

Resident Guidelines

Postgraduate Education

Department of Obstetrics and Gynecology

Faculty of Health Sciences

McMaster University

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The following guidelines are meant to apply to all Obs/Gyn Residents at every level of training. Exceptions to these guidelines will only be made on the approval of the Residency Program Director (RPD) and/or the Postgraduate Education Committee.

1. Academic Scheduling :

Well in advance of each Academic Year the Residency Program sends out a list of all the protected Academic Activities that the Residents must attend. The obvious expectation is that the Residents would then enter these activities into their electronic schedulers. This type of preemptive scheduling allows the Residents to give their individual clinical supervisors lots of advance notice about their upcoming educational commitments. Similarly this allows appropriate adjustments' in call and daytime clinical commitments to allow full attendance at the protected Academic Activities.

It is the Program's clear expectation that all Residents, as CanMeds Managers and Collaborators, will maintain an up-to-date electronic calendar of their academic commitments. In the long run this will create a smoother-running program and reduce the amount of potential friction between the Residents and Staff people.

The Residency Program attempts to maintain good communication between the Residents and Faculty by email. It is the Program's clear expectation that all Residents that are not on holidays will read and respond to their emails at least once a day. This will prevent a lot of misunderstanding and hard feelings. Many of the documents sent out from the Residency Program are in fact time-sensitive and require adherence to the above stipulation.

2. Conferences (Professional Leaves):

The program encourages professional leaves, particularly those that allow Residents' exposure to experts in other centers.

- a) A Resident must give adequate notice regarding anticipated conference leaves. In addition, they must submit information to the RPD to ensure that the upcoming conference leave is appropriate for the individual Resident's educational needs. This information can be attached to the conference request form. Conference leaves will be handled on a first-come-first-served basis. At minimum, the Program requires three weeks notice prior to the drafting of the rotation schedule, to allow a conference leave.
- b) Following a conference leave, all Residents are required to make a presentation to the resident group, (perhaps during the CPC session) concerning what they learned at the meeting.
- c) Residents who are presenting their own research at academic meetings will be eligible for additional professional leave for this function.
- d) Those Residents, who wish to take a "reading" conference leave, must submit, well in advance of the leave, appropriate goals and objectives. Written evidence of attainment of the goals and objectives are required at the conclusion of the elective.

1.1 Conference/Elective/Educational Funding

- a) The residency program will fund any Resident whose research paper has been accepted for presentation at an acknowledged scientific meeting. This funding, up to a maximum of \$2,000/

meeting must be applied for in advance of the meeting. The Program requires original receipts for Resident reimbursement. There is no limit on the number of research paper presentations that will be funded by the Program. In individual cases, the Program may fund attendance at meetings that pertain to resident's research projects that are in progress. The Department will support travel and accommodation expenses for attending the meeting regardless of whether you are presenting an oral or a poster presentation.

- b) Any resident who has their paper accepted for publication in a peer-reviewed journal will receive \$2,000 to be applied to the costs of attendance at a mutually-agreed-upon academic meeting. This amount is in addition to any funds received in Section a). Again there is no limit on the number of times the resident may receive these funds for their scholarly publications.
- c) The Program covers the registration fee for the ALARM course once/residency
- d) For electives within commuting distance of the resident's home that are not funded through ROMP or MacCARE, the Program will consider partial financial assistance for the daily travel cost provided that:
 - i. the elective site is one which the University is trying to recruit into the network of distributive learning sites;
 - ii. in the opinion of the Residency Program Director the elective will considerably advance the distributive learning needs of the Program;
 - iii. the elective will be of substantial learning value for the resident
 - iv. the resident has applied to the Residency Program Director and that application has been approved in advance of the proposed starting date.

3. Resident Holidays:

- a) Residents shall be entitled to four (4) weeks paid vacation during each year. In addition, Residents are allowed seven days of paid conference leave.
- b) Vacations may be taken by housestaff at any time. The timing of vacation is subject to the professional and patient responsibilities of the hospital for the time that the vacation is requested. The residents should be aware that if they are away for substantial portion of a given rotation there may be evaluation implications. If the faculty feel they have not had adequate time to ensure that the resident has met the Goals and Objectives of the rotation they may choose to use the new summative evaluation category on the WebEval document that reflects this fact. Alternatively the faculty may feel that they have had sufficient exposure to the resident and have determined that they have not met the Goals and Objectives of the rotation.

In the situation of a substantive rotational change, the Residents are discouraged from taking holidays during the first days and weeks of the rotation. In the unlikely situation where vacation during the first period of the rotation is unavoidable, the Resident will give notice in advance of the starting date. They will also arrange for an alternate date for orientation, etc.

- c) Housestaff may arrange for their vacation to be taken in one (1) continuous period or in one or more segments of at least one (1) week in duration, provided professional and patient responsibilities are met. Those Residents seeking to obtain approval for vacations exceeding one week in length, must gain the approval of the RPD. The approval will be based on the educational and clinical care factors involved. It is extremely unlikely that Residents will be

granted a 4-week vacation block from a single rotation unless extraordinary circumstances arise.

- d) Requests for vacation shall be submitted in writing to the RPD at least four (4) weeks before the proposed commencement of the vacation. As an exception, each Resident taking a certification examination in the spring shall have up to one month prior to the date of the examination to make a written request for one week of his/her vacation entitlement. All vacation requests must be confirmed or alternate times agreed to, within two (2) weeks of the request being made. Where the RPD rejects the vacation request, he/she will do so in writing, to the Resident and will include the reasons for rejecting the original vacation proposal.
- e) There will be no adjustment to vacation entitlement for up to seventeen (17) weeks in the case of pregnancy or leave of absence and/or up to eighteen (18) weeks in the case of parental leave of absence. Where a Resident is entitled to and takes pregnancy leave and is also entitled to and takes parental leave, there will be no adjustment to vacation entitlement for up to thirty-five (35) weeks.
- f) Except for the candidates, no Resident/Intern is permitted to take vacation in the week prior to the spring Royal College Exams.
- g) During the week of the SOGC ACM, the Program gives holiday/conference leave preference to those who are attending the SOGC ACM as Junior Members, Reporters or Presenters. These individuals must notify the RPD as soon as their attendance at the SOGC ACM has been confirmed. If following this, there are still vacant holiday slots, then the other Residents may book holidays. Approval or disapproval may be very close to the date of the proposed holiday.
- h) No residents in the program should be allowed regular holidays over the 10 day Christmas period. This applies to both interns and residents.

