Welcome to the Women’s Care clerkship! We are pleased to have you join us for 6 exciting weeks.

The block starts with a two-day introduction to Obstetrics & Gynecology. The first hour is the overall orientation to the clerkship where we will review expectations, policies, grading and tips for success. You will receive a specific site orientation during these two days or at your site once you start clinical work. The remainder of the introduction time will be used to provide interactive presentations on core Ob/Gyn topics and simulation exercises at the CAPE.

At all Women’s Care sites (University, Denver Health, St Joe’s and AHEC locations), your clinical experience includes outpatient clinic, inpatient floor work, OR time, consultation services, and night work. The nights experience may include time on Labor and Delivery, cross-coverage of Ob/Gyn inpatients, OR time and consultation services. The variety of settings will provide many unique clinical and educational opportunities.

During the clerkship, you may work with a number of providers. These providers include, but are not limited to: attending physicians, interns, resident physicians, nurse practitioners and certified nurse midwives. This diversity will further increase the depth of your clinical experience and learning opportunities.

There will be a midpoint session at the University. At this time, everyone will participate in small-group ethics discussions and suture simulation. A few additional lectures may be provided as well. At the end of the block, we will administer a NBME shelf examination.

We hope that you enjoy your Women’s Care clerkship. Please do not hesitate to contact us with any questions or concerns. Good luck and have fun!
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Curriculum & Course Overview

The following information provides an overview of the 2016 - 2017 Academic year for the Women’s Care Clerkship Curriculum. All course information will be found on the Women’s Care Clerkship Canvas site. The Canvas site includes the learning materials and requirements.

**Note:** The sole purpose of this document is to provide an OVERVIEW of the Women’s Care Clerkship. Specific course and curriculum requirements are housed on the Women’s Care Clerkship Canvas pages, which supersedes any and all information included in this document.

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Disclaimer:

This handbook/syllabus does not constitute a contract, either expressed or implied, with the University of Colorado School of Medicine and the University reserves the right at any time to change, delete or add to any of the provisions at its sole discretion. Furthermore, the provisions of this document are designed by the University to serve as guidelines rather than absolute rules, and exceptions may be made on the basis of particular circumstances.
## Women’s Care Faculty & Staff Contact Information

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Contact Phone/Email Address</th>
</tr>
</thead>
</table>
| Kristina Tocce, MD, MPH Clerkship Co-Director | Phone #: 303-724-2027  
Pager #: 303-266-1102  
E-mail: kristina.tocce@ucdenver.edu |
| Jane Limmer, MD Clerkship Co-Director | Phone #: 303-724-2019  
Pager #: 303-266-4699  
E-mail: jane.limmer@ucdenver.edu |
| Lindy Vanlandingham, MD Education Resident | Pager #: 303-266-4459  
E-mail: lindy.vanlandingham@ucdenver.edu |
| Amy Nacht, CNM, MSN, MPH Certified Nurse Midwife Liaison | Phone #: 303-848-1060  
Pager #: 303-266-0852  
E-mail: amy.nacht@ucdenver.edu |
| Deborah Jackson, MS Ed. Clerkship Coordinator | Phone #: 303-724-2031  
Fax #: 303-724-2056  
E-mail: deborah.jackson@ucdenver.edu |

## Women’s Care Clerkship Partnership Contact Information

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Contact Phone/Email Address</th>
</tr>
</thead>
</table>
| Denver Health                         | 790 Delaware Street, Pavilion C, Unit 10  
Denver, CO 80204                              |
| Jennifer Hyer, MD Clerkship Site Director | Phone #: 303-602-9725  
E-mail: jennifer.hyer@dhha.org |
| Lorrie Quintana Medical Student Coordinator | Phone #: 303-602-9728  
Fax #: 303-602-9734  
E-mail: lorrie.quintana@dhha.org |
| St. Joseph Hospital                   | 1960 Ogden Street, Suite 360  
Denver, CO 80218                              |
| Karin Wollschaeger, MD Medical Student Program Director | Phone #: 303-318-3269  
E-mail: karin.wollschaeger@sclhs.net |
| Elaine Landry, MD Medical Student Program Director | Phone #: 303-318-3262  
E-mail: elaine.landry@sclhs.net |
| Lori Walton Ob|Gyn Program Administrator          | Phone #: 303-318-3270  
E-mail: lori.walton@sclhs.net |
# Course Objectives

**PATIENT CARE:** The application of medical and biopsychosocial knowledge and skills to deliver safe and effective patient-centered care in the diagnosis, management and prevention of common health problems

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL SKILLS AND REASONING Historical Data Gathering</strong></td>
<td>Direct Observation</td>
</tr>
<tr>
<td>• Obtain accurate history from patient using a systems based approach</td>
<td>H &amp; P Assignments</td>
</tr>
<tr>
<td>• Seek and obtain additional information from secondary sources (ex. family, medical record, pharmacy) when the patient presents and throughout the duration of their care episode</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><strong>Physical Exam</strong></td>
<td>Direct Observation</td>
</tr>
<tr>
<td>• Perform an accurate comprehensive or focused physical exam on an obstetric and gynecologic patient minimizing their physical discomfort</td>
<td>H &amp; P Assignments</td>
</tr>
<tr>
<td>• Perform supervised pelvic and breast exams</td>
<td>Written Examination</td>
</tr>
<tr>
<td>• Recognize normal and abnormal findings</td>
<td></td>
</tr>
<tr>
<td>• Accurately track changes in the physical exam over time in at least one inpatient</td>
<td></td>
</tr>
<tr>
<td>• Perform both basic and advanced PE techniques as dictated by the chief complaint and patient’s presentation</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>Direct Observation</td>
</tr>
<tr>
<td>• Synthesize data, including history, physical examination, and laboratory and radiologic data to identify and prioritize the patient’s problems.</td>
<td></td>
</tr>
<tr>
<td>• Develop prioritized differential diagnoses for the following common clinical conditions in obstetrics and gynecology <em>See list of common clinical conditions</em></td>
<td></td>
</tr>
<tr>
<td>• Develop initial and long-term diagnostic and therapeutic management plans with the assistance of senior team members. (including patient education, prevention and health maintenance)</td>
<td></td>
</tr>
<tr>
<td><strong>DELIVERY OF PATIENT CENTERED CARE</strong></td>
<td>Direct Observation</td>
</tr>
<tr>
<td><strong>Patient Management</strong></td>
<td></td>
</tr>
<tr>
<td>• Recognize differences in clinical care in the context of patient’s preferences and overall health</td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT-CENTERED CLINICAL SKILLS AND REASONING</strong></td>
<td>Direct Observation</td>
</tr>
<tr>
<td>• Gather data that defines both the disease and the illness experience (patient perspective, expectations and the illness’ effect on their functioning)</td>
<td></td>
</tr>
<tr>
<td>• Develop diagnostic and management plans to find common ground in identifying problems, goals and roles</td>
<td></td>
</tr>
</tbody>
</table>
### MEDICAL KNOWLEDGE: An understanding of the anatomy, pathophysiology, presenting manifestations, evaluation and management of common medical issues encountered

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Assessment Methods</th>
</tr>
</thead>
</table>
| Core knowledge of obstetrics and gynecology with focus on the inpatient and ambulatory setting  
  • Demonstrates knowledge of core clinical conditions  
    *See list of common clinical conditions* | Written Examination  
    Direct Observation  
    H & P Assignments |
| Common modalities used in the practice of obstetrics and gynecology in the inpatient and ambulatory setting  
  • Demonstrates knowledge of and indications for and interpretation of basic clinical tests, procedures and imaging commonly encountered in the inpatient and ambulatory setting.  
    *see list of common procedures* | |

### PRACTICE BASED LEARNING AND IMPROVEMENT: The ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence and improve the practice of medicine and individual performance

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Assessment Methods</th>
</tr>
</thead>
</table>
| LEARNING AND IMPROVEMENT BY ANSWERING CLINICAL QUESTIONS BASED ON PATIENT CARE SCENARIOS  
  Locate, evaluate, and assimilate scientific evidence related to patient’s health care problems. | Direct Observation  
    H & P Assignments |
| Ask answerable questions for emerging information needs  
  • Identify clinical questions as they arise in patient care activities | |
| Acquire best evidence  
  • Access medical information resources to answer clinical questions.  
  • Effectively search evidence based medicine resources to obtain original primary literature | |
| Applies the evidence to decision making for individual patients  
  • With assistance, determines if evidence can be generalizable to individual patients | |
| LEARNING AND IMPROVING VIA FEEDBACK  
  With assistance, identify strengths and limits in one’s knowledge and performance. Set learning and improvement goals. | Mid-Point Review  
    Feedback with clinical preceptors and clerkship director  
    Direct Observation |
| Improves via feedback  
  • Respond productively to feedback from all members of the team  
  • Seek, with prompting, feedback from faculty and residents | |
| Improves via self-reflection  
  • With assistance, reflect on feedback to develop plans for improvement | |
**INTERPERSONAL AND COMMUNICATION SKILLS**: Use of effective listening, verbal, non-verbal and written communication skills with patients, families and all members of the healthcare team to provide patient-centered care

