Clinical Clerkship Rotation in Obstetrics and Gynecology

This is the University of Alberta Department of Obstetrics and Gynecology six-week rotation in for third year medical students. There are many opportunities to learn. Your active participation in clinical activities and personal dedication to scholastic achievement during this six week period is critical to your success in the clerkship.

**ORIENTATION**
Students are to report on the first day of their clerkship to room 5S149 on the 5th floor of the Lois Hole Hospital for Women at the Royal Alexandra Hospital at 0700h for welcome and orientation. Clerkship orientation will include review of goals and objectives, review of the assessment process, and outline of basic requirements for notification of absence.

**KEY CONTACTS**
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**GOALS OF THE CLERKSHIP**
Upon completion of the basic clerkship, each student should be able to:

A. Demonstrate skills in independent learning and critical thinking.

B. Establish a relationship of mutual respect between the physician, patient and the patient’s family, and acquire the basic interpersonal skills which facilitate this relationship.

C. Appreciate the role of community agencies, practicing physicians and community health care programs in facilitating optimal care.

D. Develop positive attributes which will serve as the basis for a successful professional career.

E. Develop study habits which will enhance lifelong learning.

F. Acquire knowledge and skills relevant to the field of obstetrics and gynecology as delineated in the attached Obstetrics and Gynecology Rotation Objectives.

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PROTOCOL FOR GRADING MEDICAL STUDENTS IN THE OBSTETRICS AND
GYNECOLOGY CLERKSHIP

Students are evaluated in this clerkship on their clinical performance, achievement of performance skills, and cognitive achievement by means of a written final examination.

A. Clinical Performance.

A standard assessment form is used that has been generated and approved by the Curriculum Committee, is used by other clerkships, and is published for student review in this syllabus. Please review it.

The assessments of clinical performance are the staff/faculty preceptors and senior residents (if present in the assigned hospital)

Written assessment of medical students by faculty and residents also take into account presentations, participation at conferences, and, where applicable, clinical encounters.

Written clinical performance evaluation is made in the six areas detailed in the standard assessment form: knowledge, problem solving, clinical skills, interpersonal skills, professional characteristics, and motivation/enthusiasm.

An assessment of student progress is made at the midpoint of the clerkship. Problems that are identified at this time can be addressed and should be resolved by the end of the clerkship. Obviously it is possible for difficulties to arise after the midcourse evaluation. The students’ encounter log will be reviewed at midpoint.

Students concerned about their progress at any time during the clerkship may also ask for an interim evaluation of their progress. Such evaluations are done by request only.

B. Examinations

The final examination is a 50-60 item Multiple Choice Exam. This examination is based on the goals and objectives included in this syllabus. Identification of fetal heart rate tracings, labour patterns and gross identification of some typical clinical conditions may be included.

In addition, an OSCE examination will occur at the end of each 6 week rotation. This consists of five or six stations, of 10 minutes duration, where specific clinical situations are presented. The student is expected to assess and manage the situation presented.

Electronic devices may not be used during the MCQ examination, and should not to be brought to the Exam Room. During the OSCE, students may use gestational age calculators (wheels), notepaper and pens.

The MCQ exam is worth 12.5 % of your final mark. The pass mark for MCQ exam is 60%. The OSCE is worth 37.5% of your final mark. Each student must pass both exams to pass the rotation.

Should a student not receive the required minimum mark on either exam, they are considered to have failed the rotation. The student’s performance will then be reviewed at the clinical academic standings meeting in August. At that time all of the third year courses are reviewed. Rewrites of examinations are generally allowed if a student has only failed one course during the third year; these will occur subsequent to the academic standings meeting in August.

Fifty percent (50%) of the final mark is based on your clinical evaluations. A failing grade occurs when significant problems have been identified by preceptors. The UME office will review the assessments. If a student is considered to have failed the clinical evaluation, this is also reviewed at academic standings in August. Remediation is determined then but will usually include more clinical time on the rotation.