4. Electives

- a) The Program requires at least 3 months notice regarding the specifics of the anticipated elective. This includes notice of the goals and objectives and the supervisor of this elective. A letter from the supervisor must be submitted approving the elective.
- b) Residents wishing to take a "reading" elective must supply appropriate goals and objectives in advance of the elective. These must be submitted to the RPD for approval prior to the commencement of the elective. Provisions must be made to ensure attainment of the goals and objectives at the conclusion of the experience.
- c) All costs incurred during an elective must be borne by the Resident with the exception of those outlined above in 1.1 d). This McMaster Postgraduate policy is effective February 1st, 2005. MacCare and ROMP currently provide funding for some core rotations at designated centers outside of Hamilton.

4. Maternity/Parental Leave and Sick Leave

a) Maternity/Paternity Leave

It is the University's position that: *"if the cumulative total leave period during the residency programme is more than three months, an extension of the residency programme will be required to satisfy the (Royal) College requirements". Therefore, at the RPD's discretion any resident can be granted a one-time maximum of 3 months, per residency, absence from the program, for maternity/parental leave, without delaying the date of completion of the program."*

In September of 2006 the RCPSC made the following revisions and clarification of its position on this issue.

*“Waiver of Training Requirements Associated with Leave of Absence from Residency
The Specialty Training Requirements are normally completed in sequence. Interruptions which require a leave of absence in training programs may be granted by the Postgraduate Dean on recommendation of the Program Director. It is anticipated that the required time lost or rotations missed must be made up with equivalent extra time in residency upon the resident’s return to the program. In exceptional circumstances the training requirements may be reduced by a maximum of three (3) months in a four- to six-year program or six (6) weeks in a two- to three- year program on recommendation by the resident’s Program Director and approval of the Postgraduate Dean with timely notification to the Credentials Committee. This notification must be prior to submission of the CCT and/or FITER. ”. That is, a resident who wishes to apply for an exemption from training can only do so near the end of their training”. Leave credits may not be accumulated to reduce the overall minimum required residency time or granted for achieving clinical competence. Leave credits may not be granted after the resident has taken the RCPSC certifying examinations.*

- Interpreting the policy:*
- 1. The intent of the waiver of training requirements policy is not that reduction in training requirements be granted in all cases; rather it must be restricted to exceptional circumstances. The purpose of this policy is to provide guidelines to Program Directors and Postgraduate (PG) Deans as to when it is or is not acceptable to grant a resident a waiver of training requirements following a Leave of Absence (LOA);*
 - 2. While it is recognized that each school has its own LOA policy, and that LOA approvals are at the discretion of the Program Director and the PG Dean. The purpose of these guidelines is to ensure greater consistency in applying the waiver of training requirements associated with a LOA across all residency programs;
September 19, 2006*
 - 3. The policy is not meant to prescribe the amount of time a resident has to take away from residency. Rather, the policy is about establishing consistency as to when it is or is not acceptable to grant a resident a waiver in training requirements following a LOA. When the credentials of a resident for eligibility to the certification examinations are assessed, the College must ensure that all the specialty training requirements are met and that all segments of time are accounted for. If there is a gap in training, the College must be aware as to why this gap has occurred so as to ensure that the waiver of training requirements following a leave of absence policy has been applied. This is one of the parts of verification of training that takes place when residents' files are being assessed for eligibility to the certification examinations.*
 - 4. A major change to the policy is that the waiver of training requirements following a leave of absence is approved by the PG Dean upon the recommendation of the Program Director, with timely and formal notification to the Credentials Committee. This change was made in order to ensure that the process is administered more efficiently for the benefit of residents, particularly when decisions need to be made quickly. The change was also made so as to ensure that the PG Deans are aware of all leaves of absences, whether or not a waiver of training requirements following a leave of absence has been granted.*
 - 5. When considering whether to grant a waiver of training requirements following a LOA in which time does not have to be made up, it is within the purview of the Program Director and the PG Dean to determine whether consultant competency has been achieved and establish the criteria by which a waiver of training requirements following a LOA is decided.*
 - 6. Finally, exceptional circumstances does not mean that rotations can be skipped, or that the program can be shortened by three months (in a 4 to 6 year program) or 6 weeks (in a 2 year program) because the resident has performed well in their program and would like to start practicing earlier than the planned end of residency. Residents must be aware that commitment regarding their employment can only be timed for when their residency officially end”*

Henceforth (starting with the 2006-07 PGY-1 cohort) the Program's position is that it will not exempt any portion of the resident's training except in extreme and very rare circumstances. As you are no doubt aware it is the Department's present position that routine exemption of three months of training for those on Maternity/Paternity/Sick Leave will no longer be granted. In the rare situation where a training exemption is made by the Residency Program Director, (s)he will also determine whether the resident needs to make up the attendant number of on-call nights missed during their time away from the Program.

The below cited PAIRO contract element is in agreement with the above local agreement.

"In the event that an intern or resident takes pregnancy or parental leave, subsequent to the completion of the leave she or he shall be entitled to work for the same period as the leave in order to complete her or his year of post-graduate training."

b) **Sick Time and Medical Debility Requiring Reduced Clinical Duties**

The resident who is unwell, (unless they are being mechanically ventilated in the ICU) must notify all relevant parties of their inability to come into work and make every effort to arrange coverage during their medical absence. If the resident has exhausted all coverage alternatives and has been unsuccessful in arranging for help they should contact their Chief Resident for their assistance. If their site Chief Resident is unavailable then they should be contacting one of the other Chief Residents or the respective on-call consultant.

Regarding a Resident who has had reduced clinical exposure because of:

- i) A block of time away from the program due to sick or grief leave
- or
- ii) A resident who is working reduced hours because of medical debility

The advice from the Royal College of Physicians and Surgeons of Canada (RCPSC), given to date, is that the decision is made entirely by the RPD. It is the understanding that the RCPSC's position is that the RPD must determine whether any given Resident has "met the mark". The actual number of hours, days or weeks that the Resident has spent "away" from the Program is not *in of itself* an indication of whether they have "met the mark" nor is it a determinant of the Resident's ability to sit their final examinations or graduate from the Program.