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENTS AND FAMILY</strong></td>
<td></td>
</tr>
<tr>
<td>Communicate effectively with patients and families, across a broad range of cultural, literacy and socioeconomic backgrounds.</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><strong>Communicate Effectively</strong></td>
<td></td>
</tr>
<tr>
<td>• Timely and effective written and verbal communication to pts</td>
<td></td>
</tr>
<tr>
<td>• Use verbal and non-verbal skills to establish rapport with pts/families</td>
<td></td>
</tr>
<tr>
<td><strong>Intercultural Sensitivity</strong></td>
<td></td>
</tr>
<tr>
<td>• Effectively use an interpreter during appropriate patient care scenarios.</td>
<td></td>
</tr>
<tr>
<td>• Demonstrate sensitivity to pts including but not limited to differences in race, gender, sexual orientation, and literacy.</td>
<td></td>
</tr>
<tr>
<td>• Actively seek to understand patient differences and patient perspective</td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS</strong></td>
<td></td>
</tr>
<tr>
<td>• Accurately communicate data orally or in writing to other physicians or health care providers</td>
<td>Direct Observation, H &amp; P Assignments</td>
</tr>
<tr>
<td>• Work effectively as a member of the health care team</td>
<td></td>
</tr>
<tr>
<td>• Communicate effectively with outside physicians and other health care workers</td>
<td></td>
</tr>
<tr>
<td><strong>TRANSITIONS</strong></td>
<td></td>
</tr>
<tr>
<td>• Effectively communicate with other health care providers at the time of transitions</td>
<td></td>
</tr>
<tr>
<td>• Understand “4 Pillars” of effective transitions</td>
<td></td>
</tr>
</tbody>
</table>
**PROFESSIONALISM: A commitment to the highest standards of competence, ethics, integrity and accountability to patients, families, all members of the healthcare system and the profession at large**

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICIANSHIP</strong></td>
<td></td>
</tr>
<tr>
<td>Demonstrate compassion, integrity, and respect for others. Responsiveness to patient needs. Accountability to course requirements.</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td></td>
</tr>
<tr>
<td>‟ Document truthfully</td>
<td>Ethics Curriculum</td>
</tr>
<tr>
<td><strong>Demonstrate Compassion and Respect to Pts</strong></td>
<td>H &amp; P Assignments</td>
</tr>
<tr>
<td>‟ Demonstrate compassion and empathy to all patients</td>
<td></td>
</tr>
<tr>
<td><strong>Demonstrate Personal Accountability</strong></td>
<td></td>
</tr>
<tr>
<td>‟ Dress and behave appropriately</td>
<td></td>
</tr>
<tr>
<td>‟ Timeliness in clinical and project work</td>
<td></td>
</tr>
<tr>
<td><strong>Understand and Begin and Demonstrate Individual Patient Advocacy</strong></td>
<td></td>
</tr>
<tr>
<td>‟ Explore when it is necessary to advocate for individual patient needs</td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT-CENTEREDNESS</strong></td>
<td></td>
</tr>
<tr>
<td>Respect for patient privacy and autonomy. Sensitivity and responsiveness to diverse patient population (gender, age, culture, race, religion, disabilities, sexual orientation, etc.).</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><strong>Respect patient dignity, culture, beliefs, values and opinions</strong></td>
<td>Ethics Curriculum</td>
</tr>
<tr>
<td>‟ Treat patients with dignity and respect</td>
<td></td>
</tr>
<tr>
<td>‟ Maintain confidentiality, privacy</td>
<td></td>
</tr>
</tbody>
</table>
**SYSTEMS BASED PRACTICE:** The ability to work effectively within the local and broader context of the healthcare system to advocate for and provide quality patient care

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Assessment Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WORKS EFFECTIVELY WITH OTHER CARE PROVIDERS COMMONLY ENCOUNTERED IN THE HOSPITALIZED AND AMBULATORY SETTING</strong></td>
<td><strong>Direct Observation</strong></td>
</tr>
<tr>
<td>Understands multiple aspects of patient care in the hospital and clinic in the obstetrics and gynecology patient</td>
<td></td>
</tr>
<tr>
<td><strong>Works effectively within multi-disciplinary health care team</strong></td>
<td></td>
</tr>
<tr>
<td>• Understands unique roles of other providers within the obstetrics and gynecology system including but not limited to: physical and occupational therapists, social workers, case managers, and nurses</td>
<td></td>
</tr>
<tr>
<td><strong>Acknowledges multiple forces that impact the cost of health care</strong></td>
<td></td>
</tr>
<tr>
<td>• Reflect on physicians’ impact on the cost of individual care within the hospitalized setting</td>
<td></td>
</tr>
<tr>
<td><strong>IMPROVING HEALTH CARE DELIVERY</strong></td>
<td><strong>Direct Observation</strong></td>
</tr>
<tr>
<td>Coordinate patient care within the health care system, relevant to care and transitions around the hospital. Understands complexity of patient care. Advocate for quality patient care and optimal patient care systems to improve community health</td>
<td></td>
</tr>
<tr>
<td><strong>Works effectively within multiple health care delivery systems.</strong></td>
<td><strong>H&amp;P Assignments</strong></td>
</tr>
<tr>
<td>• Explore care transitions across multiple delivery settings</td>
<td></td>
</tr>
<tr>
<td>• Aware of other health care providers within system</td>
<td></td>
</tr>
<tr>
<td>• Understands unique roles of other providers within the care system</td>
<td></td>
</tr>
<tr>
<td><strong>Recognizes system error and opportunities for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Recognize health care forces that increase the risk for error including barriers to optimal patient care</td>
<td></td>
</tr>
<tr>
<td>• With guidance, reflect upon incidents such as near misses and preventable medical errors</td>
<td></td>
</tr>
</tbody>
</table>
Common Clinical Conditions and Procedures

**List of common clinical conditions:**
- 3rd trimester bleeding
- abnormal uterine bleeding
- amenorrhea
- cervical neoplasia and carcinoma
- chronic pelvic pain
- dysmenorrhea
- early pregnancy failure
- ectopic pregnancy
- endometrial hyperplasia and cancer
- endometriosis
- gestational diabetes
- gestational trophoblastic disease
- hypertension in pregnancy
- infertility
- isoimmunization
- labor dystocia
- menopause
- normal labor
- ovarian and adnexal disease
- pelvic organ prolapse
- polycystic ovarian syndrome
- post term pregnancy
- postpartum hemorrhage
- postpartum infection
- premature rupture of membranes
- premenstrual syndrome/premenstrual dysphoric disorder
- preterm labor
- sexually transmitted infections
- undesired fertility
- unintended pregnancy
- urinary incontinence
- urinary tract infections
- uterine leiomyoma
- vulvar and vaginal disease and neoplasia

**List of common procedures:**
- abortion
- antepartum and intrapartum fetal surveillance
- antepartum care
- breast and pelvic exam; Pap smear
- cesarean section
- contraception counseling
- endometrial biopsy
- genetic screening
- hysterectomy; oophorectomy
- hysteroscopy; laparoscopy; cystoscopy
- induction of labor
- IUD insertion; contraceptive implant insertion
- normal vaginal delivery;
- preoperative vaginal delivery
- postpartum care
- sterilization
- transabdominal and transvaginal ultrasound
Accommodations

To ensure disability-related concerns are properly addressed, students with disabilities who require assistance to participate in this class should contact:

Office of Disability Resources and Services
Building 500, room Q20-EG305
13001 E 17th Place
Aurora, CO 80045
303-724-5640

“Any students with disabilities or other special needs, who need special accommodations in this course, are invited to share these concerns or requests with the instructor and contact the Disability Services Office (http://www.ucdenver.edu/student-services/resources/disability-resources-services/Pages/disability-resources-services.aspx) as soon as possible.”

Security, Student Safety, and Disaster Preparedness

Institutional emergency and disaster preparedness policies and plan are outlined in the “Emergency-Preparedness Quick-Reference Guide” for the Anschutz Medical Campus. The link is published in the Clinical Block Syllabus, posted on Canvas http://ucdenver.canvas.com, and located next to emergency phones (e.g., ED1 and 2) as well as many of the student lounge areas, small group rooms, and lecture halls. Colorado Springs Branch students located have similar policies and procedures provided by the branch.

Medical Student Policies and Procedures Manual “White Book” (http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/studentresources/Documents/StudentHandbook.pdf) publishes emergency information (section 4.1), “In an emergency, both the Office of Student Life (303-724-6407) and the Registrar’s Office (303-724-8053) will make reasonable efforts to contact a student or a student’s designated emergency contact.”

Emergency information is also found on the Student Life web site: http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/emergencies/Pages/Emergencies.aspx

Security, student safety, and disaster preparedness as well as relevant contact information for all core clinical sites will be provided to students at individual clerkship orientations and on the Canvas Phase III course location.
Recommended Resources

uWise Question Banks:
The Association of Professors of Gynecology and Obstetrics (APGO) is a non-profit membership-based organization that promotes excellence in women’s health care by providing optimal resources and support for education.

