CORE CLINICAL CLERKSHIP IN OBSTETRICS & GYNECOLOGY
SYLLABUS 2011

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DEPARTMENT WEBSITE
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WELCOME TO OB-GYN!

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I. WELCOME/COURSE BASICS

Welcome to Obstetrics & Gynecology!

The Obstetrics & Gynecology core clinical clerkship focuses on health care of women during the reproductive and post-reproductive years. The course emphasizes care of the pregnant female, normal labor and delivery, common obstetrical and gynecologic problems, preventive care, screening for gynecologic malignancies, and family planning and sexuality.

You have been assigned to one of five hospitals/practices for your clinical experience. In general, you will spend equivalent time on labor & delivery, the gynecological services, prenatal and gynecology ambulatory clinics. The course coordinator at each site will provide you with a detailed schedule of your clinical assignments.

Opportunity for Students Interested in Women’s Health

The American College of Obstetrics and Gynecologists (ACOG) offers free medical student membership to students interested in Women’s Health and OB/GYN. You will receive their educational resource materials (technical bulletins, practice committee opinions, journals, etc.) at no cost. Medical students are also able to attend certain ACOG sponsored meetings free of charge.

If you would like to become a Medical Student member of ACOG and be placed on the mailing list to receive these publications please visit the link below:

http://www.acog.org/departments/membership/medstudentapp.cfm

Department Web Site

Our complete syllabus and other helpful information, including links to several of the didactic power point and other materials can be found at:

www.uphs.upenn.edu/obgyn
A. CLINICAL SITES

Please note: specific site information, especially regarding night/weekend duties, may change from time to time.

Hospital of the University of Pennsylvania
Course Director: Ann Honebrink, M.D.
585 Dulles
honebria@pahosp.com

Assoc Course Director: Elizabeth Melendez MD
585 Dulles
melendee@uphs.upenn.edu

Course Coordinator: Roslyn Levit
584 Dulles
215 662-2459
rlevit@obgyn.upenn.edu

- Academic medical center with residency program.
- All sub-specialties (e.g. Maternal Fetal Medicine, Gyn Oncology, Reproductive Endocrinology and Infertility, Urogynecology).
- 8-9 students/rotation
- Night float required (4 nights), may involve weekend call.
- Students should let Ms. Levit know if they want to spend more of their gynecology rotation on the Gynecologic Oncology service (recommended for those interested in surgery)
- 4,000+ deliveries/year

Chester County Hospital
Course Coordinator: William Atkins, M.D.
915 Old Fern Hill Road, Building D
West Chester, PA 19380
You will receive a separate information packet during orientation regarding site specific information

- Community practice and hospital, opportunity for independent learning, can participate in radiation oncology simulations and conferences about rx of Gyn Cancers.
- MFM, Gyn Onc and Infertility Practices on site
- Residents from HUP and Pennsylvania Hospital on GYN only.
- 2 students/rotation.
- Transportation required, approximately 60 minute ride from UPenn.
- Night Call either til 10pm or all night, ~ 1 night/week, only one student assigned/night
- Call room available if taking overnight call, no housing other than on call nights
- 2700 deliveries/year
Pennsylvania Hospital
Philadelphia
Course Coordinator: Wanda Ronner, M.D. Program Director
Ms. Danielle Parker-Magnum– Program Coordinator
800 Spruce Street, 2 East Pine Building
215 829-3470
Report to Great Court on 1st floor of the Pine Building, above the cafeteria at 7:30 am first clinical day of rotation. Confirm with Ms. Levit at orientation

- UPHS hospital with independent 6 resident/year Ob Gyn residency program.
- 15 minute drive time from HUP
- Public Transportation available
- Sub-specialties available.
- 8-9 students/rotation.
- Night float required, 4 night rotation, may involve weekend call
- 5000+ deliveries/year

Pinelands OB/GYN CCA
Virtua Burlington Hospital
Course Coordinator: Christine Chao, M.D.
Office: 1617 Rte 38
Lumberton NJ 08048
609-261-5566
You will receive separate information packet at orientation regarding site specific information

- Busy community practice in NJ.
- 1 student/rotation, no residents or other students on site
- Night call optional.
- Transportation required, approximately 30 minute drive
- Return to HUP Wednesday am for weekly meeting with HUP students and DR. Honebrink/Melendez

St. Luke’s Hospital
Course Coordinator: James Anasti, M.D.- Program Director
Ms. Connie Merrick- Program Coordinator
610-954–4670
St. Luke’s Medical Center
801 Ostrum
Bethlehem, Pa
Report at 8:30 am first clinical day of rotation to Delrose Livermore in the Medical Education Department, on the 4th Floor of the E Wing, you will receive a site specific orientation packet at orientation

- Community Hospital in Bethlehem PA with Ob Gyn residency program with 5 residents/year,
- 1 hr and 15 min drive time from HUP
- 2 students/rotation, students from Temple and PCOM also rotate here
- Night call and possible weekend call required
- Housing provided
- Transportation required
- 3000 delivers/year
B. DIDACTICS

The first Monday and every Friday during your rotation is devoted to didactic learning sessions, taught by our Department Faculty. In addition, there is a lecture and small group sessions on gynecology exam skills scheduled on the first day of the rotation. During this session you will have the opportunity to perform a pelvic examination on a female volunteer under supervision. You will also have the opportunity to learn to scrub and be oriented to sterile technique for the OR/DR on the first day of the rotation. Attendance at all sessions, including the interdisciplinary sessions with Pediatrics is **mandatory**. If you are unable to attend any of these sessions, please contact Roz Levit and Dr. Honebrink/Melendez so make-up work can be assigned. The only exception is for “Learn to Scrub/Sterile Technique” sessions on the first day of the rotation - students who are scheduled for St. Luke’s receive this training at their site and do not need to attend this session. In addition, after the first block of the rotation, **students who have completed their surgical rotation and are comfortable with sterile technique AND able to gown and glove themselves with sterile technique (ie without scrub nurse assistance) can be excused from “Learn to Scrub/Sterile Technique” session.** In the delivery room it is important that you be able to gown and glove yourself, especially if you expect to be involved in vaginal deliveries! All other sessions are mandatory for everyone on the rotation.

- Didactic sessions are held at HUP and you are expected to return for these sessions. In general, sessions are scheduled from 8 am through 4:30 pm with a break mid day for lunch. Roz will send you an email by Tuesday with that week’s schedule. Please be sure to check the schedule so you can be on time for sessions and know the topics for the week and can prepare for didactic sessions. Please also bring your syllabus with you to didactic sessions since PBL and Case Conferences materials are in the syllabus. If a lecturer is late for their session, please call Roz at 215-662-2459 to let her know so she can clarify the situation. We will also have a simulation session scheduled at the Simulation Center at the Penn Rittenhouse site on the first Friday afternoon of the block. This session will be scheduled from 1:30-4:30pm. You are excused from clinical duties on Fridays but those students at HUP should attend Friday morning conference as long as it doesn’t conflict with the first scheduled didactic session.

- Our core curriculum is covered in Problem Based Learning (PBL) sessions, Case Management Conferences and lectures. For PBLs and case conferences, clinical situations have been chosen to stimulate a discussion of the important issues surrounding each case and to promote information synthesis, decision-making and problem-solving. You will get much more out of the didactic sessions and the rotation in general if you do some reading on the topics of the week prior to the sessions. There are some topics that you are responsible for but will be for self-study (see section IV. A) PBLs, Cases for Case Management Conferences and selected lecture presentations are appended to your syllabus in Section IV. B and appendices. Links to many
C. TEXTBOOKS AND OTHER SELF STUDY HELP

Reading is a critical part of your development as a physician. Listed below are selected Ob Gyn textbooks. While you should read broadly about all topics, there are some topics that are not covered in didactics (see section IV(A), reading on these topics is particularly important for your education.

**Required Text (select one):**

- Beckman CRB, Ling F, Baransky BM, Laube DW, Herbert WNP (Eds.) Obstetrics and Gynecology, Lippincott Williams & Wilkins, 6th edition, 5/09
- Callahan TL, Caughey AB, Heffner LJ (Eds) Blueprints in Obstetrics and Gynecology, Lippincott Williams & Wilkins, 5th edition, 12/08

**Review books with cases (optional):**

- Pfeifer S (Ed.) Obstetrics and Gynecology (NMS series), Lippincott Williams & Wilkins, 6th edition.12/07

**recommended choice**

In addition, the Ob Gyn Department subscribes to the Association of Professors of Gynecology and Obstetrics (APGO) sponsored uwise, a web based study guide. This program has sample practice questions and answer explanations as well as a practice test. We encourage you to use this tool as a supplement to your studying. Please also hit the “submit” button when you use the site so that your use and answers can be aggregated with other Penn students. This allows us to know how often students use this tool and to get comparative, subject sorted data on how our students do compared to other schools. This is helpful in planning curriculum development and justifying department subscription expense. No individually identified data is generated!!

To log onto uwise go to:
http://www.apgo.org/elearn/uwise/index.cfm?doc=uWISE%20Units

No matter which clinical site you are at,
Your department user name is: pahosp
Your department password is: uwise85
D. PRECEPTOR PROGRAM

At Pennsylvania Hospital and HUP, in addition to your course director, students are assigned to a faculty member and are expected to meet with him/her weekly. You will receive your preceptor’s name and contact information at your clinical site. You should contact your preceptor the first week to set up a time to meet. Meetings with your preceptor take precedence over your clinical duties. Your preceptor may ask you to prepare and present a patient or may present a case to you for discussion. Along with your on site Course Director and Drs Honebrink/Melendez and Roz Levit, your preceptor is also available to you to guide you with any questions or issues you might have during the rotation.

During the last week of the rotation your preceptor will administer an oral exam consisting of clinical cases which you will have received in time to prepare for this meeting. Their evaluation of your performance throughout the rotation is an important component in determining your final grade.
II. COURSE REQUIREMENTS/EVALUATIONS

A. CLINICAL LEARNING OBJECTIVES

Obstetrics

Knowledge:

1. Understand the management of labor and delivery of a low-risk patient.
2. Understand the indications for cesarean section.
3. Understand indications for antenatal testing (i.e., non-stress test, biophysical profile).
4. Understand the differential diagnoses for third trimester bleeding.
5. Recognize the presentation for preeclampsia and other hypertensive disorders of pregnancy.
6. Understand the basic management of common medical conditions during pregnancy including hypertension, asthma, thyroid disorders and diabetes.
7. Understand the basic management of common pregnancy complications such as third trimester bleeding, preterm labor and hypertensive disorders in pregnancy.
8. Recognize the presentation, recognition and initial management of postpartum mood disorders.
9. Understand the differential diagnosis and basic management of postpartum hemorrhage.
10. Understand the differential diagnosis and basic management of postpartum fever/sepsis.
11. Understand the principles of prenatal care including the reasoning behind routine and problem directed prenatal labs as well as the timing and elements of prenatal visits.

Skills:

1. Obtain history and perform physical exam on a pregnant patient during antepartum visit and on admission to labor and delivery.
2. Be able to describe a normal labor and delivery and perform basic maneuvers to assist a spontaneous vaginal delivery.
3. Understand the assessment of labor progress by vaginal exam.
4. Be able to interpret a fetal monitor strip and recognize normal and abnormal FHR tracing.
5. Be able to work with the Obstetric team in response to Obstetric emergencies.
6. Be able to measure uterine size after 16 weeks and evaluate fetal heart tones by Doppler or stethoscope.
Behavior:

1. Observe obstetrical ultrasound examinations and be able to recognize gross anatomical fetal structures
2. Become culturally competent in interacting with pregnant women and their families from different cultural backgrounds/beliefs
3. Be able to appropriately support actively laboring patients.
4. Understand how to integrate into a clinical care team as a medical student/future resident
5. Follow labor and postpartum course /follow up on infant of assigned obstetricl patients

Gynecology

Knowledge:

1. Understand age specific recommendations for preventive care in women.
2. Understand the principles and practice of providing family planning services (risks and benefits, side effects, efficacy).
3. Understand the physiology and normal variations in the menstrual cycle, be able to recognize when bleeding is considered abnormal.
4. Understand the differential diagnosis and basic work up/management of first trimester vaginal bleeding
5. Understand the differential diagnosis and basic work up/management of pelvic pain
6. Understand the differential diagnosis and basic work up/management of abnormal bleeding
7. Understand the common presentations, diagnostic methods and staging of gynecologic cancers and basics of and long-term follow-up of treated patients
8. Understand the indications for operative management of common gynecologic conditions such as uterine myomata, ovarian cysts, ectopic pregnancy, and incomplete abortion.
9. Correlate pre-operative diagnosis with operative findings and pathologic findings.
10. Observe and understand indications for laparoscopic surgery.
12. Observe and understand the role of the tertiary specialist in reproductive endocrine disorders and infertility and in gynecologic oncology.
13. Understand the presentation, diagnosis and treatment of common sexually transmitted diseases, pelvic inflammatory disease and vaginitis.
14. Understand the physiology, diagnosis and principles of treatment of common gynecologic issues for women in their post-reproductive years including menopausal symptoms, atrophic vaginitis and pelvic organ prolapse.

15. Understand the physiology, work-up, diagnosis and treatment options for female urinary incontinence.

16. Understand the common symptoms of the menopausal transition as well as risks and benefits of current treatment options

Skills:

1. Obtain history (including sexual and menstrual history) and perform a physical exam (including breast and pelvic exam and pap smear) on patients presenting for routine visit and common gynecologic conditions in gynecology and/or family planning clinic.
2. Be able to maintain sterile technique in the operating room.
3. Build surgical skills, especially basic suturing and knot tying
4. Be able to counsel appropriate patients regarding contraceptive methods
5. Be able to interpret and make management recommendations for both normal and abnormal pap smears.
6. Be able to prepare and interpret a wet mount of vaginal discharge

Behavior/Attitude:

1. Be culturally sensitive and competent in patient counseling surrounding sexual and family planning issues
2. Become comfortable in screening for domestic violence and in referral for assistance for victims of domestic violence
3. Follow pre and postoperative course /follow up on pathology of assigned surgical patients
4. Understand how to integrate into a clinical care team as a medical student/future resident
B. EVALUATION/ASSESSMENT:

1. Clinical Performance
Your performance during the clerkship is evaluated by your faculty preceptor, site course director, attending physicians and housestaff at each hospital. On-site Clerkship Directors are responsible for gathering local clinical evaluation input and providing the main Course Directors with written comments and assigning a clinical performance grade.

The competencies on which you are evaluated are listed below:

PATIENT CARE
- History-taking
- Physical examination

MEDICAL KNOWLEDGE
- Actual knowledge
- Problem solving

PRACTICE-BASED LEARNING AND IMPROVEMENT
- Integration of instruction
- Efficiency and effectiveness

INTERPERSONAL AND COMMUNICATION SKILLS
- Humanism and interpersonal skills
- Oral presentations
- Written work

PROFESSIONALISM
- Skills in dealing with diversity and cultural differences
- Feedback/constructive criticism
- Commitment

SYSTEMS-BASED PRACTICE
- Collaborative practice skills
- Disease prevention/routine health maintenance
- Cost-consciousness

The scale for these competencies ranges from 1 (low) to 7 (high) and has behavioral anchors. A copy of the form used by evaluators is attached in the appendix.
2. Written Shelf Examination:
On the last day of the clerkship, you will take the National Board of Medical Examiners OB/GYN Subject Examination.