Doctor's Notes: The Program reserves the right to ask that the resident provide a physicians note after three days of medical absence from clinical duties. In cases where the resident is absent from clinical duties for medical reasons for two weeks or more, a doctor's note must be provided.

c) **Chronic Illness**

The Program realizes that from time-to-time, a Resident may have a chronic medical condition that will necessitate reduced clinical activities. It is emphasized that according to the Royal College, the standards and the level of proficiency and productivity in education, administration and clinical duties does not change for those who have a chronic illness. The Program presently requires that Residents suffering from a chronic illness provide a medical opinion indicating the nature and duration of their restricted activities. The Program will honour this medically-prescribed reduction in activities. The Program encourages those who

have restricted clinical activities/duties based on their medical debility to make every effort to try to compensate for their time away from clinical teaching and administrative duties by pursuing other options such as augmented educational and administrative activities or creative ways to assist with clinical care responsibilities.

The Program encourages those with a chronic medical debility to strongly consider applying to the Royal College to become a part time Resident. This status would automatically increase the length of the Residency Program.

The Royal College has the following to add regarding these issues:

The RCPSC policies that address part-time residency and leaves of absence are found in our Policies and Procedures for Certification and Fellowship booklet in Section IV, Part 6-7.

*Essentially, under RCPSC policy, the program director may reduce the total training time by three months for a resident who is in a 4-6 year program and by 6 weeks for those registered in a 2-3 year program. It is not a given that the applicant's time will be reduced. The applicant must still complete the minimum requirements for the specialty. The RCPSC will ask the program director if the applicant has achieved consultant competence in the specialty despite the resident's absence.
e-mail: ccote@rcpsc.edu*

5. Resident On-call:

a) JBMH Call Requirements

When there is an adequate compliment of residents the PGY-2's should do six nights a month of call at JBMH. When there is a significant shortage of housestaff at the PGY-2 level, the PGY-2 on-call requirements at JBMH can be reduced to 3 nights per month. The other three on-call shifts will be done at SJH.

b) On Call during BCT Rotation in Women's Health Concerns and Sexual Medicine

This topic has been discussed this with Dr's Saperson, Lamont and Gunasekera.

The decision was made that the Ob/Gyn BCT's should do call as per the other Psych trainees at that level of training.

Effective with the July 1, 2009 inception cohort, the total length of the WHCC/Sexual Medicine Rotation will be eight weeks. This rotation will be divided into two four-week blocks, one in the PGY-1 year and one in the PGY3-4 years. For both of these blocks the following will apply:

- i) There must be no post-call days on the days on which Dr's Lamont or Gunasekera have their WHCC or Sexual Medicine Clinics.
- ii) The Obs/Gyn residents must do 2-4 Psych calls/month

c) **MUMC BUDDY SYSTEM GUIDELINES**

The Program's position is that all residents who have not done solo on-call at MUMC as a PGY3, 4 or 5 must do three buddied calls before doing solo on-call. This pertains to residents who are just starting on the Maternal Fetal Medicine service as well.

The buddy system is intended to be used when a resident, who has not begun their MFM rotation, begins call at MUMC.

The goals of the buddy system are to:

- Assist the junior resident in becoming oriented to the facility
- Assist the junior resident with familiarization with policies and procedures specific to MUMC
- Assist the junior resident in becoming familiar with the types of and approach to, patients and their associated medical conditions common to MUMC

The "buddy" will be a senior resident or resident who has successfully completed their MFM rotation. The junior resident is required to do three buddied calls prior to doing call on their own. Prior to starting their period of "buddied" call, the junior resident(s) will arrange a meeting with the MFM resident supervisor.

During call, the "senior buddy" is expected to be present on L&D to review all transfer patients, all MFM patients and any other complicated cases. The "senior buddy" must be available to discuss calls from the ward that involve medical management issues. Of course, the staff physician on call is ultimately the most responsible and any serious concerns must be reviewed with them. Because a junior resident may not be aware of what they don't know, it is imperative that the senior resident make themselves available during the entire call period for case review rather than being available only "if needed". As well, since this type of call is supposed to be a learning experience for the junior resident, it is not appropriate to be splitting the call.

d) **On-Call Electives**

Unless negotiated otherwise with the Residency Program Director it is the Program's position that residents on an on-call elective must attend that Academic Half Day.

e) **On-call Schedules**

All changes in the on-call schedule must be forwarded to the Postgraduate Program Assistant. She will make sure that all relevant clinical care areas are aware of the call schedule change.

- e) The **PAIRO/OCATH Agreement** allows Residents to do a non-graded maximum of 7/28 calls.

At the same time, there is an agreement in place that Residents in the McMaster Obs/Gyn program should have a graded monthly system consisting of:

- PGY-5 (April, May): 2 nights, no weekends
- PGY-5 (June): 6 nights (may include weekends)
- PGY-5: 4 nights, no weekends
- PGY-4 Chiefs (April, May, June): 5 nights (may include weekends)
- PGY-4: 6 nights (2 weekend nights)
- PGY-3: 7 nights
- PGY-2: 7 nights

It was agreed on April 21, 2005 that in the event that the call schedule could not be covered adequately during April and May while the Chiefs were preparing for their exams that the PGY-4 Chiefs would fill in the uncovered nights/days to ensure that all on-call was covered.

- f) **Weekend On-Call:**

Notwithstanding 16.1(b), PAIRO agrees that when a Resident is scheduled on Friday night/Saturday morning call in conjunction with a Sunday call, only the Sunday call will be deemed to be a weekend call day. In turn, OCOTH agrees that Residents shall be free of scheduled weekend call on at least two weekends (including Friday night/Saturday morning and the rest of Saturday and Sunday) over a 28-day or monthly call period.

The parties understand and agree that the restrictions noted above do not apply when Residents switch their weekend call schedules with another resident.

- g) **Points System**

The point system is a protocol, which was devised to ensure the call was spread evenly. :

- Mon- Thurs = 1 point,
- Friday = 2 points,
- Saturday = 4 points,
- Sunday = 3 points,
- Holiday = 2 points.

Maximum points per 2-month call schedule:

- PGY 2-3=27,
- PGY 4=22,
- PGY 4 Chiefs = 15
- PGY 5=8
- PGY-5 Seniors (April and May) = point equivalent of two nights

N.B. The Urogyn Resident is considered as a PGY-4, regardless of their actual year at the time of the rotation.

