteroscopy. Presentation of a completed research project is required by the end of this year. They also see patients for one-half day per week in a continuity clinic. Third year residents are given the opportunity to plan a four-week elective rotation of their choosing (i.e. Research, REI, MFM, Urogynecology, Gynecologic Oncology, Minimally Invasive Gynecology, Urology, etc.).

Rotation	Location
8 weeks Obstetrics	MVH
8 weeks Gynecology	MVH
8 weeks Obstetrics	WPAFB
4 weeks Maternal Fetal Medicine	MVH
8 weeks Reproductive Endocrinology & Infertility, Urogynecology, and Research,	WPAFB/SCF/ MVH
4 weeks Gyn Surgery or Elective	KMC
8 weeks Night Float	MVH

Fourth Year

Chief Residents perform complicated major procedures including abdominal, vaginal and oncologic surgery. Specialized procedures such as urogynecologic, laser, and robotics are also performed. They function as consultants to the junior residents in management of the obstetric and surgical suites. Chiefs will become proficient in vaginal and abdominal hysterectomy, TVT, total laparoscopic hysterectomy, and office-based Urogynecology as well as many other procedures. They also see patients for one-half day per week in a continuity clinic. The Chief Resident will arrange administrative details of the program, attend the specialty clinics, delegate responsibility to junior residents and be responsible to the attending for all patients on the OB/GYN services.

Rotation	Location
16 weeks Obstetrics	MVH
8 weeks Reproductive Endocrinology & Infertility, Urogynecology, and Gynecology Surgery	WPAFB/SCF/MVH/ KMC
8 weeks Gynecology	MVH
8 weeks Gynecologic Oncology	MVH
8 weeks Night Float	MVH

In addition to clinical rotations, R4s are required to make one Grand Rounds presentation.

Core Competencies and Program Goals

The program requires that each resident obtain competencies in the following areas to the level expected of a new practitioner according to the expectations of the Accreditation Council for Graduate Medical Education (ACGME) and the Council for Resident Education in Obstetrics and Gynecology (CREOG). The following information is an outline of the general expectations; more specific information related to the goals and objectives for each rotation are available on-line through the Residency Management System (RMS) in the Department manual section.

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:

- A. Demonstrate caring and respectful behaviors when interacting with patients and their families.
- B. Gather essential information about patients by performing a complete and accurate medical history and physical examination.
- C. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- D. Develop, negotiate, and implement effective patient management plans.
- E. Counsel and educate patients and their families.
- F. Use information technology to support patient care decisions and patient education.
- G. Perform competently all medical and invasive procedures considered essential for generalist practice in the discipline of obstetrics and gynecology.

- H. Understand the differences between screening and diagnostic tests essential for generalist practice in obstetrics and gynecology.
- I. Provide Health care services to patients aimed at preventing health problems or maintaining health, including those of underserved communities and ethnicities with healthcare disparities.
- J. Work with health care professionals, including those from other disciplines, to provide patient-focused care.

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and apply this knowledge to patient care. Residents are expected to:

- A. Demonstrate an investigatory and analytic thinking approach to clinical situations.
- B. Demonstrate a sound understanding of the basic science background of women's health and apply this knowledge to clinical problem solving, clinical decision making, and critical thinking.

Practice-based Learning and Improvement

Residents must be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- A. Identify areas for personal and practice improvement and implement strategies to enhance knowledge, skills, attitudes, and processes of care, as well as making a commitment to life-long learning.
- B. Analyze and evaluate personal practice experience and implement strategies to continually improve the quality of patient care provided using a systematic methodology.
- C. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
- D. Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
- E. Demonstrate receptiveness to instruction and feedback.
- F. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- G. Use information technology to manage information, access online medical information, and support their own education.
- H. 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 assist in effective information exchange and be able to team with patients, patients' families, and professional associates. Residents are expected to:

- A. Sustain therapeutic and ethically sound relationships with patients, patients' families, and colleagues.
- B. Provide effective and professional consultation to other physicians and health care professionals.
- C. Elicit and provide information using effective listening, non-verbal, explanatory, questioning, and writing skills.

- D. Communicate effectively with patients in language that is appropriate to their age and educational, cultural, and socioeconomic background.
- E. Maintain comprehensive, timely, and legible medical records.
- F. Communicate 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 population. Residents are expected to:

- A. Demonstrate respect, compassion, integrity, and responsiveness to the needs of patients and society that supersedes self-interest.
- B. Demonstrate accountability to patients, society, and the profession.
 1. Demonstrate uncompromised honesty.
 2. Develop and maintain habits of punctuality and efficiency.
 3. Maintain a good work ethic (i.e., positive attitude, high level of initiative).
- C. Demonstrate a commitment to excellence and ongoing professional development.
- D. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care.
- E. Describe basic ethical concepts such as: autonomy, beneficence, justice, and non-maleficence.
- F. Describe the process of informed healthcare decision making including the elements that must exist and the specific components of an informed-consent discussion.
- G. The resident must demonstrate an understanding of the use of advanced directives, living wills, and durable power of attorney for healthcare and strategies for the resolution of ethical conflicts.
- H. Discuss surrogate decision making for incapacitated patients, including who can and should act as a proxy decision maker and what standards they should use to make healthcare choices for another.
- I. The resident should be able to examine their personal values and preferences for end-of-life treatment and the values of diverse patients.
- J. Differentiate between institution-based DNR orders, community-based DNR orders (also called out-of-hospital or portable DNR orders), and advance directives. Describe the legal, ethical, and emotional issues surrounding withholding and withdrawing medical therapies.
- K. Discuss when it is appropriate to use all available technology to sustain a life and when it is appropriate to limit treatment.
- L. Discuss the principle of justice and the use of limited medical resources.
- M. Discuss the differences in ethical decision making if the patient is an adult or a child.
- N. Discuss ethical implication of commonly used ob/gyn technologies.
- O. Analyze an ethical conflict and develop a course of action that is ethically defensible and medically reasonable.
- P. Discuss important issues regarding stress management, substance abuse, and sleep deprivation.
 1. List preventive stress-reduction activities and describe their value.
 2. Identify the warning signs of excessive stress or substance abuse within one's self and in others.

3. Intervene promptly when evidence of excessive stress or substance abuse is exhibited by oneself, family members, or professional colleagues.
 4. Understand the signs of sleep deprivation and intervene promptly when they are exhibited by oneself or professional colleagues
- Q. Maintain confidentiality of patient information.
1. Describe current standards for the protection of health-related patient information
 2. List potential sources of loss of privacy in the health care system.
- R. Demonstrate sensitivity and responsiveness to the culture, age, sexual preferences, behaviors, socioeconomic status, beliefs, and disabilities of patients and professional colleagues.
- S. Describe the procedure for, and the significance of, maintaining medical licensure, board certification, credentialing, hospital staff privileges, and liability insurance.

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:

- A. 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 practices. Understand the processes for obtaining licensure, receiving hospital privileges and credentialing.
- B. Describe how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
 1. List common systems of health care delivery, including various practice models.
 2. Describe common methods of health care financing.
 3. Discuss common business issues essential to running a medical practice.
 4. Apply current procedural and diagnostic codes to reimbursement requests.
- C. Practice cost-effective health care and resource allocation that does not compromise quality of care.
- D. Advocate for quality patient care and assist patients in dealing with system complexities.
 1. Recognize that social, economic and political factors are powerful determinants of health and incorporate these factors into how they approach patient care.
 2. Demonstrate knowledge of disparities in health and health care in a variety of populations.
 3. Recognize the role of the women's health provider to advocate for patients, particularly poor and vulnerable women, and to help develop methods of care that effective, efficient, and accessible to all women.
 4. Be aware of ACOG and community resources and advocacy on behalf of underserved and vulnerable populations such as poor women and teenagers.
- E. Acknowledge that patient safety is always the first concern of the physician.
 1. Demonstrate the ability to discuss errors in management with peers and patients to improve patient safety.
 2. Develop and maintain a willingness to learn from errors and use errors to improve the system or process of care.
 3. Participate in hospital/departmental QI activities and Patient Safety initiatives.

4. Recognize the value of input from all members of the health care team and methods by which to facilitate communication among team members.
 5. Demonstrate understanding of institutional disclosure processes and participate in disclosure and discussions of adverse events with patients.
- F. 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.
1. Describe the process of quality assessment and improvement including the role of clinical indicators, criteria sets, and utilization review.
 2. Participate in organized peer review activities and use outcomes of such reviews to improve personal and system-wide practice patterns.
 3. Demonstrate an ability to cooperate with other medical personnel to correct system problems and improve patient care.
- G. Risk management and professional liability
1. List the major types and providers of insurance
 2. Describe the most common reasons for professional liability claims.
 3. Describe a systematic plan for minimizing the risk of professional liability claims in clinical practice.
 4. Describe basic medical-legal concepts regarding a professional liability claim and list the steps in processing a claim.