The APGO Undergraduate Web-Based Interactive Self-Evaluation (uWise) exams was developed to help medical students acquire the necessary basic knowledge in Obstetrics and Gynecology regardless of the future medical specialty choice.

To access uWise visit: www.apgo.org
- Click: Student & Resident Resources. (on left side)
- Click: uWISE v. 2- Then click: "Create an account"
- Use your University email address to create a new account.

There are additional resources for students on the APGO website. To access these click on the section "Student and Resident Resources".

There are also additional resources for students on the APGO website. To access these, click on the section “FOR MEDICAL STUDENTS”.

Recommended Textbooks for General Reading & Reviewing (Cramming)


Blueprints Obstetrics and Gynecology (2008) Tamara L Callahan, Aaron B Caughey
Direct Observation & Mid-Point Review Feedback Forms

Direct Observation Form

- Students are required to have one direct observation form completed per week by a supervising physician.
- Completion of at least (6) direct feedback forms required for final grade in each block

Mid-Point Review Form

- All students are required to have a mid-clerkship review with the medical student clerkship director or preceptor at their assigned site.
- Students are required to fill out the front page of midpoint feedback form with supervising physician.
- Bring midpoint review form, completed Direct Observation forms and a copy of your logger, to the midpoint review meeting.
- Complete the Student Self-Assessment portion prior to your mid-clerkship review.

Mid-Point Review

All students are required to have a mid-clerkship review with the medical student clerkship director or preceptor at their assigned site. This should take place after week 3 of the Women’s Care clerkship. 
(Please let us know if you don’t get a midpoint review from your preceptor)

Bring midpoint review form, completed Direct Observation forms and a copy of your logger, to the midpoint review meeting.

Complete the Student Self-Assessment portion prior to your mid-clerkship review.

The Midpoint and Final Activity Logger Report must be handed in at the final examination session. It must be signed by your preceptor. On the following page is a sample form of the Mid-Point review form.
WOMEN’S CARE BLOCK
University of Colorado Denver School of Medicine
Clerkship Mid-Point Feedback Form

Student’s Name: ____________________  Supervisor’s Name: ____________________

Date: ____________________  Supervisor’s Signature: ____________________

Supervisor and student should complete this front page prior to the mid-point feedback session.

Description of RIME roles for student and supervisor reference. PLEASE NOTE: The purpose of mid-point feedback is to give a student an understanding as to the perceived trajectory of their progress as they engage in a clinical block. The feedback given should not be translated into an assumption of a similar final assessment by either the faculty or the student.

Novice Reporter

- Gathers patient information reliably
- Documents and present organized and accurate data
- Communicates honestly and accurately
- Conscientious, positive attitude
- Reports truthfully, is trustworthy
- Employs humanism, compassion, empathy, integrity and respect

Novice Interpreter

- Applies knowledge and synthesizes data
- Develops reasonable differential diagnoses
- Prioritizes differential diagnoses appropriately
- Prioritizes patient problems appropriately
- Presents data and interpretations clearly
- Asks questions about meaning of data

Novice Manager

- Builds trust and negotiates with patients and families
- Offers reasonable diagnostic and treatment plans
- Incorporates patient context and preferences in plans
- Takes ownership of patient care
- Suggests appropriate referrals consults
- Arranges coordination of care
- Advocates for patients and populations
- Organized-strong time management skills
- Discerns limits and appropriate roles
- Demonstrates duty, accountability
- Handles ambiguity/uncertainty well
- Responsiveness to patients supersedes self-interest
- Consistently takes responsibility for self-education

Student Self-Assessment:

Overall, I feel that I am currently performing at the level of a (circle one):

Novice Reporter  Reporter  Novice Interpreter  Interpreter  Novice Manager  Manager

In order to progress to the next stage, I think I can:

Supervisor Mid-Point Feedback

Overall, I feel that this student is currently performing at the level of a (circle one):

Novice Reporter  Reporter  Novice Interpreter  Interpreter  Novice Manager  Manager

Student Documented Reflection:

Please provide a brief summary of your feedback conversation, including areas of strength and areas for improvement:

Figure 1 - Example of Midpoint Feedback Page 1 of 2 Only
WOMEN’S CARE CLERKSHIP
University of Colorado Denver School of Medicine
Direct Observation Form

OBSERVATION OF ______________________________

Student’s Name: ____________________________  Supervisor’s Name: ____________________________

Date: ____________________________  Supervisor’s Signature: ____________________________

Guidelines for feedback and suggestions for what to observe are on the back of this form.

This form provides formative feedback to the student and is not used for the Dean’s Letter or to determine grades.

#1 Skill/Activity Observed:
Please describe what you observed the student do, noting the setting or other relevant details.

#2 Feedback:
In your own words, describe specific examples of what this student did well.

Based on this observation, what actions/changes can the student make to improve their performance?
Guiding Principles for Feedback

- This form provides formative feedback to the student and is not used for the Dean's Letter or to determine grades.
- Observations can be short (1-5 minutes)
- Students may scribe the feedback conversation as long as the supervisor reviews and signs this form.
- Effective feedback is specific and timely (i.e., immediately follows observation). Examples:
  - What did the student do well?
    - Labs and vital signs were reported accurately
    - Stayed calm and followed instructions well while suturing in OR
    - Proposed reasonable differential of at least three possible explanations for the patient's lower extremity edema
  - What actions/changes can the student make to improve?
    - Review normal blood pressure ranges for adult patients so that you can clearly state in your assessment if the patient's blood pressure is normal or not.
    - Practice developing a summative assessment statement in your assessment. This statement should inform the team of whether the patient is worse/better/the same.
    - When describing the patient's problems, prioritize them in terms of importance to the patient's care.
- Incorporate comments about the student's professionalism in your feedback
  - Aspects of professionalism are incorporated in the description of RIME roles described at the bottom of this form.
  - Link adjectives such as reliable, accurate, compassionate, responsive or accountable to something you saw the student do.
- Examples of generic and non-effective feedback:
  - Read more
  - Nice job, will make a great physician
  - Meets expectations for their level

The RIME framework provides a holistic vocabulary for the progression of students and can be used to guide observations and feedback.

<table>
<thead>
<tr>
<th>Novice Reporter</th>
<th>Novice Interpreter</th>
<th>Novice Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td>Examples:</td>
<td>Examples:</td>
</tr>
<tr>
<td>Gathers patient</td>
<td>Applies knowledge</td>
<td>Builds trust</td>
</tr>
<tr>
<td>information reliably</td>
<td>and synthesizes data</td>
<td>and negotiates with patients and families</td>
</tr>
<tr>
<td>Documents and presents organized and accurate data</td>
<td>Develops reasonable differential diagnoses</td>
<td>Offers reasonable diagnostic and treatment plans</td>
</tr>
<tr>
<td>Communicates honestly and accurately</td>
<td>Prioritizes differential diagnoses appropriately</td>
<td>Incorporates patient context and preferences in plans</td>
</tr>
<tr>
<td>Conscientious, positive attitude</td>
<td>Prioritizes patient problems appropriately</td>
<td>Takes ownership of patient care</td>
</tr>
<tr>
<td>Reports truthfully, is trustworthy</td>
<td>Presents data and interpretations clearly</td>
<td>Suggests appropriate referrals/consults</td>
</tr>
<tr>
<td>Employs humanism, compassion, empathy, integrity, and respect</td>
<td>Asks questions about meaning of data</td>
<td>Arranges coordination of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocates for patients and populations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organized, strong time management skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discerns limits and appropriate roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrates duty, accountability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Handles ambiguity/uncertainty well</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Responsiveness to patients supersedes self-interest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consistently takes responsibility for self-education</td>
</tr>
</tbody>
</table>

Figure 3 - Example of Direct Observation Form
Shelf Exam

The Women’s Care Clerkship uses the National Board of Medical Examiners (NBME) for the final Shelf Exam. The exam will take place on the last Friday of the clerkship. Students are allotted 2 hours and 45 minutes to complete the 110 question exam.

Evaluations and Grading

All Clinical Block Directors follow the University Of Colorado School Of Medicine Phase III Student Assessment Policy.

Grades are determined by Block Directors and Grading Committees based on written evaluations of your clinical performance, conversations with supervising physicians, examining scores, project work, direct observation form completions, and professionalism.

All Clinical Block Directors will complete a Final Course Evaluation Report that will include a clinical grade, exam and project scores, RIME scale performance, final grade and a composite of the written comments*. * Positions of evaluators (i.e. resident, faculty). All Clinical Block Coordinators will post the Final Course Evaluation Report to your Canvas account and send to the Office of Student Life via email within 4 weeks of the completion of the block. The following grades can be achieved: Honors (H), High Pass (HP), Pass (P), Fail (F), Interim Pass (IP), Incomplete (I), and Pass with Remediation (PR).