- i. The point system will be used prospectively for designing the on-call schedule and for retrospectively determining Residents who must do “catch-up”. There will be no “resetting” of this system at the beginning of the academic year. When the Chief Residents publish the schedule he/she will include, in the same document, the points credited to each resident. This in turn will be reviewed after completion of the on-call block. All Residents will eventually have to make up for outstanding call nights.
- ii. Regarding scheduled absences from call (e.g. away electives, Gyn Onc, etc), the current practice, that the Resident will receive 0 points, but also that their expected number of call will be eliminated (see max points above), will be implemented. I can't make this make sense
- iii. Unscheduled absence from call due to emergencies will not be reflected in a reduction in the expected number of points.
- iv. Changes in the points will be made for call changes which were made due to an emergency absence (e.g. you were asked at the last minute to cover a call for your sick colleague). They will not be made for a switch in calls between two Residents. Caveat emptor: If you are changing call with someone to take a call of greater point value, this will not be reflected in the points.
- v. The points will be available on the computer in the resident room at McMaster under a file marked "points". Please don't make your own modifications to the file.

g) **Splitting Shifts**

It is acceptable to split weekend call shifts on occasion if both parties are in agreement and all relevant people are informed (i.e. Residency Program Assistant, paging etc). According to PAIRO guidelines, the person working the night portion of the shift must claim the call stipend. In most cases people split calls evenly, i.e. one person does the day one weekend and night the other, so this should work out fairly. Should residents decide to split call in another fashion, the person doing the night should still claim the call stipend and the two residents must work out a mutually agreeable monetary or non-monetary payback arrangement. If two residents split a call only one person may claim the call stipend. With regards to the points system, for split calls each resident will receive half the point value of that call.

h) **Christmas Call Scheduling**

Henceforth the Christmas call schedule will be made in the following fashion: (overseen by one of the Chief Residents)

1. Volunteers for Christmas Eve, Christmas Day, New Year's Eve, New Year's Day (by seniority if more than one person volunteers for a particular shift).
2. The person working Christmas Day and Christmas Eve at both MUMC and SJH the previous year will have first pick of the schedule (by seniority ie MUMC then SJH).
3. The rest of the schedule will be determined by seniority (Chief, PGY4, PGY3, PGY2).

4. If there is a disagreement, which cannot be solved amicably, the Chief Resident at SJH and MUMC will make the final decision and if necessary do the entire Christmas schedule.

5. We (residents) were encouraged (by faculty) to remember that we will have to work this issue out for the rest of our working lives and that we are actually quite fortunate to only have to cover one day of a ten day holiday!

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6. Resident Rotation Scheduling:

The Residency Program will make every attempt to provide the rotational schedule as far as possible ahead of time.

Requests for the upcoming year's rotation schedule must be submitted as early as possible. The Program will make every effort to honour the requests made. The Resident should understand that changes in the schedule will be made for the mutual benefit of all Residents. Many of these changes in the rotation schedule will be the result of negotiation. The Program may be unable to accommodate individual Resident's requests to work solo, on surgical rotations.

The RPD will support any reasonable changes to the schedule that:

- a) Are agreeable to the other residents, and
- b) Conform to all of our policies and procedures
- c) optimize the educational experience for all residents

Any changes in the schedule should be communicated to the RPD and Administrative Assistant for approval at which point the Rotational Schedule spreadsheet will be revised.

Residency Year Structures:

PGY2: 6 months Obstetrics, 6 months Gyn divided between SJH, MUMC and JBMH
PGY3: Ultrasound 1 month, Brantford Rotation 2 months
PGY3 & 4: Gyn Onc 3 months, MFM 3 months, REI 3 months, Urogyne 3 months,
Colpo/Path 3 months. Elective 6 months
PGY 5: Chief Resident (minimum of six months) Senior Resident (3 months)

For each resident rotation there will be a single faculty evaluator. This individual will be the Faculty responsible for soliciting comments from the other Faculty the residents have worked with and distilling this into a single composite evaluation.

The identified faculty individuals for each rotation are as follows:

1. PGY2 SJH — Dr. Richard Persadie
2. PGY2 MUMC — Dr. Margaret Lightheart
3. PGY2 JBMH — Dr. J. Barry Hunter
4. Maternal Fetal Medicine — Dr. Valerie Mueller
5. REI — Dr. Shilpa Amin
6. GyneOnc — Dr. John Mazurka
7. UroGyne — Dr. Richard Kalbfleisch
8. Ultrasound — Dr. Patrick Mohide
9. ColpoPath — Dr. Margaret Lightheart
10. Brantford Community — Dr. Stephen Bates

11. Chief Resident MUMC — Dr. Margaret Lighthouse
12. Chief Resident SJH — Dr. Richard Persadie

The Postgraduate Committee agreed that the sequential allotment of PGY2's should be as follows:

- SJH Obstetrics (x1)
- SJH Gynecology (x1)
- MUMC Obstetrics (x1)
- JBMH Gynecology (x1)
- SJH Obstetrics (x1)
- MUMC Gynecology (x1)
- Milton Obstetrics and Gynecology (x1)

7. Resident Research

The proposal below will be honoured:

Resident Research Methodology Proposal

- a) All Residents must complete and present at least two research projects during their five-year residency. In keeping with the APOG agreement this will be one major and another less substantial undertaking (i.e. quality assurance project) , prior to graduation. Both of these will be presented at the R.T. Weaver Scientific Day.

It was decided that henceforth residents should all have their research requirements completed before the PGY-5 year. This will obviate the stress that ensues when the Chief Resident tries to complete their research and prepare for the Royal College exams at the same time.

- b) A Resident must decide on a topic for her/his research, recruit a supervisor, perform a literature review pertaining to the topic and present their proposed research project to the residents and faculty. The once-monthly research in progress rounds overseen by Dr Sarah McDonald would be an ideal venue for this presentation. The proposal presentation should include the following: project objectives, background and rationale, hypothesis to be tested, preliminary details, methodology, anticipated results, importance of the research, and proposed timeline. At the time of the proposal presentation the faculty will evaluate the project with respect to scientific merit, feasibility, and clinical relevance. Where practical, application for external research funding (e.g. HHSC, RMA or PSI) for the project will be made.
- c) The proposal should include a project schedule including the requisite number of hours to complete the project. Once the requisite number of hours has been determined the resident and their supervisor will meet and determine the proportion of hours that will be protected time, elective time and "out of work" time. If protected time is deemed appropriate, the resident will negotiate this with the RPD and the respective rotation supervisor. Obviously protected time cannot be guaranteed for any given resident on any individual rotation. Protected time can be guaranteed during a research elective. At the March 25, 2009 Postgraduate Education meeting the residents strongly indicated that they did not support the concept of a mandatory research block.