- The Exam is given on the last Friday morning of the rotation at 8:00 am in Hirst Auditorium.
- The exam is 2 hours 30 minutes and consists of 100 case-based multiple choice questions.
- Backpacks, textbooks, notes, beepers, briefcases, PDA’s and calculators are not allowed; please leave all beepers and cell phones at home or be prepared to turn them off and hand in to the proctor.
- Hats with bills or brims (eg baseball caps) are not allowed to be worn during the exam.
- You must be on time for the exam. The exam will proceed on-time if a large percentage of the students are in attendance.
- Please bring two #2 pencils to the exam.
- You can best prepare by participating fully in the clinical rotation, attending didactic sessions, reading broadly during the clerkship and utilizing uwise.

3. Citizenship/Professionalism

In addition to clinical and exam performance, clerkship “citizenship” is a component of evaluation. Citizenship includes prompt completion of any required paperwork, including patient encounter log, feedback cards and “mini CEX” exercises. It also includes prompt and attentive attendance (including no texting or cell phone use) at on site conferences and didactic sessions. Obviously, appropriate participation in team clinical duties is also an integral part of clinical citizenship and professionalism.

C. GRADING LOGIC

Your clinical performance and clerkship citizenship contribute 75% and your shelf exam grade contributes 25% to your final grade. However, you must score at least a 65 to pass the course and at least a 77 to be eligible to receive Honors. Honors cut off is set based on the average student grade for the prior year’s entire class and therefore may be adjusted early in the year when the last student group’s scores are available (not available as of press date 12/10) Students who fail the exam will be given an unsatisfactory and meet with Dr. Honebrink or Melendez and also must retake the exam. “High Pass” will be the maximum grade that can be awarded to students who initially fail a clerkship exam. If there is a second exam failure, then the student will fail the course. Repeating the clerkship may be necessary after a second exam failure.

Clinical performance and clerkship citizenship contribute 75% to your grade. Evaluations as described above, along with completion of other course requirements (see III), feedback cards, mini clinical exam/oral case presentation (MCEX on back of feedback cards) and encounter entry contribute to this part of your grade. In addition, H&P write-ups and case presentations may be required at individual sites. If you are not
clear about H&P and oral presentation requirements, check with the site course director where you are assigned. The content of feedback cards is not used in final grade determination, but you need to turn in at least 4 feedback cards and 2 MCEX evaluations to receive a grade in the course (see III.C). **Performance and completion of required encounters, or remedial action if encounters are not completed, is also necessary to complete the course (See III.B).**

A **PASS** grade for the course requires satisfactory completion of exam and all minimum course requirements (including feedback cards and encounter log) with satisfactory clinical performance evaluations.

To receive a **HIGH PASS** grade for the course, all of the above apply, PLUS the majority of clinical evaluators must judge you to be consistently and significantly above average in your clinical performance.

To receive a grade of **HONORS** you must receive a 77 (may be revised after 12/09 scores available) or greater on the exam AND complete all minimum course requirements AND more than ¾ of clinical evaluators must judge you to be consistently and significantly above average in your clinical performance and award an honors grade on clinical performance.

Students with a borderline or failing clinical performance grade are required to perform remedial coursework or retake the course at the discretion of the Course Director.

Grades and evaluations will be available in Suite100 approximately 6 weeks after completion of the course.

**D. OTHER GRADING CONSIDERATIONS**

Every attempt will be made to ensure that your overall course grade is an accurate and fair representation of your performance on the rotation. Despite our best efforts, however, grade challenges sometimes occur. Dr. Honebrink and Melendez are responsible for your final evaluation and grade, Although it is rare for a grade to be changed, you have the right to a fair and thorough review of your grade. In addition, Dr. Melendez and Honebrink are available to discuss /clarify evaluation comments if you have concerns once your final grade is in. Our Preceptors and Residents often have constructive comments that we hope will be helpful to you as you progress in your development as physicians. If you wish to challenge your grade or further discuss your evaluations, please follow the steps below:

1) Contact the Dr. Honebrink and/or Melendez via email or phone to explain your specific objections and concerns. All questions about evaluations need to be handled through Dr. Honebrink and Melendez. Please DO NOT approach individual residents. Attendings or on site Course Directors/Coordinators to discuss your grade or evaluations.
2) If the concern cannot be resolved via email or phone, a meeting with Dr. Honebrink and/or Melendez will be scheduled, in which your objections will be discussed with you.
3) If indicated, the Dr. Honebrink and/or Melendez will further research your objections by contacting evaluators to collect additional information and details.
4) Dr. Honebrink and/or Melendez will then review the grading decision and contact you with their determination. In most cases, this process does not result in a grade change, but occasionally systematic irregularities are discovered whose correction not only helps the individual student involved, but students who come after them.

See Below for SOM guidance:
The School of Medicine expects that any challenges to a grade will be conducted in a professional manner by the student involved. **Under no circumstances should a student directly contact inpatient or outpatient team members to challenge their comments or scores. All communication should be conducted through the course director.** It is the responsibility of the course director to individually contact housestaff and faculty on behalf of students. Any efforts to circumvent this process will immediately terminate the review process. If this or any other unprofessional behavior is identified during the process of a review, that information may be forwarded to the medical school for inclusion in the student’s record.
III. COURSE CITIZENSHIP

A. ATTENDANCE POLICY
Your attendance is expected at all clinical assignments as well as didactic sessions! This is required for all students. Please contact the local course director and clerkship coordinator if you need to miss a session or clinical duties. If you are unable to be present for clinical duties please let your clinical team know as well! Any absence from any clinical rotation or didactic session must also be reported to Dr. Honebrink and Melendez as well as Suite 100 (send Suite 100 with the form found in the Appendix (Absence Report form)

IT IS YOUR RESPONSIBILITY TO BE SURE THAT YOUR CLINICAL TEAM, LOCAL COURSE DIRECTOR/COORDINATOR AND ROZ/ DR. HONEBRINK AND MELENDEZ AS WELL AS SUITE 100 ARE ALL AWARE WHEN YOU NEED TO BE ABSENT AT ANY TIME DURING THE ROTATION FOR ANY REASON.
UNEXPLAINED/UNEXCUSED ABSENCES FROM DIDACTIC SESSIONS OR CLINICAL DUTIES DO NOT REFLECT PROFESSIONAL BEHAVIOR AND MAY AFFECT YOUR GRADE!

If you are aware of an advance need to miss any rotation time(such as research presentation at a conference), please let your local course director, HUP directors as well as Suite 100 as much in advance as possible so make up work can be arranged.
B. REQUIREMENTS CHECKLIST SYSTEM
During this rotation you are required to maintain a log of the patients and procedures you observe and do. This will be available on line and we encourage you to enter your encounters regularly throughout the course of the rotation. Your final on line log must be completed by the Monday following the rotation. The course director will review every log and if you have not entered a required encounter by the Monday after the end of the rotation, you will need to complete remedial work before you can get a final grade on the course (see below). While there are minimum encounter requirements, we encourage you to enter all significant patient encounters. While this may seem to be a cumbersome process, it is an important component of our ability to be sure you have been exposed to important clinical experiences. In addition, this prepares you for your future, when you become a resident and then an attending, keeping track of your clinical activity will be an ongoing process. **You will not be considered to have completed your rotation until you log is complete. Prompt completion of your log is a part of “citizenship” and will be taken into account in your final grade.**

Specific Requirements Checklist Directions for the OB/GYN Clerkship

To enter an requirement on-line, go to:  
https://oasis.med.upenn.edu

A requirement will most often be a procedure/history/physical you directly perform (with supervision), participate in or observe. For less commonly seen conditions/patient types, it also may be something you hear about and discuss **actively** in a case presentation or conference. For this course, the following encounter types and clinical skills are required, along with a specific target number. This rotation’s log is designed to facilitate entry of these specific encounters. However, we do want you to enter all significant patient encounters you are involved in during your rotation. If your particular patient doesn’t easily fit into a log “type”, please enter as “Other” and give a **brief** (one sentence or less!) summary of encounter type under “Comments” section.
<table>
<thead>
<tr>
<th>Order</th>
<th>Requirement Checklist</th>
<th>Type</th>
<th>Description</th>
<th>Minimum required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OB-Labor and Vaginal delivery</td>
<td>Experience</td>
<td>follow a patient through labor and vaginal delivery and round post partum.</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>OB-C-Section</td>
<td>Procedure</td>
<td>Scrub on a C-section, follow patient pre and post Op.</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>OB-First trimester bleeding</td>
<td>Experience</td>
<td>Participate in patient care or discuss a case of a patient with first trimester bleeding.</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>OB-Initial prenatal visit</td>
<td>Experience</td>
<td>Perform history and participate in exam with supervision and testing and counseling.</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>OB- Return Prenatal Visit</td>
<td>Experience</td>
<td>Update history, review prenatal history, measure fundal height and check FHT with supervision</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>GYN- Breast/Pelvic Exam, Pap smear</td>
<td>Procedure</td>
<td>Perform speculum exam/pap smear/ and pelvic and breast exam with supervision.</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>GYN- Wet Mount</td>
<td>Procedure</td>
<td>Obtain and analyze microscopically a wet mount of vaginal secretions/ Discharge</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>GYN-Age appropriate preventive exam</td>
<td>Experience</td>
<td>Perform a history and participate in exam with supervision, discuss age appropriate testing and counseling.</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>GYN-Family Planning Options</td>
<td>Experience</td>
<td>Discuss family planning options with a patient or in a case presentation.</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>GYN-Sexual history</td>
<td>Experience</td>
<td>Interview a patient and take a sexual history with supervision.</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>GYN-Abnormal Vaginal Bleeding- non-pregnant patient</td>
<td>Experience</td>
<td>Evaluate and treat a GYN patient with abnormal vaginal bleeding or participate in case discussion.</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>GYN-Pelvic pain</td>
<td>Experience</td>
<td>Participate in patient care or discuss case of a patient with a pelvic pain.</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>GYN-Pelvic Mass Evaluation</td>
<td>Experience</td>
<td>Participate in patient care or discuss a case of a patient with a pelvic mass.</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>GYN-Gyn surgery</td>
<td>Procedure</td>
<td>Review patient history and scrub on a major GYN surgery case and follow a patient post op.</td>
<td>2</td>
</tr>
<tr>
<td>15</td>
<td>GYN-Sexually Transmitted illness</td>
<td>Experience</td>
<td>Participate in patient care or discuss a case of a patient with diagnosis of STI.</td>
<td>1</td>
</tr>
<tr>
<td>16</td>
<td>OB or GYN other</td>
<td>Experience</td>
<td>Please record other encounters with BRIEF description in comment field</td>
<td>0</td>
</tr>
</tbody>
</table>
Entering the data into the system

You will be entering data into the Oasis system. **Be sure to enter the patient’s medical record number for each encounter.** This allows random validation of encounters entered. If it is found that you have entered a requirement that is not verifiable, you will be asked to meet with the Associate Dean for Student Affairs. If there is no medical record number (as is the case in some of our ambulatory sites) please enter name of site where you saw the patient in the "medical record" field. You will be much happier if you enter your encounters as soon as possible after they are completed. You will have up till the Monday after the close of the clerkship to complete your encounters.

Please contact Nadir Shah at nad@mail.med.upenn.edu, for any technical questions related to the requirements checklist system.
C. FEEDBACK CARDS

The School of Medicine requires that all students have documented feedback sessions throughout the rotation. The requirement for this clerkship is 4 cards. The expectation is that you will get at least 1 card completed each week with the exception of the first and final weeks of the rotation. The purpose of these cards is to promote formative feedback from residents and attendings to medical students. Feedback cards will be handed out to you at orientation. These will be used to document that the sessions occurred. The contents of the card will not be factored into your grade, but it is mandatory that you hand the cards in to the Dr. Honebrink/Melendez or Ms. Levitt each week. While it is a good idea to seek feedback from as many sources as possible, you can seek feedback from the same resident or attending on more than one occasion. The cards can be brought to Friday didactics where the Roz will pick them up from you, or they can be delivered to the Roz’s office on 5 Dulles at HUP. If you do not hand in at least 4 cards by the end of the rotation, you will not be able to be assigned a final grade. Submission of feedback cards is part of “citizenship” and will also be taken into account in your final grade.

D. MINI-CEX

The mini-clinical evaluation exercise (CEX) focuses on the core skills that students demonstrate in patient encounters and presentations. You are required to have a minimum of 2 completed MCEX forms (found on the back of your feedback cards) completed during the rotation by a faculty preceptor, clinic attending or resident. Not all skills will be observed in all encounters. Please have at least one Mini-CEX form filled out by an attending or resident to whom you presented a case and one by an attending or resident who observed you actually seeing and examining a patient. These cards will be provided to students at orientation, and must be turned in to Roz Levit by the last day of the rotation.

E. PROFESSIONALISM

Professionalism is an important component of your clinical performance. Professionalism in a clerkship setting is measured by the following behaviors:

- Altruism
- Commitment to Competence and Excellence
- Dependability/Punctuality
- Empathy
- Honesty/Integrity
- Respect for Others
- Respect for Patients
- Responsibility/Reliability
- Self Assessment/Self Improvement
In addition for these behaviors there are expectations for attendance, appropriate attire, timely completion of required paperwork/course requirements and general professional maturity.

You will be observed during the rotation, in the clinical setting, lectures, and small groups, and you will be evaluated. Evaluators will reply to the following question:

Has the student met minimal competency in ALL domains on professionalism?

- No
- Yes but with concerns
- Yes

Answers of 'No' or 'Yes but with concerns' will be brought to Dr. Morris' attention and generally prompts a meeting with Dr. Honebrink as well.

In addition, Clinical care in Ob Gyn often involves fairly sensitive physical exams. In consideration of both patients and our students, it is our policy that whenever you are performing a breast or pelvic exam, this should be done with the patient’s permission and under direct supervision by an attending or resident. Please also see appended policy for pelvic exams under anesthesia in **SECTION V (C)**.

**F. STUDENT EVALUATIONS OF COURSE AND FACULTY**

It is important for us to know what you think we are doing well and where you think we have opportunities to improve. Students are required to complete the course and faculty/resident evaluation forms prior to receiving their final evaluation and grade from the Dean's office. Please include evaluations of your preceptor as well as other attendings and residents you have worked closely with. In addition, students are asked to complete the evaluation forms of each teaching session the week following the session. Constructive written comments are appreciated. The forms are available online and are reported in aggregate, without student identifiers.

We also request that you complete a brief evaluation of our course after you complete your exam. These evaluations are **completely anonymous** and give us real time feedback that is helpful in continuous course improvement. We always welcome your feedback, complimentary and constructive! Please feel free to contact Dr. Honebrink and/or Dr. Melendez if you have any suggestions for course improvement.

**G. WRITTEN HISTORY AND PHYSICAL EXAM**

At most sites each student is required to hand in a minimum of one written history and physical exam to either the course director or coordinator at your assigned site. Students may be asked to do additional histories at the discretion of the course coordinator, particularly in the first 6 months. This should include every component of the history, exam findings, summary sentence or two, differential diagnosis, with **concise** discussion and supporting evidence for and against each diagnosis, problem list and plan.
During this rotation breast and pelvic exams must be supervised by attending or resident physicians. They will provide you with feedback. Every student is encouraged to examine patients in the operating room under the supervision of faculty and housestaff, and in accordance with the department’s policy on pelvic examinations under anesthesia (see V(C). POLICY FOR PELVIC EXAMINATIONS UNDER ANESTHESIA BY MEDICAL STUDENTS).