Education Program

Objectives

The program uses, as its plumb, line the CREOG “A Design for Resident Education in Obstetrics and Gynecology” along with the 12th edition of “Educational Objectives: Core Curriculum in Obstetrics and Gynecology.” With the aid of these materials, our program developed its own goals and objectives which we provide to the residents at the beginning of each rotation on-line and review with the residents at the end of every rotation to ensure that the residents meet these objectives. The Wright State residents progress through a structured educational environment from total supervision to essentially independent function although faculty is available to residents even after graduation for input. Completing our program will qualify the graduate to sit for the qualifying examination from the American Board of Obstetrics and Gynecology.

Advisors & Mentors

The Intern class is assigned several advisors at the beginning of their internship. These advisors come from both senior residents and core faculty. The residents and advisors are expected to meet at least twice a year, and more frequently as determined by both the advisor and resident. Some meetings will occur individually while others may be group gatherings. Advisors are encouraged to provide educational and clinical support for the resident. At any point during their training, a resident may approach a faculty member and request them as a mentor. A mentor may assist them in various aspects of their training or a resident may have more than one mentor, e.g. a research project, Board exam preparation, and etc.

Conferences

The Department is dedicated to providing an excellent educational experience for the residents. There is weekly protected time for lectures and conferences. **Attendance at these meetings is mandatory, and attendance is taken. Punctuality is expected by everyone by 0800. Those residents on the Night Float rotation are expected to attend Wednesday morning conferences between 8:00 am and 9:00 a.m.**

The Wednesday AM conference time is protected, and the resident is relieved of clinical duties during this time. If a resident is unable to attend a Wednesday morning conference, written notification in the form of an email should be sent to the Program Director with courtesy copy to both Associate Program Directors and the Program Coordinator for **approval of absence**.

The following pages contain a summary of conferences and lectures that are scheduled within the program on a regular basis.

Name Of Activity	Frequency Per Month (App)	Conducted Or Supervised By	Bs, G, E, Mj*
Didactic Lectures	4-12	Faculty	BS, G, E, MJ
Grand Rounds	1	Faculty & Guest Speakers	BS, G, E, MJ
Visiting Professor	1 (per quarter)	Guest Speakers	BS, G, E, MJ
Fetal Monitoring Review	1	MFM Faculty	BS, G, E, MJ
Journal Club	1 (per quarter)	Faculty	BS, G, E, MJ
Resident & Program Director Meeting	1	Program Director	E, MJ
MVH Morning Report	30	OB Service/GYN Service Attending	BS, E, MJ
MVH OB/ Rounds/ Post-Partum Rounds	30	MFM Service Attending & OB Service Attending	BS, G, E, MJ
MVH GYN Rounds	30	GYN Service Attending	BS, E, MJ
MVH GYN Onc Rounds	30	GYN Onc Attending	BS, G, E, MJ
MVH Cancer Care Conference (Tumor Board)	4-5	GYN Onc Division Director	BS, G, E, MJ
MVH Multi-disciplinary Medical Conference	4-5	GYN Onc Division Director	BS, G, E, MJ
MVH Mortality, Morbidity & Improvement (MMI) Conference	2	Faculty & GYN Service Chief Resident	BS, G, E, MJ
MVH GYN Pre-op Conference	4-5	GYN Service Attendings	BS, G, E, MJ
WPMC Morning Report	16	OB Service/GYN Service Attending & faculty	BS, E, MJ
WPMC High Risk Obstetrics	4-5	OB Service Attending	BS, G, E, MJ
WPMC Pre-Op Conference	4-5	WPMC Faculty	BS, G, E, MJ
WPMC GYN Pathology	1	GYN Service Attending	BS, G, E
WPMC Mortality & Morbidity	1	Faculty & GYN Service Resident	BS, G, E, MJ

* Basic sciences (BS), genetics (G), ethics (E), and medical jurisprudence (MJ)

CREOG Training Exam

The annual CREOG in-service exam is given to all residents during the month of January. The test is a full-day exam taken on Friday or Saturday. As per policy, no leave of any type will be granted during this time. Any resident who is on an off-service rotation at this time is responsible to notify that department's attending that they will be away.

CREOG scores are generally used as a guide to determine the adequacy of educational curriculum. However, residents who score lower than 1.0 standard deviation below the mean on the year-group adjusted score usually reflect the need for academic remediation. Consequently, residents who perform below this measure will require additional academic emphasis with assistance from the Program Director and/or their Advisor in the form of Scholastic Remediation/Mentoring. They will be assigned a Faculty Mentor and review general as well as subspecialty topics monthly via pre-assigned quizzes and/or other forms of knowledge assessment.

Education Fund

Each Civilian Resident receives an annual education fund of \$1,000 through Wright State University. Annual funding is from July 1 through June 30 each academic year. Military residents are not eligible for additional funding from Wright State University. In order to assure that funds are used for a broad range of educational purposes throughout the residency, the following guidelines are established:

- A. Education funds can be used to attend conferences/educational meetings. No reimbursement will be given unless prior approval has been received. If there is no prior approval, resident will assume responsibility for all expenses. Following are specific guidelines for attending conferences:
 1. Additional expenses for national meetings for those residents presenting papers may be covered by the Department at the discretion of the Department Chair and Program Director. Department may cover travel expenses up to \$250 for papers being presented if you are a co-author and \$500 for primary authors or residents presenting.
 2. Up to two additional travel days may be added as needed for all year levels at the discretion of the Administrative Chief Resident and Program Director.
 3. Residents sponsored by the Air Force will be funded from TDY funds when available from the USAF.
- B. Education funds may be used to buy medical-related textbooks, journals, computer equipment and software (up to 1 computer or tablet per 4 years), etc. at any time during residency. Limitations may apply to purchase of non-educational products and will need approval of Program Director.
- C. Residents should request reimbursement by completing a Reimbursement form and submitting it to the Residency Coordinator. Reimbursement forms are available in the Resident Lounge and online in New Innovations.
- D. Unspent education funds cannot be carried over from one academic year to the next.
- E. Administrative Chief Residents may also receive an additional educational stipend of \$1,000 through Wright State University. For military residents, applicable legal protocols to receive Gift in Kind in lieu of stipend will be followed.

Research Projects

All residents are required to complete Scholarly Activity in the form of a research project by the end of May in their third year. Residents are required to follow a timeline to allow for consistency and progression of the project. The research project may be a prospective or retrospective study, or an analytical analysis such as a meta- analysis or decision analysis. Case reports and literature reviews do not fulfill the criteria for resident research unless approved by Program Director.

Residents will meet regularly with Dr Maxwell and their Mentor to discuss updates. Resident is required to be familiar with deadlines and information in the Resident Research manual.

Projects are presented in mid-May with one award given for “Excellence in Research.” Residents receive a plaque, a nameplate added to the Department plaque and an educational grant. All residents are required to be in attendance at this research day presentation, and normally may not take vacation during this time. Projects are encouraged to be presented to compete for awards at the Wright State University, Miami Valley Hospital, and The Dayton Area Graduate Medical Education Consortium (DAGMEC.) Projects may also be submitted to National and International meetings as deemed appropriate by the RRC and resident’s mentor. Preparation of a finished manuscript for publication is strongly encouraged. Refer to your research manual for more details.

Research Project Timeline (see Research Manual for specific details)

Date	Activity
R-1	
December	Complete WSU Training, Meet Research Director
March	Meet with Research Advisor/Mentor
May	Present IRB proposal & progress on Resident Research Day
May	Design and draft protocol
May	Prepare final draft protocol with references
R-2	
July	Submit proposal to IRB
September	Start collecting patients and data
Quarterly	Meet with Dr Maxwell and/or Mentor regarding updates
May	Present findings/progress on Resident Research Day
June	Collect patients and data
R-3	
September	Meet with Mentor, Research Director
February	AFD Abstracts (if applicable)
March/April	Finalizing data analysis
May	Present paper at Resident Research Day
R-4	
October	Present paper at AFD/ACOG meeting
October	Submit paper for publication
February	Submit for poster presentation (if not done already)
April	DAGMEC Presentation (if applicable)

Section

3

Attending and Resident Responsibilities

The purpose of this section is to establish performance and patient care responsibilities for attending physicians, first, second, third, and fourth year residents and 3rd and 4th year medical students assigned to the services within the Wright State Department of Obstetrics and Gynecology provided at the MVH, WPMC, and Kettering Medical Center (KMC). This instruction is to ensure the structure is in place for OB/GYN residency training and will also aid nursing personnel as well as the attending physicians and residents working in all areas. The Accreditation Council for Graduate Medical Education (ACGME) guidelines are followed for residency teaching and supervision. OB/GYN Residents and medical students work under the direction of the OB/GYN chief resident and the attending physicians.