- d) The program will provide as many resources as are available to support the Resident researcher.
- e) The Resident will meet at predetermined intervals with their supervisor and other faculty as deemed necessary, to insure that adequate progress is being made and that Resident Researchers receive a positive learning experience.
- f) The resident research supervisor and the resident researcher together will determine when the research project is complete. The research supervisor will notify the RPD and the Resident Research Director in writing that the project is ready for presentation at RT Weaver Day. The project must be presented beforehand to a reasonable-sized group amongst whom is the resident's project supervisor.
- g) Any resident that has their research accepted for publication in a peer-reviewed journal will receive \$2,000 to be used to attend an appropriate conference of their choice. This amount will be available once for each published paper. This award is in addition to the \$2000 already allotted to residents who have their research findings accepted for presentation at an appropriate academic meeting.
There is no limit on the number of research papers that a resident can receive these funds for during their residency at McMaster.

8. Attendance at Academic Half Day

The Resident Academic Half Day represents an important and vital educational venue. Both the residents and the faculty put a great amount of effort into administering and preparing these sessions. Accordingly, attendance by the residents needs to be high. Fortunately there are very few residents in the Obstetrics and Gynecology Program who have anything less than good attendance at Academic Half Day. The following methodology for the Academic Half Day was agreed upon:

In keeping with the Royal College's requirement for attendance at Academic Half Day and documentation of attendance of each resident, the Program had developed a methodology for both ascertaining attendance rates and evaluating speakers. Effective July 1, 2005 for each of the three afternoon AHD sessions each resident in attendance will fill out an evaluation sheet. The Program Assistant or designate will collect these sheets and both the evaluation and attendance for each will be collated. The programs present position is less than ideal attendance will be reflected in the resident's Web Eval evaluation in the current rotation.

The Program Assistant will provide a summary re resident attendance at the Academic Half Day to the RPD.

The "Grace Day" has been abolished. The justifications for these decisions are as follows:

- i) The Academic Half Day is the pivotal point of our academic educational program. Accordingly, this educational venue needs to be given protection and top priority. Residents who have non-academic tasks to perform should do so during quiet periods on their clinical rotations or after hours. Between post-call, off-call and lieu days there are plenty of opportunities for residents to look after their personal business.
- The only way to attract top quality faculty speakers is to make this a personally satisfying undertaking for them. To have poor resident attendance demoralizes the faculty speakers and makes them less likely to want to participate in future academic half-day sessions. Accordingly the top-notch speakers become

increasingly difficult to recruit for this function and we must then default to lower quality speakers.

- iii) The Residents and the Residency Program put a great deal of time and effort into the Academic Half Day and its' preparation. Residents need to be respectful of this fact and place the Academic Half Day very high on their priority list.

The Program realizes that from time to time residents will have illnesses or will be in the very uncommon and unlikely situation where the only time that they can look after personal business is on a Wednesday afternoon. Should either of these events come to pass, it is the Residency Program's expectation that the Resident will provide notice in advance of the upcoming Academic Half Day indicating their absence and the reasons for this. Providing pre-emptive and timely notification will be deemed an indication of the Resident's proficiency as Physician "Manager" and "Professional". It is the Program's expectation that any elective doctor/dentist/lawyer...etc. appointments would occur either on post-call days, holidays, or during negotiated time off from the clinical rotation. These engagements are not to occur on Wednesday afternoons during the AHD. Any resident who finds themselves unable to arrange a time for these commitments other than Wednesday afternoons should contact the RPD for their assistance.

As the end of your Wed morning draws near please ensure that all relevant parties know that you will not be available and then turn off your pagers and cell phones.

There are no problems with folks having their voice mail or the vibrators turned on so that at a break in the sessions you can return personal calls.

Those that know they have an upcoming once-in-a-lifetime clinical opportunity will have already let the RPD know about this and make the necessary contact arrangement so as to minimize the disruption of the AHD session. That is no beeps or bongs or clangs or favourite music clips or!!!

- a) Should any given residents' attendance be below acceptable standards, a letter will be sent to the resident and the Program Director. Should there be no adequate justification for these absences then that rotation's ITER may reflect this in the "Scholar" or "Professional" section of the Can Meds competencies.
- b) The Program's expectation that all residents attend both the Academic Half Days and all of the other protected educational venues. Attendance at educational venues is considered part of the Can Meds competency "Scholar" section.
- c) When the BCT's are faced with competing educational venues on Wed Afternoon (i.e. RT Weaver vs. BCT Half Day), they may attend our Dept activity providing that this is an infrequent event and that the BCT Program Assistant is given written notice well in advance indicating the reason for non-attendance at the BCT Half Day. They do not have to use conference leave time for attending protected Department educational sessions.
- d) **Electives without AHD**
In the exceptional circumstance where the resident is doing an on-call elective yet they are a significant distance from Hamilton and as such are absent from Academic Half Day, the resident will be required to make up an equivalent number of learning hours by doing distance education/e-learning. These situations should be few and far between.
- e)

9. Resident Evaluations

- a) All residents are responsible for meeting with the physician charged with preparing their evaluations both at mid-rotation and at the end of the rotation. At the end of rotation meeting the resident and faculty will review the WebEval ITER and it will be signed by both parties. All mid-unit evaluations, however brief, must be submitted on WebEval to the RPD.
- b) If after a concerted effort, a resident finds that faculty are unwilling or unable to meet with them for their rotation evaluations, then the resident should E-mail the RPD indicating the steps they have gone to. Failing this, the resident who fails to have a timely evaluation submitted at mid- and end- of rotation will have their CanMEDS ITER reflect this difficulty in acting as a proactive resident Manager. On March 25, 2009 the Urogyn rotation supervisor agreed to comply with the entire mid- and end- of rotation WebEval submission process.
- c) It is the Program's position that a good resident Communicator (see CanMEDS roles) will access their email (including WebEval correspondence) daily and ensure that any time-sensitive material in their MUMC mailboxes is dealt with in a timely manner. Obviously this does not apply to those who are on holidays without internet access.
- d) As with all CanMEDS roles the Resident's performance in each area will be reflected in the concurrent rotation evaluation. For example if a resident exhibits exemplary Communication skill surrounding arrangements for Journal Club while they are on the UroGyne rotation this notable performance will be noted as a special addendum to the UroGyne WebEval document. The On-Call evaluation will be maintained in a separate WebEval file and will not be attributed to the daytime rotation that the resident is on. Both residents and faculty will have access to any evaluations that they have mutually posted.