IV. OTHER INFORMATION

A. DIDACTIC SESSIONS/SUPPLEMENTAL READING TOPICS 2011

Lectures are scheduled in each of these topics. While we try to keep this to a minimum, for a variety of reasons, specific topic lectures may be not be given on a particular rotation. Please be sure to do extra reading on topic areas when that subject’s didactic session is omitted! Many didactic session outlines/presentations are included in section IV.D and VI. Appendix, and links to selected topics are available on our department web site at: http://www.uphs.upenn.edu/obgyn/education/medstudents.htm

OBSTETRICS
1. Maternal Physiology in Pregnancy
2. Nutrition in Pregnancy and Lactation
3. Labor & Delivery
4. Intrapartum Care
5. Hypertensive Disease in Pregnancy
6. Obstetric Hemorrhage
7. Prenatal Diagnosis and Fetal Anomalies
8. Post Partum Depression

GYNECOLOGY
1. Menstrual Physiology
2. Family Planning
3. Amenorrhea
4. Pelvic Pain
5. Ectopic Pregnancy
6. Sexually transmitted diseases
7. Vulvovaginitis and Vulvar disease
8. Infertile Couple
9. Abnormal Uterine Bleeding
10. Gynecologic Malignancies
11. Ovarian Cancer Survivors
12. Menopause and Postreproductive gynecology
13. Urogynecology
14. Preventive Care in Women’s Health
CLINICAL DECISION MAKING
General review session

SELF STUDY (required reading in textbook)
1. Antepartum Care (prior to attending prenatal clinic)
2. Intrapartum Care or Normal labor and Delivery (prior to starting on L&D)
3. Breast disease

INTERDISCIPLINARY SESSIONS WITH PEDIATRICS
1. Adolescent health
2. Family violence

B. SELECTED LECTURES/PROBLEM BASED LEARNING PRESENTATIONS

1. CLINICAL SKILLS

1) GYNECOLOGY EXAM (LECTURE & WORKSHOP)

This is required for all students.

All students are required to attend both the video/lecture and the small group sessions that you have been assigned. The purpose of these sessions is to provide each student with an opportunity to perform a pelvic examination on a female patient under supervision.

Learning Objectives:
1. Demonstrate knowledge of a thorough gynecologic examination including breast and lymph nodes, abdomen, pelvic, pap smear, and obtaining cultures for the detection of sexually transmitted diseases.
2. Describe the current recommendation for Pap smear screening.
3. Discuss the indications for testing for sexually transmitted diseases.
4. List the indications for recto-vaginal exam.
5. Teach and/or reinforce self-breast exam.
6. Identify the different types of speculums and their indications.
7. List three barriers to women receiving reproductive health care.

2) STERILE TECHNIQUE/LEARN TO SCRUB

This is required of all students EXCEPT those assigned to St. Luke’s (you have a separate session at this site). Also, after Block 1, if you have already completed your Surgery Block and are confident with your scrubbing/sterile technique skills AND are able to gown and glove yourself, you do not need to attend this session.
This session takes place in the Delivery Room at HUP (7th floor of the Ravdin Building). Students learn appropriate scrub, gown/glove technique as well as how to maintain sterile technique in the OR/DR. This session is held on the first monday afternoon of the rotation in tandem with your pelvic exam skills session.

3) SIMULATION CENTER (at Penn Rittenhouse Campus, first Friday afternoon of rotation)

This is required for all students. You will receive hand out materials Friday morning.

TO BRING WITH YOU to the Sim Center on Friday afternoon

Skills practiced include:

1. Spontaneous Vaginal Delivery
2. Foley insertion
3. Orientation to Surgical Instruments
4. Basic knot tying and suturing
5. Assessment of cervical dilation
6. Minor Gyn procedure simulation

The goal is to familiarize you with these techniques and make you more comfortable with them in patient care.

2. OBSTETRICS

1) MATERNAL PHYSIOLOGY (LECTURE/CPC) see appendix and http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
Describe the maternal physiologic changes that occur in the following systems with pregnancy:
   Cardiovascular
   Pulmonary
   Renal
   Hematologic

2) NUTRITION IN PREGNANCY AND LACTATION (LECTURE) see appendix and http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. To produce healthy, normal weight infants while minimizing risk to mother
2. To determine appropriate weight gain during pregnancy for normal, under and overweight women
3. To recognize the additional energy, vitamin and mineral requirements for women during pregnancy and lactation
4. To understand how to manage the breast feeding woman.
3) NORMAL BIRTH (LECTURE) (see appendix and http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. Understand the normal mechanisms of labor.
2. Know the possible presentations & positions of a fetus during labor.
3. Become familiar with the standard management of normal labor & delivery.
4. Know how to identify and treat common disorders of labor.

4) INTRAPARTUM MANAGEMENT (see appendix and http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. Describe initial assessment of laboring patient (exam, laboratory studies, monitoring)
2. Demonstrate knowledge of techniques used to monitor mother and fetus during labor
3. Understand basics of interpretation of fetal monitoring strips, including both reactive strip and characterization of decelerations
4. Understand the definitions and causes for protracted labor
5. Describe indications, contraindications and prerequisites for operative delivery
6. Know basic indications, contraindications & methodology of labor induction.

5) HYPERTENSIVE DISEASE IN PREGNANCY (PBL) see appendix and http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. Define preeclampsia and eclampsia
2. Demonstrate understanding of the pathophysiology of pregnancy induced hypertension/preeclampsia
3. Describe the symptoms and physical findings in preeclampsia
4. Describe the evaluation and management of the pregnant patient with pregnancy-induced hypertension
5. Demonstrate knowledge of the potential complications of PIH and preeclampsia/eclampsia

Case 1: An 18 year old nulliparous female with no prenatal care was brought to the ER after having two "fits" at home. Her mother thinks she is about eight months pregnancy and noticed that her face and hands had become puffy within the preceding 3 days, and
that she had complained of headache, blurred vision, and abdominal pain earlier in the day. Her past medical was unremarkable.

Examination showed a comatose pregnant young woman with foamy spittle at the mouth. Her blood pressure was 160/110, pulse 118, and her temperature was 99.6°F. The chest examination was unremarkable. Examination of the gravid abdomen showed a fundal height consistent with 34 weeks, a single fetus, vertex and engaged, with a fetal weight of approximately 2,000g. Fetal heart rate of 136 bpm. There was generalized edema present. Deep tendon reflexes were 4+/4+ with sustained knee and ankle clonus. Vaginal exam - cervix 1-2 cm dilated and 75% effaced. The vertex was presenting at 0 station. Membranes were intact.

Laboratory evaluation:

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>U/A</td>
<td>3+ proteinuria</td>
</tr>
<tr>
<td>CBC</td>
<td>Hct 45%, platelets normal</td>
</tr>
<tr>
<td>SMA</td>
<td>BUN 14 mg/100 ml serum</td>
</tr>
<tr>
<td></td>
<td>creatinine 1.0 mg/100 ml</td>
</tr>
<tr>
<td></td>
<td>Electrolytes - normal</td>
</tr>
<tr>
<td>plasma uric acid</td>
<td>8.6 mg/100 ml</td>
</tr>
<tr>
<td>PT/PTT</td>
<td>normal</td>
</tr>
</tbody>
</table>

**Study Questions:**

1. Define mild preeclampsia, severe preeclampsia and eclampsia.
2. What are the risk factors for preeclampsia?
3. What is HELLP syndrome?
4. How do you manage preeclampsia? eclampsia?
5. How would you follow this patient in labor and postpartum?
6. Why is MgSO₄ used? What are the side effects?
7. What are the complications of preeclampsia?

**Case 2:** A 16 year old primigravida at 35 weeks gestation comes for her routine prenatal visit. Her BP is 150/90 and she has 1+ proteinuria.

**Study Questions:**

1. How would you manage this patient?
2. What laboratory studies would you obtain?
6) OBSTETRIC HEMORRHAGE (PBL) AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives
1. Demonstrate knowledge of the causes of third trimester bleeding
2. Define the characteristics of placenta previa and abruption placentae
3. Describe the maternal and fetal complications associated with placenta previa and abruption
4. Describe the evaluation and management of third trimester bleeding
5. Demonstrate knowledge of risk factors and causes of post-partum hemorrhage
6. Describe the management of the patient with post-partum hemorrhage

Case 1: A 32 year old G2P1 is brought to L&D by her local ambulance team. She is 36 weeks from her LMP and has had an uncomplicated pregnancy prior to this evening, when she began having bright red vaginal bleeding. Upon further questioning, she does admit to having had some light bleeding on one or two occasions last week. She has disregarded these prior episodes because she had been busy and assumed she had just "over done it." Her previous pregnancy was delivered at term by classical Cesarean section for footling breech presentation.

An ultrasound exam reveals an active fetus in the vertex position, placenta is anterior and extends to the cervix, but does not appear to be covering the cervical os.

She is having contractions every 2-3 minutes with increased bleeding. Her vital signs are stable. Fetal heart tones are good.

Laboratory studies:
CBC: hemoglobin of 8.0 gm/dl and hematocrit of 24%, MCV, MCH, and MCHC are low normal. WBC and platelet count - normal.

B negative blood type, with positive anti-D antibody (titer 1:4).

Electrolytes, liver enzymes, and coagulation studies normal

She begins bleeding heavily. Her blood pressure drops from 110/60 to a palpable systolic pressure of 70. Fetal heart tones drop from 120 to 90 BPM.

Study Questions:

1. What are the causes and pathophysiology of third trimester bleeding?
2. How would you evaluate third trimester bleeding?
3. How would you manage a patient with placenta previa? with placental abruption?

4. What are the risk factors for placental abruption?

**Case 2:** A 34 year old G6P6 patient at term has just delivered a 4000 gm infant after second stage of labor lasting 3 1/2 hours. The placenta delivered spontaneously and the patient is bleeding briskly.

**Study Questions**

1. What is the average blood loss with vaginal delivery? Cesarean section?

2. What are the risk factors for postpartum hemorrhage?

3. What is the immediate approach to assessment and management of postpartum hemorrhage?

7) **PRENATAL DIAGNOSIS (PBL AND SEE APPENDIX and HTTP://WWW.UPHS.UPENN.EDU/OBGYN/EDUCATION/MEDSTUDENTS.HTM FOR ADDITIONAL MATERIALS)**

**Learning Objectives:**

1. Demonstrate understanding of the common indications for prenatal genetic counseling and testing.
2. Demonstrate ability to assess genetic risk based on family history and ethnicity.
3. Understand differences between screening and diagnostic testing for chromosomal abnormalities and limitations of testing.
4. Describe methods, risks and limitations of prenatal diagnostic tests.
5. Demonstrate knowledge of folate supplementation for prevention of neural tube defects.
6. Discuss maternal serum alphafetoprotein (AFP) testing in pregnancy.

**Case:** 36 year old G4P1SAB2TAB1 female with diabetes presents for prenatal care at 8 weeks gestation. Obstetrical history remarkable for one elective termination of a fetus with spina bifida and two miscarriages. She currently works at a day care center. Denies alcohol, tobacco or drug use. Her family history is remarkable for a brother with cystic fibrosis and an uncle with mental retardation. She and her partner are of Eastern European Jewish ancestry.

**Study Questions:**


2. What prenatal screening tests would you offer her?
3. What would you have recommended prior to conception?

8) POST PARTUM DEPRESSION/PREMenSTRUAL DYSPHORIC DISORDER
3. GYNECOLOGY

1) MENSTRUAL CYCLE AND REPRODUCTIVE PHYSIOLOGY (LECTURE AND CASE-BASED DISCUSSION, SEE APPENDIX AND HTTP://WWW.UPHS.UPENN.EDU/OBGYN/EDUCATION/MEDSTUDENTS.HTM FOR ADDITIONAL MATERIALS)

Learning Objectives:
1. Demonstrate understanding of the physiology of the reproductive cycle, specifically, the events of the hypothalamic-pituitary-ovarian axis.
2. Describe a normal menstrual cycle.

Lecture Outline:
I Overview:
   Purpose: pregnancy
   menarche avg 12.8 yrs
   "normal cycle" length 28 days (range 24-35)
   follicular phase (proliferative phase)
   ovulation
   luteal phase (secretory phase)

II Compartments
   A. Hypothalamus
      GnRH decapeptide, half life 2-4 mins
      released into portal circulation
      stimulates release FSH and LH
      pulsatile secretion
      follicular phase 70-90 mins
      luteal phase 100-216 mins
      increased pulse frequency --> suppression of pituitary

   B. Anterior Pituitary
      FSH, LH, TSH, ACTH. Prolactin
      glycosylated polypeptides: a and B subunits
      same subunits: FSH, LH, TSH, hCG
      LH and hCG: B subunit differs by 30 amino acids

   C. Ovary
      1. Gametes
      oocytes number decrease with age, max at 20 weeks gestation
      continuous atresia independent of ovulation
      arrested at first meiotic prophase, fertilization only occurs after
      progression through metaphase II primordial follicle: oocyte
      surrounded by single layer granulosa cell
2. Hormone producing cells
   granulosa cells: respond to FSH, make estrogens
   theca cells: respond to LH, make androgens

2 cell theory of steroidogenesis:
   theca cells metabolize LDL cholesterol to androgens in response to LH
   androgens transferred to granulosa cells
   androgens aromatized to estrogens in granulosa cells predominantly under stimulation of FSH (aromatase)
   (testosterone --> estradiol, androstenedione--> estrone)
   note: luteinized granulosa cells synthesize progesterone directly from LDL cholesterol

regulatory aspects
   E (both low and high) always suppresses FSH
   E low suppresses LH, high will stimulate LH surge
   P always suppresses FSH, LH

regulatory proteins:
   inhibin: granulosa cells, inhibits release of FSH
   activin: stim release FSH

II Phases of the Menstrual Cycle
A. Follicular phase: stimulation of follicular growth
   Role of FSH:
      initiate follicular growth
      increase concentration FSH receptor on granulosa cell (1500/cell)
      induce aromatization (A-->E)
      early E allows follicle to respond to FSH
      FSH with E stimulates proliferation of granulosa cells

   E vs A environment
   E environment good, leads to proliferation and growth of follicle
   A environment bad for follicle, leads to atresia by:
      promotes irreversible 5a reduction of androgens to DHT
      further inhibits aromatase

Dominant follicle
   selected by cycle day 5-7
   increasing E leads to negative feedback----> decreased FSH
   dominant follicle continues to grow while lesser follicles become atretic due to advantage of dominant follicle (ie. more FSH receptors, more granulosa cells, etc)
   FSH induces LH receptors on granulosa cells
B. Ovulation
release of oocyte from follicle
triggered by LH surge
induced by persistent elevated estrogen level (?)
Estradiol >200pg/ml for >50 hrs
occurs 10-12 h after LH peak, 34-36 h after initiation of LH surge

Role of LH surge:
1. release of oocyte
   not purely pressure phenomenon
   increased collagenase--> degeneration of connective tissue

2. resumption of meiosis
   oocyte progress through metaphase II
   metaphase II necessary for fertilization to occur
   release polar body

3. promotes luteinization of granulosa cells in dominant follicle
   responsible for progesterone secretion in response to LH pulse

Role of FSH surge
involved in breakdown of follicle wall and separation of oocyte from follicle

C. Luteal phase
length constant average 14 days (12-17)
corpus luteum produces progesterone which is important to support the endometrium
lutetinized granulosa cells synthesize progesterone from LDL cholesterol
secretion of progesterone episodic: follows GnRH pulse
decreases 9-11 days post ovulation (mech poorly understood ?apoptosis)
with decrease in P production, FSH, LH increase and follicular recruitment begins again
production of hCG by pregnancy rescues corpus luteum and allows for continued production of progesterone to support pregnancy

III. Endometrium
home for the embryo/fetus to develop
responds to hormonal changes
follicular phase=proliferative phase=> E leads to proliferation of endometrium
endometrial thickness 0.5 mm at beginning of cycle, grows to 5.0mm just prior to ovulation
secretory phase=luteal phase =>stabilization of endometrium, daily changes occur in response to progesterone secreted by corpus luteum
optimal timing of implantation 6-7 days after ovulation at which time endometrium and embryo are "synchronized"
2) FAMILY PLANNING (LECTURE AND CASE-BASED DISCUSSION, SEE APPENDIX AND HTTP://WWW.UPHS.UPENN.EDU/OBGYN/EDUCATION/MEDSTUDENTS.HTM FOR ADDITIONAL MATERIALS

Learning Objectives:
For each method of contraception the student should demonstrate knowledge of the following:

- physiologic and pharmacological basis of action
- effectiveness
- advantages and disadvantages
- contraindications
- side effects
- non-contraceptive benefits
- financial considerations

Students should be familiar with oral contraceptives, progestin contraceptives, barrier methods, IUDs, emergency contraception, surgical methods.