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Patient Encounter Log:
You are required to track your patient encounters during the rotation (see attached form). These are minimal requirements. If you do not anticipate meeting these requirement, please notify your site coordinator as soon as possible, allowing time for rectification of the issue. You are also required to enter these encounters on MedSIS. These entries will be evaluated at your midpoint evaluation and the final evaluation. **Your final examination scores will not be released until the patient encounter log is complete on MedSIS.**

Professionalism:
a. Your dress, cleanliness and behavior must be appropriate to your profession and acceptable to your preceptor physician and site director. Wear your white coat and name tag when on duty in clinic, on formal ward rounds, and scheduled conferences.
b. Always introduce yourself as a student physician to the patient and the patient's family or friends. Never walk into a room and begin an exam or procedure without introducing yourself.
c. Personal cell phones are to be turned off when participating in clinical responsibilities, e.g. rounds, operating room, educational conferences, etc.
d. Punctuality. It is expected that your attendance at rounds, meetings and departmental functions will be punctual. If you cannot make an appointment, it is expected that you will notify concerned parties in a timely fashion.

Miscellaneous Information:

**Absence due to illness:** If you become ill during the clerkship and are unable to carry on with your responsibilities, call the site clerkship co-coordinator as soon as possible and report your illness. In addition, notify the chief resident on your service.

**Absence due to other reasons:** The Clerkship Director (Dr. V. Jain) or hospital Clerkship Coordinator can excuse your absence from the clerkship for reasons other than illness, if necessary. Arrangements will have to be made at least one week in advance of your planned departure. As soon as you have the approval, you are to alert the chief resident on your service of your absence.

**Problems:** If you have any problems during the clerkship (people problems, school problems, personal problems, etc.), please discuss this with the Clerkship Director or Clerkship Coordinator in your hospital. Unresolved problems do affect clinical performance and how we function as professionals. We cannot help you with a problem we do not know about, so please take the responsibility to talk with someone when you have any kind of problem during this clerkship.

**Evaluations:** Two evaluations are requested (on MedSIS):
   1. Program evaluation
   2. Your faculty preceptor.
Student evaluations are used to improve teaching performance and the clerkship design. Mature students use evaluation forms as a means of improving medical education. They are most useful to faculty in describing situations or behaviors that concern you or to point to inadequacies that need attention. Preceptor evaluations are anonymous and will

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only be given to the preceptors at the end of the year to protect your anonymity. Your cooperation in this endeavor is appreciated.

**Educational Activities for Medical Students:**

Educational lectures, presentations and meetings take precedence over clinic responsibilities except when students are involved in emergent life-saving activities. If you are involved in a clinic activity at the time an educational exercise is scheduled, you should request supervising faculty/residents to excuse you so you can attend the educational activity.

**Night Call:**

Students are expected to take night call roughly every seventh night. This experience should allow the student to:

- Evaluate a patient who is newly admitted to the hospital
- Follow an unstable patient’s changing course through a continuous 24-36 hours period
- Gain insight into the decision-making process of junior physicians when more senior physicians are not directly available
Additional Reading:
In a six-week clerkship, the student must rely on readings from authoritative sources to establish a well-rounded database in obstetrics and gynecology. The purpose of this list is to aid the student in achieving an understanding and appreciation of the scope and depth of OB/GYN by not only reading about clinical situations encountered on a daily basis, but also conditions not likely to be commonly encountered but which are nevertheless important to understand.

General Texts:


Obstetrics Texts

Gynecology:

Reproductive Endocrinology:

Gynecologic Oncology:

Maternal-Fetal Medicine:


BASIC Ob/Gyn HISTORY

DATE / TIME

ID (Identifying Data)
- Age
- GTPAL
- Gestational age (if applicable)

CC (Chief Concern)
- Symptom(s) for which patient is seeking care or advice
- Put in patient's own words!

HPI (History of Presenting Illness)
- Clear, chronological account of symptom development
- Ex: Abdominal pain
  - L - location
  - P – provoking / relieving factors
  - Q - quality
  - R - radiation
  - S – severity
  - T – timing (onset, duration, frequency)
- Associated symptoms
- Significant positives / negatives
- Cardinal Ob Sx
  - Contractions (CTX)
  - Leaking of fluid (LOF)
  - Vaginal bleeding (PVB)
  - Fetal movement (FM)

PMH (Past Medical History) PSH

(Past Surgical History) PObsHx (Past Obstetrical History)
- Chronological account of previous pregnancies, including complications

PGyneHx (Past Gynecological History)
- Menstrual Hx – menarche, frequency/duration/flow, dysmenorrhea, dyspareunia, intermenstrual bleeding, postcoital bleeding, menopause
- Sexual Hx (including STIs)
- Pap Hx

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Meds
- List of current medications including dose and frequency of use
- Note recently discontinued, added or medication changes

Allergies
- Note specific reaction

Fx (Family History)
- Note age and health, or age and cause of death, of immediate family members
- Note occurrence of common medical conditions (ex: DM, CAD, HTN, Dyslipidemia, CA, renal failure, etc.)
- Pedigree may be useful