Less-Than-Satisfactory Evaluations: Based on our previous experience and the collective opinion of the Faculty educators it has been decided that all residents receiving "less than satisfactory" rotation evaluations will undertake their remedial evaluative rotation directly under the supervision of McMaster Faculty. In the case of the subspecialty rotations this will obviously be with the same Faculty who gave the original "less than satisfactory" evaluation. Unless there are exceptional circumstances, all those who obtain a less-than-satisfactory evaluation in their rotation will be expected to do the remedial rotation at McMaster University.

10. Resident Appeals

Resident appeals regarding evaluations with which they do not agree will go through the following steps:

- a) Discussion with the involved Mentor
- b) Discussion with the Ombudspersons
- c) Discussion with the Residency Program Director
- d) An Evaluations Review Board (ERB) hearing

The final agreement reached is that resident appeals should use the existing processes and forums to deal with the evaluation in question. The first step would be to discuss the, less than satisfactory evaluation with the Clinical Supervisor. Failing this, a discussion should be undertaken with the RPD. If neither of these discussions has resulted in a satisfactory resolution of the issue, then the resident has the right (and in some situations, is required by the University Guidelines) to take the issue to the ERB. At any of the three previously described steps, the resident has the option of involving the ombudspersons or a resident advocate of their choice. The Post Graduate Education Committee will not be involved in hearing Resident Appeals.

In July 2003 the Dept. formed an Evaluation Committee with the appropriate terms of reference. This group will oversee individual evaluations as well as the evaluation process in general. Effective February 2009 there is an elected resident representative on the Evaluation Committee. The Committee reviews all "less than satisfactory" evaluations and recommends to the RPD an educational plan. This is then discussed with the involved resident.

The University has subsequently developed a Postgraduate Student Evaluation Document (approved 2009) which is in alignment with that of the Obstetrics and Gynecology Department.

This document reads as follows:

UNSATISFACTORY EVALUATION AND REMEDIAL PROGRAM

1. If an unsatisfactory evaluation is given on a rotation the student should discuss it with his/her own program director as soon as possible. The Program Director will forward a copy of the evaluation to the Postgraduate Education Evaluation Review Board (ERB) and the Assistant Dean, Postgraduate Medical Education along with an outline of remediation plans.
2. If the student does not accept the unsatisfactory evaluation then the student may appeal the decision, in writing, to the Chair, ERB.
3. If the student accepts the evaluation, a remedial program will be negotiated and implemented but only upon full agreement between all parties: the student; the program director; and the director of the program providing the rotation which was deemed unsatisfactory.
 - a. If the student completes the remedial program with a satisfactory evaluation then the student will proceed in the program. The Program Director will notify the ERB.
 - b. In the instance where the student who has received an unsatisfactory evaluation undergoes remediation and receives an unsatisfactory, the student shall be considered to have two unsatisfactory evaluations.

The Postgraduate Office should be notified of all unsatisfactory evaluations - the remedial plan should be reviewed by the Board prior to implementation. A single borderline evaluation does not require ERB notification. 3 borderline evaluations in a 5 year program would constitute ERB review.

It is agreed that, all PGY2 Residents and Chief Residents working at MUMC will keep a log of the faculty with whom they had worked during the day and on-call. This list would then be submitted to the MUMC site co-coordinator who, in turn, will solicit the opinions of the respective faculties to arrive at a summative ITER for each of these residents at the mid-point and at the end of their rotation.

Remedial Rotations:

It is the Program's position that those residents that receive a less than satisfactory rotation evaluation will need to do a remedial rotation to meet the Goals and Objectives. The time allotted for the remedial rotation may be taken out of elective time or the resident will have to extend their residency program by the length of their remedial program.

11. OR Assists

When an educational event that the residents are required to attend is occurring at the same time as surgery requiring an assist, it is the surgeon's responsibility, in conjunction with the Chief Resident, to find his/her own assist.

12. SJH Handover

Monday, Tuesday, Thursday ----- 0700 hrs
Wednesday, Friday ----- 0730 hrs
Weekend ----- 0900 hrs

13. MUMC

Guidelines for Documentation and Clinical Care

All antenatal, postpartum and gynecologic patients will be rounded on daily.

Whenever a patient is seen, a note should be written.

Each note in the chart must be prefaced with date and time.

Each page in the chart must be correctly labeled with the patient's name and hospital ID number.

Transfer notes must include the referring physician's name or the name of their original caregiver clearly noted.

Antenatal pts on L&D need frequently updated progress notes. At minimum, a note should be done at the change of every shift.

As procedures are performed, or prior to discharge, the Face sheet must be completed.

In general the SOAP strategy, as outlined in the CPSO guidelines, should be used

Subjective Data

- Presenting complaint, including the severity and duration of symptoms;
- Whether this is a new concern or an ongoing/recurring problem;
- Changes in the patient's progress or health status since the last visit;
- Past medical history of the patient and his or her family, where relevant to the presenting problem;
- Salient negative responses.

Objective Data

- Relevant vital signs;
- Physical examination appropriate to the presenting complaint;
- Positive physical findings;
- Significant negative physical findings as they relate to the problem.
- Document abnormal lab results, radiology findings . . . and the actions taken

Assessment

- Patient risk factors, if appropriate;
- Ongoing/recurring health concerns, if appropriate;
- Review of medications, if appropriate;
- Review of laboratory and procedure results, if available;
- Review of consultation reports, if available;
- Diagnosis, differential diagnosis, or problem statement in order of probability and reflective of the presenting complaint.

Plan

- Discussion of treatment options;
- Tests or procedures ordered and explanation of significant complications, if relevant;
- Consultation requests including the reason for the referral, if relevant;
- New medications ordered and/or prescription repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;
- Any other patient advice or patient education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the patient including patient refusal to comply with your suggestions.