Cases for Discussion:

Case 1: A healthy 18 year old female freshman presents for her first gynecologic visit and exam. Menarche was at age 12, menses occur regularly every 28 days. She exercises regularly. Occasionally smokes on the weekend. She has a boyfriend but is not currently sexually active. Family history is remarkable for a mother with breast cancer at age 50.

B. How would your counsel this patient?

C. What are her contraceptive options?

Case 2: 24 year old patient calls your office on Monday morning, frantic because the condom she was using on Friday night broke.

What would you advise her to do?

Case 3: 39 year old G3P3 presents to your office for her 6 week postpartum visit. Her pregnancy was complicated by gestational diabetes and chronic hypertension. She is breast feeding. Her BP is 140/80.

What are acceptable methods of contraception for this patient?

Any contraindications? absolute? relative?
3) AMENORRHEA (CASE MANAGEMENT CONFERENCE AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives
1. Define primary amenorrhea, secondary amenorrhea and oligomenorrhea.
2. Describe the causes of amenorrhea and the approach to diagnosis.
3. Describe the signs and symptoms of androgen excess.
4. Describe the relationship between oligomenorrhea, hirsutism and obesity?

Case 1: A 25 year old nulliparous surgery resident presents for routine visit. Her last menstrual period was 4 months ago. Menarche was at age 16. She uses a diaphragm for contraception.

Case 2: A 16 year old high school junior is concerned because she has not gotten her period.

4) PELVIC PAIN - DYSEMENORRHEA & ENDOMETRIOSIS (PBL AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR PRESENTATION)

Learning objectives:
1. Discuss the differential diagnosis and evaluation of acute and chronic pelvic pain.
2. Define primary and secondary dysmenorrhea.
3. Discuss the treatment of dysmenorrhea.
4. Describe the symptoms and physical findings suggestive of endometriosis.
5. Demonstrate understanding of the incidence, pathogenesis and diagnosis and methods of treatment of endometriosis.

Case 1: A 20 year old woman presents to her gynecologist with a 4 year history of increasing lower abdominal pain with her menses. The pain begins on the first day of her menses and lasts 2-3 days. She also complains of lower back pain and nausea. Menarche occurred at the age of 13 and her menses occur every 28 days and last 5 days. Physical and pelvic exam are normal.

Study questions:
1. How is dysmenorrhea diagnosed? How is it distinguished from other types of pelvic pain?
2. What is the pathophysiology of dysmenorrhea?
3. What are reasonable approaches to treatment?
At the age of 30, the patient presents with a two year history of infertility. Her menses are still regular but she has 2-3 days of spotting before her menses are due. She also complains of pain with intercourse and pelvic pain. In reviewing the patient’s history, the gynecologist notes that over the past year the patient was repeatedly treated by her internist with antibiotics for recurrent microscopic hematuria.

Study questions:
What is the most likely diagnosis?
What are the main theories regarding the pathogenesis in this case?
How would you evaluate and treat this patient?

Case 2: A 35 year old woman presents to your office with persistent RLQ pain. Her past medical history is unremarkable with the exception of a ruptured appendix 1 year ago requiring emergency surgery. Her abdominal and pelvic exams are also unremarkable with the exception of a well healed appendectomy scar.

Study questions:
What questions would be important to ask in evaluating the patient?
What is the most likely diagnosis?
How would you treat this patient?

Case 3: A 28 y.o. woman presents with a 6 hour history of severe right lower quadrant pain, which began suddenly on arising from bed. Since the pain began, she has been nauseated and has vomited twice. She reports two other episodes of similar pain in the past week, both of which resolved within 30 minutes.

Study questions:
1. What other history would you find helpful?
2. How would the physical exam findings assist with your differential diagnosis?
3. What diagnostic tests would you order?
4. What is your differential diagnosis?
5) ECTOPIC PREGNANCY (PBL)

Learning Objectives
1. Discuss the risk factors for ectopic pregnancy.
2. Describe the symptoms and physical findings suggestive of ectopic pregnancy.
3. Discuss the evaluation and treatment options for ectopic pregnancy.

Case: A 26 year old, G2P1, presents to the ER with a chief complaint of severe abdominal pain. The patient states she is pregnant, her LMP was approximately 2 months ago. She has had occasional vaginal spotting. She is sexually active and has not been using birth control. Past Ob/Gyn history remarkable for a SVD of a full term 7 lb female infant 6 years ago. She was treated for a pelvic infection two years ago.

While talking to you, she complains of "feeling dizzy."

Examination remarkable for:
- T 98.9   HR 130   RR 18   BP 90/60
- Abdomen - slightly distended, few bowel sounds, guarding with lower quadrant rebound
- Pelvic - scant blood in vaginal vault, cervix closed; uterus top normal size, anteverted; adnexa unable to evaluate secondary to discomfort, no mass appreciated on rectal exam

Study Questions
1. What is the incidence of ectopic pregnancy?
2. What are the risk factors for ectopic pregnancy?
3. What is the pathophysiology of an ectopic pregnancy?
4. What tests are useful for diagnosis?
5. What are the treatment options?
6. What effect is there from an ectopic pregnancy on future fertility?

6) SEXUALLY TRANSMITTED DISEASES/ PID (PBL) AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives
1. Understand the basic epidemiology of common sexually transmitted diseases.
2. Describe the symptoms and physical findings of gonorrhea, chlamydia, herpes, simplex, syphilis, human papillomavirus, HIV and hepatitis B.
3. Discuss the methods of diagnosis and treatment of these disorders.
4. Discuss methods of screening and prevention.
5. Describe the symptoms, evaluation, management and sequelae of salpingitis and tuboovarian abscess.

**Case:** This patient is a 23 year old, G2P0020 female who comes into the ER complaining of 8 hours of right lower quadrant pain. The pain is sharp, stabbing, intermittent in nature and non-radiating to the back. It is associated with 3-4 episodes of nausea and vomiting that preceded the pain. She also complains of dizziness and has had loose bowel movements since the onset of the pain. The pain increases with movement. Fetal position is least painful. She has a similar episode of pain 10 years ago.

The patient states that her last menstrual period ended yesterday. She denies fever, chills, dysuria, increased urinary frequency, hematuria, and melena. She had noted some increased vaginal discharge over the last few weeks but no itching or burning.

Menstrual history is menarche at age 13, cycles every 26 days with 5 days of bleeding. She had a chlamydia infection 9 years ago that was treated with antibiotics. Two years ago she had a vaginal monilia infection that was treated with Monistat. Her last Pap smear was 1 year ago and was normal. She has used oral contraceptives intermittently for 8-10 years and last used them 2 years ago. She occasionally uses condoms.


Past surgical history – tonsillectomy 17 years ago, elective abortion 6 and 8 years ago.

**Physical examination:**
Vital signs:
   T 99.2°  BP: 112/70 mm Hg  Pulse: 96 beats/minute, RR:16
HEENT: within normal limits
Chest: clear
Abdomen: Bowel sounds, present tender to palpation throughout but greater in the right lower quadrant. There is guarding and rebound tenderness.
Pelvic Exam: Normal external genitalia, pink, rugose vaginal walls, and a closed cervix with green discharge. The uterus and adnexa cannot be evaluated completely secondary to pain and guarding. Cervical motion tenderness present.

Laboratory Tests:  Hgb: 14.3  WBC 11.1
U/A negative  urine HCG negative

**Study Questions**

1. What are the minimal symptoms and signs to consider the diagnosis of PID?

2. What are common risk factors and history suggestive of PID?
3. What are the causative organisms of PID?

4. What are other sexually transmitted organisms? Do any of these organisms cause PID? What are the health consequences of these other sexually transmitted infections?

5. What are other causes of abdominal pain and how do you differentiate PID from other diagnoses?

6. What are other causes of abdominal pain and how do you differentiate PID from other diagnoses?

7. What are the sequelae from PID?

8. What are the recommendations for screening for sexually transmitted diseases?

**Case continuation**

The patient is admitted with a presumptive diagnosis of acute pelvic inflammatory disease. Twelve hours later, her nurse notifies you that she has a temperature of 102.4°F orally, pulse 105 and BP 100/60, and respiratory rate of 20. The patient complains of increasing abdominal pain and wants "something for the pain". Abdominal examination is unchanged.

**Study questions**

1. How would you evaluate this patient further?

2. How would you follow this patient in the hospital? after discharge?

3. When is surgical intervention indicated?
Learning Objectives
1. Describe the variations of normal physiologic secretions.
2. Describe the clinical findings, evaluation and management of Candida, Trichomonas and bacterial vaginosis.

Case: An 18 year old, G1P0Ab1, female presents to your office complaining of slight vulvar itching and a foul smelling vaginal discharge. She first noticed this problem about 2 weeks ago and says it is getting worse. She used an over-the-counter cream about 1 week ago without relief.

Her last menstrual period occurred 1 week ago and she is currently taking oral contraceptives. She denies any history of similar symptoms in the past, but did have chlamydia treated about 6 months ago.

On examination, she is afebrile. Her abdomen is nontender to palpation. On pelvic exam, you note a foul smelling, gray discharge with a "positive whiff test" when the wet mount is done and the vaginal pH is noted to be elevated. Clue cells are present on wet mount. On bimanual exam, there is no tenderness on palpation and the uterus and adnexa are normal in size.

Study Questions
1. How common is vaginitis?
2. What are the common causes of vaginitis?
3. What are the risk factors for vaginitis?
4. What is considered a normal ("physiologic") vaginal discharge?
5. What are the symptoms of vaginitis?
6. How is vaginitis diagnosed and treated?
8) INFERTILE COUPLE (CASE MANAGEMENT CONFERENCE AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. What is the prevalence of infertility in couples? Males? Females?
2. Discuss the common causes of infertility.
3. What tests are used in the initial infertility evaluation?

Case: A 34 year old nulligravida and her partner, a 36 year old male seek advice because they have been trying to conceive for 18 months. Menarche was at age 14 with normal sexual development. Menses are regular every 28-30 days and last 6-8 days. She has a history of severe cramping with her menses during the first 2 days, relieved with Motrin. She has had normal pap smears since age 18. She used oral contraceptive pills from age 22-26. She denies a history of pelvic inflammatory disease. She has had 3 sexual partners. Married for 4 years, intercourse twice a week. Husband in good health, never fathered a child, nor treated for sexually transmitted disease, does not use tobacco, occasional beer.
Past medical history: unremarkable
Past surgical history: tonsillectomy at age 16
Review of systems: Intentional weight loss of 30 lbs. 5 years ago, now at ideal body weight.
Family history: No infertility, birth defects. One of 4 children, all healthy.
Social history: Lawyer. Occasional glass of wine, no smoking or drug use.
Medications: none

9) ABNORMAL UTERINE BLEEDING (CASE MANAGEMENT CONFERENCE AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives
1. Discuss the causes of abnormal uterine bleeding.
2. Contrast the differences in etiology and evaluation of abnormal bleeding for women in different age categories.
3. Describe the pathophysiology and treatment of dysfunctional uterine bleeding.
4. Discuss the symptoms, physical findings, evaluation and management options of uterine leiomyomas.
5. Discuss the approach to the patient with post-menopausal bleeding.
Case 1: A 36 year old female nulligravida presents to your office for her routine examination. She has regular menses, lasting 8 - 10 days with a heavy flow the first 4 - 5 days. She also complains of tiredness.

Physical examination is remarkable for:
   abdomen - soft, nontender, no masses are palpable
   pelvic - normal external genitalia, nulliparous cervix
   bimanual reveals a 12-week size uterus, consistency compatible with fibroids; no abnormal adnexal masses are appreciated.

Hemoglobin is 9.2.

Study Questions:

1. How would you evaluate this patient?

2. Discuss indications for treatment and management options; contrast surgical and medical treatment.

Case 2: An 18 year old female presents to your office complaining of heavy menstrual bleeding and dizziness. She is passing "clots" and has been bleeding for 8 days. Her last menstrual period was 3 months ago.

Physical examination is remarkable for:
   abdomen - soft, nontender, no masses are palpable
   pelvic - normal external genitalia, nulliparous cervix
   bimanual reveals a normal size, anteverted uterus and adnexae

Hemoglobin is 9.

Study Questions:

Discuss pathophysiology and management of DUB - dysfunctional uterine bleeding.

Case 3: A 62 year old female patient with diabetes, G3P3, presents for her routine yearly exam. Menopause occurred seven years ago but she complains of recent vaginal spotting.

Physical examination is remarkable for:
   Ht 5'2" Wt 160 lbs BP 155/85
   Breast - no masses appreciated, no dimpling or discharge
   Abdomen - soft, nontender, no masses palpable
   Pelvic - normal cervix, small anteflexed uterus, adnexa non-palpable

Study Questions:
1. What are the causes of post-menopausal bleeding?

2. What are the risk factors for endometrial hyperplasia and cancer?

3. Describe your approach to evaluating the source of this bleeding.

10) GYNECOLOGIC MALIGNANCIES (CASE MANAGEMENT CONFERENCE)

CASE: 26 year old G1AB1 presents for annual exam. She would like to restart birth control pills. No complaints and no history of medical problems.

Gyn history: Menarche at 12. Menses regular, q30 days, lasting 5 days. Occasional mild dysmenorrhea. Had “warts” treated a few years ago. Had elective termination of pregnancy 9 years earlier. Thinks she had an abnormal Pap smear a few years ago but never returned to the clinic. Contraceptive history: OCs in past without problems.

Social history: Single, works as a sales clerk, smokes 1-2 ppd, occasional alcohol on weekends, denies drug use. 10-15 sexual partners in past.

Family history: Parents are in good health. One sister, age 17. Maternal grand mother had uterine cancer.

PE unremarkable. Pap, GC and chlamydia cultures taken.