Faculty

Attending physicians/preceptors are members of the Department of Obstetrics & Gynecology. OB/GYN physicians are Licensed Independent Practitioners (LIP's), who hold faculty appointments at Wright State University Boonshoft School of Medicine. OB/GYN attending physicians are ultimately responsible for the clinical care rendered to patients.

Inpatient

The attending physician evaluates each patient within 24 hours of admission, or sooner if indicated. The attending physician co-signs the residents History & Physical (H&P) and any "Do Not Resuscitate" notes and orders, daily resident notes as well as discharge summaries. The attending physician supervises patient evaluations, therapy, discharge planning, and rounds on the patient when deemed appropriate. The attending will review the patient's chart prior to discharge to ensure the work-up is complete, correct, and proper follow-up was arranged as well as contact with a referring physician was established if referred. On occasion, the attending will give a telephone order to the nurse. This order must be signed, stamped, dated and timed within 24 hours. Another attending may sign/stamp the order for the attending physician. The attending physician will be notified of all major procedures and in general will be in attendance unless their presence is deemed more critical for patient safety elsewhere. In these cases, a senior resident may be delegated to supervise the procedure.

Progressive resident responsibility will allow resident to perform certain procedures (based on year level and competency) with Attending immediately available if other patient care is more critical and requires Attending present.

Outpatient

Attending responsibilities for clinic include precepting first through fourth residents and the nurse practitioners. The attending will write a note, sign and stamp each of the resident's notes. The attending will precept all residents' procedures in clinic for billing purposes. Attending physicians are expected to give formative feedback frequently to residents and are required to submit a written or computer-generated evaluation of the resident's performance at the end of each rotation.

- A. Residents on subspecialty rotations are supervised by the attending sub-specialist. The sub-specialist will determine, on a daily basis, the level of responsibility he/she wants to delegate to the resident based on level of training and proven ability.
- B. The Program Director (PD) reviews all resident evaluations. The Clinical Competency Committee (CCC), which consists of the OB/GYN physicians, Nursing representation, and other relevant faculty; reviews the academic status of the residents at least quarterly and recommends academic remediation plans as needed. Morbidity and mortality reports are reviewed by the PD. Serious academic actions, such as probation, or patient safety concerns are forwarded to the hospital's Professional Education committee (PEC), and the Wright State University's Designated Institutional Officer (DIO) in charge of graduate medical education. Near the close of each academic year, the CCC determines the suitability of resident promotion to the next graduate level based on review of the resident's academic files and evaluations. The Associate PD at WPMC and the Associate PD at MVH are in direct communication with the PD at frequent intervals. The academic progress, as well as patient safety issues of both the military and civilian residents, is discussed openly and joint decisions are made on each resident for resident promotion and graduation. The PD communicates with the Director of Medical Education (DME) at MVH as well as the chief of medical staff at MVH about resident issues and patient safety concerns. The Wright-Patterson Medical Center PEC is composed of the PDs of all the residency programs at the WPMC and is chaired by the DME of the WPMC. All significant resident academic actions as well as patient safety and quality of patient care issues are discussed, and a disposition is made by the committee, and then forwarded to the Executive Committee of the Medical Staff via the DME.

Resident

The following responsibilities involve all 6 competencies, especially professionalism, patient care, and medical knowledge.

Beta Board

Maintenance of a “beta board patient log” for viable and nonviable early pregnancies/ectopic pregnancies/molar gestations will occur by the second or third year GYN resident with chief resident and attending supervision. The resident in charge of the beta board will ensure that an attending OB/GYN physician is aware of each individual patient being followed on the beta board. All documentation must be co-signed and stamped by an attending OB/GYN physician. In the absence of the second or third year GYN resident, a surrogate will be appointed and follow up as above. Beta board will be presented at least once per week at morning report or rounds. New Beta board patients will be presented at morning report/rounds.

Certifications

All residents are required to maintain current Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Neonatal Resuscitation Procedure (NRP) status.

FLS Certification: Fundamentals of Laparoscopic Surgery (FLS) Certification is an ABOG requirement prior to registering for the ABOG Qualifying Exam that Chief Residents take upon graduation. All residents participate in FLS training, and 2nd year residents are expected to obtain FLS certification prior to their PGY3 year. Certification testing is offered at SAGES testing centers within driving distance of Dayton.

Clinic

In the ambulatory clinic, first year residents precept and discuss all patients with their assigned attending OB/GYN in real time. The residents’ clinic patients are examined by the attending OB/GYN when clinically indicated. The resident documents a problem-oriented note to include the Subjective, Objective, Assessment, and Plan (SOAP note) in the outpatient record and this is co-signed/stamped by the attending OB/GYN.

In the ambulatory clinic, second and third year residents precept and discuss new patients with their assigned attending OB/GYN in real time. The resident presents and discusses follow-up patients before the patient departs the clinic. The resident’s clinic patients are examined by the attending OB/GYN when clinically indicated. The resident documents a problem-oriented (SOAP) note in the outpatient record and this is co-signed/stamped by the attending OB/GYN.

In the ambulatory clinic, fourth year residents may precept lower level residents and discuss complex patients with their assigned attending OB/GYN in real time. The resident presents and discusses complex patients before the patient departs the clinic. The resident’s clinic patients are examined by the attending OB/GYN when clinically indicated. The resident documents a problem-oriented (SOAP) note in the outpatient record and this is co-signed/stamped by the attending OB/GYN. **It is important and PREFERRED for completion of medical records while patient is seen in the clinic by the end of the day, no later than within 24 hours of the visit.**

Dictating Discharge Summary

Complete and sign Discharge Summaries in the Electronic Medical Record (Epic): **Completion of Discharge Summaries time is due within 72 hours of discharge of patient.**

- A. Date of admission
- B. Date of discharge
- C. Principle discharge diagnosis
- D. Additional diagnoses
- E. Consultants – list by name and specialty
- F. Procedure – list only, give results later
- G. Brief admission physical exam – age, chief complaint, brief HPI with only pertinent facts; be concise, not necessary to include negatives
- H. Brief admission physical exam – vital signs – only pertinent systems
- I. Admission lab/EKG/X-ray results – Avoid saying, “Neurology consultant recommended a CT scan. CT scan was done. It showed a large intraventricular hemorrhage.” Instead say, “CT showed a large intraventricular hemorrhage.”
- J. Hospital course – be as concise as possible. Not necessary to include specific ventilator settings or day to day variation in Hgb levels, theoph levels, and etc. This is not the place to justify treatment; that should have been done in the progress notes. Not necessary to explain why studies were ordered, just give results.
- K. Condition on discharge – choose from “good”, “fair”, “serious”, and “critical”
- L. Discharge instructions: must include: activity, diet and medications
- M. Specific instructions – wound care, other treatments, problems for which patient should notify physician.
- N. Follow-up Plans – include all scheduled appointments, physician referrals and outpatient treatment plans; must include primary care follow-up for every patient
- O. Dictate instructions for copies to be sent to specific names of follow-up physicians or clinics (e.g. “send a copy of this summary to Dr. James Smith [location if known] and to the Five Rivers Health Centers at Miami Valley Hospital).

Duty Hours

The ACGME requires us to restrict resident hours to 80 hours per week. This rule applies to hours dedicated to clinical activities within the hospital. The 80-hour rule does not apply to time spent reading outside the hospital(s). When work shift is completed then resident work obligation is finished and no extra time can be spent that would violate duty hour restrictions. **Duty hours cannot be changed or altered without prior approval of Program Director.**

Residents are charged with the self-reporting of all violations of this system. Our Program takes this requirement very seriously and monitors your work hours on a regular basis. Recording of resident hours is ideally recorded daily in the New Innovations system. Residents should record hours daily if at all possible and no less frequently than weekly. The record should reflect actual hours worked. Residents enter their hours individually into the New Innovations System on a daily basis. These records are monitored by the Program Manager and the Program Director for violations. Additional documentation may be requested in the case of a violation.

Due to the specific construct of the work schedule, it is normally unlikely for an individual resident to work more than 24 hours consecutively or for more than 78 hours a week. Duty hour

restrictions apply to averaging less than 80 hours per week over a four-week timeframe. The program utilizes a night float system at each of the hospitals, MVH and WPMC.

At MVH, there are four residents on night float each weekday night Sunday-Thursday. This represents one resident in each year level. They cover all hospital duties from 1730 until 0700 the following morning. These duties include covering L&D, Emergency Department consultations, post-partum patients, antepartum patients, in-house GYN patients, and the GYN/ONC service. Morning “transfer of care” begins at 0700 with night float team being released by 0730. The “day team” assumes patient care at 0700 for new admissions. There are, therefore, no instances in which another resident need be contacted in the timeframe covered by the night float team. Individuals on night float are released from all other clinical duties. Continuity clinics are not done during night float. Those residents on night float are not placed into the call schedule at all. The call schedule therefore, includes only the period of time of Friday 1700 until Sunday at 1700. **This cannot be adjusted or changed.** Residents from each year from non-Night Float rotations (R1-R4) will cover the weekends with a rotating call schedule insuring that every resident in the call pool has one day in seven off averaged over four weeks and usually at least one full weekend off per month.

