

## Clinical Clerkship Rotation in Obstetrics and Gynecology (OBGY 546)

This is the Department of Obstetrics and Gynecology core rotation for third year medical students. There are many opportunities to learn over this six-week rotation. Your active participation in clinical activities, along with personal study, is critical for you to be successful in this clerkship.

### Orientation

Students are to report on the first day of their clerkship to the Royal Alexandra Hospital, according to the schedule provided to you by the clerkship administrator. Students will have the Clerkship orientation with the Clerkship Director, Dr. Peggy Sagle via Zoom. The 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 outlined in the attached Obstetrics and Gynecology Rotation Objectives.

## **Assessment of Medical Students in the Obstetrics and Gynecology Clerkship**

Students are evaluated in this clerkship on their clinical performance and achievement of procedural skills and tested with a final MCQ examination and OSCE.

### **A. Clinical Performance.**

A standard assessment form is used (MDPA) that has been approved by the Curriculum Committee, is also used by other clerkships.

The assessments of clinical performance are done by 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.

A formal 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.

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 also review the assessments.

If a student is considered to have failed the clinical evaluation, this is reviewed at academic standings in August. Remediation is determined then but will often include more clinical time on the rotation.

### **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 four 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 be used only when it is necessary, such as for Zoom MCQ Examination & OSCEs. 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; the pass mark is 60%. 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. Rewrite of an examination is generally allowed if a student has only failed one course during the third year. The timing of this can be arranged with the UME office.

Students must pass all three parts of the assessment to pass this rotation.

## **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 requirements, 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 assess.med. 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.**

## **Professionalism**

- a. Your appearance and behavior should be appropriate 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 and the UME office.

### **Absence for other reasons**

If students need to be absent from the rotation for a reason other than illness, the UME office must be informed, and an absence request completed (as per the UME absence policies), ideally at least 10 days before the absence occurs. The Clerkship Director and administrator should also be notified, as well as your clinical supervisor, as soon as the student is aware of the planned absence (conferences, presentations). Also let the chief resident know the dates you will be away.

## **Problems**

If you have any problems during the clerkship (people problems, school problems, personal problems), please discuss this with the Clerkship Director or Clerkship Coordinator in your hospital. Unresolved problems can affect clinical performance and how one functions as a professional. We cannot help you with a problem we do not know about, so please talk with someone when you have any kind of problem during this clerkship.

## **Evaluations**

Two evaluations are requested from each student.

1. Program evaluation
2. Evaluation of your faculty preceptor.

Student evaluations are used to improve teaching performance as well as the design of the clerkship. They are most useful to us if they describe situations or behaviors that concern you or point out areas needing attention. Preceptor evaluations will only be given to the preceptors **at the end of the year** to protect your identity. Your constructive feedback on the rotation is appreciated.

## **Educational Activities for Medical Students**

Educational lectures, presentations and rounds take precedence over clinic responsibilities unless students are involved in emergent life-saving activities. Tuesday has been designated your educational day and staff know that you must attend sessions then.

### **Night Call**

Students are expected to be on call overnight 3-4 times in a 3-week period. This experience is designed to 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-hour period
- Gain insight into the decision-making process of junior physicians when more senior physicians are not directly available.
- Understand the differences in work environments at night or on weekends

Attendance at the student lectures each Tuesday is Mandatory and will be recorded. Students who are on call on Monday nights are to leave at 2000h to attend teaching sessions on Tuesdays.

### **Student Evaluations**

**All Evaluation Forms are designed for point of contact feedback.**

Ideally, they should be filled out at the same time as preceptors are interacting with the student.

Using any device, the form can be pulled out by the student/preceptor from

<https://assess.med.ualberta.ca>

**At least 3 EPA's attempted during each of the 6 weeks of the rotation (at least 18 in total)**

EPAs are to be completed at least DAILY while on rotation.

All preceptors and residents are aware that this is a requirement of your rotation, but the onus is on the student to ensure they are completed each day.

**Long form MDPA - Clerkship Assessment Midpoint/Final: to be completed by the Site Coordinators only.**

Using any device, the form can be pulled out from <https://assess.med.ualberta.ca>

### **Additional Reading: Reference List**

In a six-week clerkship, the student must rely on readings from authoritative sources to establish a well-rounded knowledge of obstetrics and gynecology. The purpose of this list is to aid the student in achieving an understanding and appreciation of obstetrics and gynecology, by not only reading about clinical situations encountered on a daily basis, but also about conditions rarely encountered, but which are nevertheless important to understand.

#### General Texts

“Obstetrics and Gynecology fourth edition” edited by Beckmann C., Ling F., Laube D., Smith R., Barzansky B., Herbert W. 2002, Lippincott Williams & Wilkins.

“Current Obstetric and Gynecologic Diagnosis and Treatment,” edited by DeCherney and Nathan, 9th edition, 2003, McGraw-Hill.

“Hacker and Moore’s Essentials of Obstetrics and Gynecology”, 4<sup>th</sup> edition

#### Obstetrics Texts

Williams Obstetrics, 21 Ed, New York, NY, McGraw-Hill, 2001,

#### Gynecology Texts

Comprehensive Gynecology, 4 Ed, edited by Stenchever MA, Droegemueller W, Herbst AL, Mishell Jr. Mosby, St. Louis, 2001.

#### Reproductive Endocrinology

“Clinical Gynecologic Endocrinology and Infertility,” Speroff, Fritz, 2004, 7th Edition, Lippincott, Williams and Wilkins.

#### Gynecologic Oncology

“Clinical Gynecologic Oncology,” DiSaia, Creasman, 2002, 6th Edition, Mosby.

#### Maternal-Fetal Medicine

“Maternal-Fetal Medicine. Principles and Practice,” Creasy, Resnik, 2003, 5th Edition, Saunders.

#### Gynecologic Surgery

“Te Linde’s Operative Gynecology.” Rock 2003. 9th Edition, Lippincott– William Wilkins.

#### Operative Obstetrics

“Operative Obstetrics,” Hankins, Clark, Cunningham, Gilstrap, 1995, Appleton & Lange.

## 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

### Meds

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

### Allergies

- Note specific reaction

### 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

### Social History

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

BASIC OR NOTE

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 POST-OP ORDERS

### DATE / TIME

D – Diet (ex: Clear Fluids)

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)

### 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

## POST-OP ROUNDING

### 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 sanguinous (blood), serosanguinous (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 Pfannenstiel 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 Pfannenstiel 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 POST-OP 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)