Impression: Normal gyn exam.
Plan: Check pap and cultures.
   Offered HIV testing; patient will consider.
   Restart OCs.
   Recommend stop smoking.
   Counseling on contraceptive use and STD prevention provided.
   Return in one year for annual exam.

Lab results:
GC and Chlamydia negative.
Pap smear – low grade squamous intraepithelial lesion.

Questions for discussion:

3. What is the next step in management of this patient?

4. What do you tell the patient?

5. What are her risk factors for cervical dysplasia?
6. Who and when should cervical screening be done? When should her sister be screened for cervical dysplasia?

7. What are the treatment options?

8. How should she be followed?

CASE: 38 year old G6P6 whose last menstrual period was 3 weeks ago, complains of post-coital bleeding for 4 months.

Gyn History: Menarche at age 11. Menses every 28 days for 4-5 days. Last pap smear 5 years ago and she reports was normal. History of condyloma treated with podophylin. Bilateral tubal ligation 5 years ago.

Ob history: Six SVD, largest 6lbs8 oz., and first child at age 14.

Review of systems: Normal bowel movements and urination.

Medical History: Hypertension, no treatment.

Social history: married, works as nurse’s aide. Smokes 1 ppd, drinks 3-4 beers per week, socially.

PE unremarkable.

Pap smear: carcinoma in situ

Colposcopy is performed: Squamocolumnar junction seen in entirety. Biopsies of suspicious area show severe dysplasia. Endocervical curettage is negative.

Questions for discussion:

1. What is the pathophysiology of cervical dysplasia and cervical cancer?

2. How would you proceed? What are her options?

CASE: 24 year old G1 presents for her first prenatal visit. Her LMP was 10 weeks earlier. Home pregnancy test was positive. She complains of severe nausea and vomiting, able to keep fluids down. Past medical history unremarkable. On exam, uterine fundus palpable midway between umbilicus and pubic symphysis. Fetal heart tones are not appreciated with Doppler.

Questions for discussion:

• What is the differential diagnosis?
• How would you evaluate the patient?

**CASE:** 68 year old woman G4P4 presents complaining of severe vulvar itching. Her LMP was 16 years ago; she took hormone replacement therapy for 5 years, stopped approximately 10 years ago. Her last pap smear was over 10 years ago.

**Questions for Discussion:**

1. What is the differential diagnosis?

2. What is your initial step in the management of this patient?

**CASE:** 58 year old G0P0 presents to office complaining of vaginal spotting.

**PMH:** IDDM, HTN

**GYN HISTORY:** Last period at age 53. Has taken combination hormone replacement therapy since that time. No abnormal pap smears. No STD’s. Normal monthly periods until menopause.

**PE:** Weight 254 lbs. Ht 5' 3".
   - Vulva normal, vagina with scant old blood in the vault, cervix appears normal, uterus about 6 weeks size. No adnexal masses palpable.

**Questions for discussion:**

1. What is the differential diagnosis for vaginal bleeding in this woman?

2. What is the next step in the work up of this patient?

**PATHOLOGY:** Pipelle biopsy returns with diagnosis of "well differentiated endometrioid adenocarcinoma arising on a background of complex atypical hyperplasia"

**Questions for discussion:**

3. What are the patient's risk factors for developing endometrial cancer?

   • What are the treatment options?

   • What is her prognosis?
11) OVARIAN CANCER (PANEL DISCUSSION)
A panel discussion by ovarian cancer survivors designed to provide students with first-hand stories about ovarian cancer, in particular, the early warning signs of ovarian cancer.


12) MENOPAUSE/POST REPRODUCTIVE GYN (CASE MANAGEMENT CONFERENCE) AND SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. Discuss the physiologic changes that happen to women as they move through the menopausal transition
2. Describe the symptoms and physical findings associated with menopause.
3. Describe routine preventive care for post-reproductive women
4. Recognize common gynecologic issues in post-reproductive women with some understanding of diagnosis and treatment options
5. Evaluate post-reproductive woman for pelvic functional and relaxation assessment and list treatment options
6. Describe the indications, contraindications, risks and benefits of hormone replacement therapy. Discuss non-hormonal alternative therapy.
7. Discuss nutritional, calcium, and exercise recommendations for the post-menopausal woman.

Case: A 50 year old, G3P3, presents to your office complaining of hot flashes, emotional difficulties, and insomnia. The "hot flashes" occur 2-3 times per day and frequently at night. She also reports that she has been having trouble sleeping for the past 6 months and is extremely fatigued. She begins to cry in your office. Her last menstrual period was 6 months ago.

Menarche was at age 14. She denies intermenstrual bleeding. Obstetrical history includes three vaginal deliveries of full term infants weighing 8 to 9 lbs.

Family history remarkable for maternal hip fracture at age 60.

Social history remarkable for smoking 2 packs of cigarettes per day and drinks alcohol socially. She eats three meals per day. Drinks milk in her coffee. She works as a receptionist and rarely exercises.

Review of systems remarkable for occasional loss of urine.

Physical Examination remarkable for:
13) URINARY INCONTINENCE IN WOMEN (LECTURE) SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Definition
Urinary incontinence (UI) is defined as involuntary loss of urine that is a social or hygienic problem (International Continence Society, 1973)

Magnitude of the Problem
Prevalence increasing in an aging population
Wide variations in reported prevalences—overall ~35%
- Younger women (<40 years): 28% during exercise
- Older women (>40 years): 8 to 41%
- Nursing homes: 40 to 70%
- Annual cost: $16 billion per year
- Leading cause of admission of relatives to nursing homes

Why women are at risk
- Anatomy: female urethra is very short: only 4 cm allowing easy damage to the urethral sphincteric mechanism (also allows easy access of bacteria to urinary tract, hence UTI's are more common in women)
- Pregnancy: pressure of gravid uterus and relaxing effect of hormones on urinary sphincters increases UI during pregnancy to 33%
- Childbirth: damage to urethral supports and sphincters
- Menopause: loss of estrogen results in weaker collagen; this adversely affects the urethral supports and urinary sphincters

Risk factors
- Female: male 3:1
- Age >60 years
- Race: Caucasian > African-American or Asian
- Pregnancy and Childbirth
- Menopause??
- Smoking: increases risk of stress and urge incontinence
- Caffeine: increases urge incontinence
- Obesity
Pelvic organ prolapse: such as cystocele is often associated with UI (due to common causative factors such as loss of urethrovessical support from childbirth or aging) but it does not cause UI in itself. (So correction of cystocele does not correct UI!)

![Diagram of pelvic organs]

Types of Urinary Incontinence

**Stress urinary incontinence (SUI), sphincteric incontinence:**
UI associated with increased abdominal pressure.
Also called genuine stress urinary incontinence or GSUI. It is of two types:
1. Anatomic: SUI due to loss of support to the urethrovessical junction
   Common cause: childbirth
2. Intrinsic sphincter deficiency: SUI due to weakness of the urinary sphincter.
   Common causes: aging, prior surgery causing scarring at the bladder neck, diabetes.
   Leakage occurs with minimal exertion, large volume leaks. On urodynamics, abdominal leak point pressure and maximal urethral closure pressure are low.

**Urge incontinence, detrusor instability(DI):**
UI associated with an uncontrollable urge to void.
Caused by involuntary detrusor contractions.
Usually idiopathic—detrusor instability. When associated with a neurologic disorder—detrusor hyperreflexia.

**Mixed Incontinence:** both stress and urge incontinence are present

**Continuous Incontinence:** continuous leakage of urine as with a genitourinary fistula

**Overflow incontinence:**
UI associated with overdistension of the bladder.
Acutely presents as failure to urinate followed by dribbling of urine, and bladder is overdistended. Chronically can present with symptoms of stress OR urge OR continuous incontinence

**Functional incontinence:**
UI associated with decreased mobility or cognitive disorders
Screening
Ask the question!
Do you leak urine?
Tell me about the problems with your bladder
Tell me about the problem you are having holding your water

History taking: Chief Complaint and HPI
I. Type of UI: stress, urge, mixed, continuous, or overflow
II. Time course of symptoms
III. Severity of UI: frequency, amount, # pads/day
IV. Associated symptoms:
   - Frequency, nocturia, urgency (associated with DI)
   - Voiding difficulty: such as hesitancy, or failure to empty completely. If present, it complicates the evaluation and management of UI. Anti-cholinergic medications or surgery may be contraindicated in these women.
V. Fecal incontinence: associated with UI in 10-25% cases

Medical History
I. Delirium, stroke: overflow UI, urge incontinence
II. Immobility as with arthritis, muscle weakness: functional incontinence, urge incontinence.
III. Diabetes: associated with sphincter deficiency, urge incontinence, neurogenic involvement in advanced DM causes overflow incontinence

Medications: DIURETICS: eliminating this may significantly improve UI
Anti-depressants, anti-psychotics, alpha-blockers, alpha-agonists have been shown to cause UI

Genitourinary history
I. Estrogen loss (hot flushes, vaginal irritation due to atrophy): increase symptoms such as urgency and frequency
II. Bowel habits: Constipation worsens UI

Surgical History
Prior anti-incontinence surgery, prolapse surgery, perhaps hysterectomy: can increase scarring at the bladder neck and cause intrinsic sphincter deficiency

Social History
- Living conditions: toilet accessibility for elderly people with limited mobility
- Fluid intake: both excessive and low intake has been shown to adversely affect UI
- Smoking, caffeine intake

General Examination
Mental status
- Mobility: if poor can worsen urge incontinence
Edema: mobilization of fluid at night can cause nocturia and urge UI
Neurologic Exam: Look for lower limb weakness, sensory loss in lower limbs and abnormal knee and ankle jerks for neurologic causes of UI such as multiple sclerosis, stroke, neuropathies
Abdomen: mass, ascites can cause UI by pressure effect

Pelvic and Rectal examination
Skin condition: uriniferous odor, moist, excoriated skin
Atrophic changes in vagina indicating estrogen loss
Pelvic prolapse: often associated with UI (but does not cause UI)
Pelvic muscle tone: pubococcygeus contraction (Kegel’s exercise): often weak in patients with UI
Rectal exam: tone of rectal sphincter, stool mass
Cough stress test on a full bladder: for objective demonstration of SUI

<table>
<thead>
<tr>
<th>Time</th>
<th>Intake</th>
<th>Output</th>
<th>Leak</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 am</td>
<td>5 oz coffee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 am</td>
<td>3 oz</td>
<td>yes</td>
<td></td>
<td>on way to bathroom</td>
</tr>
<tr>
<td>10 am</td>
<td></td>
<td>yes</td>
<td></td>
<td>coughing</td>
</tr>
</tbody>
</table>

Gives information on intake, output, and factors causing leakage

Tests
• **Post void residual volume of urine (PVR):** catheterize patient in office after she voids: This helps to rule out retention which can complicate the diagnosis and management of UI. It also provides a sterile specimen for U/A and culture.
• **Urinalysis and culture:** straight cath or clean catch
• **Urodynamics:** evaluation of the function of the bladder and the urethra using **Cystometry:** measure the pressure-volume relationships of the bladder: detrusor contractions can be visualized for diagnosis of detrusor instability, differential diagnosis of SUI can be done by measurement of abdominal leak point pressure. In intrinsic sphincter deficiency, it is less than 60 cm of water pressure at 200 cc of water filling.

**Urethral pressure profilometry:** measures intraurethral pressure along the length of the urethra. In intrinsic sphincter deficiency, maximum urethral closure pressure is less than 20 cm of water pressure.

**Uroflowmetry:** measures urine volume voided over time: simple, non-invasive. Rules out voiding dysfunction.
• **Cystoscopy:** to evaluate the anatomy of the bladder and urethra, and ureteric openings
• **VCUG, IVP:** sometimes indicated to evaluate upper/lower urinary tract

Treatment of SUI
Pelvic muscle rehabilitation: Kegel’s exercise with or without biofeedback

Imipramine (combined anti-cholinergic and alpha-agonist): 10-75 mg per day: for intrinsic sphincter deficiency only. Side effects: confusion in elderly, constipation, hypertension, and dry mouth

Surgery: - bladder neck suspension for anatomic SUI
- suburethral sling or collagen injection for intrinsic sphincter deficiency

Treatment of Detrusor Instability
- Bladder training: strategies to control urgency (deep breathing, Kegel's), timed voiding
- Pelvic muscle rehabilitation
- Medications:
  - Oxybutinin 2.5 mg bid to 5 mg qid, Oxybutinin LA: 5 or 10 mg qd
  - Tolterodine 1-2 mg BID, tolterodine LA 2 or 4 mg qd

DIFFERENTIAL DIAGNOSIS OF URINARY INCONTINENCE

<table>
<thead>
<tr>
<th></th>
<th>Detrusor Instability</th>
<th>Anatomic SUI</th>
<th>Intrinsic Sphincter deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic pathology</td>
<td>Irritable detrusor muscle</td>
<td>Loss of support to the urethrovesical junction (UVJ)</td>
<td>Weakness of the urethral sphincter</td>
</tr>
<tr>
<td>Symptom</td>
<td>Urge incontinence</td>
<td>SUI</td>
<td>SUI with minimal exertion, large volume leaks</td>
</tr>
<tr>
<td>Exam</td>
<td>No characteristic finding</td>
<td>Hypermobility of UVJ</td>
<td>Hypermobility of UVJ, fixed scarred urethra if due to prior surgery</td>
</tr>
<tr>
<td>Diagnosis by Urodynamics</td>
<td>Detrusor contractions on cystometry</td>
<td>Leak point pressure (&gt; 60) and maximum urethral closure pressure (&gt; 20)</td>
<td>Leak point pressure (&lt; 60) and maximum urethral closure pressure (&lt; 20)</td>
</tr>
<tr>
<td>Treatment</td>
<td>Pelvic muscle rehab, medications (Anticholinergics), behavioral</td>
<td>Pelvic muscle rehab, surgery, no meds!</td>
<td>Pelvic muscle rehab, medications (imipramine), surgery</td>
</tr>
</tbody>
</table>
14) PREVENTIVE CARE FOR WOMEN—SEE APPENDIX AND http://www.uphs.upenn.edu/obgyn/education/medstudents.htm FOR ADDITIONAL MATERIALS

Learning Objectives:
1. Understand the criteria for an effective screening/preventive intervention
2. Learn age specific recommendations for preventive intervention in healthy women
3. Understand how to triage pap smears
4. Understand how to elicit genetic risk factors for gynecologic and breast cancers

4. INTERDISCIPLINARY SESSIONS WITH PEDIATRICS

1) ADOLESCENT HEALTH

Learning objectives:
1. Understand causes of adolescent morbidity and mortality.
2. Understand adolescent emotional, cognitive, and physical development
3. Understand how to assess psychosocial functioning.
4. Understand brief in-office interventions related to adolescent health issues.
5. Understand how to adolescents’ increasing autonomy in pediatric practice and transitions to adult care settings.

2) FAMILY VIOLENCE

Learning objectives:
6. Understand how adult and pediatric victims of family violence present in the medical setting, in order to identify patients with subtle indicators.
7. Learn how to discuss issues of family violence and child abuse with individual patients and families.
8. Know your legal mandate to report suspected child maltreatment to child welfare and law enforcement agencies, and how to file a report.
C. ORAL PRESENTATION GUIDELINES

The oral case presentation (OCP) is an essential means of physician-physician communication. You are encouraged to present patients as often as possible since this is a skill you will use throughout your medical career. Guidelines below are used in structuring oral presentations and are used by evaluators in evaluating your presentation skills.