All resident teams check out to the night call team at approximately 1730 each night and their team beeper is handed over to the appropriate night float representative, i.e. the Chief Resident is given the GYN/ONC Chief beeper and so on. At WPMC, there are two R2s and one R3s assigned during each rotation, with an additional R3 in the call pool. Since the rotations are two months long, this requires that they break up the night float responsibilities into two 15-16 night periods. The individual on night float covers the house in the same manner and timing as those on at MVH. They cover all in-house responsibilities for all OB/GYN services.

Private OB patients are allowed to be followed by the residents only if the ACGME required Duty Hours Regulation will be adhered to. If the patient happens to deliver during the day when the resident is available in the house, they may be delivered by the resident, but the resident will not come in during off duty hours and care for the patient. Based upon these constructs, the hour requirement cannot be violated. Cross coverage of a call for an emergent need, i.e. assisting a fellow resident in their schedule will be permitted only if the average hours still work out to less than 80 hours per week calculated over a four-week period. All attending physicians monitor the direct release of “day shift” teams as soon as checkout has completed at 1730. All attending chief of services, fully agree with the checkout system and the carrying of the appropriate service beeper by the night float residents. Attending physicians covering L & D in the morning insure that the night float team is released as soon as check out is completed.

It is the responsibility of each resident to enter their duty hours into the New Innovations system on a daily basis whenever possible. This also includes entering vacation time, conference time, sick time and maternity leave. In the event that a resident is not entering their duty hours in a timely manner, the Program Director reserves the right to require the resident to be pulled off of their services or use vacation time in order to update the system with their hours.

Evaluations

Interns will meet with the Program Director quarterly during the first 6 months, and every six months thereafter unless more frequent meetings are deemed necessary by the Program Director, to ensure they are progressing well in their first year of residency. R2 through R4 residents will

meet with the Program Director and/or the Associate Program Directors on a rotating basis, at a minimum, semi-annually. In addition, faculty and chief residents and faculty complete evaluations of the residents for each clinical rotation. These evaluations are used for promotion as determined by the Program Director with recommendations from the Clinical Competency Committee. The evaluations become part of the resident's permanent file. Nursing staff also complete evaluations of the residents. The Clinical Competency Committee uses these evaluations for review purposes. If consistent problems are noted, one's advisor will be contacted to review this file for discussion with the resident. If the resident has a question about the content of an evaluation, please contact the evaluator directly. If one still has concerns, the resident may contact the Program Director. All residents are required to complete evaluations of the rotations, faculty, and program.

- A. Focused assessments are a requirement of the ACGME and RRC. Our program has five different focused assessments. The Program Director expects that one of each assessment will be done per rotation. The set of five assessments should be a true "360° Evaluation." This entails getting an assessment from each person involved in one single patient encounter. The resident is responsible for asking the faculty, the nurse, another resident, the student or the patient to evaluate them on the correct form. These forms are also available in New Innovations for faculty and peers to complete their evaluations online.
- B. Global assessments of medical students, faculty and other residents are expected every two months. A resident should be able to fill these out as he/she goes through the rotation if there are specific comments he/she desires to make. Save them and then submit at the end of the rotation. An evaluation of the overall program will be completed annually by the residents and faculty.
- C. Surgical Procedure evaluations are done online or through paper. It's a goal every procedure that you do should be evaluated by your Attending. Ask for Feedback at the end of each case.

Experience Reporting

As every resident knows, hospital privileges are earned by experience. These experiences must be recorded to prove that you have completed them. Accuracy is a necessity. In the world of statistical reports, if the experience is not recorded it has not been done. Additionally, statistics are reviewed regularly by the ACGME Obstetrics & Gynecology Resident Review Committee (RRC.) These reviews require detailed records of resident experience in the program. Accurate statistics are critical to our accreditation.

The ACGME has created a program that all residency program (OB/GYN plus all others) that we began using in early 2004. It is called the "Oplog." One should enter surgical and clinical case data weekly, regardless of rotation. Procedures may be entered on a hand-held computer or other device with internet access. Each year a Chief Resident is designated to provide assistance with data entry and "unbundling" cases appropriately. The Program Director reserves the right to adjust a resident's rotation and/or clinic schedules to allow the resident to get adequate experience. **If a resident is to graduate on time, they must document through their Oplog case numbers, they have met the ACGME minimums. This is true for all categories,**

including hysterectomies, cesarean/vaginal deliveries, operative vaginal deliveries, laparoscopy/hysteroscopy, invasive cancer cases, and uterine evacuation procedures (e.g. D&C for miscarriage). The Program Director reserves the right to extend a resident's training if it is deemed a good faith effort was not made by the resident to meet these minimums.

The Program Manager reviews reports weekly to ensure that data entry is occurring in a timely manner. In the event that a resident is not inputting their numbers in a timely manner, the Program Director reserves the right to require the resident to use vacation time in order to update their OPLOG records. **This data reporting must stay current with weekly recording.**

Informed Consent

The resident will explain to the patient the reasons for the proposed interventions and therapy as well as the risks involved. A signed consent form is required for all major and minor invasive procedures unless: a) The patient is unable or not qualified to sign the consent and no immediate family is available or reachable, b) A life threatening situation exists. The attending OB/GYN physician should co-sign notes and review the consent prior to the procedure and ensure the patient understands the need for the procedure and the risks involved unless the procedure is life-threatening and time is the limiting factor.

Laboratory

The resident is responsible for all laboratory results via the computer as designated by the appropriate institution. Laboratory results, normal and abnormal, will be followed up with the patient either in a subsequent clinic visit, via the phone, or by mail. All abnormal results will be acted upon in a timely fashion. Documentation of follow-up will be done via the electronic medical record (Epic at MVH). Any treatment of a patient for a laboratory abnormality must be precepted by an attending OB/GYN.

If the resident will not be able to follow-up on a laboratory result for a reason of leave or illness, the resident will ensure that another resident knows of the laboratory results to follow-up on. A surrogate will be documented in the system and the designated resident will follow-up on these results. Leave will not be granted until documentation of a surrogate is noted. If this is not done, the resident will be cited for this deficiency in the resident's folder, and the fourth-year resident will automatically become the surrogate.

Licensure

All residents have to take Part 3 of their respective licensing exam (Allopathic or Osteopathic) and have their results by the end of their R1 year. All Military residents must have a license by the completion of their second year. All civilian residents are strongly encouraged to obtain licensure after successful completion of Part 3 of their respective licensing exam. The residents renew Ohio training licenses every 3 years, typically in April or May. This can be accomplished on line in less than ten minutes. A user name and password must be used for access to this site.

Lines of Supervision

Wright State University Department of Obstetrics and Gynecology is a hierarchical program. When multiple levels of residents are working together as a team on a given service, it is expected that the Chief Resident on the service will be ultimately responsible for the efficient conduct of the service. This will include assignment of duties to junior residents as appropriate. The Chief Resident will also be responsible for communicating with the assigned attending. The junior residents on the service are expected to perform the duties assigned by the chief resident and to report appropriately to the chief resident. The attending physician is ultimately responsible for oversight of resident activities. In all cases, there is a designated attending physician who is readily available for resident consultation and oversight as defined by regulatory agencies to include the hospital and department policies.

Teaching is an essential component of this residency program at all levels. The following is expected of residents in the program:

- A. Residents at all levels will be responsible for the supervision and instruction of medical students.
- B. Senior residents will be responsible for the supervision and instruction of junior residents.
- C. Chief residents will be responsible for the supervision and instruction of all other residents and medical students.
- D. Attendings will be responsible for the supervision and instruction of all residents in the program and medical students rotating through the facilities that make up a part of the program.

A resident may seek cross-coverage from any other resident at or above their level in the program where resident responsibility is involved. Attendings may cover for any level of resident if requested and if the faculty member agrees.

Medical Records

Computerized Electronic Medical Records (EMR) are now used at all facilities- EPIC/Essentris/ and AHLTA. Training is required for EMR use. Medical record timeliness is crucial and all institutional policies regarding timing of completion must be followed. The residents must visit or call to assess medical records to be completed on a weekly basis even if the resident is on an away rotation at the Miami Valley Hospital or other another location. The resident must complete the charts. If the resident does not complete their records and three documented phone calls have been made to that resident, leave/vacation will be denied until the records are completed and one vacation day will be denied.