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honors (H)</td>
<td>Student demonstrates advanced level of performance/competency in course requirements.</td>
</tr>
<tr>
<td>High Pass (HP)</td>
<td>Student demonstrates above expected level of performance/competency in course requirements.</td>
</tr>
<tr>
<td>Pass (P)</td>
<td>Student demonstrates expected level of performance/competency in course requirements.</td>
</tr>
<tr>
<td>Fail (F)</td>
<td>Student does not demonstrate expected level of performance/competency in course requirements.</td>
</tr>
<tr>
<td>Pass w/ remediation (PR)</td>
<td>Student demonstrates expected performance/competency in the course requirements after remediation.</td>
</tr>
<tr>
<td>In Progress (IP)</td>
<td>Student is unable to complete requirements for a block due to illness or extenuating experiences.</td>
</tr>
<tr>
<td>Incomplete (I)</td>
<td>Student is unable to completed requirements with a less than passing grade at the completion of the block.</td>
</tr>
<tr>
<td>Withdrawal (W)</td>
<td>Student is unable to complete the block before being assigned a final grade and requires approval from Course Director and Assistant or Associate Dean.</td>
</tr>
</tbody>
</table>

All grades remain permanently on your transcript except IP and I, which are replaced with the appropriate grade after you have completed the course. The grade is composed of the following:

There are 2 major components to the final clerkship grade: Clinical and Cognitive Assessments. The Clinical Grade is determined by a grading committee’s review of Clinical Evaluations.

The Cognitive Grade consists of the following: Shelf Exam Score, Ob H&P, Gyn H&P, and Ethics Curriculum.
Final Clerkship Grades are NORMATIVE. Students must achieve a clinical grade of Honors to qualify for a final grade of Honors. Students must achieve a clinical grade of High Pass to qualify for a final grade of High Pass. Cognitive grades will be calculated including the parameters outlined above. The clinical and cognitive grades will then be combined for the final grade; up to 20% of the students will receive a final grade of Honors and up to 20% will receive a final grade of High Pass.

At the end of the academic year, all grades will be reviewed and some students may be increased to Honors or High Pass to a maximum of 30% in each category, but the total combined assignment of Honors and High Pass cannot exceed 50%.

ALL COMPONENTS of the clerkship must be successfully completed to achieve a passing final clerkship grade.

Details of the grading plan are outlined below:

1. **Clinical Assessment**
   The number of clinical evaluations obtained will vary by site.
   I. University – Two evaluations will be completed at the end of each week (or two weeks) spent on a specific service. An attending or fellow will complete the “Attending” evaluation. The senior resident will complete the “Resident” evaluation after collecting input from the other residents on the team. Evaluations will be weighted by time spent on the service. The final number of evaluations may vary between students.

   II. Denver Health – The clinical score will be determined by a comprehensive faculty evaluation (50%) and resident evaluations (50%). The resident evaluations will be completed at the end of each week that the student is on service; the most senior resident of the service will be responsible for completing this evaluation with input from the other members of the resident team. The final number of resident evaluations may vary between students.

   III. St. Joseph Hospital - The site director will collect evaluations from appropriate residents and Attendings for each student. At the end of the rotation, these evaluations will be

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Grade</td>
<td>65%</td>
</tr>
<tr>
<td>Cognitive Component</td>
<td>35%</td>
</tr>
<tr>
<td>Final NBME Shelf Exam</td>
<td></td>
</tr>
<tr>
<td>Gyn H&amp;P</td>
<td>5%</td>
</tr>
<tr>
<td>Ob H&amp;P</td>
<td>5%</td>
</tr>
<tr>
<td>Ethic Curriculum Score</td>
<td></td>
</tr>
<tr>
<td>Participation in CAPE Activities &amp; Midpoint Session</td>
<td>Pass/Fail</td>
</tr>
<tr>
<td>Patient Learning Logs (Logger)</td>
<td>Pass/Fail</td>
</tr>
<tr>
<td>Direct Observation Forms (6)</td>
<td>Pass/Fail</td>
</tr>
</tbody>
</table>
submitted to the clerkship director and a final composite clinical grade will be assigned. The final number of evaluations may vary between students.

IV. 6 week AHEC sites (other than St. Joe’s) - The preceptor will complete a clinical evaluation with input from other individuals that worked with the student at the site. Students placed at these AHEC sites usually receive one evaluation; however, this may vary depending on the site and the schedule at the site.

2. Cognitive Assessment
   I. Shelf Exam: 20%
      i. The national mean is 76.
      ii. A shelf score of 60 is required to pass the clerkship.
      iii. A minimum score of 76 (2014-2015 UCH Mean) is required to be eligible for a High Pass.
      iv. A minimum score of 80 (2014-2015 UCH Mean) is required to be eligible for Honors.

      *Please note: In the event you fail the shelf exam, a grade of IP (In progress) will be given at the time the grade is due to student affairs. You will be required to retake the shelf exam and your grade will be revised upon passing the shelf exam.*

      *Important: When there are requests to delay block/clerkship examinations, a delay should be granted when it is consistent with the absence policy. In the event of an examination failure or when a delay is granted, students may take exams on the following Mondays: fall break, winter break, and Monday immediately after the last Phase III ICC. Saturday makeup exams are now available. Please contact the Women’s Care Coordinator for more information. Exams may also be taken when they are administered at Denver Health during the LIC. Fees may apply.*

   II. Direct Observation Forms
       You will be required to obtain one Direct Observation Form (DOF) each week, completed by an attending or resident physician, nurse practitioner or Certified Nurse Midwife. You will be required to bring your DOFs to your midpoint review as well as upload them to Canvas and submit the remaining DOFs each week for the remainder of the clerkship. Upon your final exam you must have obtained and uploaded at least five (5) completed Direct Observation Forms.

   III. Ob and Gyn H&Ps
       Two formal H&Ps with Evidence Based Medicine sections will be submitted and graded by an attending physician. The evaluation form is included in this syllabus. Please review the specific instructions regarding these assignments under the “H&P Instructions” tab of the syllabus. A 60 is the minimal score required to pass each assignment. Any assignments scoring below a 60 must be revised to a passing effort.
Both H&Ps must be completed satisfactorily to achieve a final passing clerkship grade. 10 points will be deducted for each week that the assignment is late.

IV. Ethics Curriculum
During the midpoint session, each student will participate in case-based small group discussions. Each student will need to prepare an outline of an ethical dilemma stemming from an experience that he/she was involved with during the Women’s Care clerkship. Specific instructions for the outline can be found under the “Ethics Curriculum” tab of the syllabus and on CANVAS. Please bring this outline to the midpoint ethics session and submit it to your ethics session preceptor. You will receive a score for your outline and participation in the small group discussion. A 6/10 is a passing score. Any assignment scoring below this must be revised to a passing effort. One point will be deducted for every week that the assignment is late. Assignments that do not outline a “right vs. a right” scenario will also need to be rewritten. Assignments that need to be revised or redone can receive a maximum score of 6/10.

V. CAPE Activities & Midpoint Session
Participation is required in these 2 activities to pass the clerkship. Only excused absences and absences due to illness will be permitted; these must be approved by the Block Director. Any missed sessions will need to be made up before a final grade will be released for Women’s Care.

Hazard Exposure/Needle stick
Medical Treatment: Employees and student interns that have needle-sticks or bodily fluid exposures should seek immediate medical attention in the Emergency Room of the hospital where the work related incident occurs.

Exceptions are:

- University of Colorado Hospital (UH) - Go to the Infectious Disease Clinic at Anschutz Outpatient Pavilion, 1637 Aurora Court, 7th floor, between 8:00 AM and 4:00 PM Monday -Friday, or the Emergency Room after hours.

- Denver Health Medical Center (DHMC) - Go to the Occupational Health and Safety Center (corner of 6th Avenue and Bannock, 4th Floor) between 8:00 AM - 3:30 PM Monday through Friday or the Emergency Room after hours.

- Employees/Student Interns working in small clinics or in laboratories off campus should go to the nearest emergency room or facility that can perform a blood draw. • Students, volunteers
or others not covered by workers’ compensation should contact their personal healthcare provider.

On the CUSOM website at: Needle-Stick & Bodily Fluid Exposures

Logger

In order to ensure that students are seeing all of the required conditions and adhering to duty hour restrictions during Phase III, the following requirements of students and clerkship directors are in place:

- **Student Logger Requirements**
  - Update their Logger at least once weekly, including duty hours for the week.
  - Only be required to log a required clinical condition once during the block in which it is required.
  - Log honestly, including truthfully reporting duty hours and patients seen.
  - Provide their logger to the clerkship director or their designee at the midpoint and end of a block, or at the end of the block for blocks less than 4 weeks in length.

- **Duty Hour Requirements**
  In addition to your clinical responsibilities, students are required to complete Phase III Foundations of Doctoring course requirements and occasional activities mandated by the Dean of Student Affairs. In addition:
  - Students will have no more than 80 hours a week of scheduled participation averaged over a course. This does not include time students should spend reading about their patients or doing patient write ups.
  - Students will have no more than 30 consecutive hours of scheduled participation during one period of time.
  - Students will have a minimum of 24 consecutive hours scheduled off in 7 days averaged over a course.