General Ob Gyn Initial Sentence: _yo G_P_ female with an LMP of ____ (with EDC of ___ for pregnant patients) presents with- this leads into History of Present Illness

History of Present Illness: Clearly states the chief complaint, provides chronology of events with severity, persistence, associated symptoms, exacerbating and relieving factors, pertinent positives and negatives

Past Medical History: Provides relevant information from the past medical history, including hospitalizations, surgery, current medications, allergies and social and pertinent family history as well as obstetric/sexual/menstrual history.

Review Of Systems: Reviews pertinent positive and negatives from other systems

Physical Exam: Presets relevant positive and negative findings in a logical sequence.

Studies: provides relevant data including labs, imaging and other studies

Summary statement/differential diagnosis: Demonstrates judgment to synthesize and summary statement and generate an appropriate differential diagnosis.

Plan: Adequately characterizes diagnostic and therapeutic management, and provides rationale for proposed plan

Organization/coherence: Prioritizes, is efficient and logical
D. SOAP and POST OP NOTE and OPERATIVE NOTE GUIDELINES

Once a patient has been admitted to the hospital and the admission H&P has been done, daily progress notes are used to communicate and document the patient’s hospital course and recovery. SOAP is the acronym for the format for these progress notes. Also, when patients are seen in the out patient setting for a problem oriented visit, the SOAP note format is most commonly used. Post operative care is also generally documented in the SOAP note format. The acronym stands for:

Subjective findings (ie how is the patient feeling, what symptoms are they having)
eg: I have pain in my incision area

Objective findings: What are the patients vital signs (include I and O on post op patients), what are pertinent physical exam and lab/radiologic findings.
Eg: T 98.8, P 90, BP 140/80, R15, In-2000/ Out-1500
Lungs: Clear; Cor:  RRR, no Murmurs
Abd: soft, + Bowel Sounds, incision clean dry and intact, tender over incisional area only

Assessment: Summary of diagnosis and /or patient status.
Eg: Satisfactory recovery Post op Day 1, s/p TAH/BSO

Plan: What is the plan for this patient
Eg: Initiate PO fluids, pain meds and ambulation, D/C foley

Operative notes briefly communicate details regarding a surgical procedure. A more detailed summary of the operative procedure is also dictated ( by the resident or attending – not by you!) While specific format may vary from site to site, in general an operative note includes the following information:

Pre Op Diagnosis: eg Post menopausal Bleeding
Post Op Diagnosis: eg. Same with submucous fibroid and abundant currrettions, R/O endometrial cancer
Procedure: eg D&C, Hysteroscopy
Surgeon: Attending who scrubbed on the procedure
Assistants: Residents/students scrubbed
Anesthesia: Type of anesthesia used
Drains: eg Foley
Fluids: Amount of fluid given intra op and amount of urine drained pre and intraop, as well as amount of fluid in and out of uterus in a hysteroscopic case
Estimated Blood Loss: How much blood was lost during the procedure- if you are writing the note, ask the attending or resident what they think this is!
Specimen: What, if any tissue was sent to pathology
Complications: What, if any complications occurred intraop (ask residents about this if you are documenting- it can sometimes be tricky to judge what is a complication vs a normal part of the procedure)
Operative findings: What was found at the time of surgery. In general, the findings on exam under Anesthesia are included here as well as what was seen/measured intraop and what the results of frozen section were if this was done.

E. DOCUMENTATION GUIDELINES

The medical record is a permanent recording of a patient’s hospital course or out patient care. Documentation in the medical record is primarily used for communication among team members and for historical reference in the ongoing care of a patient. In addition, medical record documentation is used to support billing for patient care. When medicolegal issues arise, the medical record is also the primary source for information and is frequently used in legal proceedings. For all these reasons, but most importantly because of the role of the record in patient care, accurate documentation is crucial. In addition, a particular format and documenter are often required to satisfy insurer imposed regulations for appropriate billing.

As a medical student, your role frequently is that of a reporter and gatherer of information. Learning what information to gather and report and how to concisely report it should be one of your major goals during all your clerkships. While different specialties may emphasize specialty specific areas for documentation, some general principles apply.

1. It is only appropriate to document facts in the medical record. Especially as a medical student, be sure that you are only recording information that is important to the patient’s care. If you are not sure about something, ask your resident or attending before you put it in the record.

2. There are specific regulations that prohibit using medical student documentation for billing purposes- DO NOT be offended if the resident or attending “rewrites” what you have written- this is not because the information you have gathered/reported is not important or valued, it is because that information needs to also be recorded by a resident or attending to support billing. Having your note for reference is very helpful.

3. While not usable for billing in most circumstances, your chart documentation is a part of the permanent record and is read by the care team and by future care givers reviewing the record. In addition, it will be part of the record if there is ever a medico legal issue. Please keep all of this in mind when you enter documentation into the chart.

4. Communicating and recording patient care in the medical record is a learned skill. Do not expect to be an expert at this on your first rotation. By the time you graduate, you should be a pro! If you are not sure if you should put something in the record- ASK!
F. HUP OBGYN RESIDENTS MED STUDENT SURVIVAL GUIDE
These “survival guides” were developed by HUP residents but the general information is applicable to other sites. They are suggestions for how to get the most out of your Ob Gyn rotation.

BASIC SURVIVAL FOR ALL SERVICES

1. Be on time.

2. Find the chief and introduce yourself as the Med Student as soon as you arrive on the floor your first day.

3. Introduce yourself to the nurses and other residents and attendings and re-introduce yourself each time you need a nurse’s help or scrub on a new case and each time you work with a different resident or attending.

4. Expect it to be hectic at all times. Be interested and look for opportunities to follow patients and participate. If you wait to be invited, you will miss out on clinical experiences,

5. Please do not sit at the main resident’s desk in the delivery room or on post op floors and read. You will be in the way. Read somewhere else if there is absolutely nothing else to do and you can sew and tie knots like a champ.

6. Expect ONLY to participate in the care of patients to whom you take the time to introduce yourself.

The more closely you follow your pts and the more interested and helpful you are, the more you will learn and the more deliveries and procedures you will do!

OB Survival Guide/TO DO LIST:

MAKING THE MOST OF YOUR EDUCATION

1. Read about:
   a. Fetal Heart Tracings
   b. Normal Labor Curves
   c. PTL
   d. PPROM
   e. Preeclampsia/HELLP
   f. Postop/Postpartum Fever
   g. Every other interesting disease/complication that you see.

2. Discuss this with senior residents, but in general, you should follow 2-3 patients on the labor floor. Choose an interesting mix.
3. The **Chief and L& D Attending** provide most of your general guidance – whom to follow, where to do, what to do.

4. The **3rd year** will have the most time for teaching and feedback.

5. The **2nd years** will be running the labor floor; try to follow the 2nd year for exams, deliveries but he/she is doing a hectic job and may not have the most time for teaching.

6. The **Interns** will be caring for the Post Partum patients, the Antepartum patients, and triage pts in the PEC. They will be able to teach you about the management of these patients. Go to the PEC if things are quiet on L&D

7. Round **each morning before board sign out** on all patients you delivered and in whose C-Section you participated. This means:
   a. Write down the names of patients you will round on.
   b. Write a note each morning on a blank sheet of progress note paper.
   c. Review it with the intern or 3rd year after board sign out.
   d. Do not place it in the chart until a resident reviews it.

8. Follow pertinent labs, vitals, urine output during the day. Come up between deliveries to do this.

9. Scrub for every C-Section unless a patient you have been following is about to deliver vaginally.

10. Understand The Board. It will be explained to you in the beginning but it can be confusing, so please ask questions.

11. Find the PEC (Perinatal Evaluation Center). If the Labor Floor is not busy, you can help triage patients there.

12. When you follow pts, that means know every aspect of their history, follow the labor curve, know pertinent VS, urine output, labs. You will learn much more if you should try to appreciate the whole course of the patient’s pregnancy, labor and delivery and be present when the patient delivers.

13. Learn how to write a Mag note. Read about the indications for Magnesium and the reasons for writing a Mag note. If a resident doesn’t teach you how we write these notes on the first day, ask someone to teach you.

14. Practice suturing on the LF and at home. We can help you with supplies, instruction, etc here but you have to practice to be good at it.
15. When your patients are not doing anything interesting, check TO DO box on the board; that means you can always be checking labs, calling for old records, etc on other patients.

16. Be sure to introduce yourself to patients you are following. Unless there is an emergent situation, do not expect to participating in a delivery if you have not introduced yourself and followed the patient.

**GYN ONC Survival Guide/TO DO LIST:**

**MAKING THE MOST OF YOUR EDUCATION**

1. Read about:
   a. Pelvic/Abdominal Anatomy
   b. Postop Fever
   c. GYN cancers (Ovarian, Cervical, Endometrial) basics
   d. Items on General Gyn list
   e. Know risk factors, signs/symptoms, diagnostic tests
   f. Know staging if you are comfortable with the above
   g. Read about every other interesting disease/complication that you see

2. Discuss this with the 3rd year (senior on GYN ONC), but in general, you should follow any patients in whose surgery you participate. If it is a slow OR week, choose other patients that you find interesting. Be sure to follow at least 2 patients/week while you are on service.

3. The 3rd year provides most of your general guidance – which cases to participate in, where to go, what time to round.

17. The Intern will be on the floor taking care of the patients. Offer help to him/her when you are not in the OR.

18. Before you scrub on an OR case, be sure to introduce yourself to the patient (if at all possible), know her entire history, not just her reason for surgery.

19. When you follow pts, that means know every aspect of their history, medicines, pertinent VS, urine output, labs. Follow up on these and keep current on them, between cases if necessary.

20. Round each morning on all patients in whose surgery you participated. This means:
   a. Write down the names of patients you will round on.
   b. Write a note each morning on a blank sheet of progress note paper.
   c. Do not place it in the chart until a resident reviews it.
21. Participate actively in PM rounds – that means visiting the patients, knowing their events of the day, helping to gather VS.

22. Practice suturing at home. We can help you with supplies, instruction, etc here but you have to practice to be good at it. You will not likely be allowed to sew in the OR if you have not practiced.

23. Choose a topic about which to present a 5-10 minute talk during your second week.

24. It can be difficult to read the chart before a case because everyone else needs to see it, but do your best. Also, do your best to politely introduce yourself to the patient preop. Remember, she is about to have surgery and is very likely to be nervous or scared.

**GYN Survival Guide/TO DO LIST:**

**MAKING THE MOST OF YOUR EDUCATION**

1. Read about:
   a. Fibroids
   b. PID/TOAs
   c. Abnormal bleeding
   d. Ectopic pregnancy
   e. Postop Fever
   f. Items on Gyn Onc list
   g. Every other interesting disease/complication that you see.

2. Discuss this with senior residents, but in general, you should follow any patients in whose surgery you participate. If it is a slow OR week, choose other patients that you find interesting. If you are not at all interested, just choose 2 randomly.

3. The **Chief** provides most of your general guidance – which cases to participate in, where to go, what time to round.

4. The **3rd year** will have the most time for teaching and feedback.

5. The **2nd years** will be carrying the pager most of the time – follow him/her on consults if you are not in the OR.

6. Participating in surgery is a privilege. Introduce yourself to each patient, know her entire history, not just her reason for surgery.

7. Round **each morning** on all patients in whose surgery you participated. This means:
a. Write down the names of patients you will round on.
b. Write a note each morning on a blank sheet of progress note paper.
c. Do not place it in the chart until a resident reviews it.

8. When you follow pts, that means know every aspect of their history, medicines, pertinent VS, urine output, labs. Follow up on these and keep current on them, between cases if necessary.

9. Choose a topic about which to present a 5-10 minute talk during your second week.

10. Practice suturing at home. We can help you with supplies, instruction, etc here but you have to practice to be good at it. You will not likely be allowed to sew in the OR if you have not practiced.

11. It can be difficult to read the chart before a case because everyone else needs to see it, but do your best. Also, do your best to politely introduce yourself to the patient preop. Remember, she is about to have surgery and is very likely to be nervous or scared.
V. RELEVANT Penn SOM POLICIES/DOCUMENTS

A. Infectious Disease Precautions for Clerkships
If you are exposed to patient blood and body fluids, immediately contact the Student Health Service on the Ground Floor of Penn Tower (215-662-2850). Please notify the course coordinator and occupational health at your site.

All students enrolled in clerkships must take measures to prevent exposure to blood or body fluids. This policy applies to all students at the University of Pennsylvania School of Medicine.

Procedures
1. Every patient and every patient specimen must be assumed to be a potential source of infection.

2. Every effort must be made to avoid needlestick injury or injury with other sharp instruments contaminated with blood or body fluids. Contamination of open cuts, abrasions, or mucous membranes with blood or other body fluids must be avoided.

3. Gloves will be worn whenever contact with blood, body fluids, mucous membranes, or non-intact skin is anticipated. Gloves must be changed between patients or when torn. Gloves should be removed after patient contact, and before touching other surfaces such as door handles, counter tops etc. Gloves will be worn in the following situations:
   a. Handling soiled items.
   b. Touching/cleaning soiled surfaces.
   c. Performing invasive or vascular access procedures.
   d. Handling of blood or body fluid specimens and all fluid-filled containers.
   e. Starting IVs, drawing blood, and manipulating stopcocks or lines.
   f. Emptying the drainage from a urinary catheter. To prevent cross-contamination from one catheter drainage spout to another, medical students should discard used gloves, washed hands, and put on new gloves before emptying a second patient’s drainage bag.
   g. Performing speculum or digital vaginal/rectal exam

4. If aerosolization or spattering of blood or body fluids is likely, additional barrier precautions, i.e., gown, mask, and protective eyewear must be used.

5. Careful handwashing between patients and following contact with patient’s blood or body fluids is essential, even when gloves have been worn.

6. Needles should not be bent, broken, or recapped into their original sheaths, removed from disposable syringes, or otherwise manipulated by hand before disposal. Needles should not be changed between venipuncture and injection of blood into blood culture bottles. If a needle must be removed,
used the slot available on the needle disposal containers, or use a hemostat. If recapping is unavoidably necessary, either use a hemostat to hold the cap or place the cap on a level surface and thread the needle without holding the cap. Needles and all sharp instruments must be disposed of in appropriate needle disposal containers. Such items must not be left of trays or on bed linens.

7. Resuscitation masks will be readily available for all patients.

8. Blood spills must be cleaned up promptly (wearing gloves) with a disinfectant solution.

9. Medical students with exudative lesions or weeping dermatitis should not provide direct patient care or handle patient care equipment. Such personnel should report to the Student Health Service for evaluation.

10. Health care workers sustaining needlesticks or other exposures to blood or body fluids must be evaluated by the Student Health Service. Laboratory tests and other diagnostic studies that are not covered by a student’s insurance will be paid for by the Medical School providing they are required by the Student Health Service because of exposure of a student through the student’s activities in a course approved for credit by the University of Pennsylvania School of Medicine.

11. Clinical Laboratory staff (medical students) must adhere to departmental infection control policies dealing with specimen handling.

12. All medical students who have potential exposure to blood or body fluids are encouraged to obtain Hepatitis B vaccination from the Student Health Service.