The residents at the base can sign someone's records at the base and vice versa. Dictations will be done by the individual resident and should not be put off until that resident is at the specific institution again. They need to be completed in a timely fashion. Dictations will be done at the time of the operation and within the same day of discharge of the patient. Interim summaries will be dictated by the upper level resident if the patient becomes the patient of a more junior resident at the time of transfer. (For instance, if an antepartum patient is set up to deliver and then becomes the R1s patient on the postpartum service, the senior resident will dictate the antepartum course of the patient.)

Residents are required to maintain up-to-date medical records in order to remain in compliance with their contract. The Program Manager checks the status of individual resident records weekly. Delinquent records are tracked and are reported to the Program Director for follow up. Should you need to complete a record in person, call the following numbers to have records pulled prior to your arrival at the Medical Records Department:

MVH	208-2070
WPAFB	257-9328

Operative reports must be dictated by the responsible resident at the time of surgery. If an operative report is not dictated immediately, the resident will not be permitted to perform/assist at surgical procedures until the delinquent operative report is completed. Maintaining records in a timely manner is a Joint Commission requirement; therefore, residents may be required to use vacation days to complete appropriate records if non-compliance is exhibited.

For OB patients, timely problem-oriented progress notes will be made as often as clinically indicated for intrapartum patients, and not less than daily for antepartum or postpartum patients. Operative notes are written directly after the surgery prior to leaving the patient. An operative report is dictated within the hour unless patient care takes the resident away for an urgent reason. The operative report needs to be dictated within 24 hours. A day of surgery note will be written on the patient at the end of the day.

For GYN patients, again, operative notes are written directly after the surgery prior to leaving the patient. An operative report is dictated within the hour unless patient care takes the resident away for an urgent reason. The operative report needs to be dictated within 24 hours. A day of surgery note will be written on the patient at the end of the day. Progress notes will be written on postoperative patients or patients admitted to the GYN service as often as clinically indicated but not less than daily.

On-Call

The Wright State University Program initiated a Night Float Call System several years ago to accommodate the ACGME resident 80-hour work week rule. Night Float residents take call daily Sunday Night through Thursday Night. Call starts at 1730 and is completed at 0700. Residents from OB Days, GYN, Oncology and other services will cover weekend call shifts as per a “call team schedule.” This is made in advance of each rotation block and reviewed by the Administrative Chief Residents and Program Director. Weekend call starts at 1700 on Friday and is completed at 0700 Monday. Residents cover weekday holidays too. The residents are expected to take call in such a way as to not interfere with the RRC guidelines for the 80-hour work week rule. Call is in-house for the resident. An attending OB/GYN physician is always on call for OB/GYN patients to answer resident’s questions, to evaluate patients with the residents, and to precept patient care. Below are the schedule formats for both MVH and WPMC.

Miami Valley Hospital

	R-1	R-2	R-3	R-4
Sunday 0700-1730 1700-0700	Call Team NF	Call Team NF	Call Team NF	Call Team NF
Monday 1730-0700	NF	NF	NF	NF
Tuesday 1730-0700	NF	NF	NF	NF
Wednesday 1730-0700	NF	NF	NF	NF
Thursday 1730-0700	NF	NF	NF	NF
Friday 1700-0700	Call Team	Call Team	Call Team	Call Team
Saturday 0700-0700	Call Team	Call Team	Call Team	Call Team

Wright-Patterson Medical Center

	R-1	R-2	R-3	R-4
Sunday 0800-1700 1700-0700	No Call	Call Person NF	Call Person NF	No Call
Monday 1700-0700	No Call	NF	NF	No Call
Tuesday 1700-0700	No Call	NF	NF	No Call
Wednesday 1700-0700	No Call	NF	NF	No Call
Thursday 1700-0700	No Call	NF	NF	No Call
Friday 1700-0800	No Call	Call Person	Call Person	No Call
Saturday 0800-0800	No Call	Call Person	Call Person	No Call

Pathology Data

The first year GYN resident collates weekly pathology reports and distributes to attendings and residents at the weekly pre-op conference. The resident is ready to discuss the plan for each patient.

Physicals/TB Testing

All OB/GYN residents must have a current TB test and physical examination on file for the Ohio State Inspection conducted the first week in March. All OB/GYN residents are on a consistent yearly schedule and are required to have their physical forms and TB test results in the Employee Health Office by the end of February. Interns who have their physicals and TB tests in June must repeat the process in February.

Portfolios

The residents' portfolios are in the program Manager Office. Any lectures (even five-minute lectures), M&M, papers, case reports, letters of appreciation, special projects, tips for the program that are presented to the residents or medical students, or any thing a resident can think of to put in the portfolio should be placed in the portfolio. This needs to be done frequently and as the project is completed or presented. Again, this can be anything that makes the resident look good and individualizes the resident. **Portfolios are available and should be reviewed by residents.**

Pre-operative Conference

The chief resident, or the surrogate, presents each scheduled patient for surgery at the weekly pre-op conference. The patient's history and physical is to be completed by or under the direction of the fourth-year resident. All pertinent data should be presented and the resident is ready to defend the indications for surgery and describe the indicated surgery. All major surgery should be presented at least once a week prior to scheduled case.

Procedures

Over the course of the residency, the residents have the opportunity to obtain proficiency in various procedures. Residents are required to have supervision for procedures/operations. The residents are required to track their procedure numbers in the database provided by the Accreditation Council for Graduate Medical Education (ACGME) called the OPLOG. The log should be updated weekly in the computer system. The log is reviewed by the Program Manager and the Program Director regularly and by the Clinical Competency Committee quarterly. Specific procedure evaluations (3) may be required on each rotation and listed in the rotation objectives.

Writing/signing orders

Residents may write orders for patients. If a telephone order is given to the nurse, the resident has up to 24 hours to sign, stamp, date and time the order when it is signed. (Most orders are completed electronically at our institutions). Other same year residents or higher-level residents may sign, stamp, date and time this order. An attending physician may sign, stamp, date, and sign this order too. A resident may not sign a telephone order given by the attending physician.

A discharge note is required for all patients and will include the following: chief complaint, history of present illness, pertinent laboratory data, hospital course, all diagnoses, operations and procedures, condition on discharge, medications, physical activity, diet, follow-up directions, and profile changes/duty status if applicable. The medical records "face sheet" or AF IMT Form 560 must be filled out with all of the diagnoses and procedures for the hospitalization.

Narrative summaries are required for all patients with extended length admissions or complex hospital courses as well as all patients transferred from other hospitals. The summaries should give

details yet be brief. Again, the narrative should include the following: chief complaint, history of present illness, past medical history, review of systems, physical exam, laboratory data, hospital course, all diagnoses, operations and procedures, condition on discharge, medications, physical activity, diet, follow-up directions, and profile changes/duty status if applicable. Charts must be dictated the day of discharge.

Clinic Notes

A note for all patients must be in place by the end of clinic day. Each annual physical must include elements of primary care.

Section

4

Clinical Activities

This section will provide you with an overall picture of the clinical activities and specific guidelines for many clinical areas in which residents work.

Continuity Clinics

As a resident, you will see patients in two primary locations – the Well Women’s Clinic and the Perinatal Clinic at WPMC and the Five Rivers Health Center - Center for Women’s Healthcare at MVH. The experience gained from these clinics will include general office experience as it relates to running a medical practice, menopausal medicine, preconception health care, urogynecology and basic gynecology.

Moonlighting

Moonlighting in this program is not permitted.

Procedure Progression

Obstetrics & Gynecology residents are permitted graduated levels of patient care responsibility related to the year of training and individual academic progress. At all times, residents are accountable to attending physicians/preceptors who are members of the Department of Obstetrics & Gynecology. OB/GYN attending physicians are ABOG Board Certified or Board Eligible Licensed Independent Practitioners (LIP’s), most of whom hold faculty appointments at Wright State University School of Medicine. OB/GYN attending physicians are ultimately responsible for the clinical care rendered to patients.

Increasing responsibility must progress in an orderly fashion, culminating in a chief resident (R-4) year. The R-4 year consists of 12 months of clinical experience. The R-4 must have sufficient independent operating experience to become technically competent, and have enough total responsibility for management of patients to ensure proficiency in the diagnostic and treatment skills that are required of a specialist in obstetrics-gynecology in both office and hospital practice under the supervision of an attending.

All residents are supervised during surgical procedures regardless of year level of training and/or academic status. Second, third, or fourth year residents, in rare circumstances, may initiate emergent surgical procedures in the absence of an attending physician in the room, particularly if their presence is urgently needed elsewhere.

The resident physician will generally be the primary physician for the patient. However, members of the team will be introduced to the patient and her family, as appropriate, and the attending OB/GYN physician will be identified as the senior physician on the case. The team consists of the attending OB/GYN physician, the residents involved in the care of the patient, and the medical student.