Specifics:

Antenatal pts:

- Twice weekly a more comprehensive note detailing maternal and fetal health (including date of celestone administration) should be done
- These comprehensive notes should include any plans regarding mode of delivery and plans for neonatal resuscitation as appropriate
- Any MFM discharges that are returning to their referring physician should be discharged with a brief note outlining the main issues during their stay, a plan of management and a copy of the most recent ultrasound report for the patient to take with them. As well, telephone communication with the referring physician regarding the plan is advised.
- A dictated discharge summary must also be done

Postpartum pts:

- Require a written delivery note in the progress notes as well as completion of the delivery summary
- A dictation for any operative delivery, including Cesarean sections, operative vaginal deliveries, twins, shoulder dystocia or anything else out of the ordinary
- MFM pts require a dictated discharge note
- Any MFM discharges that are returning to their referring physician should be discharged with a note outlining the main issues during their stay and a plan of management. As well, telephone communication with the referring physician regarding the plan is advised.

Gynecologic Patients:

Subjective Data:

Level of pain, adequate analgesia
Nausea, vomiting, passing flatus, bowel movement
Fever
Chest pain, palpitations, dyspnea, leg/calf pain or swelling, fatigue, lightheadedness
Incisional pain, redness or discharge
Voiding difficulties, dysuria, frequency, hematuria

Objective Data:

Vital signs
Fluid intake and output
Urine colour and volume
Chest, cardiac, and leg examination
Abdominal examination: wound colour drainage, swelling tenderness, edge approximation, mark any erythema

Documentation

A dictated note as well as a brief progress note should be written for all operative procedures
In general, unless a patient is critically ill or the patient's condition changes, one progress note per day is sufficient
Clearly mark post op day, type of surgery,
Results of investigations (return to document if not available when rounding in am)
Follow up on any test results before leaving at 5pm and document in chart
Communicate any concerns in the assessment and contact MRP
Clearly document plan, and discussion with MRP if any made
Dictate discharge summary if complicated postoperative course or in hospital more than 7 days

Morning Handovers

Teaching will occur from 0700-0730 on each weekday and this is followed by handover at 0730 hours. It was agreed that handover for residents and staff should occur at 0730 hours on weekdays and 0800 hours on weekends. The purpose of these sessions is two-fold: Firstly, to maintain excellent administrative communication so as to optimize patient quality of care, Secondly, to provide an informal educational discussion of patients in the institution.

GyneOnc Coverage:

Starting Jan 1, 2008, the Program will provide 24/7/52 coverage of the Gyn Onc service. The resident(s) from both Gyn Onc and Colpo/Path will do their call covering Gyn Onc. Any additional housestaff required will be drawn from the MUMC resident pool or the Chief at SJH.

It was agreed that the Chief Resident at the Hamilton Health Sciences Corporation would assist, to as great a degree as possible, with the provision of resident coverage for extra GyneOncology OR's at the Henderson Hospital. In return, the Chief Residents requested that the GyneOncology office give them as much advance notice as possible to make the arrangements. The most senior resident available for any given GyneOncology OR will be dispatched. Further more it was also agreed that each Colpo Path resident will provide coverage for the Gyn Onc service on a 1/3 basis. This resident will do handover with the Gyn Onc service in the afternoon prior to taking call.

14, Chief Resident

- a) It is much easier to assume the responsibilities of Chief Resident if you have had a proper orientation by a former Chief Resident. Accordingly, all outgoing Chief/Senior Residents personally must meet with incoming Chiefs to outline the Chiefs' responsibilities at both the McMaster and St. Joseph's Hospital site. This should be done well in advance of the beginning of the rotation.
- b) The Obstetrics Chief Resident at MUMC will look after high risk and interesting patients on Labour & Delivery. The PGY2s or the staff person should undertake the supervision of junior trainees in tasks such as sterile speculum examinations, vaginal checks etc.
- c) As a matter of clarification please be aware that it is the Program's expectation that all Chief Residents will ensure, oversee, and attend informal daily teaching sessions with the more junior residents, interns and clinical clerks. This is excellent preparation for the OSCEs at the Royal College examinations.
- d) **Time of Responsibility:** It is the Chief Resident who is making up the schedule for the respective months of the academic year to handle and implement all on-call and holiday requests for that period of time. That is, it is not the responsibility of the resident who is presently on the rotation to handle these requests for times in the future when they will not be the Chief resident at that site. Some of these problems will be obviated by the new Electronic Postgraduate Scheduling module that will be operational in the spring of 2009.
- e) **Obligations:** In the event that the Chief Resident is away on holidays, leave or is sick, the involved individual will make appropriate arrangements for staffing the Chief Resident Obstetrics Clinic (McMaster and SJH). Obviously the Chief Resident will be unable to cover any gynecologic OR's during their Chief Resident's Clinic. Except in extenuating situations, the Chief Resident will have no clinical responsibilities during the Academic Half Day. In the spirit of the role of the Chief Resident, it was agreed that on weekends they will round on their own patients. If they are unable to do so, they will directly contact the on-call resident to ensure that there is seamless patient care.
- f) **Evaluations:** The issue of collation of the Chief Resident's rotation evaluations at MUMC was discussed. It was agreed that all Chief Resident's summative evaluations must include an evaluation from the Chief Resident Clinic Supervisor and two other faculty., as determined by the Residency Program Assistant's review of their calendar. The site coordinator, in turn would collate these evaluations and provide a summative ITER at both mid rotation and at the end of the rotation.
- g) **Chief Resident Rotations:** In times of Chief Resident surplus, the Chief Resident would be required to do six months as Chief at the Hamilton Hospital sites. In the presence of a relative deficiency of Chief Residents, the individual Chiefs may be

required to do up to nine months of at the Hamilton Hospital sites. Our Program requires the final year Residents to do between six and nine months as Chief. In the presence of four Chiefs the, "fourth Chief" who is then allowed to do a chief rotation at an alternate site must have completed 6 months as Chief at the Hamilton Hospitals.

- g) Should there be a surplus of Chief Residents; the Chief Residents will spend 3 months at SJH and 3 months at MUMC. In the situation where there is a shortage of Chief Residents then of the 9 months of Chief residency, 3 months would be spent at SJH and 3 months at MUMC. The remaining 3 months would be spent at whichever institution was deems most appropriate. This latter issue would be determined by the RPD.
- h) It is the Program's expectation that all chief residents will ensure, oversee, and attend informal daily teaching sessions with the more junior residents, interns, clinical clerks.

It was decided to stay with the present Chief Resident assignment, which is as follows:

The Chief Residents will be seeded in the following sequence:

Chief resident #1 – MUMC

Chief Resident #2 – SJH

Chief Resident #3 – MUMC

Chief Resident #4 and thereafter – the Chief Resident surplus time will be divided as equally as possible amongst the Chief Residents to allow them to have an approximately equal amount of elective time with the overage.