13. Any questions regarding this policy may be referred to the Infection Control Section or the Student Health Service.

B. Exposure to Blood or Body Fluids

Penn Med policy regarding potential exposures is as follows:

Any medical student who sustains a needlestick or other wound resulting in exposure to blood or body fluids should follow the following protocol. Please keep in mind, that drug prophylaxis following a high-risk exposure is time sensitive, therefore you must immediately seek help from the appropriate hospital department.
Immediately wash the affected area with soap and water and cover the area with a dressing if possible. For an ocular exposure, flush thoroughly with water. Inform the supervising resident and immediately report to the areas listed below. Please bring the source patient information with you.

**At HUP, the VA or CHOP**

1. Go directly to HUP’s Occupational Medicine Division.

2. If they are closed, report to the HUP Emergency Department.

3. Identify yourself as a medical student who has just sustained an exposure.

4. You will see health care provider who is trained in assessing the risk of the exposure. If you are seen in the Emergency Room, an occupational medicine doctor is on-call 24 hours a day to provide immediate consultation on post-exposure drug treatment and counseling. Do not hesitate to ask the physician treating you to page the Occupational Medicine doctor carrying the needlestick pager.

5. You will be counseled and advised about post-exposure prophylaxis, if necessary.

6. If indicated, you will be given a starter pack of the prophylactic drugs
7. which are recommended in accordance with the current guidelines of the
8. Center for Disease Control.

9. Base-line blood tests will be done on you.

10. The physician at Occupational Health will contact the attending physician of the source patient to expedite the process of getting consent to test the source patient.

11. You will be given a schedule as to when to return to Occupational Medicine for follow-up testing.

If you are at the following hospitals, please go to the place listed. You will be treated in accordance with the hospital’s needlestick policy for healthcare workers. All affiliated hospitals’ needlestick policies have been reviewed by the Director of Infection Control for HUP and meet established standards. All follow-up testing for the students is done at HUP Occupational Health. Students should bring their records to HUP Occupational Health so that appropriate follow-up testing can be scheduled.

**Chester County Hospital** – Report to the Emergency Department.

**Chestnut Hill Hospital** – Report to the Emergency Department.
Englewood Hospital – Report to the Employee Health service between the hours of 8:00 am – 4:00 pm or to the Emergency Room after those hours.

Pennsylvania Hospital - Report to Employee Health or to the Emergency Room if they are closed.

Presbyterian Hospital – Report to Occupational Medicine or to the Emergency Room if they are closed.


Underwood Memorial Hospital – Report to Employee Health or to the Emergency Room if they are closed.

Virtua Health - Report to Occupational Health or to the Emergency Room if they are closed.

York Hospital - Report to the Employee Health Service or call the Safety Hotline at extension 4444 if they are closed.

Outpatient Ambulatory Sites - Report to HUP Occupational Medicine or to its satellite at Radnor, whichever is a closer distance to your site.

Billing Procedures
All expenses that a student incurs, associated with needlesticks, will be paid for by the School of Medicine. At HUP or Presbyterian, these charges should automatically be billed to the School. However, if you do receive a bill for any of these services, please bring it to Nancy Murphy in the Office of Student Affairs immediately, so that the charges can be transferred to the school account. At affiliated hospitals, typically the bill will be sent to your home address. Please bring it to Nancy Murphy immediately so that the School of Medicine can pay the bill.
C. POLICY FOR PELVIC EXAM UNDER ANESTHESIA BY MEDICAL STUDENTS

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

POLICY STATEMENT

PELVIC EXAMINATIONS UNDER ANESTHESIA BY MEDICAL STUDENTS

STATEMENT OF POLICY:

Medical students are frequently assigned to the operating room as a member of the surgical team during the core clerkship and elective courses in Obstetrics and Gynecology. The attending physician, who is responsible for the care of the patient, also is responsible to determine the level of participation of the student, the specific tasks that the student may perform and to assure the appropriate supervision of the student.

As a part of many gynecologic surgeries, a pelvic examination under anesthesia (EUA) is performed to provide valuable information for the safe conduct of the operation. When an EUA is planned as part of the procedure, it is important that all aspects of the surgical procedure, including the EUA, be discussed with the patient and that the written consent specifically include "examination under anesthesia" along with other elements of the procedure. In addition to the surgeon, other physician members of the surgical team may perform an EUA to confirm the findings or render an additional opinion. In this circumstance, the EUA also may provide an opportunity to teach other physician members of the team regarding the surgical decision-making process, and the selection of the surgical approach.

A medical student who is part of the surgical team may not perform an EUA unless the patient specifically consents to also having a medical student perform the examination. This written consent for a medical student to perform an EUA should be obtained using the form entitled “Pelvic Examination under General Anesthesia”. This form must be signed by the patient and must be present in the medical record at the time of the EUA by the medical student, and will remain part of the permanent medical record. At all times, the personal wishes of the patient should determine the extent of her participation in the education process. Refusal to have a medical student perform an EUA should not in any way affect the care of the patient.

EUA should be performed only by members of the surgical team who are directly involved in the care of that patient.

The EUA should only be performed when it is an appropriate part of the evaluation of the patient and should never be performed solely for teaching.

An EUA planned as part of the procedure should only be performed with the written consent of the patient.

Prior to a medical student performing an EUA, the form entitled “Pelvic Examination under General Anesthesia” must be signed by the patient and be part of the medical record.

When an EUA is performed, the patient should be draped similarly to when a pelvic examination is performed in the office.

EFFECTIVE DATE: July, 2003
D. SAFE AND HEALTHY LEARNING ENVIRONMENT

http://www.med.upenn.edu/student/safe_environ.html

I. INTRODUCTION

The University of Pennsylvania School of Medicine is committed to the principle that the educational relationship should be one of mutual respect between teacher and learner. Because the school trains individuals who are entrusted with the lives and well being of others, we have a unique responsibility to assure that students learn as members of a community of scholars in an environment that is conducive to learning.

Maintaining such an environment requires that the faculty, administration, residents, fellows, nursing staff, and students treat each other with the respect due colleagues. All teachers should realize that students depend on them for evaluations and references, which can advance or impede their career development. They must take care to judiciously exercise this power and to maintain fairness of treatment avoiding exploitation or the perception of mistreatment and exploitation. The quality and worth of a University of Pennsylvania School of Medicine education rest not only in the excellence of the content and the skills that are taught, but also in the example provided to students of humane physicians and scientists who respect their professional colleagues at all career levels, their patients, and one another.

II. RESPONSIBILITIES OF TEACHERS AND LEARNERS

The teacher-learner relationship confers rights and responsibilities on both parties. Behaving in a way that embodies the ideal teacher-learner relationship fosters mutual respect, minimizes the likelihood of learner mistreatment, and optimizes the educational experience.

Responsibilities of Teachers

- Treat learners fairly, respectfully, and without bias related to their age, race, gender, sexual orientation, disability, religion, or national origin.

- Distinguish between the Socratic method, where insightful questions are a stimulus to learning and discovery, and overly aggressive questioning, where detailed questions are repeatedly presented with the end point of belittlement or humiliation of the learner.

- Give learners timely, constructive, and accurate feedback and opportunities for remediation.

- Be prepared and on time for all activities.

- Provide learners with current material and information and appropriate educational activities.
Responsibilities of Learners

Be courteous and respectful of others regardless of their age, race, gender, sexual orientation, disability, religion, national origin, or role in your education.

A medical student should act in accordance with the University of Pennsylvania School of Medicine Code of Conduct,
http://www.med.upenn.edu/student/standards/part3.htm#4

Be aware of the medical condition and current therapy of patients.

Put patients' welfare ahead of educational needs.

Know limitations and ask for help when needed.

 Maintain patient confidentiality.

View feedback as an opportunity to improve knowledge and performance skills.

III. DESCRIPTION OF INAPPROPRIATE BEHAVIOR

Inappropriate behaviors are those that are not respectful or professional in a teacher-learner relationship. Determining whether a given behavior is inappropriate involves a subjective assessment of the intentions of the performer and the perception of the recipient. Clearly inappropriate behaviors, which compromise the integrity of the educational process, include, but are not limited to:
Unwanted physical contact (such as touching, hitting, slapping, kicking, pushing) or the threat of the same;

Sexual harassment (see the University of Pennsylvania Policy Sexual Harassment Policy, [http://www.upenn.edu/almanac/v50/n20/OR-harassment.html](http://www.upenn.edu/almanac/v50/n20/OR-harassment.html));

Discrimination based on age, race, gender, sexual orientation, disability, religion, or national origin;

Requiring learners to perform personal chores (e.g., running errands or babysitting);

Verbal harassment, including humiliation or belittlement in public or privately;

Use of grading and other forms of assessment in a punitive or self-serving manner;

   Romantic or sexual relationships between a teacher and student (see the University of Pennsylvania Policy on Consensual Sexual Relations Between Faculty and Students, [http://www.upenn.edu/assoc-provost/handbook/vi_e.html](http://www.upenn.edu/assoc-provost/handbook/vi_e.html))

**IV. WHAT TO DO IF YOU BELIEVE INAPPROPRIATE BEHAVIOR OR MISTREATMENT HAS OCCURRED**

While we believe that the professional behavior is generally practiced and respected by the members of our diverse community of scholars throughout the School of Medicine, we recognize that there may be occasions when real or perceived incidents of unprofessional behavior directed toward learners occur.

The School of Medicine is committed to establishing the facts through a fair process, which respects the rights and confidentiality, to the extent possible, of the involved parties. Exchanges of information, whether verbal or written, will be handled in a confidential manner. However, at any level, there may be situations that limit the ability for confidentiality, such as those involving potential harm to a student or others, including sexual assault.

A complaint should be reported as soon as possible but not more than 90 days after the alleged incident. Several avenues are open to the student who experiences an incident of inappropriate behavior and mistreatment.

**A. Informal Pathway**

The student may consider speaking directly with the person. If the behavior stems from a misunderstanding or a need for increased sensitivity, the person will often respond positively and stop. Open communication may clarify any misunderstanding or issue(s) and lead to a successful, informal resolution.

**B. Counseling and Guidance**
A student, who has concerns about the learning environment, may speak with the Course Director, the Office of Student Affairs, an Advisory Dean, a School of Medicine Ombudsperson, or a peer advisor.

All involved parties must agree upon all informal resolutions. For tracking purposes, a written record of the resolution must be filed with the Associate Dean for Student Affairs; however, this can be done without reference to specific names.

C. Consultation with the Associate Dean for Student Affairs

If Steps A or B are not successful or appropriate, a student must refer the complaint to the Associate Dean for Student Affairs, who will make one last attempt at informal resolution.

D. Formal Pathway – Preliminary Inquiry

Inquiry into a violation of these standards of conduct committed by any individual, whether or not affiliated with the University, should be initiated by written complaint and filed with the Vice Dean for Education within 90 (ninety) days of the violation.

The complaint must be detailed and specific, and accompanied by appropriate documentation. The Vice Dean has the responsibility to protect the position and reputation of the complainant.

Upon receipt of a properly documented complaint, which has been made in good faith, the Vice Dean shall inform the respondent of the nature of the charges and identify the complainant. The Vice Dean shall also appoint an inquiry officer, who may not be a member of the same department as, or collaborator with, the complainant or respondent. The inquiry officer shall be unbiased and have appropriate background to judge the issues being raised. He/she must be a faculty member of the School of Medicine. An inquiry officer will be appointed within two weeks of the receipt of a properly documented complaint and the complainant and respondent will be notified. The Vice Dean shall also make every effort to protect the identities of both complainant and respondent with respect to the larger community.

The inquiry officer shall gather information and determine whether the allegation warrants a formal investigation. He/she shall then submit a written report to the Vice Dean, the complainant, and the respondent. The report shall state what evidence was reviewed, summarize relevant interviews, and include conclusions. This report shall ordinarily be submitted within 30 calendar days of receipt of the written complaint by the Vice Dean. If the inquiry officer finds that a formal investigation is not warranted, the complainant shall be given the opportunity to make a written reply to the officer within 15 calendar days following receipt of the report to the Vice Dean. However, if the inquiry officer finds that a formal investigation is warranted, the respondent shall be given the opportunity to make a written reply to the report within 15 calendar days following submission of the report to the Vice Dean. Such replies shall be incorporated as appendices to the
The entire preliminary inquiry process shall be completed within 60 calendar days of the receipt of a properly documented complaint by the Vice Dean unless circumstances clearly warrant a delay. In such cases the record of inquiry shall detail reasons for the delay.

If the report of the inquiry officer finds that a formal investigation is not warranted, the Vice Dean may (i) initiate a formal investigation despite the recommendation of the preliminary inquiry committee, or (ii) not initiate a formal investigation, but take such other action as the circumstances warrant, or (iii) drop the matter. The Vice Dean ordinarily shall complete the review within 10 days of receipt of the report. The Vice Dean shall inform the concerned parties of the decision. In the event the Vice Dean determines, in consultation with legal counsel, not to initiate a formal investigation, the Vice Dean shall, as appropriate, use diligent efforts to restore the reputation of the respondent and to protect the position and reputation of the complainant if the complaint is found to have been made in good faith.

If no formal investigation of the respondent is conducted, sufficient documentation shall be kept on file to permit a later assessment of the reasons that a formal investigation was not deemed warranted.

If the report of the inquiry officer finds that a formal investigation is warranted or the Vice Dean decides the matter should be pursued through a formal investigation the Vice Dean shall:

notify the complainant and respondent;

initiate a formal investigation as provided in section E.

E. Formal Investigation

To initiate a formal investigation, the Vice Dean shall appoint a formal investigation committee of not less than three individuals, all of whom shall be faculty members of the School of Medicine. The Chair of the Student Standards Committee will chair the formal investigation committee. The formal investigation shall be initiated within two weeks of completion of any inquiry that finds that such an investigation is merited.

The formal investigation committee shall undertake a thorough examination of the charges. Whenever possible, interviews shall be conducted with the complainant and respondent, as well as with others having information regarding the allegations. Summaries of these interviews shall be prepared, provided to the interviewed party for comment or revision, and included as part of the file. During its proceedings, the committee shall have access to and consult legal counsel. When appearing before the committee the respondent and the complainant may each be accompanied by an adviser. The student's adviser shall be a School of Medicine faculty member and the respondent's adviser must be a University of Pennsylvania employee. The committee shall not conduct formal hearings.
Except in unusual cases, the respondent and the complainant shall not appear before the committee at the same time.

Following the completion of its investigation the committee shall submit a written report with full documentation of its upholding the complaint or not to the Vice Dean with copies to the complainant and respondent. This report shall describe the policies and procedures under which the investigation was conducted, how and from whom information was obtained, the findings, and the basis of the findings and texts or summaries of the interviews conducted by the committee. This report shall ordinarily be submitted to the Vice Dean within 60 days of the appointment of the formal investigation committee. The complainant and respondent shall be permitted to make a written reply to the Vice Dean within 15 calendar days of receipt of the report. Such replies shall be incorporated as appendices to the report of the formal investigation committee. The entire formal investigation process shall be completed with 90 calendar days of its initiation, unless circumstances clearly warrant a delay. In such cases, the reasons for a delay shall be documented.

F. Resolution

If the report of the formal investigation committee finds the charges to be unfounded, the matter shall be dropped and the concerned parties shall be informed. The Vice Dean has the responsibility to take an active role to repair any damage done to the reputation of the respondent or the complainant (provided the complainant acted in good faith), and to take appropriate action should the Vice Dean determine that the accusation was knowingly false.