Scheduling of ALL procedures, surgeries, inductions, etc. must be coordinated with the Chief Resident of that specific service and/or covering Attending.

Clinical Communication

Every clinical care episode has an Attending supervising patient care. Notes are co-signed to the covering Attending. **Changes in patient clinical status must be communicated with Upper level resident and Attending. Documentation of plan of care including discussion with covering Attending should be done.** These events occur more regularly with in-patient care or laboring patients but are not limited to these situations.

Obstetrics

The following can be accomplished under the supervision of an attending obstetrician/gynecologist:

- A. First year residents:
 1. Routine postpartum care
 2. Read NST's of patients with an estimated gestational age of 36 weeks or greater
 3. Evaluation of triage patients with an estimated gestational age of 36 weeks or greater. (Must be under the direct supervision of the more senior resident if patient is less than 36 weeks)
 4. Admission history and physicals (H&P's) with the supervision of the senior resident. H&P's must be completed and, in the chart, as soon as possible, but under no circumstances later than 24 hours after admission
 5. Insertion of intra-uterine pressure catheter, and fetal scalp electrode, amnioinfusion.
 6. Placement of foley bulb and Cook catheters for cervical ripening
 7. Spontaneous vaginal delivery
 8. Repair of 2nd degree episiotomy or laceration under the supervision of the senior resident
 9. Initiation of tocolytics, pitocin, antibiotics, or transfusions after consultation, and order labor epidurals with the senior resident and staff
 10. Colposcopic examination of the cervix/vagina/vulva with senior resident and attending supervision
 11. Supervision of the medical students

- B. Second and third year residents:
 1. Same procedures as the first-year residents
 2. Supervision of the first-year residents and medical students
 3. Evaluation of triage patients with an estimated gestational age of less than 36 weeks including reading NST's
 4. Emergent operative vaginal delivery or normal vaginal delivery if the OB/GYN attending is with another emergent patient
 5. Repair of 2nd degree episiotomy or laceration
 6. Repair of 3rd or 4th degree laceration under the supervision of Chief Resident or OB/GYN attending
 7. Initiation of Emergent Cesarean Section.
 8. Serve as a consultant to other inpatient services and completes the consultations in a timely manner
 9. Evaluate unstable and critically ill patients as well as patients requiring surgery; these patients are discussed with the attending at the time of admission
- C. Fourth year residents
 1. Same procedures as the second and third year residents
 2. Supervision of the second and third year residents
- D. Third year medical students
 1. Admission history and physicals with supervision of residents; however, documentation in the medical record may not be completed by the third-year medical student
 2. Evaluation of triage patients with an estimated gestational age of 36 weeks or greater under the supervision of a resident
 3. Insertion of intrauterine pressure catheter or fetal scalp electrode under the supervision of a resident
 4. Participation in the vaginal delivery in what appears to be a normal spontaneous vaginal delivery
- E. Fourth year medical students
 1. Same procedures as third year medical students
 2. Documentation in the medical record may be completed by the fourth-year student; all orders must be cosigned and stamped by the resident; all progress notes must be cosigned/stamped by the resident
 3. Admission history and physicals with supervision of residents; H&P's may be signed by the fourth-year medical student but needs to be co-signed/stamped by the resident and then staff

Gynecology

The following can be accomplished under the supervision of an attending obstetrician/gynecologist:

- A. First year residents
 1. Routine postoperative care
 2. Performance of preoperative history & physical examination, and counseling for minor procedures with senior resident supervision
 3. Emergency Room patient evaluation with senior resident supervision
 4. Annual examinations including: pap smears, breast examination, bimanual pelvic assessment, appropriate cultures, and/or biopsies of endometrium or vulva

5. Pelvic ultrasound with supervision of the senior level resident or staff
 6. Initiation of antibiotics or transfusions after consultation with senior level resident and/or staff
 7. Supervision of medical students
- B. Second year residents
1. Same procedures as the first-year resident
 2. Supervision of first year residents
 3. Performance of preoperative history and physical examination and counseling for major procedures with senior resident supervision
 4. Emergency Room patient evaluation
 5. Gynecological patient problem evaluation and consultation with senior resident supervision (inpatient and outpatient setting)
 6. Colposcopic examination of the cervix/vagina/vulva with senior resident and attending supervision
 7. Pelvic Ultrasound with supervision
- C. Third year residents
1. Same procedures as first and second year residents
 2. Performance of preoperative history and physical examination and counseling for major procedures
- D. Fourth year residents
1. Same procedures as first, second, and third year residents
 2. Colposcopic examination of cervix/vagina/vulva with associated biopsies after discussion with the attending OB/GYN.
- E. Third year medical students
1. Admission history and physicals with supervision of residents; however, documentation in the medical record may not be completed by the third-year medical student
 2. May assist with procedures and biopsies under direct resident or attending supervision
- F. Fourth year medical students
1. Same procedures as the third-year medical students
 2. Documentation in the medical record may be completed by the fourth-year student; all orders must be cosigned/stamped by the resident. All progress notes must be cosigned/stamped by the resident
 3. Admission history and physicals with supervision of the resident; H&P's may be signed by the fourth-year medical student but needs to be co-signed/stamped by the resident and then the staff

Section

5

Policies

Residency is considered a job and not just an education. As with any employer, there are policies in place to protect both your interests. This section will familiarize you with the policies in place for the Residency Program.

Academic & Professional Standards

The Program adheres to the Wright State University Resident Policy Manual’s “Academic and Professional Standards / Due Process” Policy #504. In addition, Miami Valley Hospital has a section in their Resident Handbook for “Grievance and Due Process Procedures.”

Faculty, nurses, and/or residents may bring concerns regarding a resident to the attention of the program director. Concerns may also be discussed during the Clinical Competency Committee’s quarterly meetings. These concerns will then be addressed with the resident individually. In the event that the issues are not addressed to the satisfaction of the Clinical Competency Committee, the Program may pursue further action with the resident such as remediation or dismissal from the program as noted in the above-named policy.

Remediation

In the event that the Clinical Competency Committee determines that a resident is not progressing as expected, remediation may be required. The Program bases their remediation on the Wright State University Resident Manual’s “Academic and Professional Standards/Due Process” policy #504. Remediation will be considered for any resident that fails to achieve proficiency in any one of the six ACGME Competencies. In the event that a resident receives a score lower than 180 on the Annual CREOG Exam, this may result in a resident being asked to spend extra time studying outside their clinical duties and/or working with their advisor or mentor as part of the Scholastic Remediation Program.

Voluntary Transfer from Program

In the event that a resident desires to leave or transfer to another residency for any reason, the resident must notify the Program (Program Director or Chair) in writing no later than 60 days but preferably 120 days. This allows Program time to find a replacement resident if available and is consistent with Premier and Wright State University policies. Request to Voluntary Transfer not meeting the above time frame will be denied.

Recognizing Resident Fatigue and/or Stress

Symptoms of fatigue and/or stress are normal and expected to occur periodically with the resident population, just as it would in other professional settings. Not unexpectedly, residents may on occasion, experience some effects of inadequate sleep and/or stress. Stress, sleep deprivation, and depression can have significant consequences on resident well-being and patient care. Departmental and institutional didactic sessions are scheduled throughout the year to address these issues.

Fatigue for the sake of this policy is defined as extreme tiredness in the absence of illness affecting or potentially affecting clinical judgment and performance such that patient safety is endangered. Monitoring for fatigue may take place either by individual resident self-monitoring or by direct observation by hospital personnel including but not limited to nurses, attending physicians, and other residents. Signs and symptoms of resident fatigue and/or stress may include but are not limited to the following: inattentiveness to details, forgetfulness, emotional lability, mood swings, increased conflicts with other, lack of attention to proper attire or hygiene, difficulty with novel tasks and multitasking, and impaired awareness (fall back on rote memory.)

Response

The demonstration of resident excess fatigue and/or stress may occur in patient care settings or in non-patient care settings such as lectures and conferences. In patient care settings, patient safety as well as the personal safety and well-being of the resident, mandates implementation of an immediate and proper response sequence. In non-patient care settings, responses may vary depending on the severity of and the demeanor of the resident's appearance and perceived condition. The policy below is intended as a general guideline for those recognizing or observing excessive resident fatigue and/or stress in either setting.

Attending Clinician and Supervising Resident Responsibilities

- A. In the interest of patient and resident safety, the recognition that a resident is demonstrating evidence for excess fatigue and/or stress requires the attending or supervising resident to consider immediate release of the resident from any further patient care responsibilities.
- B. The attending clinician or supervising resident should privately discuss his/her opinion with the resident, attempt to identify the reason for excess fatigue and/or stress, and estimate the amount of rest that will be required to alleviate the situation.