The Royal College requires each Chief Resident to do six months of Chief Residency training. In the case of a "deficiency" of Chief Residents the program may require that some of the Chiefs do more than six months of Chief Residency. It is understood that this amount in excess of six months may be unequally applied to the different Chief Residents depending on the Chief Resident compliment at the time.

15. Senior Candidate Resident Rotation (April/May)

Clearly the over riding imperative is to provide optimum preparation for the Chief Residents writing the Royal College Examination. Prior to the examination, in the months of April and May, the senior candidate resident will attend one half -day clinic of their choice and may either assume full on-site duty for one day per week or, if feasible, attend two further half day clinics. One of the clinics could be the Chief Resident's clinic and the other would be a clinic of the individual Resident's choice. This clinic attendance would need to be pre-approved with the staff person overseeing that particular clinic. The Residents' plan for the upcoming April / May pre-exam rotation must be submitted to the Residency Program Director before the rotation begins.

16. Expectations of Residents who have successfully completed the Royal College Exams (June)

After the examination the Senior Candidate Residents will undertake full on-site clinical responsibilities.

Appropriate Wednesday afternoon activities:

- a) attendance at the academic half day
- b) pre-arranged formal teaching session with junior trainees
- c) pre-arranged procedure (i.e. LAVH)

d) pre-arranged personal educational activity

It is the program's expectation that the Senior Candidate Residents who are engaging in these activities will let the Program Director know in advance which of these options they have chosen

At times other than Wed afternoon it is the Program's expectation that these Senior Candidate Residents will fully participate in all of the expected teaching, clinical and administrative functions.

17. MUMC / SJH Daytime Housestaff list

The Residency Program Assistant will be responsible for the drafting and circulation of this document.

18. Journal Clubs

There will be a total of four Gala Journal Clubs held on a quarterly basis. These will alternate between MUMC (evening sessions) and SJH (noon hour sessions). A maximum of three papers will be presented per session. The Residents are responsible for arranging the presenters. Obviously, those unable to present will arrange an alternative well in advance of the actual day.

19. Practice OCSE's

These will be held on a quarterly basis at MUMC. The Residency Program Assistant will be coordinating all aspects of the practice OSCE's. The senior residents may wish to organize additional practice OSCEs in preparation for examination.

20. Resident Files

Residents have full access to their resident file. All of the resident files are kept in a locked filing cabinet in the RPD's office. Residents wishing to review their files must book a time in advance with the Program Assistant. At this pre-booked time the resident may view their file under the supervision of the Program Assistant. At no time must the file be taken by the resident from the room. The Program Assistant will be happy to photocopy any documents from the file that the resident wishes.

The Program will make every effort to inform the Resident within an appropriate period of time regarding the receipt of any new resident file documents

Our position on this issue is entirely consistent with that of the Royal College as follows:
(The term applicant is used instead of resident)

"Dear Doctor Bates;

Currently in our policies and procedures booklet, there is a policy that states, Section II, Part 2.5,

"All documents and information obtained in the course of an assessment of training become and remain the confidential property of the Royal College. No such information or documents shall be available or disclosed to applicants."

Due to the new legislation, the RCPSC must change this policy. Applicants

will now have the right to see any personal documentation in their file.

Should you wish to discuss any of the following RCPSC policies, please do not hesitate to contact me at 1-800-668-3740, ext 203.

Sincerely,

*Connie Côté
Manager, Credentials Unit
Office of Education
The Royal College of Physicians and Surgeons of Canada
774 Promenade Echo Drive
Ottawa ON K1S 5N8
Tel: 613-730-8191 ext 407
Fax: 613-730-3707”*

21. REI Surgical Rotation

The group decided that the Chief Resident would review the weekly OR list. Any infertility surgery will be assigned to the REI resident.

22. Colpo/Path Rotation.

The Colposcopy/Pathology is presently a mandatory rotation in our Program.

In the new Objectives of Training that start with the 2009 inception cohort the Specialty Committee of the Royal College has indicated:

*“A **working level** of knowledge is required for the following:*

2.1.25. Gynecologic Oncology

Principles of colposcopy, including its limitations and the indications for referral for colposcopic assessment Principles and complications “

*The definition of “working level” is as follows; “A **working level** indicates a level of knowledge sufficient for the clinical management of a condition, and/or an understanding of an approach or technique sufficient to counsel and recommend it, without having personally achieved mastery of that approach or technique. “*

Dr. Bates indicated that the Colpo-Pathology rotation may be divided in to a maximum of two segments, any which of which must be a minimum of one month in length. The resident is responsible for recording their activities in the Colposcopy clinic. The Program can only support a resident (following graduation) doing independent Colposcopy if they have satisfactorily completed this three month rotation. In addition it is required that the resident has satisfactorily performed at least 25 repeats and 75 new patient colposcopies during their training. Please see attached SCC Guidelines.

Dr. Bates indicated that the Program expects the Colpo Path resident to fully participate in the Pathology component of this rotation as outlined by Dr. Daya. It is the resident’s responsibility to meet with Dr. Daya on the first day of the rotation to review the goals and objectives and learning expectations of the trainee.

23. Procedural Logging

All residents in the Program are expected to log all their procedures. To access the procedural logging module within WebEval please follow these steps.

1) After entering your username and password for WebEval

<https://pgwebeval.medportal.ca/app/index.php>

you will be in the home screen.

2) Click on the "Forms" tab at the top of the page

3) Click on the " Logs " link on the left hand side of the screen

4) Click on "ObGyn Procedure Log" and then the "view" link.

The PGY-1's in our Program should try to log all Obs/Gyn procedures in which they had a substantive role.

24. Educational Resources . Over the past few years the faculty have requested funding for educational resources that are kept "on-site". After some discussion it was decided that all "walking" learning resources, be they text or CDs, must be kept in the Resident Library in Lynn's office. In turn, the residents may sign these out and take them to whichever site they wish. If the Faculty wish to fund their own on-site learning resource for the residents then the Program will be very supportive.

25. Abortion Services

The Program respects the personal views of residents with regards to the various moral, ethical and religious issues that arise. In the residency program, we respect residents' views and preferences on the subject of abortion. Residents who are not willing to be agents of abortion will not be expected to be involved in the performance of abortion. We do expect our residents to participate in the supportive care of such patients, when needed, and to deal with complications and consequences such as bleeding and infection.