- **Clerkship Directors or their Designee will:**
  - Review student logger data at the midpoint and end of a block, or end of the block for blocks less than 4 weeks in length, to ensure students are on track to see all required clinical conditions.
  - Review aggregate data twice yearly to ensure that all required clinical conditions are seen by all students and to ensure that alternate methods are used minimally to achieve this.

- **Students not completing their requirements will face the following consequences:**
  - Dishonest Logging of Patient Encounters or Duty Hours will be deemed a violation of the Student Honor Code and be referred to the Student Honor Council for further discussion.
  - Students will not receive a grade until a completed logger has been turned in at the end of the block.

Please refer to the video presentation from ICC 7001 for instructions on how to successfully use the logger if you run into technical issues.
Student Expectations of Professionalism

Academic Honesty Statement
Students are expected to adhere to the Honor Code of the University of Colorado School of Medicine which states that students must not lie, cheat, steal, take unfair advantage of others, nor tolerate students who engage in these behaviors. Please check the website for information on the Medical Student Honor Code.
http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/AcademicLife/HonorCouncil/Pages/default.aspx

Students are also expected to:

- Contact the appropriate block faculty and student life for all voluntary and involuntary absences.
- Check email and Canvas regularly for communication about block activities and updates. Respond within 24 hours to all block emails requiring individual student response.
- Attend all block conferences and required events and arrive on time to these events.
- Complete all required coursework and evaluation.
- Use smart phones and electronic tables with discretion
- Wear professional dress.

Reporting issues of professionalism of others:
The Office of Professionalism exists to provide faculty, residents, fellows and students a resource on campus to obtain a fair and equitable treatment for all matters. Under appropriate circumstances, the office can serve as an advocate for fair and equitable treatment for faculty, residents, fellows, and students and can facilitate safe reporting of mistreatment or abuse.

The Office is available to help faculty, residents, fellows, and students with all issues and concerns and provides consultations, short-term coaching, counseling, referrals, alternative dispute resolution and facilitation. The Office can also assist faculty, students, and staff members in preparation for various meetings and conversations.

The services of the Office of Professionalism are provided free of charge.

Contact the office by emailing Barry H. Rumack, MD at barry.rumack@ucdenver.edu or Josette Harris at Josette.harris@ucdenver.edu. For faster response, (no confidential information please) call 303-724-7854. Offsite and onsite visits are by appointment only. Building 500, 8th floor, room 8000C.

Mistreatment
The University of Colorado School of Medicine has a responsibility to provide an environment conducive to effective learning and compassionate, high quality patient care by creating an atmosphere of mutual respect and collegiality among faculty, residents, students, and staff.

The School of Medicine is committed to creating a learning, research and clinical care environment that is supportive, that promotes learner well-being and that is free from ridicule, exploitation, intimidation, sexual or other forms of harassment, physical harm and threats of physical harm. To that end, the
University of Colorado School of Medicine will not tolerate the mistreatment of students, nor will it tolerate retaliation against any learner because he or she has reported, in good faith, a violation of the school’s professionalism standards. The School of Medicine shall also: 1) provide mechanisms and procedures by which learners may safely report mistreatment against them or others; 2) provide information to students about what will happen to their reports of mistreatment; and 3) use data from these reports to educate faculty, residents, professional staff and others about what constitutes mistreatment, with the goal of reinforcing a culture of respect.

The American Association of Medical Colleges states, “Mistreatment, either intentional or unintentional, occurs when behavior shows disrespect for the dignity of others and unreasonably interferes with the learning process.” Examples of mistreatment include: public belittlement or humiliation; verbal abuse (for example, speaking to or about a person in an intimidating or bullying manner); physical harm or the threat of physical harm; requests to perform personal services; being subject to offensive sexist remarks, or being subjected to unwanted sexual advances (verbal or physical); retaliation or threats of retaliation against students; discrimination or harassment based on race, religion, ethnicity, sex, age, or sexual orientation; and the use of grading or other forms of assessment in a punitive or discriminatory manner. For additional information about mistreatment, go to: [http://www.ucdenver.edu/academics/colleges/medicalschool/facultyAffairs/Professionalism/Pages/DefinitionsExamples.aspx](http://www.ucdenver.edu/academics/colleges/medicalschool/facultyAffairs/Professionalism/Pages/DefinitionsExamples.aspx)

**Procedures for Reporting Student Mistreatment**

If a student feels that he or she has been subject to mistreatment during the Women’s Care Clerkship, there are a variety of options for reporting. We recognize that students may differ in how they want to address this issue, and the SOM provide a wide array of reporting options. [http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/studentresources/Documents/StudentHandbook.pdf](http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/studentresources/Documents/StudentHandbook.pdf)

**Communication**

The preferred Women’s Care method of communication is email. The Clerkship Coordinator will be able to answer most of your rotation questions. Questions which the coordinator is unable to address will be immediately discussed with the Directors in a timely manner. All students should feel free to contact our Directors at any time.

The Women’s Care clerkship also uses Canvas. You will find all course materials there. If you are unable to locate materials, please email the Clerkship Coordinator.

**Absences**

An “excused absence” is an absence for which permission has been granted. Excused absences include requested absences that have been approved prior to the absence or absences that result from involuntary or emergent situations that are approved after the absence has occurred.

- Requested absences: An absence for an event or events such as family events, conferences, review courses, personal appointments. Every attempt must be made by the student to schedule these situations outside of required curricular elements.
• Involuntary situations: An absence for serious illness, family illness, jury duty and academic difficulties. The student must notify the Office of Student Life, the Course, Clerkship or Block director, or the appropriate Assistant Dean of any involuntary absence of greater than two days. The ultimate responsibility for notification lies with the student.

• Emergency Situations: A situation where permission could not be requested prior to the absence.

An “unexcused absence” is an absence for which permission has not been granted. An involuntary situation can be an unexpected or unforeseen event (e.g., sudden illness) that after the fact could be considered an “excused absence” with the approval from the appropriate curriculum director or Assistant Dean. All absences should be reported to the Block Directors, and/or appropriate Assistant Dean and Clerkship Coordinator.
Assignments

The ability to obtain and document a complete and thorough history, perform an appropriate physical exam and develop an assessment and plan is one of the most important components of learning during your Ob/Gyn rotation. We hope to provide you with valuable feedback through the evaluation of 2 H&P assignments.

H&Ps

**Students are required to complete two H&Ps.**

One OB H&P: The patient should be at least 22 weeks gestation.

One GYN H&P: This may include a patient with general Gyn issues (annual exam, menorrhagia, uterine fibroids, dysmenorrhea, etc.) as well as an issue related to infertility, Gyn/Oncology, adolescent gynecology, pelvic pain and first trimester pregnancy (ectopic pregnancy, threatened abortion, etc.)

These can be done in any order.

**Grading:** The H&Ps will each count for 5% of your overall course grade.

1. Your first H&P must be graded by the **Attending or Fellow** that you have presented the patient to. This patient encounter can take place in clinic, on the Inpatient floor, in the OR, or on Labor & Delivery. You can write this H&P in EPIC or in Microsoft Word. You will be required to have an Attending/Fellow review it and complete the H&P #1 Faculty Evaluation Form. You must turn in the evaluation form, but not the H&P itself, to Canvas by the assigned date. There is no Evidence Based Medicine Section required for the 1st H&P.

2. Your second H&P will be evaluated by a pre-determined faculty member and must include an Evidence Based Medicine Section. The assigned evaluator is site-specific (see chart below).

<table>
<thead>
<tr>
<th>Assigned Site</th>
<th>Preceptor[s] Grading H&amp;P #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital</td>
<td>Drs. Tocce/Limmer</td>
</tr>
<tr>
<td>Denver Health</td>
<td>Preceptors assigned by Dr. Hyer</td>
</tr>
<tr>
<td>Exempla St. Joseph</td>
<td>Preceptors assigned by Dr. Wollschaeger</td>
</tr>
<tr>
<td>AHEC sites (other)</td>
<td>Drs. Tocce/Limmer</td>
</tr>
</tbody>
</table>

Please refer to the Ob/Gyn H&P Faculty Evaluation Forms for the point distribution of the various components of the H&P. A **minimum score of 60** is required to pass each H&P assignment. If a score of less than 60 is earned, you will be required to revise the H&P until it is satisfactory. A score of 60 will
then be awarded. Students are required to turn in two (2) satisfactory H&Ps in order to pass the clerkship.

**Late Policy:** 10 points will be deducted for each week (7 days after due date) that the assignment is late.

**Due dates:** Your H&P #1 Faculty Evaluation Form should be completed and turned into Canvas by the Friday of the 3rd week of the clerkship. The 2nd H&P should be turned in to your site-specific preceptor by Wednesday of the 6th week of the clerkship. If the evaluators cannot return the completed H&P #2 Faculty Evaluation Form to you by the last day of the clerkship he/she will get it to the Women’s Care Clerkship Coordinator when completed.