If the report of the formal investigation committee finds the charges against a respondent to be substantiated, the following offices will be notified.

For a non-faculty UPHS employee (including but not limited to nursing, housestaff, and fellows), the Vice Dean shall inform the UPHS Office of Human Resources.

If a non-faculty employee of the University of Pennsylvania is named in a complaint and charges are substantiated against him/her, the Vice Dean shall inform the University's Human Resources Office.

If charges against a faculty member (including Clinical Care Associates) are substantiated, the Vice Dean shall inform the Dean of the School of Medicine who will proceed to take whatever actions are appropriate to the seriousness of the offense and in accordance with University procedures and which consider the previous record of the respondent. For major offenses by members of the standing (including clinical) or research faculties, the Dean of the School of Medicine shall determine whether there is substantial reason to believe that just cause exists for suspension or termination, and shall take other steps as may be appropriate under the University's procedure for Suspension or Termination of Faculty for Just Cause. For less serious offenses which do not warrant suspension or termination, the Dean of the School of Medicine may impose
penalties including, but not limited to, removal from a particular project, a letter of reprimand, special monitoring of future work, probation, or below average salary increases, including zero salary increases, for one or more years.

The respondent shall have access to all established University grievance and appeal procedures in accordance with the stated jurisdiction of such procedures.

G. Procedures

If the Vice Dean is the respondent or in any other way has a conflict of interest or the appearance of a conflict of interest, he or she is obligated to remove him or herself from the case during the preliminary inquiry and formal investigation, and the Dean of the School of Medicine shall appoint someone else to assume responsibility for carrying out these procedures.

Complete records of all relevant documentation on cases treated under the provisions of this policy shall be preserved in the Office of the Vice Dean for at least ten years.

The School of Medicine may act under these procedures irrespective of possible civil or criminal claims arising out of the same or other events. The Vice Dean, with the concurrence of the Dean of the School of Medicine, after consulting with the Office of the General Counsel, shall determine whether the University shall, in fact, proceed against a respondent who also faces related charges in a civil or criminal tribunal. If the University defers proceedings, it may subsequently proceed irrespective of the time provisions set forth in these procedures.

The Vice Dean shall have the authority to take any actions on behalf of the School of Medicine that he or she deems necessary to protect the complainant and/or the respondent, or to address other needs or deliberations related to the situation, pending the investigation and resolution of the complaint.

Retaliation against any member of the school community, who comes forward with a complaint or concern, is prohibited. If an individual believes that he or she is being subjected to retaliation as a result of coming forward with a concern or a complaint, he or she should refer the matter to the Vice Dean.

E. Modules 4 and 5 Holiday Policy
http://www.med.upenn.edu/student/holidays.html

Students are allotted the following holidays: Memorial Day, July 4th, Labor Day, and Thanksgiving (5PM Wednesday to 5AM Monday) and Summer and Winter breaks (see the academic calendar for details).

The School of Medicine recognizes that there are other holidays, both religious and secular, which are of importance to some individuals and groups. Students who wish to observe these holidays must inform the course director before the course begins and during the site selection process, if applicable. The course director may provide the student with an alternative arrangement to make-up the day(s) missed, on-call
assignments, exams, etc. The timing of make-up work is at the discretion of the course director and may fall during vacation periods. Missed days which can't be completed before the course end date will result in a grade of "Incomplete".

This general policy does not apply to sub-internships (where the student substitutes for an intern on a patient care team) or externships (where the student functions as an additional intern on a patient care team). In these situations, coverage is dictated by patient care needs, and holiday observances are the prerogative of the department involved. Students are advised to obtain departmental holiday policies prior to starting these rotations (and in the case of electives, prior to selecting the elective), and to discuss any special needs with the course director as far in advance as possible.

F. PORTS

PORTS Overview for Clerkship Students

“PORTS” is an acronym for Penn Occurrence Reporting and Tracking System. PORTS was developed in 2001 by the Department of Clinical Effectiveness and Quality Improvement at the University of Pennsylvania. It is a web-based incident reporting system. This system is available to all clinical and non-clinical staff at each of the 3 Penn hospitals as well as all of the Penn outpatient clinics.

The purpose of any incident reporting system, including PORTS, is to provide an easy way for staff to identify events in which an error occurred or events in which the quality or safety of care was threatened in any way, even when no patient harm occurred (these types of scenarios are described in patient safety as “near misses”). These reports provide the opportunity for Penn to learn more about the at-risk areas and imperfect systems that exist within our hospitals and implement improvement projects to prevent future patient harm.

Medical students can enter PORTS reports. They can enter a report in one of 3 ways: using their Penn key, using their first and last name, or reporting anonymously. All information entered into PORTS is confidential. If students or any reporters do identify themselves with their PennKey or name, their name will never be disclosed (shared) with anyone else. On occasion, reporters will get called by a member of Risk Management or Patient Safety after their report is entered in order to ask additional questions more about the incident or to provide follow-up and feedback. If a medical student witnesses or is involved in an event and is unsure about whether it should be reported, they should ask their attending and/or clerkship director for direction. In addition, if a medical student is anxious or nervous about any part of the incident reporting process or if they are told specifically not to enter a ports report by their clinical supervisors and they are uncomfortable with this conversation or direction, they should consult with their clerkship supervisor.

General questions from the clerkship directors about PORTS and patient safety concerns at Penn can be directed to one of the Patient Safety Officers at the 3 Penn Hospitals:
Here is the link to PORTS and where to find it on the home page (see next page for picture of PORTS site on intranet home page)

http://uphsnet.uphs.upenn.edu/wagform/MainPage.aspx?config=PortsV2

G. DUTY HOURS
Duty Hours Policy (adapted for medical Students on Ob Gyn Rotation)

1) Definitions
   a) Duty hours are defined as all clinical and academic activities related to the on site clinical clerkship; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

2) Duty Hour Limits
   a) Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
   b) Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Students may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

3) Time Off
   a) Students must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
   b) Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

4) In House Call/Night Float
   a) At applicable sites, students are expected to participate in the equivalent of 4 night float shifts, ideally occurring Sunday thru Wednesday to promote consistency with the resident night float team and give a period of rest before Friday didactic session. Over night experience is an important part of the rotation, especially on the Obstetric service.
   b) On the first week of the rotation, night float schedule is modified to accommodate orientation day.
c) When a holiday falls during the night float week, night float shifts can be made up thru weekend call and should be scheduled with the assistance of the onsite course director.

d) At sites where night call is required, students should adhere to hour limits as discussed in section 2) a. Students should use their judgment regarding participation in clinical activities on the day after call, especially if their night of “call” has been quiet. Students should also take advantage of on site call rooms so they are adequately rested before driving home after night call.

H. SUITE 100 ABSENCE FORM
When you need to be absent from any part of your rotation FOR ANY REASON you must notify your local team/course coordinator/course director, Drs. Honebrink and Melendez and Roz Levit and submit the attached form to Suite 100. Planned absences require as much advanced notice as possible so make up work can be arranged if necessary.

1. Absence Information

Student Name: ____________________________________________
Clerkship: ______________________ Site: ______________________
Dates of Absence: _____________________________ To _____________________________
From: _____________________________
Reason for Absence (examples of excused absences include traveling to present original work at national meetings, family wedding or participation in a wedding party, death in the family, personal or immediate family illness; examples of unexcused absences include traveling to spend time with significant other, attending to other SOM course assignments or attending to elective doctor appointments). Please be aware some make up work will be required in lieu of attendance.

You must submit requests for absences, other than illness or death in the family, at least 4 weeks prior to the first day of the affected clerkship to the clerkship director and Anna Delaney (delaney@Mail.med.upenn.edu).

STUDENT SIGNATURE _____________________________ DATE _____________________________

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2. **Approval**

- [ ] Approved
- [ ] Rejected

Comments:
APPENDICES

B. EVALUATION FORM

University of Pennsylvania School of Medicine

EVALUATION OF STUDENT PERFORMANCE: ______________________________

Student Name: __________________________     Course Director: _____________________

Year in School: MS3  MS4  Other: ____________     Dates of Elective: _______________

<table>
<thead>
<tr>
<th>I. PATIENT CARE (Circle number most consistent with observed behavior)</th>
<th>☐ Not Able to Assess (check only if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. HISTORY TAKING (appropriate to the specialty)</td>
<td></td>
</tr>
<tr>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>Incomplete and disorganized history; very poor interview skills</td>
<td>History lacks focus; barely adequate interview skills</td>
</tr>
<tr>
<td>Takes an appropriate history; adequate interview skills</td>
<td>Thorough and appropriate history; excellent interview skills</td>
</tr>
<tr>
<td>B. PHYSICAL EXAMINATION (appropriate to the specialty)</td>
<td>☐ Not Able to Assess (check only if appropriate)</td>
</tr>
<tr>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>Incomplete and disorganized; major deficiencies in technique</td>
<td>Fails to follow-up/define clinical findings; some deficiencies in technique</td>
</tr>
<tr>
<td>Performs an appropriate and technically sound physical exam</td>
<td>Exceptionally thorough exam with careful attention to clinical findings; excellent technique</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. MEDICAL KNOWLEDGE (Circle number most consistent with observed behavior)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ACTUAL KNOWLEDGE</td>
</tr>
<tr>
<td>1  2  3  4  5  6  7</td>
</tr>
<tr>
<td>Fund of knowledge is inadequate</td>
</tr>
<tr>
<td>Solid fund of knowledge</td>
</tr>
<tr>
<td>B. PROBLEM SOLVING</td>
</tr>
<tr>
<td>1  2  3  4  5  6  7</td>
</tr>
<tr>
<td>Unable to integrate the elements of a clinical database; has no or only rudimentary problem solving ability</td>
</tr>
<tr>
<td>Able to synthesize most aspects of the clinical database into a solid differential diagnosis and/or overall plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. PRACTICE-BASED LEARNING AND IMPROVEMENT (Circle number most consistent with observed behavior)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. INTEGRATION OF INSTRUCTION</td>
</tr>
<tr>
<td>1  2  3  4  5  6  7</td>
</tr>
<tr>
<td>Little evidence of supplemental reading</td>
</tr>
<tr>
<td>Does some supplemental reading as well as assigned reading</td>
</tr>
<tr>
<td>VI. B. EFFICIENCY AND EFFECTIVENESS</td>
</tr>
<tr>
<td>1  2  3  4  5  6  7</td>
</tr>
<tr>
<td>Works slowly and in a disorganized manner</td>
</tr>
<tr>
<td>Organizes workload in an efficient and effective manner</td>
</tr>
</tbody>
</table>
### IV. INTERPERSONAL AND COMMUNICATION SKILLS
(Circle number most consistent with observed behavior)

<table>
<thead>
<tr>
<th>A. HUMANISM AND INTERPERSONAL SKILLS</th>
<th>□ Not Able to Assess (check only if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insensitive to patients and families feelings, needs and wishes</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes has difficulty establishing rapport with patients and families</td>
</tr>
<tr>
<td>3</td>
<td>Relates well to most patients and family members</td>
</tr>
<tr>
<td>4</td>
<td>Consistently demonstrates respect, empathy and compassion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. ORAL PRESENTATIONS</th>
<th>□ Not Able to Assess (check only if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Incomplete and disorganized; major deficiencies in characterization of clinical issues</td>
</tr>
<tr>
<td>2</td>
<td>Presentations incomplete; some omissions/inaccuracies in characterization of clinical issues</td>
</tr>
<tr>
<td>3</td>
<td>Adequate delineation of primary problem with reasonable characterization of clinical issues</td>
</tr>
<tr>
<td>4</td>
<td>Clear delineation of primary and secondary problems; excellent characterization of all clinical issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. WRITTEN WORK</th>
<th>□ Not Able to Assess (check only if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recorded findings are inadequate; major deficiencies in analysis of problems</td>
</tr>
<tr>
<td>2</td>
<td>Lapses in recorded findings; some omissions/inaccuracies in analysis of problems</td>
</tr>
<tr>
<td>3</td>
<td>Recorded findings are appropriate; analyzes primary problems in a complete manner</td>
</tr>
<tr>
<td>4</td>
<td>Recorded findings are well organized, conscientious and accurate; detailed analysis of all health care issues</td>
</tr>
</tbody>
</table>

### VII. V. SYSTEMS-BASED PRACTICE (Circle number most consistent with observed behavior)

<table>
<thead>
<tr>
<th>A. DISEASE PREVENTION/Routine HEALTH MAINTENANCE</th>
<th>□ Not Able to Assess (check only if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rarely raises prevention/routine health maintenance with patients or incorporates these needs into health care plan</td>
</tr>
<tr>
<td>2</td>
<td>Acknowledges importance of prevention/health maintenance issues but fails to incorporate them into health care plan</td>
</tr>
<tr>
<td>3</td>
<td>Generally able to integrate prevention/health maintenance needs with other elements of the health care plan</td>
</tr>
<tr>
<td>4</td>
<td>Expert in integrating prevention/health maintenance principles and practices into the health care plan</td>
</tr>
</tbody>
</table>

**FEEDBACK**

Has the student accepted and incorporated feedback? (PLEASE CHECK ONE):

- □ No
- □ Yes, but with concerns
- □ Yes

If you answered YES, BUT WITH CONCERNS or NO to the question listed above, comments MUST be provided.

Respect for Patients

Has the student met minimal competency in ALL domains of professionalism? (PLEASE CHECK ONE):

- □ No
- □ Yes, but with concerns
- □ Yes

If you answered YES, BUT WITH CONCERNS or NO to the question listed above, comments MUST be provided.
MEDICAL KNOWLEDGE and SKILLS

Has the student achieved minimal competency for medical knowledge and skills? (PLEASE CHECK ONE)

□ No
□ Yes, but with concerns
□ Yes

If you answered YES, BUT WITH CONCERNS or NO to the question listed above, comments MUST be provided.

OVERALL COMMENTS

Please describe the student’s strengths.

Please describe areas in which improvement is needed.

RECOMMENDED GRADE (PLEASE CHECK ONE):

□ Withdraw
□ Incomplete
□ Unsatisfactory
□ Low Pass
□ Pass
□ High Pass
□ Honors

Evaluator’s Signature ________________________________ Date _____________

FINAL GRADE (PLEASE CHECK ONE):

□ Withdraw
□ Incomplete
□ Unsatisfactory
□ Low Pass
□ Pass
□ High Pass
□ Honors

Course Director’s Signature ________________________________ Date _____________
C. ADDITIONAL LECTURE MATERIALS

Slides and articles

The following presentations are current as of 2/2010. These are included for general preparation for the topic and review afterward. Faculty do update their presentations from time to time so presentations may change throughout the year but basic content should remain the same. Also, individual topics are frequently shared by 2 faculty members who may or may not share the same presentations.

Included presentations/supplemental materials are:

1. Normal Birth
2. Intrapartum Management
3. Nutrition During Pregnancy and Lactation
4. Obstetric Hemorrhage
5. Prenatal Genetics
6. Preeclampsia- Eclampsia (Hypertension in Pregnancy)
7. Family Planning
8. Periodic Assessments/Prevention tables (Go with Preventive Care didactics)
9. Abnormal Uterine Bleeding
10. Initial Evaluation and Management of the Infertility by the Primary Care Physician (article)
11. Female Infertility
12. Pelvic Pain
13. Menopause/Postreproductive Gyn
14. Vaginitis/PID