- C. The attending clinician should attempt to notify the chief/supervising resident on-call, program director or department chair, respectively, depending on the ability to contact one of these individuals, of the decision to release the resident from further patient care responsibilities at that time.
- D. If excess fatigue is the issue, the attending clinician must advise the resident to rest for a period that is adequate to relieve the fatigue before operating a motorized vehicle. This may mean that the resident should first go to the on-call room for a sleep interval no less than 30 minutes. The resident may also be advised to consider calling someone to provide transportation home.
- E. The attending should notify the on-call hospital administrator for further documentation of advice given to the resident removed from duty.
- F. If stress is the issue, the attending, upon privately counseling the resident, may opt to take immediate action to alleviate the stress. If, in the opinion of the attending, the resident stress has the potential to negatively affect patient safety, the attending must immediately release the resident from further patient care responsibilities at that time. In the event of a decision to release the resident from further patient care activity, notification of program administrative personnel shall include the chief/supervising resident of the service, program director or department chair, respectively, depending on the ability to contact one of these individuals.
- G. A resident who has been released from further immediate patient care because of excess fatigue and/or stress can not appeal the decision to the responding attending.
- H. A resident who has been released from patient care can not resume patient care duties without permission of the program director or chair when applicable.

Resident Responsibilities

- A. Residents who perceive that they are manifesting excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the chief resident, and the program director without fear of reprisal.
- B. Residents recognizing resident fatigue and/or stress in fellow residents should report their observations and concerns immediately to the attending physician, the chief resident, and/or the program director.

Program Director Responsibilities

- A. Following removal of a resident from duty, in association with the chief resident, the program director will determine the need for an immediate adjustment in duty assignments for remaining residents in the program.
- B. The program director will review the resident's call schedules, work hours, extent of patient care responsibilities, any known personal problems, and stresses contributing to this for the resident.
- C. The program director will notify the departmental chair and/or division director of the rotation in question to discuss methods to reduce resident fatigue.
- D. In matters of resident stress, the program director will meet with the resident personally. If counseling by the program director is judged to be insufficient, the program director will refer the resident to the appropriate professionals for counseling.
- E. If the problem is recurrent or not resolved in a timely manner, the program director will have the authority to release the resident indefinitely from patient care duties pending evaluation from the professional counselor.

- F. The program director will release the resident to resume patient care duties only after advisement from the professional counselor and will be responsible for informing the resident as well as the attending physician of the resident's current rotation.
- G. If the professional counselor feels the resident should undergo continued counseling, the program director will be notified and should receive periodic updates from the counselor.
- H. Extended periods of release from duty assignments that exceed requirements for completion of training must be made up to meet RRC training guidelines.

Grievances

The Program adheres to the Wright State University Resident Policy Manual's "Complaints and Grievance Policy #506. In addition, Miami Valley Hospital has a section in their Resident Handbook for "Grievance and Due Process Procedures."

Each class of residents has two or three assigned faculty advisors or mentors who are in positions to identify problems, whether they are academic or non-academic. In addition, residents are encouraged to seek out a faculty member who will mentor them throughout their time here at Wright State in both professional and personal issues. This is not required but is suggested. Often the relationship between the faculty and resident is close and very supportive; therefore, potential areas of concern may be noted and evaluated by one of these faculty members. The Program Director and Associate Program Directors offer their time to the residents to discuss personal and/or professional issues.

Residents may discuss grievances or concerns with the Program Director, Program Manager, Chairman of the Department, or one of the two R4 Administrative Chief Residents. Monthly Program Director meetings with the residents are provided on Wednesday mornings to discuss residents' concerns. Residents are also encouraged to report concerns directly to the Director of Medical Education or the Wright State Designated Institutional Officer if they do not feel comfortable bringing specific issues up with our department personnel. Of course, residents are encouraged to handle minor disputes and grievances among themselves. Residents are advised that any major concerns should be brought up to the Program Director or Associate Program Director's attention immediately in order to address a concern or issue.

Leave of Absence and Time Off

The Program follows the Leave of Absence policy set forth by the American Board of Obstetricians and Gynecologists (ABOG) as included in their Annual Bulletin. The Bulletin is available for review at their website: www.abog.org. Leave of Absence beyond the allotted time by ACGME will require additional time beyond June 30th/Graduation. It is required for residents to obtain a new State Training License for any additional training time beyond June 30th/Graduation.

Application

All vacation requests must be submitted to the Administrative Chief Residents by June 15 of each year, except interns, whose requests must be submitted by July 15. All vacation requests must be submitted with a leave/vacation form. Vacation should be taken in one-week blocks. If changes to approved requests are needed, the request must be submitted to the Administrative Chief Residents no later than eight weeks prior to the first of the month in which the leave is desired. The leave form must be signed by the Administrative Chief Resident prior to submitting to the Program Manager for final approval. In addition, medical records at both hospitals will need to be completed prior to the start of leave time. **Air Force residents must submit leave form AF988 when on vacation regardless of location or rotation at the time. Violation of this policy is considered absent without leave (AWOL) status. Contact the Manager at the Base for more information (522-2665).**

Leave forms will not be accepted unless they are completed in their entirety including contact information stating where you can be reached. Approvals are granted on a first-come, first-served basis by class in descending order. Completed forms will be given priority over incomplete forms regardless of date of submission. **Final approval of any leave must be communicated directly to Program Director or designee and supervising Faculty on specific rotation.**

Approval Guidelines

MVH

No more than one resident from a service may be on leave at any one time. At least three interns must be available for MVH call at any time. At least four R2/R3 residents must be available for call at MVH Friday through Sunday. This does not include Night Float which consists of one R2 and one R3 who take call Sunday PM through Friday AM. At least three Chiefs must be available for MVH call at any time.

WPAFB

No more than one resident from a service may be on leave at any one time. Residents who take call at WPAFB are: OB R2 & R3; GYN R2 & R3.

Other Restrictions

- A. A resident may be absent only one week during any two-month rotation.
- B. No more than two weeks of vacation can be taken consecutively (two different rotations needed for this).
- C. Vacation during off-service rotations is subject to the approval of the affected department. Note: **The ICU rotation does not allow for vacation and Emergency Medicine requires you notify them no later than the 10th of the month prior to the start of the rotation.**
- D. Leave requested during a one-month rotation should be avoided and is restricted to the discretion of the responsible attending for that service. Residents who take leave during a short rotation will be responsible for meeting all call responsibilities for that rotation.
- E. No leave will be granted between June 15 and July 15, as this is a time of transition within the program.

- F. Residents will not be granted leave time during Resident Research Day usually held annually on the third Wednesday in May.
- G. Residents will not be granted leave during the scheduled CREOG examination time.
- H. Residents will not be granted leave during the last week of December to allow all residents to have some time off during the holiday season. Residents will not be granted leave during the Night Float rotation except under extreme circumstances as approved by the Program Director.
- I. Sufficient resident coverage for the call schedule must be maintained; therefore, two residents from the same year group cannot be granted time off during the same weekend.
- J. Sufficient resident coverage for the service must be maintained.
- K. Leave time does not carry over from year to year.
- L. Date of earliest request submission will vary from year to year depending on when the schedule for the upcoming year is completed and approved. All residents will be notified when submissions are being accepted.
- M. Any leave affecting the schedule at Wright-Patterson Medical Center (i.e. continuity clinics for Air Force residents and any residents rotating at WPAFB during their leave time) must be entered into the red leave binder maintained by the Administrative Assistant to the Department Chair at WPAFB. The contact number is 522-2665 for assistance.

Wellness Program

The Wellness Program is overseen by a chief resident and faculty advisor. These individuals, in conjunction with residents, plan and execute wellness activities on a monthly basis during the didactic period. Areas of wellness covered according with ACOG include Physical, Environmental, Spiritual/Mindful, Social and Emotional/Intellectual. An Annual Resident retreat is usually held in the fall.

Residents are also provided one-half day of personal time once every 8 weeks. This day may be taken on any rotation except Well-Woman Clinic and ER. This time will be coordinated well in advance with the service chief resident or faculty as applicable, and as a general rule clinics should not be cancelled or rescheduled to accommodate this time.

Conferences/Meeting Presentations/Global Health

All OB/GYN residents are given the opportunity to attend an annual national meeting or conference of their choice provided it meets an identified educational need and is approved by the Program Director. This conference time at educational conferences is not counted as regular work and is applied to total leave for that year level. Two travel days may be used to supplement this meeting time on a case by case basis. The WSU Program will need proof of attendance to document that the conference was attended by the resident. Otherwise, the time will be counted as vacation. Additionally, if approved in advance by the Program Director, conference leave time may be used for research instead of attending a meeting. **This educational time may be forfeited if the resident is delinquent on administrative duties or has unapproved absences from Wednesday education conferences.** When using this leave for research, residents must sign in daily with the Resident Manager. When using for Global Health must have prior approval by program director and Summary of educational experience submitted to Program Director when return from trip.