Sx (Social History)
- Education / Occupation
- Household / Marital status (screen for domestic violence)
- Smoking (pack years)
- EtOH
- Recreational street drugs
DATE / TIME

Preop Dx: ______________________________
Postop Dx: ______________________________
Procedure: ______________________________
Surgeon: ________________________________
Assistants: ______________________________
Anesthesia: _____________________________(Type of Anesthetic)
Findings: _______________________________
Complications: __________________________
Estimated Blood Loss (EBL): ________________
Drains: ________________ ex: Foley, JP (including location), Vaginal packing
Disposition: ______________________________ ex: Stable to RR
BASIC POSTOP ORDERS

DATE / TIME

D – Diet (ex: CF)

A – Activity (ex: AAT)

V – Vital signs (ex: Routine postop VS) “4 Is”

I – IV (ex: IV RL @ 150 cc/hr)

I – Ins & Outs (ex: I&O q4h, Call MD if u/o < 120cc/4h) I – Investigations (ex: CBCD POD#1)

I – Incentive spirometry (ex : q1h while awake) “Anties”

Anti-Pain

• Narcotic (ex: Morphine 5-10mg sc/IM q4h prn)
• Anti-inflammatory (ex: Voltaren 50mg pr q8h x 48hrs then prn)
• Tylenol (ex: Tylenol pl/#3 i-ii po q4-6h prn)

Anti-Emetic

• Gravol 25-50mg po/IM/IV q4h prn
• Maxeran 10mg IM/IV q6h prn

Anti-Thrombin

• Heparin 5000 units sc q12h (q8h if ↑ BMI)

Anti-biotics

• If required, usually Ancef & Flagyl (pen-allergic – Clinda & Gent)

Antecedent

• Preop meds

“Drains”

• Foley vs. Suprapubic
• JP
• Vag pack

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POST-OP ROUNDED

Basics:
- CF to DAT (means the nurses can advance the diet as the patient tolerates clear fluids to full fluids to solids)
- Urine output – should be urinating 0.5cc/kg/hr – which is approximately 30cc/hr – so in 8 hours the patient should void at least 240cc (8hr X 30cc)
- JP drains – before pulling, should be <30cc/8 hrs consistently, trending downwards in volume. Document if sanginous (blood), serosang (mix of blood and serous fluid) or serous (nonbloody fluid). If a drain is left too long, the body starts to produce serous fluid and the volumes start increasing.
- PVR (post-void residuals) – done in patients who have had a procedure which might affect voiding function (ie. anterior vaginal repair, TVT). Write order as: D/C Foley. Do TOV (trial of voids) with PVRs (post-void residuals) as per protocol. The protocol is that the patient voids >200cc and has residuals of <100cc on three consecutive voids. What this protocol entails is that the patient voids into a measuring hat (TOV), then the nurse does an ultrasound with the “bladder scanner” to determine the PVR. These values are recorded on a sheet of paper at the front of the chart.
- PCA (Patient controlled analgesia) – used after most laparotomies
- Vaginal packs – are always removed POD#1. Should not be left in the vagina more than 24 hours.
- Staples +/- sutures – If a pfannensteil incision, D/C POD #3 (which is typically when the patient goes home). If a midline incision, D/C POD #5-7 – can be done at the Ob/Gyne’s office, or if from out of town – GP or ER.

“Typical” course post laparotomy (ie. TAH +/- BSO):

POD #1
- D/C Foley (if urine output has been good)
- Decrease IV rate – SL (saline lock) IV when drinking well
- Mobilize

POD#2
- D/C PCA

POD#3
- D/C home
- D/C staples +/- sutures if pfannensteil incision

“Typical” course post anterior vaginal repair OR Burch +/- other procedures:

POD#1 – Do NOT D/C Foley
POD#2 – D/C Foley. Do TOV with PVR as per protocol
BASIC POSTOP PROGRESS NOTE

DATE / TIME

POD # _____ - Procedure ___________________________

S (Subjective), Procedure & POD Dependent
  • Shortness of breath / chest pain / leg pain
  • Pelvic pain control
  • Nausea / vomiting
  • Flatus
  • Vaginal bleeding

O (Objective)
  • Vital signs
  • Urine output
  • JP output & quality
  • Bloodwork
  • Physical examination – incision, abdomen

A (Assessment) P

(Plan)