**Components of the H&P Assignment: Please Read Carefully**

**Chief Complaint:** In the patient’s own words.

**History of present illness and past history:** Complete and concise description of the patient’s identifying data (age, G/P’s), history of present illness, OB history, Gyn History (including sexual history), medical history, surgical history, social/family history, genetic history for Ob patients, medications, allergies, and a review of systems.

**Physical exam:** Should include a detailed exam highlighting pertinent positives. Gyn patients must have a complete pelvic exam documented.

**Labs and diagnostic tests:** must be included. This includes a review of all prenatal labs and imaging for OB patients.

**An assessment** of the patient’s problem is to be clearly stated, including a differential diagnosis. You should explain in detail the justification for your primary diagnosis.

A separate **Plan** section should follow.

**Evidence Based Medicine Section for H&P #2**

After the assessment and plan, the student **MUST** include a section investigating a **clinical question** that is relevant to the patient presented in the H&P. The clinical questions should be clearly stated. An **evidence-based discussion** addressing the clinical question must follow. The student must critically review a minimum of **two references** from peer-reviewed journals. The sources must be referenced in the text and cited at the end of the H&P. PDF copies of the two sources must be uploaded to Canvas with the H&P.

*The goal of the Evidence Medicine Section is to pose a clinical question and answer it by critically evaluating the current literature. You only need two (2) sources. Please review each source by following steps 3a to 9 outlined in the “Evidence Based Medicine Notebook” included in the course syllabus.*

If you have any questions regarding the H&P assignment, please feel free to contact:

- Dr. Kristina Tocce ([kristina.tocce@ucdenver.edu](mailto:kristina.tocce@ucdenver.edu))
- Dr. Jane Limmer ([jane.limmer@ucdenver.edu](mailto:jane.limmer@ucdenver.edu))
Example of H&P #1

H&P #1 FACULTY EVALUATION FORM

<table>
<thead>
<tr>
<th>Identifying Data</th>
<th>Circle the Appropriate Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint (1 point off if not included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of Present Illness (10%)</td>
<td>1   2   3   4   5</td>
<td></td>
</tr>
<tr>
<td>Past History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN History (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/Surgical History (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications/Allergies (1 point off if not included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social/Family &amp; Genetic History/Review of Systems (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam (10%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory/Diagnostic Tests (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment &amp; Plan (30%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Score</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Add the number of points in [ ]s

Student Signature ___________________________ Date ____________

Evaluator Signature ___________________________ Date ____________

Definition of the H&P Rating Scale
1=Unsatisfactory: Fails to meet expectations (inaccurate data or major omissions),
2=Marginal: Difficulty meeting expectations (needs organization, lacks supporting detail),
3=Meets Expectations: Majority of the time meets expectations (accurate, identifies on-going problems)
4=Commendable: Frequently exceeds expectations (documents key information, comprehensive),
5=Excellent: Consistently exceeds expectations (Concise, reflects thorough understanding of disease process).

Figure 4 – H&P #1 Grading Rubric
Example of H&P #2

H&P #2 FACULTY EVALUATION FORM

<table>
<thead>
<tr>
<th>Identifying Data</th>
<th>Circle the Appropriate Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint (1 point off if not included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of Present Illness (10%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Past History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN History (5%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Medical/Surgical History (5%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Medications/Allergies (1 point off if not included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social/Family &amp; Genetic History/Review of Systems (5%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Physical Exam (10%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Laboratory/Diagnostic Tests (5%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Assessment &amp; Plan (30%)</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>Evidence-based decision making (30%) A clinical question MUST be investigated, critically reviewing 2 sources from peer reviewed journals. The sources must be cited in the text.</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
</tbody>
</table>

Overall Score
Add the number of points in [ ]s
/100

Student Signature ___________________________ Date ______________________

Definition of the H&P Rating Scale
1-Unsatisfactory: Fails to meet expectations (inaccurate data or major omissions).
2-Marginal: Difficulty meeting expectations (needs organization, lacks supporting detail).
3-Meets Expectations: Majority of the time meets expectations (accurate, identifies on-going problems)
4-Commendable: Frequently exceeds expectations (documents key information, comprehensive)
5-Excellent: Consistently exceeds expectations (Concise, reflects thorough understanding of disease process.)

Figure 5 – H&P #2 Grading Rubric
Evidence Based Notebook

We use the following 10 step guideline to help presenters increase efficiency in assessing a study’s validity and results and to increase confidence in limiting a presentation to the core essentials. Faculty members model the process and residents learn through reflective practice.

1. DESCRIBE THE CASE OR PROBLEM THAT ATTRACTIONED YOU TO THIS PAPER
Start your article presentation with a brief case presentation, or briefly explain how the article is relevant to a patient or problem you are considering. This helps listeners more fully engage with your presentation and makes it more of a story.

For example, “An otherwise healthy 68 year old man came to see me after he suffered a transient ischemic attack (TIA) and I wondered if he should be on statin even though his risk of cardiac disease was low.”

2. EXPLAIN WHY YOU CAME ACROSS THIS ARTICLE
Very briefly describe the search strategy you used to track down this particular article.

“I found this paper by searching Medline using the terms cerebrovascular accident, Hydroxyethyl Esters, or flaxseed, and the Clinical Query for therapy (maximizing specificity) which identified 3 articles.”

3A. DESCRIBE THE STUDY …
In a case presentation we start with some standard descriptors of the patient followed by the chief complaint or statement of the clinical problem.

- This is a 55 year old male smoker from Bangladesh who presented with 2 hours of burning chest pain and is ADMITTED AS A RULE OUT.

When presenting an article, we can think of some standard descriptors. For example:

- What type of question was asked—for example, diagnostic, therapeutic, prognostic, aetiologic, or economic?
- What type of study (method) was used—for example, randomised controlled trial, retrospective cohort, case control, meta-analysis, cross-sectional, descriptive, decision analytic, or cost effectiveness?
- Where was the study done (if relevant)—for example, multicentre, veteran affairs centre, population based, Antartica, New York City, academic medical centre, or subspecialty clinic?
- Any other outstanding features—for example, well known author or first study of its kind.

So we might start by saying, “This was a multinational, randomised, controlled trial of therapy, and the first study designed to answer the question…”

3B. … AND THE RESEARCH QUESTION:
The chief complaint of an article is the research question or hypothesis to be tested. A well built research question has 4 basic components (PICO—see section 5 below): 1.

- Population—who was studied?
- Intervention or exposure—what therapy, risk factor, tests, etc.?
- Comparison or control—what alternative to intervention or exposure?
- Outcome—clinical, functional, economic, etc.?

“Does high dose atorvastatin for 5 years reduce the incidence of stroke among patients with recent stroke or TIA and no known coronary heart disease?”

4. STATE THE IMPORTANCE/RELEVANCE/CONTEXT OF THIS QUESTION
Following this 1 line description of the study and statement of the question, concisely state the importance of this question. This information can usually be found in the author’s introduction where they put their study in the context of other literature. This context can be described in 1–3 sentences.

“Therapy with statins reduces the risk of stroke among patients with coronary heart disease and those at increased risk of cardiovascular (CV) disease. No studies thus far, however, show that statin treatment decreases the risk of recurrent stroke among otherwise healthy patients with a history of stroke or TIA.”

5. DESCRIBE THE METHODS BY GIVING MORE DETAIL ON THE QUESTION COMPONENTS
Following this brief background, 1 way of briefly describing the methods is to give a bit more detail on the Patients, Intervention, Comparison, and Outcomes (PICO) related to the question:

P—The study included 4371 patients, 85% men with an average age of 63 years and mean LDL cholesterol of 133 mg/dl. All patients had a recent stroke (69%) or TIA (31%). These with atrial fibrillation, embolism from other cardiac sources, and subarachnoid haemorrhage were excluded.

I—“Atorvastatin 80 mg daily or identical placebo.”

C—“After a median of 4.9 years of follow up, the primary outcome was incidence of fatal or non-fatal stroke, and all cause death. Secondary end points include a composite end point of stroke or TIA, major coronary event, major CV event, acute coronary event, any coronary event, revascularisation, and any CV event.”

6. STATE YOUR ANSWERS TO THE CRITICAL APPRAISAL QUESTIONS ON VALIDITY
Next, briefly answer the appropriate critical appraisal questions on validity using the JAMA users’ guide to the medical literature and elaborate with some explanation, questions, or concerns if needed. Although it is a bit formulaic to go through each question, it is a good habit to develop, and use of the GATE frame makes it easier. Remember, if you suspect bias, consider not only its possible presence, but also its direction, magnitude, and impact on the study’s conclusions; not all flaws are fatal. Be cautious to not get lost in the statistics/analysis section. Remember, “Statistics are a tool while study methods rule!”