Year	Allowance
R1	5 days
R2	5 days
R3	5 days
R4	5 days

Family Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 requires covered employers to provide up to 12 weeks of job-protected leave to “eligible” employees for certain family and medical reasons. Miami Valley Hospital has developed various leave policies in accordance with the Family and Medical Leave Act of 1993. These policies include the Disability Leave Policy, the Family Illness Leave Policy, and the Parental Leave Policy. In all instances, the minimum requirements of the Family and Medical Leave Act are met and some hospital policies provide employees with greater benefits or protections than required by the Family and Medical Leave Act. **The intent of all forms of leave is not to exceed a maximum of 12 weeks in any of the years of residency training, or a total of 24 weeks over the four years of residency.** This policy includes, but is not limited to, vacation, sick leave, maternity leave, paternity leave, adoption leave, conference leave, or personal leave. If the maximum weeks of leave per residency year are exceeded, the residency must be extended for a duration of time equal to that which the resident was absent in excess of 12 weeks in the PGY-1, PGY-2, PGY-3, and PGY-4. If the total leave limit is exceeded, the residency must be extended for the duration of time that the individual was absent in excess of 24 weeks.

Maternity and Paternity

12 weeks are allotted for maternity leave. Maternity leave officially begins the day after the mother is discharged from the hospital. Paternity leave of 3 weeks is also available (this may be taken any time during the first 8 weeks of child’s life and weeks should be consecutive). The military allows for up to 12 weeks paid leave.

Adoption Leave

Per Wright State University Policy, a maximum of 3 weeks is allowed for leave related to adoption of a child.

Sick

In the event that a resident is too ill to come to work or if an emergency arises, the following contacts are to be made:

- A. Chief on your service (or the attending if no Chief is available)
- B. Program Manager at 208-2287 or Program Director – cell 513-465-4999

An absence permit must be completed for any illness or emergency that extends beyond 2 calendar days.

Doctor’s appointments & Missed “Partial” Day

Resident must notify rotation attending, chief resident and Program Director (or Designee) when they will need to miss work or education due to a doctor’s appointment or other personal matter. See “Personal Time Off” above.

Vacation

Time may be taken at the Resident’s discretion. **Vacation time may be required to be applied/removed/delayed in the event that a resident is not in compliance with medical records, Duty Hour data entry, or OpLog data entry (at chair’s or program director’s discretion) this must be checked by resident with Program Manager prior to each vacation.** All activity previously listed should be current one week prior to intended vacation. Vacation is considered a continuous, seven-day block consisting of five weekdays and two weekend days (preferably Monday thru Friday). The weekend leave that is desired must be clearly indicated on the request. Every attempt will be made to allow the surrounding weekends off although this is **not guaranteed**.

Year	Allowance
R1	3 weeks
R2	3 weeks
R3	3 weeks
R4	3 weeks

Social Media Policy

Social Media networks, including but not limited to, Facebook, Twitter, LinkedIn, are prohibited from use in professional related activities during your residency. While these social media areas can be used personally, they must be kept separate from work related activities.

Communication using a secure and approved network, ie. IQMax or similar system used by the hospital’s EMR for patient related communication, is required.

Residents should be aware and familiar with the varying social media policies at the different institutions during each rotation.

In addition, patient related photos are not permitted to be taken with cell phones or personal cameras. Photos may be taken with patients’ permission and with hospital equipment.

Wright State University Boonshoft School of Medicine’s Social Media Policy:

<http://www.med.wright.edu/web/socialmedia>

MVH Social Media Policy

http://policy.mvh.phpds.org/Site_Published/MiamiValleyHospital/document_render.aspx?documentRender.IdType=29&documentRender.GenericField=1&documentRender.Id=31122

No Smoking Policy

Because we recognize the hazards caused by exposure to environmental tobacco smoke, it shall be the policy of Wright State University Boonshoft School of Medicine Department of Obstetrics and Gynecology to provide a smoke-free environment for all employees and visitors. The policy covers the smoking of any tobacco product and the use of oral tobacco products or “spit” tobacco. This policy is in accordance with Miami Valley Hospital’s no smoking policy number: EMP009. A medical examination including chemical screening, flu shot and nicotine screening will be conducted by the hospital’s employee health program and required of all prospective employees following the job offer and prior to the first day of work, which must be successfully completed as a condition of employment.

Interviews

R3s and R4s are allowed five days to participate in interviews. **Additional days must be considered as vacation and maybe limited due to other absences.** These interviews may be to aid in securing a job or a fellowship position or post residency necessary transitions. The military residents may have five days to house hunt instead of these five days for interviewing.

Selection and Promotion

Selection

The Program follows the Wright State University Resident Manual Policy 201 “Residents – Selection” as the basis for our selection of residents. This policy is available on the Wright State website at www.med.wright.edu/fca/gme/rm201.html. Applications from candidates must be submitted via the [Electronic Residency Application Service](#) (ERAS) through their medical school or the Educational Commission for Foreign Medical Graduates (ECFMG). Applications cannot be accepted directly by the department. Entry into the program for civilian candidates is through the [National Resident Matching Program](#) (NRMP). The program participates in the “All in” process for R1 positions with the NRMP match. Entry of military candidates into the integrated residency program is through the Department of Defense’s Joint Services Graduate Medical Education Selection Board.

Candidates for this program shall have graduated from an approved medical school. Due to our integrated status with the United States Air Force, candidates must be an US Citizen or Permanent Resident. Candidates will be reviewed based on their performance in medical school, Step I and Step II exam scores, personal statement, and reference letters. Both Step I and Step II must be passed before the program’s final list is due to the NRMP in February to be eligible for the program. Qualified candidates will be invited by mail to visit the facilities and meet with the residents. Interviews are scheduled as October through January.

Those candidates matched with our program begin their training on July 1. A number of local and department sponsored orientation programs are held in June; all new interns are required to attend these events. Residents within our program also hold a faculty appointment at the level of Resident Instructor through Wright State University.

Promotion

The academic and clinical progress of each resident is reviewed at the end of each academic year. The Program Director or Associate Program Directors meet with interns quarterly and all R2-4s semi-annually. These evaluations are also taken into consideration during the annual review. In addition, the Department's Resident Clinical Competency Committee (CCC) meets quarterly to discuss resident progress. Any deficiencies found in the academic or clinical ability of a resident are discussed during these meetings. In the event that a resident is progressing as expected, their contracts are signed annually and a letter is added to their file stating that they have demonstrated a satisfactory progression in the application of obstetrical and gynecological skills, knowledge, and fulfillment of responsibilities.

Graduation

The chiefs' last day for clinical activity varies but is approximately mid-month in June. The remainder of June is meant for board review, written exam, completion of medical records, and post-residency transitions. Chief Residents (R4) must remain available for emergencies or clinical assignment until completion of residency on June 30th.

Section

6

Communication

Good communication is essential to the smooth operation of any organization and is especially critical where patient care is involved. It is important that we have accurate contact information for each resident. Please communicate with resident Manager when there is a change in any form of communication. This section discusses communication policies that must be followed both in and out of the clinical setting.

E-Mail

Wright State University Boonshoft School of Medicine establishes free email accounts to all residents upon entry into the program. This account is to be used for the duration of the residency program. An address will be assigned along with a changeable password. Residents are required to check email daily, as this is a standard form of communication within the department. **Not checking your email is not a valid excuse for not having or returning needed information. All residents must have and use for primary communication a Wright State University and/or a PremierHealth email address.** Please contact the Program Manager to make the necessary updates.

Private Health Information should only be sent via premierhealth email address, not via wright.edu email address.

Mailboxes

Each resident is given a mailbox located in the resident lounge. Routine notices and other forms of written communications will be placed in these mailboxes and you are required to check them at least two times per week. Department administration will maintain and publish a current listing of email addresses and pager numbers. Your mailing address will be: 128 E. Apple Street, Suite 3800 CHE, Dayton, Ohio 45409.

OB Emergency Phone Line

The OB Emergency Line is to be used as a triage tool for any OB or GYN patient with questions regarding legitimate problems. These problems do not have to be emergencies; however, they should be problems or questions that need immediate answers.

GYN patients are told to call the Resident Physician on call for any post-op problems, as it is important for patients to have a resource other than the ER. Most issues can be dealt with over the phone resulting in one less trip to the ER for the second-year resident. In addition, it allows us to properly triage the patient.

Interns should transfer or refer any call with which they feel uncomfortable handling. An upper level resident will be happy to answer any questions or take the call if necessary.

Secure Messaging

Texting is NOT allowed as a means for work/residency related information! Communication using a secure and approved network, ie. IQ MAX or equivalent hospital EMR secure messaging, is the required method at Miami Valley Hospital. Other facilities may have different secure networks and policies must be adhered.