For a study of the efficacy of therapy, these questions apply:

- Did the experimental and control groups start out with a similar prognosis?
  - Were patients randomized? YES
  - Was randomisation concealed? YES.
  - Were patients analysed in the groups to which they were randomised? YES—intention to treat analysis.
  - Were groups similar re known prognostic factors? YES—see table 1.

- Did the experimental and control groups retain a similar prognosis after the study started?
  - Were patients, clinicians, and outcome assessors aware of group allocation? NO—all were blinded to random allocation.
  - Was follow up complete? YES and similar in each group.
7. SUMMARISE THE PRIMARY RESULTS

At last, the results. Some like to present the bottom line result up front in their presentation titles, similar to the format in ACP Journal Club and Evidence-Based Medicine. Alternatively, you can report the results after the descriptors and research question. We find that when browsing a journal our eyes go from the title (if it sounds interesting) to the conclusions in the abstract. The inner question is, “If this is true (valid) would it be interesting or important to me?” Or, if you prefer to keep people in suspense, save the bottom line answer for the results:

“Atorvastatin reduced the rate of fatal and non-fatal stroke from 13.1% on placebo to 11.2%, a statistically significant 16% relative reduction in risk over 5 years. There was no difference in overall mortality.”

Limit your summary of the results to the primary question and only present secondary results if they are relevant. It is helpful to bring your listeners’ eyes to a particular row on a table or a bar on a graph to illustrate your point. You will not insult anyone by taking them by the hand and leading them through the paper. And feel free to play with the numbers.

“As you can see under secondary outcomes in table 2, major coronary events were reduced by 35% from 5.1% to 3.4%. The primary result suggests an absolute reduction of 2% in fatal and non-fatal stroke so that we would need to treat 50 patients with 80 mg of atorvastatin for 5 years to prevent 1 event, a modest impact.”

8. DESCRIBE WHY YOU THINK THE RESULTS CAN OR CANNOT BE APPLIED TO YOUR PATIENTS’ SITUATION

Finish with your assessment of the study’s external validity—can you apply these results to your patients? Or better, are the patients or setting so different from your own so as to make these findings useless to you? How much might you have to adjust the study findings due to differences between the study’s patients or setting and your own?

“Would the efficacy be larger or smaller in older patients? In addition, the authors excluded patients at higher risk of haemorrhagic stroke and, in fact, atorvastatin may have increased the risk of haemorrhagic stroke in this study.”

9. CONCLUDE WITH YOUR OWN DECISION ABOUT THE UTILITY OF THE STUDY IN YOUR PRACTICE—RESOLVE THE CASE OR QUESTION WITH WHICH YOU BEGAN

If you started your presentation with a case, be sure to leave time to come back to the case at the end and try to apply the study’s findings to your patient or problem. Give the listeners a sense of closure:

“Atorvastatin may modestly reduce the risk of recurrent cerebrovascular events in patients with recent ischaemic cerebrovascular accident or TIA. I will offer this medication to such patients but will still focus more on those at higher risk of cardiac events.”

10. FINALLY, PREPARE A 1 PAGE SUMMARY OF THIS OUTLINE ABOVE AS A HANDOUT

The summary will serve as your notes for the presentation and will help guide the group’s attention. It also provides a storable record of the article, similar to Critically Appraised Topics or CATs.

Believe it or not, you can do this in 10 minutes easy, 4 minutes with very tight editing, and 2–3 minutes hitting just the highlights.

These guidelines have dramatically improved the enthusiasm for, quality of, and attendance at our journal clubs which have now been running continuously for more than 11 years. Residents are expected to present the paper in 16 minutes, provide a concise 1 page summary using the outline above, and lead a 20 minute discussion on the clinical and methodological issues. As a result, residents have improved both their presentation and critical appraisal skills. In our experience, this approach, familiar to residents because they are parallel to patient case presentations, is easily learned and portable. Developed for a smaller group of primary care residents, the model is now used for all medical residents and fellows. Slides from these workshops are available at www.evidence-basedmedicine.com. We believe this model has contributed to the long running success of our journal club and made it a lively, relevant, and fun way to simultaneously explore methods and medicine.

MARK D SCHWARTZ, MD
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New York University School of Medicine
New York, New York, USA


Figure 6 – Evidence Based Notebook
Medical Student Ethics Curriculum
Developed by Drs. Kathy Witzeman, Dept. of OB/GYN, Denver Health; Jean Abbott, Center for Bioethics and Humanities; Jackie Glover, Center for Bioethics and Humanities; and Kristina Tocce, Dept. of OB/GYN, University of Colorado.

Goals and Objectives:
1) Identify an ethical issue in the practice of Obstetrics and Gynecology;
2) Apply an 8 step process of ethical decision making to an identified ethical issue;
3) Describe the ethical and legal rights of the fetus in relation to the mother in Obstetric Care decisions as described in the sample oral case presentation and as can arise in some students’ presentations;
4) Work in a team to review and discuss ethical issues in Obstetrics and Gynecology; and
5) Create and maintain a safe environment for discussion of difficult values differences among students and practitioners.

Assignment
Each student must:
1) Identify an ethical issue that arose during his/her Women’s Care clerkship experience. This must be a “right” vs. “right” issue where there are ethical reasons to choose among possible courses of action and not a “right” vs. “wrong” issue. “Right” vs. “Wrong” presentations must be rewritten.
2) Prepare a case presentation outline that will be turned in and graded. This is not a paper requiring full sentences – but an outline with bullet points of the key information and points of analysis. Maximum of 4 pages. A case presentation outline rubric, a sample, and the assessment rubric are provided.
3) Work with your assigned small group to plan the discussion of these cases. You can identify one or two cases for more in-depth discussion of key issues or you can present and discuss all of the cases with less discussion of each.

Assessment
The preceptor of each small group will assign a grade (possible 10 points) based on the student’s individual outline and student participation in discussion. Late presentations will have 1 point deducted for each day the presentation outline is late. Each preceptor will use the assessment rubric provided. This ethics grade will constitute 5% of the final clerkship grade.

Case Presentation Outline Rubric
- Describe a case scenario that raises ethical questions.
- Identify the ethical questions (the “shoulds”) pertinent to the situation.
- Identify your first or “gut” reaction to the situation.
- Identify the medical, psychosocial, legal or other facts of the situation. Use References to medical literature, ethical guidelines, and laws as appropriate.
- Identify the stakeholders and the values of each. May include patient, family, institution, healthcare professionals, you as the student, the community (sometimes via the law.) Identify the areas of overlap among values and also the areas of tension among values.
- Identify options for the resolution of the ethical issue. Describe the pros and cons of each.
Choose what you would or should do for the resolution of this issue.
Justify your choice. Refer back to the values at stake and the pros and cons of the choices. Anticipate objections to your choice and respond to the objections. Refer to ethical guidelines as appropriate.
Suggest how this ethical issue could have been avoided, if possible.

**Resources:**
ACOG Committee Opinion #390, December 2007, Reaffirmed 2010. Ethical Decision Making in Obstetrics and Gynecology
ACOG Committee Opinion #214, April 1999, content revised January 2004. Patient Choice in the Maternal-Fetal Relationship
ACOG Committee Opinion #213, Nov 2013: Elective Surgery and patient Choice
ACOG Committee on Ethics. ACOG Committee Opinion # 385, 2007. The limits of conscientious refusal in reproductive medicine.
ACOG Committee Opinion #622, Feb 2015. Professional Use of Digital and Social Media
ACOG Committee Opinion #627, March 2015. Healthcare for Unauthorized Immigrants
ACOG Committee Opinion #613, November 2014. Increasing Access to Abortion
ACOG Committee Opinion # 600, June 2014. Ethical issues in the Care of the Obese Woman
ACOG Committee Opinion # 594, April 2014. Immersion in Water During Labor and Delivery

[Link to the AMA Code of Ethics](http://education.asahq.org/sites/education.asahq.org/files/users/1392/2012-ethics-syllabus.pdf)
Sample Case Presentation Outline (note – this sample argues one way – a case can be made for the opposite choice) – 4 page maximum

Case Scenario:

- GB – 34 year old Caucasian woman G1P0 at 41 4/7 weeks by LMP and 18 week ultrasound
- Presented to L&D at 9 pm with leaking fluid since midnight the night before with mild contractions and a “spot of bleeding” when she wipes after using the toilet
- Felt fetal movement, but less since her “water bag” broke
- Uncomplicated prenatal course with the exception of culturing positive for GBS (Group B Strep) at 37 weeks.
- Hands the nurse a birthing plan on admission
- Dr. C is covering and has not met GB. Her partner is their regular OB and he is out of town.
- When Dr. C meets GB and her husband, they hand Dr. C a copy of the birthing plan
- Birthing plan states very clearly – as little medical intervention as possible and under no circumstances do they want a C-section
- Dr. C says that she understands what they want but would like to examine GB and monitor the baby and her contractions before making any decisions
- Initially the fetal heart rate monitor/tocometer indicates a fetal heart rate (FHR) in the 150s, moderate variability and is overall reassuring. Contractions are 5-6 minutes apart. Rupture of membranes confirmed. SVE is 2-3cm/75%/-2.
- Dr. C agrees to expectantly manage GB’s labor. Dr. C would like to check routine admission labs (T&S, CBC) and start an IV to administer penicillin to treat for the GBS. GB reluctantly agrees saying that she knows it’s in her baby’s best interest to reduce the risk of neonatal infection.
- About 6 hours later, FHR is now in the 160s with decreasing variability and several variable decelerations. Contractions are every 2-3 minutes and the SVE is 6 cm/80%/-1.
- Notably – there is now thick meconium stained fluid. Dr. C recommends an intrauterine pressure catheter to allow for amnioinfusion. GB refuses even after thorough counseling.
- Dr. C, although against her usual judgment acquiesces and counsels GB and her husband that she is concerned about their baby but will continue to monitor closely in hopes that she will progress quickly through labor.
- After another hour the FHR pattern worsens and is now 160s to 170s with minimal variability, and deeper variable decelerations. GB now has a temperature of 38.4C. Her SVE is unchanged.
- Dr. C again counsels the couple about her concerns for their baby’s well-being and recommends placing internal monitors and starting amnioinfusion as an intermediary measure.
- Dr. C expresses concerns that they may need to move to C-section soon if the FHR tracing does not improve.
- Despite counseling, GB and her husband continue to refuse intervention – both the amnioinfusion and the C-section.
Ethical Question(s):
- Should Dr. C honor their refusal of interventions? Should Dr. C seek a court order for the C-section?

Gut Reaction(s):
- This couple is putting their baby’s well-being at risk by refusing interventions. I realize that they want a “natural childbirth” but isn’t their baby’s health more important than this natural experience? But to involve the courts seems to be so extreme and it seems to violate my relationship with this couple. But it is VERY difficult to stand by and witness the harms that could follow to this baby – who is also my patient.

Facts:
- Birth plan indicates that the couple wants a “natural birth” with little medical intervention and absolutely no C-section
- Dr. C has never met this patient and husband before and is covering for her partner who is their regular OB and is out of town
- The baby’s condition is worsening (FHR pattern in the 170s with minimal variability, and deeper variable decelerations. GB has a temp of 38.4
- GB has accepted IV penicillin to treat GBS
- Dr. C counsels the couple about her concerns for the baby’s well-being and wants to place an internal monitor to start amnioinfusion as an intermediary measure but may need to have a C-section.
- GB and her husband continue to refuse interventions after thorough counseling
- GB appears to have decisional capacity – but that would need to be assessed and documented.
- “A woman’s refusal of a medically indicated cesarean delivery may often lead to greater complications for the fetus, the woman, or both. One population-based study that compared 1898 women who refused and 164,064 women who did not refuse showed that the women who refused experienced significantly higher rates of adverse perinatal outcomes, indicated by lower Apgar scores and higher rates of perinatal mortality and intrapartum death.” Deshpande NA, Oxford CM. (2012) Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery. *Reviews in Obstetrics and Gynecology*. Vol. 5 No. 3/4 pages e144-e150
- According to the ACOG Committee Opinion, Maternal Decision Making, Ethics and the Law – it is recommended that “pregnant women’s autonomous decisions should be respected. Concerns about the impact of maternal decisions on fetal well-being should be discussed in the context of medical evidence and understood within the context of each woman’s broad social network, cultural beliefs, and values. In the absence of extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine, judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman’s autonomy.” Page 9.
Stakeholders Values:

- **Patient** – values her autonomy and her claim to make decisions that affect her, her body and her family. She also values the well-being of her baby (beneficence) and wants to reduce the risk of neonatal infection by accepting IV penicillin (non-maleficence). She also values the involvement of her husband (family relationships).

- **Family** – GB's husband values respect for his wife's autonomy and her ability to make her own decisions.

- **Dr. C** – values respecting the autonomy of GB but also concern for her and the baby's well-being (beneficence and non-maleficence). She is concerned to maintain a trusting and therapeutic relationship. She is also concerned to maintain a trusting relationship with her partner who is out of town. Dr. C also values justice – concern for the rights of the baby when they are in conflict with the rights of GB. And perhaps justice in the form of getting judicial review.

- **Institution** – the hospital values respecting patient's autonomy but also values good outcomes for mothers and babies. Since both are patients – they value maximizing good outcomes for both. The hospital values justice in the form of following fair policies and procedures.

- **Society** – some states value the rights of the fetus above the rights of the pregnant woman (Review in Obstetrics and Gynecology – Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery) and other states values the rights of the pregnant woman.

- There is agreement that respect for patient autonomy and beneficence and non-maleficence are important values. There is a tension between which should take higher priority when in conflict and how to understand beneficence and non-maleficence (the benefits and harms associated with a court ordered c-section vs. the benefits and harms associated with not doing it.

Options:

- **Continue to counsel but ultimately respect GBs refusal of interventions.** Pro’s – honors GBs autonomy and maintains a trusting and therapeutic relationship. It also supports GBs interpretation of what is beneficial and harmful in her obstetric care. Con’s – high risk of harm to the baby according to Dr. C’s professional judgement.

- **Continue to counsel but work with legal office to seek a court order for the interventions.** Make sure that GB and her husband are aware of what you are doing. Pro’s – respects professional judgment about reducing the high risk of serious harm to the baby and respects due process. GB and her husband can make their case to the judge. Con’s – does not respect GBs autonomy and damages the trust and therapeutic relationship.

Choice:

- **Continue to counsel but ultimately respect GBs refusal.**
Justification:

- Respect for autonomy should be prioritized over fetal well-being. This is supported by guidelines of the American Academy of Pediatrics and ACOG that state that a court order should be the ultimate last resort and must be justifiable and only considered in exceptional circumstances. (Reviews in Obstetrics and Gynecology) This is not an exceptional circumstance. If counseling is not effective – including bringing in a neonatologist to talk with the family about possible outcomes – then GBs wishes should be respected.
- The pros of respecting patient autonomy and maintaining a trusting and therapeutic relationship outweigh the cons of maternal and fetal harms.
- Possible counterarguments focus on the rights and well-being of the fetus and professional integrity in looking out for the well-being of both patient (beneficence and non-maleficence.)
- A response would focus on respect for the pregnant woman who has voiced concern for the well-being of her baby. She does not wish to harm her baby – but has a different view of what would be harmful. Dr. C should try to build on the shared value of baby well-being in the counseling and provide the most current medical information. But ultimately the choice is GBs because it is her body and her family.

Prevention:

- When Dr. C’s partner worked with GB and her husband in developing the birth plan, the issue of refusal of interventions including C-sections should have been discussed. Dr. C and her partner should have a clear understanding of what they are willing to honor in their practice and what they aren’t. That should be clear when GB still had the opportunity to switch practices. When the partner went out of town – the birth plan for someone 41 weeks pregnant should have been reviewed with Dr. C.
- Clear hospital policies and procedures developed with the hospital ethics committee.
Case Presentation Outline Assessment Rubric

Student Name: _________________________________  
Preceptor Name: _________________________________

1) **Description of the Case / Points ______**  
   - □ 0 - Missing Multiple pieces of key information  
   - □ 0.25 – Missing one key piece of information  
   - □ 0.5 – Complete information

2) **Ethical Question(s) / Points ______**  
   - □ 0 - No ethical question(s) identified  
   - □ 0.25 – Key ethical questions missing  
   - □ 0.5 – Complete identification of ethical question(s)

3) **Facts / Points ______**  
   - □ 0 – Missing key facts / no references  
   - □ 0.5 – Key facts present but no references  
   - □ 1 – Thorough description of facts including references to medical literature, ethical guidelines or laws

4) **Stakeholder and Values / Points ______**  
   - □ 0 – No identification of key stakeholders and their values  
   - □ 1 – Missing either Key stakeholders or values (have one but not both)  
   - □ 2 – Complete discussion of stakeholders and values

5) **Options / Points ______**  
   - □ 0 – Missing key options and no discussion of pros and cons  
   - □ 1 – Missing either options or discussion of pros and cons (have one but not both)  
   - □ 2 – Thorough discussion of options and thorough discussion of pros and cons

6) **Justification / Points ______**  
   - □ 0 – Missing robust justification and missing possible counterarguments and response to them  
   - □ 0.5 – Missing either Robust justification or possible counterarguments and response to them (have one but not both)  
   - □ 1 – Thorough justification including possible counterarguments and response to them

7) **Prevention / Points ______**  
   - □ 0 – No discussion of possible prevention strategies or discussion that prevention is not possible  
   - □ 0.5 – Implausible prevention strategies discussed  
   - □ 1 – Thorough discussion of possible prevention strategies or thorough discussion that prevention is not possible
8) **Small Group Discussion / Points ____**
   - □ 0 – not present or no participation in discussion
   - □ 1 – Participation minimal and superficial points that did not advance the discussion
   - □ 2 – Active participation with insightful comments that advanced the discussion

Total Points_______ /10
Summary Comments:
________________________________________________________________________
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